

Situations:

A MODEL FOR THE ANALYSIS OF
MENTAL HOSPITAL PRACTICES.

A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHOLOGY,
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by

S. C. Papenfus, B.A. (Hons), B.A., B.Soc.Sc.

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"And after all, what is madness and how shall
we distinguish it from reason, unless
we place ourselves outside both
the one and the other
which is for us
impossible?"

Miguel de Unamuno

DEDICATION

To Willem van Ryswyck,
Philosopher and Friend,
for inspiration
over
coffee.

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PREFACE

This thesis is a resubmission based on the following recommendations:

- (1) That the research plan be clearly stated along with research reasons for which the observations were made.
- (2) That the appropriateness of the term 'model' to the theoretical work be discussed and a clear outline of the model be provided.
- (3) That the appropriateness of the model to all the material in the re-creation of the two days of hospital life be discussed.
- (4) That the derivation of the recommendations for Hospital A from the model be shown.
- (5) That the possible weakness of the research methods and the model be discussed.



The thesis as a whole aims to demonstrate that the socialization model, presented in Chapter VIII, is an appropriate model for use in analysing mental hospital practices and that the classificatory schema based on it is appropriate for describing the processes at work in these practices. The classificatory schema itself takes into account (a) culturally embedded criteria for assessing patient behaviour and patterns of construing, (b) culturally embedded means of 'shaping' patient behaviour and patterns of construing, (c) culturally embedded forms of ambiguity latently presented in the appraising and shaping of patient behaviour and patterns of construing and (d) the potential ways in which this ambiguity can interfere with the process of patient resocialisation itself.

The model serves to focus attention on two existential problems which members of staff face in committing themselves to their institutional roles: that of disclosing therapeutic rationale to patients and that of embodying this rationale in concrete commitments to patients.

The first of these problems is dealt with on epistemological grounds, the second on moral grounds. A staff member who misrepresents the institutional bases of his role conduct to a patient prevents him from effectively construing the structure and function of institutional practices. A member of staff who misrepresents conduct consequences to a patient prevents the growth of a sense of institutional accountability necessary for the development of mutually responsive role commitments.

The argument is put forward in this thesis that certain kinds of integrity 'ought' to be realized in mental hospital practices: epistemological integrity in explicating therapeutic rationale and authenticity in embodying institutionally ordered roles. In practice, the former may be incorporated in the second. They are separated analytically in this thesis for the sake of theoretical clarity. The argument presented is based on a series of analyses of current mental hospital practices.

The plan of research:

Two ways of going about the research were considered:

- (1) Developing a theoretical model from observations made.
- (2) Testing hypotheses derived from a preformulated model.

The participant observation method of research, which goes a long way to combining these two research strategies, was finally adopted. It facilitates the formulation of a theoretical model without posing too great an inductive burden on theoretical exposition at the expense of hypothetico-deductive rigour, while, at the same time, avoiding the use of tight experimental control procedures which would interfere with ongoing (therapeutic) functions. This method allows for the ongoing formulation of research hypotheses to be tested out by observation of what actually happens 'in the field'. No extrapolation to real life is necessary.

Explanations are sought in terms of the (hospital's) social structure itself, seen together with the events it purports to explain. Finally individual findings are incorporated into a model of the organization under scrutiny. This final stage of analysis involves problems of presentation and proof.

The plan of research explicated below is covered in accordance with the chapter sequence of the thesis. Although this was not the exact sequence followed in carrying out the research, the fact that each chapter is (a) largely self-contained, and (b) follows a logical sequence in the thesis makes this form of presentation preferable.

In Chapter I, some recorded observations are put forward in support of the hypothesis that the medical model of mental illness is used, in some mental hospitals at least, as an ideological prop to tie together diverse practices while obscuring moral, social and psychological considerations with respect to patients' problems. What is happening is that patients are being construed as suffering from certain 'medical' conditions over which they have little or no control. Hospital staff - the alleged experts in cure and care of mental patients - are professionally elected and sanctioned to cope with patient problems in terms of this medical model. Observations were made in order to discern the manner in which certain aspects of patient behaviour are construed, the manner in which staff members justify their professional conduct to patients and the manner in which patients, in turn, judge and construe staff conduct. Ideological considerations contained in propositions about mental disorder as 'illness' are looked at in terms of their functional significance in shaping patient conduct. Situations recorded in Chapter I point to some of the mutually impermeable constructions placed upon certain events by staff and patient members of the hospital community.

In Chapter II, the hierarchical structuring of staff-patient encounters is discussed. The character and functional significance of the one-way-communication cultures of the hospitals studied is demonstrated and analysed. What is happening is that information is not filtering uniformly through the hospital culture. Both patients and staff are controlled by bureaucratic power structures which prevent them from moving, on their respective levels, from the object to the subject side of knowledge and control. Observations were made in order to discern the nature of staff - patient power relations and the way in which staff and patients made sense of their role positions in the light of these relations.

In Chapter III, a proposition put forward in Chapter II is explored theoretically, namely, that only by introducing subjective-aim-in-view into consideration of mental hospital practices can their manifest and latent functions be adequately accounted for. People act in certain definite ways for certain definite reasons. They order their activities to attain certain goals. Acting in common with other people their conduct can be described in terms of role relations and institutional practices. An examination of objectives aimed at in the process of role validations and institutional legitimations provides answers to the questions "what are these people doing here? and Why are they doing it?"

In Chapter IV, the role model discussed in Chapter III is used to analyse what is happening in Witch-doctor/client, African Zionist priest/religious practitioner and therapist/client encounters in their various institutional settings. Similarities and differences between these encounters and settings are discussed. The question is raised as to how people know what they know and how their knowledge is objectified in institutionally ordered encounters. What is happening is that cues are being provided

for guiding and stabilizing conduct considered to be appropriate in various settings with various sets of role partners. Such cues are underlined by various basic assumptions about what is being done and why it is being done. Such knowledge may or may not be held in common by all the role partners involved. The knowledge which the participants have of their situations differs in essence from that which an outside researcher would acquire in the process of his research. The knowledge which a participant observer strives after is knowledge in a double sense: knowledge of an objectivated social reality and knowledge of what is known in that reality. The knowledge which the above-mentioned participants in various social encounters have of their situations is explored in order to discern its effects in shaping conduct, the limitations set on information exchange and the manner and extent to which the various role partners hold one another accountable for practical results.

What is happening in Hospital A is that black African patients and staff there are constrained to use only limited aspects of their actual and potential knowledge in order to construe the nature of situations within a framework permeable to the constructions of Western psychiatry. Similar difficulties remain, however (albeit to a lesser extent) in the treatment of white patients in Southern Africa.

Observations were made in order to discern the type of information available to witchdoctor clients, religious practitioners of the African Zionist sect, and patients in mental hospitals in various settings. Observations were made, furthermore, to discern the degree of mutual accountability variously situated role partners accorded one another in view of the power invested in them in their institutionally ordered role positions.

In Chapter V the context of control of mental hospital cultures in general is discussed. The function of various public constructs, such as publicly avowed justifications for certain acts, is scrutinised. What is happening is that, instead of goals being specified and the means to attain them made explicit, therapeutic programmes in mental hospitals often tend to be obscured or lost in the bureaucratic running of things. The flow of information is constricted. Patients may be scape-goated by staff in order to avoid sanctions due them by virtue of their professional shortcomings. The therapeutic system may be laid open to abuse through the development of private exchange systems between staff and patients. Professional jargon may place language barriers between staff and patients. A sense of mutual accountability may be numbed by some or all of these factors.

Observations were made in order to discern and to demonstrate some of the forms which the above-mentioned obscurations could embody in particular therapeutic situations. Three basic therapeutic questions are suggested to analyse the therapeutic effectiveness of staff-patient therapeutic encounters. What conduct is demanded? What motives are avowed to justify conduct demands? What incentives are used to reinforce conduct demanded?

In Chapter VI the question of construct sharing between staff and patients is raised most radically. Therapeutic agents, whose presumed aim it is to help patients to transcend the limitations of their construct and conduct patterns, need to understand these from the patients' points of view. Conversely, patients whose presumed need is to learn to cope more effectively with the demands of their life situations (including demands that they cope with these demands in a socially acceptable manner) need to know both what they know and what they stand in need of concretely realizing. In other

words, they have to commit themselves to understanding the limitations of their personal construct systems in order to transcend these limitations. Such insight, it is argued, can best be acquired through coming to grips, in concrete situations, with the implications contained in one's construction of these situations. This problem is central to the joint therapist-patient enterprise. It is a problem of both the therapist and the patient. It is the problem of participant observation itself.

In Chapter VII, the problem of the resolution of role conflicts in marginally situated patients is raised. It is often necessary for patient role positions not to be clearly compartmentalized in certain therapeutically ordered situations, where status transitions need to be effected. When certain patients can be pointed to as 'models of patient progress' it is likely that the logic of progressively ordered role demands and the consequences of conduct commitment to various role choices thus exemplified will lead other patients to an understanding of hospital expectations and commitments with regard to patient progress. The problem of patient marginality, it is argued, can best be overcome through a well-organized and systematically applied programme of explicit status advancements.

Up to this point, theoretical developments have been advanced hand in hand with observations to explain and demonstrate their descriptive usefulness. Issues surrounding the problems of knowledge and commitment are explored in some detail. The problem of formulating an appropriate model of mental hospital practice and of developing a comprehensive system of notation for aiding the analysis of staff-patient interactions and their institutional ramifications has not yet been faced.

Information becomes knowledge when its practical usefulness is realized. It is the participant observer's task to observe participants putting their own hypotheses to the test and to hypothesize the effects of the information they acquire thereby on subsequent constructions of situations and commitments to action in these situations.

In Chapter VIII, theoretical extrapolations are advanced in terms of a socialization model which sets out a schema of cultural evolution and then considers the requirements for the integration of an outsider into an already evolved cultural matrix. This model is taken to be representative of the resocialization of a patient in the culture of an effectively functioning mental hospital. The analogy breaks down, it is true, when one considers that the therapeutic community of a mental hospital consists almost solely for the purpose of socialization, or, more precisely, resocialization of patients. Nevertheless, the socialization model is considered sufficiently analogous to the resocializing function of mental hospitals to serve as a context for scrutiny of this function.

The 'leap of faith' from an analysis of certain current mental hospital practices to the formulation of an ideal of therapeutic practice is generated in part by reflection on these practices and their consequences. The model itself is a vantage point in terms of which an analysis of mental hospital practices can begin to take on both therapeutic and culturally relevant significance. The model's descriptive usefulness and the analytical usefulness of the classificatory schema based on it remain empirically undemonstrated. Instead, the theoretical and practical implications of the model and classificatory schema are merely logically deduced from this point

onwards. This applies to all the ground covered subsequent to the presentation of the model in Chapter VIII.

"Concrete knowledge", Goldmann (1969) suggests, "is not a sum but a synthesis of justifiable abstractions". Constructs, Kelly (1955) stresses, contain both assumptions about what the world is like and assumptions (or hypotheses) about how to deal with it. Where barriers are placed between people and information and where behaviour is shaped under such conditions, constructs attainable by patients in the situations which evolve are subject to various potential falsifications (a) of therapeutic rationale and (b) of conduct consequences.

The classificatory schema sets out the nature of possible restrictions on the exploration of hypotheses central to the concrete realization of therapeutic end-points and the ideal of corporate accountability between staff and patients considered necessary for such therapeutic progress. The "mutual monitoring processes that last during the time (patients and staff) are in one another's immediate physical presence and extend over the entire territory within which such mutual monitoring is possible" (Goffman, 1969) - that is, staff-patient situations - are looked at from the dual (overlapping yet analytically distinguished) perspectives of their institutional integrity and their limited internal coherence. Attention is focussed on the epistemological integrity of demand justifications in terms of legitimate hospital practices and the authenticity of staff conduct in terms of expectations engendered in situations themselves. In effect, the following questions are asked of staff conduct in relation to patients (1) 'To what extent is the rationale justifying patient conduct demands grounded in the legitimate

institutional practices of the institution as a whole.?' and (2) 'Are expectations generated with respect to conduct consequences likely to be met in practice?'

By combining these two questions with respect to a given situation four permutations can be seen to be possible

- (1) Epistemologically strong and authentic
- (2) Epistemologically strong yet inauthentic
- (3) Epistemologically weak yet authentic
- (4) Epistemologically weak and inauthentic

These combinations have been termed respectively 'comprehensive', 'subversive', 'analigned' and 'disjunctive'. The rationale for the choice of terms is given in Chapter VIII. The question can now be asked of any given situation: is this situation, in which certain expectations are being generated, therapeutically comprehensive, aligned, subversive or disjunctive?

In Chapters IX and X, two days of hospital life are portrayed. Various situations are earmarked in this chapter for analytical scrutiny. They are classified in Chapter XI, according to the analytical principles set out and demonstrated on twelve of the total set of thirty-four ear-marked situations, in the same chapter.

In Chapter XI the theoretical and practical limitations of the model are discussed.

In Chapter XII a formal therapeutic strategy is developed for improving existing conditions in Hospital A according to criteria discussed.

The appropriateness of the term 'model' to the theoretical work.

The originally submitted thesis actually lacked the clearly explicated model contained in this thesis. The model presented here is analagous to the structure and function of a mental hospital in the following respects:

(a) The outsider, C, who enters the culture of A and B in the model is analagous to a patient who enters the on-going processes of a mental hospital.

(b) The need of A and B to develop legitimations for their institutional order is analagous to the need of a mental hospital to present its patient members with an account of its mode of operation and the implications of this mode of operation for patients' future conduct commitments in the hospital.

(c) The 'overhauling' of C's construct system in the model is analagous to the resocialization process taking place in the mental hospital in its development of meaningfully integrated demand situations for patients.

The logical imperatives implicit in the model are explicated in the schema for classification of staff-patient situations which follows.

The appropriateness of the model to all material contained in the recreation of two days of hospital life.

Obviously not all situations encountered in Hospital A will be of therapeutic significance. Attention is focussed on staff-patient encounters and interactions. This is the focus of convenience of the model itself. The remainder of the re-creations demonstrate the context in which these situations occur and hence the context of situational analysis itself.

The practical and theoretical limitations of the classificatory schema and its application are discussed in Chapter XI.

The derivation of the recommendations for Hospital A.

These are discussed in Chapter XII of the thesis. The argument put forward is briefly as follows: in the absence of an explicit and systematically applied therapeutic strategy, fewer bases exist on which an ideal of personal and institutional accountability can be concretely realized. The recommendations put forward aim at developing a culturally based means-end programme which would help to establish a sense of moral accountability which, it is argued, goes a long way to ensuring epistemologically integrated and authentic staff conduct in relation to patients.

The theoretical and practical limitations of the model and the classificatory schema.

These are discussed in Chapter XI

The basic weakness of the research itself can be traced largely to the inherent limitations of the participant observation research method as a whole. Its method of proof is inherently weak since variables described are not subjected to direct experimental manipulation. Furthermore, the observations made cannot be exactly replicated, since real life situations rarely duplicate themselves. Finally, of the many variables which account for the form, content and sequence followed in any specific situation only a limited number of these can be focussed on at any particular moment in time.

The strength of the research method lies in its emphasis on concrete (rather than derived and experimentally abstracted) sets of circumstances. Whatever is being observed is taking place in the area of direct practical interest. The main difficulty lies in the researcher having to focus attention on limited yet theoretically significant areas of interest. This is why the problem of description and presentation of the material has been

so central to the development of this thesis. Although statistical rigour has been generally absent, comprehensive scrutiny of contextual variables is considered to have advanced theoretical knowledge of the field of study to a point where more detailed and rigorous analysis can now begin.

The Collection of Data

Data for this thesis were collected over a period of thirteen months, spaced over a period of five years, during which time the present writer worked and lived in a variety of capacities in three different mental hospitals, two in the Republic of South Africa and one in Swaziland. These hospitals appear in the thesis under the titles 'Hospital A', 'Hospital B' and 'Hospital C'.

In Hospital C, two months were spent working in three different wards in the capacity of a nursing aide, during the 1965-66 University vacation period. In the latter year, half a month was also spent drawing maps of patient activities in a research project supervised by A. Paul Hare, then Visiting Sociology Professor to the University of Cape Town. A further two month period was spent working in a nursing-aide capacity in Hospital B during the 1966-67 University vacation. In 1968, a pilot study was undertaken in Hospital B, drawing social maps for a one month period, in order to establish a comprehensive system of notation for various patient activities. During all this time, notes were made on daily activities, staff-staff conversations, staff-patient conversations and co-operative activities, and patient-patient encounters, activities and conversations.

In 1969 two African assistants and myself left Cape Town and travelled to Swaziland, stopping at Lumku Missiological Institute, en-route, for two weeks of preparatory training in the participant observation method of research.

On arrival in Swaziland, an unexpected three months' delay in getting research underway was utilised to gather data and information on local customs, beliefs and practices. Meetings were arranged with a local witchdoctor to whom one assistant and myself paid a number of visits, to receive 'treatment' for various states of affairs - stomach complaints, the warding off of evil spirits and enhancing personal power in certain social relationships.

Having had to forfeit one assistant during this period, I enlisted another, an ex-school-teacher, who was to enter the hospital one week before I did, also as a pretending patient.

At the beginning of November, Joshua Sithole, my co-worker who was to gather information from the staff side of the therapeutic community, took up a job in the role of a nursing attendant in Hospital A. I refer to him in the thesis as my 'assistant-staff'. On his 'off-days', he would report to me on his findings, and we would discuss research tactics, findings, and the sort of questions he should try to answer. Three weeks later, my 'assistant-patient', Rommel Mdwara, entered the hospital as a pretending patient, having been thoroughly briefed on the sort of experiences he could reasonably expect to undergo as a patient, and the sort of information he was to collect. His main difficulty lay in concealing the notes he was making from the staff, who were unaware of the research in progress. (Only the Superintendent and the Head Nurse were informed.) Information was collected from Rommel, by Joshua, who would then bring it to me. We would discuss respective findings and re-organise certain research strategies. Joshua acted, to a large extent, as a "shill" (Goffman, 1969) in promoting Rommel's patient-role performance.

At the end of November, I myself entered Hospital A as a pretending patient, sleeping in a different dormitory to the one in which Rommel was placed, and not openly communicating with him for one week. Each of us kept separate accounts of patient and staff life during this time.

At the end of the first week Rommel and I struck up a 'patient-

friendship' and, on occasions, were able to work under the supervision of Joshua, during which time we were able to exchange information and compare findings. At the end of the third week, the Head Nurse had us both 'transferred' to a different dormitory, enabling us to work in still closer collaboration.

At the end of the fifth week, Rommel and I were "discharged". Joshua remained on in the role of a nursing attendant, during the following three weeks.

My own reports were made in English and isiSwati, Rommel Mdwara's reports were also in English and isiSwati. Being fluent in isiSwati, Rommel acted to a large extent as an interpreter and translator for myself. (During 1965-66 academic years I took a two-year course in African languages. In 1967, in preparation for participant observation research, I took a month-long course in isiZulu - an Nguni dialect, which could be described as midway between isiXhosa and isiSwati in its pattern of inflection and vocabulary changes - at Lumka Missiological Institute. As a result, I was capable of following most conversations, although I had certain difficulties in this area.) Joshua Sithole's reports of the first two months were in isiXhosa and isiSwati, being more fluent in these dialects than in English. I felt that this would also keep his accounts of conversations and situational encounters closer to their experienced context.

The next three weeks were spent translating Joshua's report into English. After having briefed the entire staff on our research programme, Rommel Mdwara was re-admitted as a patient so that he could gauge the effects of my entry into the therapeutic community as a staff member, from the patient side. I then entered, as a staff member, working in collaboration with Joshua now, and using information gathered by Rommel to set up various situations in order to ascertain patient reactions. At all times we kept as close as possible to expectations accorded us as staff members and patients, seeking more to learn the nature of counter-positional roles and role-expectations than to change the nature of the conditions under observation.

After one month's participant observation as a staff member, the entire exercise was called off. A short while before this, Joshua had to return to Cape Town, as his South African travel document had expired.

I then engaged two recently-matriculated Swazis to help me to map patient activities for a twenty-eight-day period. Maps were drawn 24 hours a day for twenty-eight days, supplying a complete record of patient and staff activity during this time.

The maps were drawn as follows:

The whole hospital area was divided into twenty separate areas with rough outlines of these areas reproduced (700 copies of each area) on separate sheets. On each mapped area, patients, numerically encoded, were represented in the various activities in which they were engaged, using different colours for different activities, as follows:

- Green : standing or sitting, not talking
- Blue : standing or sitting, talking
- Black : engaged in work
- Red : receiving medication or sedated by means of injections.

Lines linking patients drawn in blue showed the direction of conversation; speaking alone, no lines; one way conversation, an arrow from one patient to another; two conversing, two-way arrows; three, three arrows and so on. Movement was indicated by dotted lines.

Staff members were assigned numbers from 1 to 20 prefaced by 0. All numbers for patients and staff-members were learnt by heart, from photographs, before mapping activity was undertaken.

An extra month was then spent at the hospital by myself, working with staff and patients, asking questions openly, discussing certain aspects of staff life with staff, and life before commitment and in the hospital itself with patients, drawing up lists of patients prescriptions, ages,

and time of commitment to the hospital. I also entered into extra-hospital pastimes with staff members, especially with a Zionist member of staff who introduced me to an understanding of the Zionist religious sect's rituals and practices.

Situations :

In the analytical model presented here, the term 'situation' is used to refer to "any environment of mutual monitoring possibilities that lasts during the time two or more individuals find themselves in one another's immediate physical presence, and extends over the entire territory within which this mutual monitoring is possible."

(Goffman, 1967)

It may be argued that, in the past, an adequate theory of mental hospital practice has been obscured by the framework set by the medical model of mental illness. Problems in living faced by mentally disordered persons, construed as 'symptoms' of 'mental illness', tended to be functionalised in terms dictated by the 'illness' metaphor. Under these conditions the patient's own understanding of his problems was not considered relevant. His beliefs and assertions did not need to be confronted with evidence to dispute their content. Instead, the question of how a patient's mental disorder was sustained, was reduced to the psychological level of explanation. In many mental hospitals this state of affairs still prevails today.

The position assumed in this thesis functionalises mental disorder in terms of the cultural context in which it finds its particular expression. More precisely, mental disorder is considered as a function of the mentally disordered person's attempting to cope with demands made upon him in various situations. The situations considered here are those which he is obliged to confront in the mental hospital context.

SECTION A.

"Man ought not to know more of a thing than he can creatively live up to."

(Nietzsche)

"Man is a symbol. So is an object or a drawing. Penetrate beneath the outward message of the symbol or you will put yourself to sleep. Within the symbol is a design which moves. Get to know this design."

(Khwaja Pulad)

"In a true symbol the particular represents the universal, not as a dream or a shadow, but as the living and instantaneous revelation of the unfathomable."

(Goethe)

* * * * *

CHAPTER 1 : MENTAL HOSPITAL PSYCHIATRY AND THE MEDICAL MODEL OF MENTAL ILLNESS

Verbal analogy - scientific doctrines - reification of term 'mind' - therapeutic triad - medical model as ideology, 'myth' - vested interests - situations - interpretations - concrete knowledge - mind as relational construct - social psychological model - control - illness metaphor 'humane' - social and moral criteria - illustrations of situations.

* * * * *

Considerations focussing upon the medical model of mental illness fall roughly into two categories. Those concerned with the theoretical issues involved, and those concerned with the practical effects of applying the model itself. I deal simultaneously with these considerations here. Both have a direct bearing on issues of professional commitment in the practice of psychiatry, and more especially, the practice of psychiatry in mental hospitals. (Illustrations referred to in the text appear at the end of the chapter.)

Theoretical Issues / Practical Effects

In medicine, the term 'illness' is used in a literal, non-figurative sense to denote an undesirable alteration or change away from optimal levels of organic bodily functioning. However, the term 'mental illness' is used to denote maladaptive changes in something other than the body and is generally applied to various patterns of behaviour which are considered inappropriate by implicit psychological and social standards.

Looked at in historical and cross-cultural perspective it is possible to point to a wide variety of methods used to cope with problems arising from the conduct of persons whose behaviour may be judged as 'undesirable' in terms of the harm it does both to other people and to themselves.

Such methods of coping with 'mental disorders' can be shown to differ in accordance with the presumed aetiology of the afflicted individual's presumed condition - demon possession, organic disturbance, maladaptive

learning, childhood trauma or the results of witchcraft practices, to name a few.

According to scientific and medical doctrines which developed in the latter half of the nineteenth century, true science was considered to be impersonal and concerned solely with material things. Moral values were seen as illusory, and every observable phenomenon was considered to be reducible to laws governing the actions of material particles (Barzun, 1958; Bockoven, 1957). Behaviourally disordered persons came to be regarded as suffering from a medical condition, whose treatment rested on a scientific physical basis. Yet, paradoxically, the term 'mental illness', can be shown to rest, not on an understanding of physical cause-effect relationships, but rather on a verbal analogy (Sarbin, 1968). The paradigm which psychiatrists have used to account for its nature and origins - and hence the strategies they have used to cope with it - have been based on the Galenic model or 'germ theory'. This model views microbes, toxins and growths as material causes of diseases of the body and understands their effective operation in accordance with mechanical principles. They operate inside the body. Since the appropriate causes of abnormal behaviour could not be accounted for in these terms, they had to be sought along different lines. The dualistic mind-body concept provided a means of establishing the causal locus of abnormal behaviour inside the mind. The appropriate label for non-somatic diseases became 'mental illness'.

Instead of construing this concept as the verbal analogy which it essentially is, much mentalistic psychiatry, even today, ascribes literally to the 'mind', considering it as a real entity, that, like the body, can become sick. Seen from within this perspective, behaviour disorders appear as 'symptoms' of underlying mental diseases. Once the patient is hospitalised, this assumption further dictates a set of practices within the hospital that have become subject to much recent criticism because of their authoritarianism (Holzberg, 1960), degradation (Sarbin, 1967), dehumanisation (Goffman, 1961) and illness maintenance (Schwartz, 1960).

Some of these characteristics are illustrated in the case of an admission of a patient into 'Hospital B', at the end of this chapter (Situation 1(a)).

The medical model stresses mental illness as something requiring treatment rather than moral judgement, even though the patient's disorder tends to be intrinsically related to his acting in such a way as to give offence to witnesses. Furthermore, the standard way of dealing with such offences in the wider society is usually to sanction the offender negatively and correctively. (See Situation 2).

The primary triad involved in the therapeutic relationship is comprised by the doctor, the patient and the community at large - the patient, whose real unimpaired self needs to be guarded against the disorder; the doctor, as the specialist of choice and 'guardian' of the real self; and the community - of which the patient is a member - in whose name the doctor is given a mandate to treat the disorder. This relationship has been likened to a service triad, where the patient, as the possessor of the malfunctioning object is required to hand it over to the specialist, in whose hands the total responsibility for the repair rests (Goffman, 1961). (See Situation 3.)

In his interpretation of the data deemed relevant to the patients' mental disorder, much of the material with which the psychiatrist deals is neither understandable nor usable outside the context of a system of human values. (In later chapters, I shall deal with the psychiatrist and the nursing staff as a single functional unit or 'team', since they can jointly be regarded as having been given the public's mandate to cure the patient of his illness, having been given positive social sanctions as relevant specialists in matters of 'cure' and 'care'.) Students of mental health have found it difficult to define such terms as 'health', 'illness', and 'normality' without reference to morals. Worse still, they cannot discuss the proper treatment of what they have found without recognising and involving their own moral commitments (London, 1964).

Under such circumstances, the medical model inevitably presents itself as an ideology, unwittingly restricting consideration of a large number of important theoretical issues which are concealed by unwarranted assumptions present in the medical model. Embracement of these assumptions by practising psychiatrists remain largely uncontested in

current mental hospital practices. Such assumptions and related 'vested interests', it might be argued, exist at the expense of possible psychiatric improvements, which are not open to consideration within the paradigm set by the medical model itself. "Someone whose mind is imprisoned in a metaphor, cannot see it as a metaphor. It is just obvious" (Laing, 1968). The following quotation, extracted from the same paper by Laing, himself a psychiatrist, demonstrates the latter's own realisation of the importance of wider social considerations in the treatment of mental disorder:

"I started to see through the dense opacity of social events from the study of certain people who were labelled psychotic or neurotic, as seen in mental hospitals, psychiatric units and out-patient clinics. I began to see I was involved in the study of situations and not simply of individuals." (Emphasis Laing's).

The term 'ideology', as used above, is meant to denote a distortion of the true state of things. Confinement of considerations of mental health problems within the paradigm set by the medical model is a 'political' limitation of knowledge. Within the framework set by the sociology of knowledge (Merton, 1951) such limitation may be construed as 'false consciousness' and will be similarly treated in this thesis. This is not a moral accusation, but rather a recognition of certain professional and theoretical contingencies shaping psychiatric practices and beliefs. Such a recognition is made in the light of the consideration that "the laws governing scientific belief are essentially similar to those governing perception and all other modes of experience." (Taylor, 1957).
The Function of the Medical Model of Mental Illness.

If, as I have argued, the medical model is essentially an ideology or a "myth" (Szasz, 1960) resting on two fundamental errors of assumption,

- (1) that a person's belief can be explained away by a defect or disease of the nervous system, and
- (2) that a symmetrical dualism exists between mental and physical symptoms,

then it might prove worthwhile to consider the full implications of the practical application of such a myth.

Myths constitute frameworks of knowledge. They function as internal organising frameworks, for the structuring of information relevant to their central meanings. Such frameworks may increase the usefulness of available information by putting it together in a structure it would not otherwise have, yet the organisation of information which emerges might be considerably worse than the best arrangement of available information. Myths offer internally coherent systems of explanation. They are not themselves open to disproof within the paradigm of possibilities which they predefine. They may throw up useful categorisations but they deny the possibility of aligning these to a more comprehensive system of explanation, since this lies outside the framework set by the myth itself.

In a later chapter the social psychological model of mental illness will be discussed, and its relevance to an understanding of situations which arise in mental hospitals will be demonstrated. However, certain features which are incorporated in this model, bear consideration here.

The meeting of patient with psychiatrist can be said to constitute a 'social situation' - "one in which people orient their actions toward one another." (Parsons, 1966). The meaning which emerges from this meeting depends on the nature of the abstractions generated therein, abstractions which will have bearing on interpretations of past experiences of the patient and, at the same time, focus his attention on future experiences which he may reasonably anticipate. If these abstractions relate to the realm of illness, then the patient can be expected to be validated in what has been termed the "sick role". (Parsons, 1951). If, on the other hand, the encounter points up more than merely "illness", if, that is, certain moral questions are raised, then, to be logically consistent, these should necessarily be considered in terms of the nature of the supposed 'illness' in relation to them. In other words, as Goldmann(1969) puts it, "concrete knowledge is not a sum but a synthesis of justified abstractions." (Emphasis mine).

I would like to propose, as an alternative to the medical conception of the term 'mind', that it be regarded as a relational concept - "the interplay of the organism with social situations mediated by symbols" (Mills, 1940) -

and that the mental hospital be considered as an institution for the disengagement of certain socially unpredictable (or asocially predictable) members of a given society, in order to rehabilitate them in conformity with a social paradigm wherein predictable (and socially acceptable) behaviour is more or less guaranteed. Human society means that peoples' behaviour is being removed from the randomness of chance and regulated by established and inescapable expectations. It therefore follows that the mental hospital is open to consideration as an extension of the controlling functions of the society in which it occurs. It may, perhaps, most usefully be considered as "part of a micro-political power struggle" (Laing, 1968) and its practitioners would, under such a consideration, do well to realise that they are involved in 'situations' and not simply with 'isolated individuals.' The thesis that behaviours traditionally called 'abnormal', are no different either quantitatively or qualitatively in their development and maintenance from other learned behaviours, has been forcibly put forward elsewhere. (Ullman and Krasner, 1969). Viewed as a formally organised social institution, the mental hospital may usefully be considered as a system for reconciliation of deviants whose non-conforming behaviour does not appear to benefit from the moral paradigm operating outside the hospital community. The assumption here is that the deviant is not able to reconcile conforming and deviating in terms of the strategies offered him outside the hospital. In many cases, as Laing and Esterson (1964) have demonstrated, these strategies are themselves self-contradictory.

In mitigation against the argument built up against the medical model thus far, it should be noted that the concept of 'mental illness' offers a mode of conceptualising the mentally disordered person which is relatively humane. It provides the mentally disordered person and his relatives with a socially acceptable explanation of the former's conduct. It might be argued, therefore, that the medical model protects him from labelling of a more drastic kind, which could do irreparable harm to his reputation and future possible social re-integration. By defining mental disorder as a medical problem, the patient is, perhaps, protected. This line of argument is adopted by Ausubel (1961), who goes on to state that "since personality

disorder and immorality are neither co-extensive nor mutually exclusive conditions, the concept of mental illness need not necessarily obscure the issue of moral accountability." This point is well taken. On these grounds the continued use of the term 'mental illness' might be conceded. The danger lies, however, in the 'illness' metaphor being taken literally, so that the medical model of mental illness be invoked to deal with its occurrence.

Finally, where physical determinants such as toxins and drugs, growths such as brain tumors, and certain germs which attack the nervous system, can be shown to give rise to organic disturbances, behaviourally manifested, the medical model must, naturally, be recognised as the appropriate model to invoke in dealing with these disturbances. However, where such determinants are not found to be present in contributing to behaviour disorder - and where behaviour disorders remain even after physical determinants have successfully been dealt with - psychiatrists would do well to drop the medical analogy and deal with behavioural issues on a level more in keeping with the social and moral criteria used to assess the presence of these disorders, and the social-psychological determinants which demonstrably account for their continued presence.

* * * * *

Situation 1(a) (Authoritarianism; degradation)

Alex M. arrived at Hospital B with his parents, late one afternoon. When I met him, he was walking around the wards, and appeared to be 'nonchalantly' smoking a cigarette. I approached him and tried to enter into conversation with him, incorrectly assuming that he was a new patient at the time. He immediately set about invalidating my assumption - which he appeared to have gathered from my manner of approaching him - by telling me that he was just visiting the hospital out of interest. He backed up this assertion by asking questions about how the hospital was run and what my duties as a male nurse were.

In the meantime, as I discovered later, his parents were discussing

his admittance to the hospital - unbeknown to himself. (Such a situation is not acceptable, as a rule, to either psychiatrists or nursing staff. The 'betrayal' which it involves is a recognised stumbling block to later co-operation.)

Subsequent conversations with him gave the impression that his parents were rather 'straight-laced' immigrants, who wished to bring up their son according to the traditions and manners of their country of origin. He had been living in a University residence for one year and had, during this time, apparently adopted ideas and habits at variance with those his parents desired for him. Violent arguments had ensued on his return home for the long vacation, each side eventually calling the other 'mad'. Finally they had mutually agreed that a visit to a psychiatrist would not be inappropriate, but that the visit should take the form of independent interviews with the psychiatrist by his parents and himself, leaving the decision up to the psychiatrist as to who was, and who not, 'insane'. Apparently confident of his case, Alex was awaiting his turn for an interview when I left my day's work.

On the following day, I found him locked in a padded cell. The only clothes with which he was left were his underpants, a gown and some slippers. He refused to speak either to myself or to any other member of the nursing staff. The room was bare except for a mattress and some bedding on the floor. Alex spent two nights and a day in this room.

On the next day, he was given pyjamas and placed in a single room. On that day I managed to engage him in conversation. His attitude was one of extreme condescension toward the nursing staff and he only decided he would speak to me because I was not present at the time of his "humiliation", as he called it, at the hands of "these barbarians who claim to be nurses." The story he related to me about his admission to the hospital was as follows:

"My parents were with these two psychiatrists for about an hour and a quarter and I started to get a bit worried about what they were discussing all this time. Eventually they came out and my father informed me that I was to be kept

'under observation' for a few days.

"I was absolutely shocked and horrified at this sudden about-face. I thought I was going to interview the psychiatrist as we had agreed. That was the arrangement and the whole reason I had agreed to come here.

"I told them this was ridiculous. Then I discovered they had packed one of my suitcases - which I knew nothing about - and they were going to bring it inside. I thought I would just leave. You know, walk out calmly. Then I saw these two bloody barbarians at the door so I rushed out past them and made a run for the gates with everyone giving chase.

"Once I was outside the hospital grounds and had a bit of time to think over my position, I realised that I had no money, no means of transport and that I knew nobody in this town. So I decided I might as well come back and talk some sense into the situation. Instead, when I arrived at the clinic - after walking calmly all the way up the road like any civilised human being - these two idiots and a third bastard who doesn't seem to be here today - you know who I mean - they grabbed hold of me, dumped me on a trolley and wheeled me to that bloody padded cell, with everyone looking on as if I was some sort of circus act. Can you imagine? Can you just put yourself in my position?

"Anyway, that's not the end of it. When we got there, they tried to hold me down and give me an injection . . . I tell you, I fought the three of them for, it must have been nearly fifteen minutes, then I said I would let them inject me if they stopped treating me like a wild animal. The next morning I woke up, as you saw me, without even a cigarette,

lying on the floor and dressed only in my underpants. So you see now why I am not overjoyed with my treatment in this hospital. "

Situation 1(b) (Interpretation of patient behaviour as symptomatic of underlying illness)

The nursing staff appeared to regard this patient's condescension toward them as symptomatic of a mental illness. The following is an example of the way in which Nurse B was spoken to by the patient when I went with the former to give Alex his midday meal and some medication. His behaviour on this occasion was later pointed to, by the same nurse, as a demonstration of behaviour which he regarded as 'symptomatic' (of schizophrenia).

"You can just put my food down and get out, thank you. If I need you I'll call you, otherwise don't try to come in here and make polite conversation. You're a public servant and so long as I am in here you are no more than my servant. In fact, you personally are not fit to be called a human being, and I don't intend to treat you like one. "

Nurse B asked me what sort of illness I thought this patient had. When I told him I could not see that he had any illness, he replied, "I thought you were a student of psychology". He informed me that it was obvious that the patient was suffering from "delusions of grandeur". He explained away my ignorance by telling me that I was still "new at the game" and had therefore not yet learnt to "interpret" symptoms.

Situation 1(c) (Staff-patient encounters as social situations)

From Alex M, Nurse B would plead "reasonableness", explaining his own initial conduct away by saying, "Nobody could tell how you were going to behave after you had run away like that. "

Alex retorted that Nurse B was supposed to be a judge of human behaviour, that he had no right under any circumstances to assault him and that he intended to "take the matter to court" as soon as he got out of

the hospital. He was just waiting for his parents to return, he explained, and if they did not apologise for the whole thing and admit to their error and deceit he would have nothing further to do with them.

"And as for you", he told Nurse B, "you should be thrown out of this hospital and put in charge of animals in a zoo. But I think even animals deserve more respect and consideration than you have shown me."

Nurse B related to me the extreme difficulty presented by such cases who are brought to the hospital under a deception.

"The doctors don't have to do the dirty work of getting them settled in the ward. They just prescribe their medication and that's that. The next time the doctor sees the patient he's already sedated and doesn't present any problem. But it's a hell of a job to get the patient to trust us and to take us as his friends. Terence M is a similar case. The relatives bring them here on some or other pretext and then they just bugger off and the whole thing's our responsibility. It's not fair on us and it's not fair on the patient. Sometimes it takes weeks before we can come right with them."

By the time patients have "settled down" and have come to "feel more at home" (phrases recorded from psychiatrist - patient conversations) they are usually prepared to answer questions put to them by the psychiatrist, in context - questions such as "How are you getting on now?" and "Do you feel better than when you first came in?" (Questions recorded from psychiatrist - patient informal chats in the corridor and dining room.)

By making discreet enquiries among the patients, I gathered that 'case conferences' took the form of formal discussions about future home life and work relations and the continuation of drug prescriptions 'outside'. Future home and work relations were simultaneously related to future out-patient discussions.

Situation 2(a) (The hospital as a corrective agency)

The function of the mental hospital as a 'corrective' rather than a 'treatment' agency was openly recognised by a parent of one of the patients at Hospital A. The patient, Cornelius P, told my 'assistant-staff', "My father told me that he had said to the doctors that they could keep me here for up to a year or longer, until I learnt to respect (ukuhlonipha) and to come out of my insolence (inkabi). But now that time has passed and I am still here. I wrote, but he never replied. He said he would come and see me, but he has not come. There is nothing more. Now I would like to go home, because I am thinking of my mother." (Recorded by J. Sithole.)

Situation 2(b) (The hospital and social control)

Samane P, another patient at Hospital A told me, "I am not mad. I am here because I want to revenge my mother, because my stepfather has been ill-treating her and beating her. But he knew I was looking for him so he called the police to arrest me. He knows he will lose the case if we go to court, so he decided to say that I am mad instead." (Recorded by myself.)

Situation 3 (The patient as the possessor of a malfunctioning object.)

Johannes M, a patient at the 'Neuroclinic' of Hospital B told me, "The doctor said if I come in here I come as a patient and I must take whatever treatment I get. He told me if I start any trouble I'm out. (That is, out of the hospital.) I had a hell of a time last time I was in here ... He said to me, since I'm a voluntary patient yes, I signed myself in. Once you sign yourself in, you've got to take whatever treatment they give you. I'm only afraid of getting shocks, really. But that's how it is. You just got to take what they give you."

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CHAPTER II : REFLECTIONS ON THE 'CHARACTER' OF MENTAL HOSPITALS.

Mental hospitals as total institutions - institutional aims - administrative biases - resistance to change - ward work and staff 'making out' - informal exchange systems - staff-patient relations - bureaucratic control - administrative distance - division of labour, rights and power - paper work - self-assessment criteria - a ranking order observed - ward status : reactions to demotion - requirements for a comprehensive understanding of hospital character.

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In the previous chapter, some consideration was given to the function of the medical model of mental illness in its latent function of determining the course of mental hospital practices along certain lines, largely predetermined by the nature of the medical model itself. In this chapter consideration is given to the way in which bureaucratic organisation of mental hospitals, seen as 'total institutions', further conditions the form and function of these practices.

Mental Hospitals as Total Institutions

Mental hospitals have been characterised by Goffman and others as 'total institutions' and their functional processes have been compared with those of other total institutions such as jails, boarding schools, military academies and convents. The common features of all these formally organised institutions have been characterised by Goffman (1961) as follows:

- (1) All aspects of life are conducted in the same place and under the same single authority.
- (2) Each phase of the members' daily activity is carried out in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together.

- (3) All phases of the day's activities are tightly scheduled, with one activity leading at a pre-arranged time to the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials.
- (4) The various enforced activities are brought together into a single rational plan, purportedly designed to fulfil the official aims of the institution.

The term 'institution' refers to a set of socially accredited ways of achieving some pre-established purpose in society. Formally organised institutions can be understood and investigated in terms of the structuring of organisational personnel in fulfilment of the social functions they serve. An institution consists of an idea and a structure which embodies this idea and prescribes means for its actualization. Institutions direct and control human conduct to pre-established ends. When institutions are formally organised they function so as to impose standards of conduct on their organisational members, consonant with their functional requirements, subjecting them to sanctions in the interest of maintaining these standards.

Administrative Biases

In the course of time, however, an institution may be compromised by and even lost in its 'establishment', the original spirit becoming the letter. The greatest hazard to its integrity would seem to lie in the organisation of its personnel. In mental hospitals upper level personnel may define 'official' patient needs which encompass their own biases, yet because of their administrative distance from therapeutic issues, they may not be in an ideal position to do so.

While working at Hospital C in 1965, I found my work activities in the role of nursing attendant confined, to a surprising degree, to menial physical labour, or, alternatively, overseeing similar work among patients. Any attempt at engaging in what might be considered as a 'therapeutic' relationship with patients was frowned upon by higher nursing staff and tended to be labelled 'loafing'. The following is a conversation between

the head male nurse and myself on the occasion of my 'dishonourable' transfer from an open to a closed ward:

Head Nurse: "Your job is to work in the ward not to go wandering in the gardens with patients."

Myself: "But this patient seemed depressed, so I decided to try to get him to talk about his problems, and I thought it would be easier for him to do so away from the other patients. In any case there was no other work for me to do in the ward, so I "

Head Nurse: "What do you mean 'no other work' for you to do? Do you decide what work to do and what not to do? You're supposed to be around, so that when there's something for you to do, you're there to do it. I'm transferring you to Ward 4. It's a closed ward so there'll be no more walks in the garden for you."

Myself: "Thanks very much. I hope they'll give me some work there, because I don't like sitting around with nothing to do either."

Head Nurse: "I'll make sure they give you enough to keep you busy, and by the way, we start at 6.30 in the morning, not twenty-five to seven or twenty to seven."

Resistance to Change: - also *Stanton, Swartz* - *resisted by ind. p.*

Just as older nursing staff tend to be the "tradition carriers" of the hospital (Goffman, 1961), the same may be said of older institutionalised patients, whose long attachment to the hospital gives them a feeling of staff identification. In fact my confrontation with the Head Nurse had been brought about through my having been reported by William D, one such old institutionalised patient, who considered he knew how the hospital should be run and would go to the Head Nurse whenever he had a chance to report what he considered to be some infraction by junior staff members.

"You new blokes are too soft", he would tell me, "In the old days a staff like de Villiers wouldn't last here three weeks before he'd be given his pay packet and asked to leave."

Ward-Work and Staff 'Making Out '

Working in Ward 4, one could usually find one of the nursing attendants on 'observation', watching patients in the fenced-off yard outside, his main duty being "to see that none of them tries to escape." (Explanation to me by nursing attendant on observation). The remainder, it seemed, were required to do 'ward-work'. This included making the patients' beds, cleaning, or getting patients to clean and tidy up the ward area. One of my fellow nursing attendants advised me on how to keep out of trouble (while doing as little work as possible) as follows:

"I always carry a cloth around with me, so when the Charge Nurse comes around I'm always shining up the door-knobs or cleaning the windows or something. Then you can relax on the job. Otherwise if he comes out and finds you doing nothing, or just talking to the patients, he'll give you a hard time and want to know why you're loafing."

My refusal to comply with such impression management (in what appeared to be ritual collaboration in mutual impression building) soon led me into a confrontation with the Staff Nurse in the ward.

Staff Nurse: "Yes? What are you doing now, Mr. Papenfus?"

Myself: "I'm just chatting to this patient. Why, was there something you wanted me to do?"

Staff Nurse: "Look here, your job is not 'chatting to patients'. The Head Nurse has asked me to keep an eye on you. You were transferred here for loafing in Ward Two, so just keep busy and you'll keep out of trouble."

Myself: "I'll tell you what. Give me a routine for the day and I'll do it, but I'm not going to pretend I'm busy - like you must know some of these other staff are doing - when there's nothing to be done."

Staff Nurse: "There's no routine in this place. Every day there's different work to be done and if you look around you'll find something to do, otherwise come and ask me."

Myself: "I would be pleased to. I don't like people calling me a loafer when there's work to be done, but up to now I'm not doing any less than anyone else, except I don't start cleaning windows when I hear you walk out of your office."

The Staff-Nurse's refusal to take me up on my charge of impression management confirmed my suspicions that he was well aware of the covert collaboration he himself was perpetuating in this area. I came to find conversations with both junior and senior staff on the question of ward work equally humiliating. Our relations with the patients seemed to be confined to cleaning them, supervising their ward work, serving them food, seeing they did not fight and seeing they did not run away.

Systems of Exchange and Staff-Patient Interactions

As Turner (1947) points out, the exchange system which an organisation engenders may incorporate its own code of behaviour. In the service of this code, legal technicality may be placed above reciprocity. Informal systems of exchange may operate not only to grant favour to some, but also to withhold fair consideration from others. Loopholes in regulations, may become tools by means of which a staff member elevates his own status and so increases his bargaining power. In mental hospitals, where, constitutionally, one might expect a principle of symmetrical dependence to hold sway (that personnel be required to attend most earnestly to those patients most in need of attention), the complementarity assumed in this relationship often gives way to a relationship of subjectivity, where asymmetrical dependence becomes the governing principle. In this way, patients who best fulfill certain 'unofficial' staff needs, are apt to receive the most attention.

At Hospital C I got the following advice from a fellow nursing assistant:-

"You're too soft with these patients, man. They'll take advantage of you if you're too interested in them. I mean I don't mind helping a bloke like Jerry who's a genuine type of guy and is ready to do you a favour in return for a favour. You know what I mean? But look at this Abrahams now. Surely he just asked you to get him something. Tomorrow night it'll be something else. The next night something else, until you get fed up with him and his favours. Then he'll just leave you and brag to his pals, that he's made a sucker out of you. Don't give them anything. They'll just use you."

Abrahams, who had seen us talking, and had correctly guessed that he had been included in the conversation, came striding down the dormitory.

"Don't listen to him, staff," he said to me, "These other staff all hate me. They like to scandal behind a person's back."

"Yes, I think you're right Abrahams, man," I said to him.

"Huh!" said my fellow staff, walking off in disgust, "I can see you're not going to last long in this place."

Abrahams looked searchingly into my face and when I winked at him gave me a broad grin and shook me by the hand.

It was obvious that both sides had spoken with conviction. Abrahams would certainly 'use' me as much as he could. When I had lost patience with him, he would probably see me as simply joining the rest of the staff, who were generally construed - by the less-favoured patients - as mean and secretive.

I got a sample of the other side of the picture when I was a pretending patient in Hospital A.

I was speaking to my 'staff-assistant', when I found a patient alongside me. I indicated to my assistant that our conversation was being overheard and quickly changed the topic to food. Afterwards, Moffat, the patient, said to me, "You see, he is pleased you are talking to him now. The staff are stealing our minds, but they don't tell us what they are doing."

I told him, "No, this Joshua is a nice chap."

"Yes," he agreed grudgingly, "he is the latest one here. He came just before you and he is still nice, because he is new."

On another occasion, Moffat took me into his confidence and told me, "These staff think I am stupid and I let them think that way, so I can find out what they are doing. They like to speak English when they walk among the patients, thinking no-one can understand them. I understand them, but I don't let on. When they speak to me in English I pretend I don't understand. That's how they do their work. Everything is like a secret from us in the way the staff are carrying on in this hospital."

* * * * *

In Hospital C, Jerry, one of the more 'favoured' (hence one of the more 'successful' patients in initiating favourable exchange patterns), entered into conversation with me in the following way, at the same time drawing me into his own exchange system:

"Staff!" he called me, "How about a quick game of cards before you knock off?"

He kept his own pack of cards and could be seen in the evenings sitting on his bed with members of staff and/or other patients, indulging in this pastime (sometimes for money), before the staff 'knocked off' from their day's work.

"You know, staff, if you get me some wood I can make something for you. We've got no more wood in the workshop and a person can't just sit around when he's used to working. I can make you a cabinet, a radiogram, a book-case, whatever you like ... Well, you can just give me some old clothes or a tie or something. We're not allowed to actually work for money here, but what can you do? I'm not looking for pay. I just want something to keep me busy."

Jerry's 'honest line' approach was very favourably received among all the staff. Although the exchange system he set up was technically 'illegal' he put his own case to the staff in such a way as to make them feel he was a

'genuine type' who was really 'hard done by' and would appreciate it if the staff could just help him out on the side - all of which was probably true. Yet all such exchanges were 'on the side', as it were, and could not be encouraged or openly recognised between higher and lower nursing staff.

The Effects of Bureaucratic Control

Blau notes that much hypocrisy and false personalisation may be engendered in bureaucratic organisations and that "Personalised service, innovations and individual treatment may become risks rather than reinforced behaviour." (Blau, 1959). Thomson (1963) notes that opportunities for hierarchical success in modern bureaucracies depend to a large extent on ability and willingness to engage in "impression management."

At Hospital B, where I worked as a nursing attendant in 1966, Hennie S, a fellow nursing attendant, told me that the Staff Nurse had warned him that there was going to be a "dormitory inspection" on that day. After we had seen to the polishing of the floors, we made up the beds and then made sure they were "all in a straight line".

Hennie said to me, "We're going to lock all the doors today. None of the patients must walk on these floors or come in and start sitting on the beds."

"But the patients are supposed to be allowed to come in and lie down for an hour after lunch", I protested.

"Bugger that", he replied, "They can come in after the Super's finished his inspection. No patients are coming into these rooms till he's left."

Dimoche (1952), noting that psychiatric hospitals usually suffer most of the defects and obtain few of the benefits involved in bureaucratic organisations, cites the following characteristic features of all bureaucracies:

- (a) The presence of an organisational hierarchy in which each lower office is under supervisory control of the next higher so that no position is left uncontrolled and no order avoids systematic checking and reinforcing.

- (b) A systematic division of labour, rights and power.
- (c) The continuous organisation of official functions bound by rules. (Rules save effort by obviating the need to derive a new solution for every problem and facilitate the standardisation and equality of treatment of many cases.)
- (d) Administrative acts, decisions and rules are formulated and recorded in writing.

Etzioni (1964) sees the ultimate justification for a professional act in its being, to the best of the professional's knowledge, the right act; while the ultimate justification for an administrative act is that it is in line with the organisation's rules and regulations. Where these are in accord there is obviously no conflict. However, creativity cannot be bureaucratically ordered, and when knowledge becomes specialised it tends to be compartmentally confined. In mental hospitals where I have worked, I found that lower echelon staff need to exercise circumspection in the application of any therapeutic knowledge they may have.

Ullman notes that what he calls the "aide culture" has as its goal the comfort of the aide, rather than the adjustment of the patient. "His aim is the discharge of his duties, as he sees them with the least effort." (Ullman, 1967). Since 'status' in mental hospitals is often somehow related to not interacting with patients, patient contact is often prolonged at the lower levels of the organisation, and contact between aides and higher echelon staff tends to be on an administrative rather than a therapeutic basis.

(a) Administrative Distance from Therapeutic Issues:

At Hospital A, Nurse S complained to me about the Superintendent as follows:

"Can you see what he's doing? He doesn't come and see the patients, he just sits in his office and drinks tea every day with his friends."

(b) Division of Labour Rights and Power:

In Hospital C, staff characteristically occupied themselves with tasks relating to ward upkeep, and related to patients largely in terms of such duties. The payment of tobacco rations was largely for work done in this field. Patient behaviour was by and large not related to conduct required of them in the wider society. This emphasis was to a large extent perpetuated by the staff's ignorance of higher orders relating to decisions regarding the date of patient discharge. The patient's concerns about his discharge therefore tended to remain outside the staff's area of concern and responsibility.

A similar state of affairs at Hospital A, caused Enoch S, a nursing staff working there, to speak out against the superintendent as follows:

"The Superintendent is really not fair with us. We don't know what he thinks of us at all. He is always friendly toward us, but he wants to have all the say with the patients without considering our position at all...

"Look, a patient can have been asking us for months when he is going to be discharged, but we only know on the morning. Then it is just time for us to supply him with his clothes. Then the patients take us as fools who don't know anything. It's no wonder patients like Adrian can tell us, "You're just Khasa's boys." He's quite right. Mr. Khasa treats us like his 'boys', but he pretends to respect us." (Recorded from a personal conversation.)

During a 'tea break', I shared one day with the Superintendent and a visiting doctor, I was witness to the following conversation: "This last case we had in here was just a typical case of malnutrition coupled with and exasserbated by drinking this home-made 'tywala'. I think we should just keep him here, give him vitamin pills and the sort of food he's been missing, and let him go again in about three months."

In this way, I gained the impression that the date of discharge, in many cases, is decided upon right at the time of admittance, but this information is at no time communicated to the nursing staff.

Various 'working consensi' come to be evolved within the framework of mental hospitals, which might well be at variance with the

purported aims of the hospital as a therapeutic institution. Goffman (1961) speaks of "the morally loosening effects of living in a world within a world, under conditions which make it difficult to give full seriousness to either of them". The general paucity of rights, as well as equipment, means that both patients and staff have very few means at their disposal for building up a ritual regard for one another. Without a variety of role activities to fall back on (to create 'role-distance') the average patient is likely to find his self-esteem constantly threatened. On the other hand, the average patient tends to have very little positive role identity he can build on, and so possesses little, in the way of self-esteem, that he can lose. He learns instead "the art of shamelessness". (Goffman, 1961).

(c/d) Administrative Definitions : Paper-work.

Hospital A was the least 'work-oriented' in the 'work-is-not-chatting-to-patients' sense, of the three hospitals studied. Patients and staff also shared a great many cultural beliefs in common, which were not shared by the administrative hierarchy for most functional purposes. Even as institutionally differentiated groups, staff and patients shared a certain common 'foreign-ness' with respect to the practice of Western psychiatry. Notwithstanding these factors, relations between staff and patients tended to be stabilised along lines more conducive to notions of mental illness as presented by the medical model than along alternative lines. The following hospital report, written out in full, illustrates the type of jargon in which hospital reports, to be read by the superintendent, are written (Names alone have been altered.)

<u>DAY REPORT</u>	
WARD: Male	DATE: 20.1.70
PATIENTS AT 7 a.m. 116	ABSCONDED: -----
ADMITTED: -----	DIED: -----
DISCHARGED: -----	PATIENTS AT 7 p.m. 116
REPORT: (1)	Mdzelwa P. has been very confused walking up and down the yard. Care given.

- (2) Majombolo is still confused and he has seen the Doctor.
- (3) Samuel P. is still very noisy and fighting against everyone in the yard.
- (4) Austin P. has been very dull and is getting very thin. Care is given.
- (5) Jabulani P. has been very confused. Larg. 100mg injection given at 11.25 a.m.
- (6) Bonwane P. has been very dull. Care given.
- (7) Lucky P. complained of a headache. 2 aspirins given and he is still very confused.
- (8) Mpikheleli P, David P and Jans P are still at large.
- (9) Other patients have been in their usual condition

Criteria for Self-Assessment:

Hospital A lacked a therapeutically graded patient hierarchy which might enable patients to assess their progress in the hospital. The absence of such a ranking order was openly expressed by Moffat P as follows:

"It makes no difference if you've been here six months or if you came yesterday. We are all treated the same. You can't tell who is sick and who is not."

If the hospital's institutional function be viewed as the establishment of socially approved standards of conduct and the checking of behavioural eccentricities, it follows that at least some recognition of attainment of such standards should find expression in order for certain necessary complimentaries of relationship to be preserved.

The levelling function of the wearing of patient uniforms was communicated to a patient in the following recorded conversation:

Dennis P (an escapee who had been returned to the hospital by the police) had a sports shirt on when he returned.

Sonny-Boy S said to him "Dennis khulula ihempe le (Dennis take off that shirt)."

Dennis : "Why? This is my shirt" (In English)

Sonny-Boy : "Awafani njengabanye sizokwazi njani ukuba usisigulani? (How are we going to tell you're a patient in that shirt?)"

Dennis : "You mean if I wear this shirt you can't see that I'm mad?"

He refused to take off his shirt. Sonny-Boy went to strip him and a wrestling match followed.

Dennis said : "Don't treat me like this. If you want my shirt talk nicely to me."

Enoch S came up to Dennis and said, "Dennis. Mususi hlupha, ngoba uyazi ukuthi ihempe lakko funeka lifane nelabanye. (Dennis. Don't worry us. Your shirt must look like the other patients' shirts.)"

Dennis took off his shirt and said to Sonny-Boy, "You should speak like Enoch" (He used his surname).

(Recorded by J. Sithole)

* * * * *

The following is an extract from a discussion recorded by R. Mdwara, my assistant-patient, in Dormitory Two, centring around who was going to be discharged first:

Solomon P said, "All those who are receiving shock treatment will be discharged first, followed by those who have recovered."

A Rank Order Observed

In Hospital C (Ward Four), patient status was made evident through dining room seating arrangements. One of the patients who sat at the 'first table' showed me his own set of private cutlery, which he washed himself. At his table there were four seats, and all who ate at this table knew and recognised that theirs was the "first table".

Patients sitting at lower tables would point out to me a number of tables which were the "best tables", for the most "improved" patients in the ward, without drawing such fine distinctions between individual tables. The overt distinctions, however, were clear and explicit - better plates,

better cutlery, fewer at a table.

More degraded patients ate with spoons instead of knives and forks, but were not as degraded as those who ate with spoons on the verandah.

On the verandah itself, where I spent most of the meal times feeding helpless patients and those reluctant to eat at all, distinctions were made between the 'top' table, which had chairs instead of benches, and the 'bottom table', (which was in effect two long tables joined together, seating about eighteen patients in all.) At the 'top' table, quarrels would sometimes break out as to who was sitting on whose chair, and who had the right to the table's better spoons. Insults would fly between patients as to who was and who was not a "bloody feeb", and who was most likely to give the other "syphilis" by eating with "his" spoon. (Recorded from a verandah argument.) These fights were sometimes settled by staff recognition of whose chair was whose, and at other times they were settled by refusal to recognise any issue at stake, making one or both parties responsible for the argument, and threatening either one or both with demotion to the 'bottom' table, where there would be "no more fighting over chairs" and where they might even be forced to eat with their hands, just to teach them a lesson. (Recorded in settlement of a verandah argument.)

The rank order just depicted was related more to ward behaviour, and subsequent ward privileges, than to therapeutic progress leading toward discharge. Owing to the presence in this ward of patients labelled "criminally insane" (who were committed to the hospital for a period determined by the State President), ward privileges and statuses did not altogether overlap with privileges recognizably related to progress leading to discharge. This was more related to the ranking system constituted by parole rights, granted by the psychiatrists.

The Rank Order and Situational Encounters

Hence, in Ward Four, there was no recognition in table-ranking of distinctions between 'criminal insane' and 'ordinary' patients. There was, however, implicit recognition of this distinction in the granting of ground parole and town parole to eligible patients. These types of parole referred respectively to patients' rights to walk unescorted around the grounds of the hospital, and to their rights to go unescorted out of the hospital gates. Such rights were privileges to those who received them and were also implicit recognitions of patient improvement. The granting of these rights was the duty of the ward psychiatrist.

During the month that I worked as a nursing aide in Ward Four, the psychiatrist was only observed (by me) to visit the ward on three occasions. On each occasion, patients who were to see him were informed ahead of his arrival. On the first occasion there were over twenty patients in all who were informed of their impending interview, and all these were paid special attention by staff members, in a pre-visit 'smartening up campaign'.

Between staff and patient, the question "Are you ready to see the doctor?" came to mean, "Is your hair combed? Is your face clean?" and "Are your clothes neat?" Patients' names were called and they were individually inspected by nursing attendants. (Observed during pre-visit staff-patient encounters).

Between patient and patient, the question "Are you ready to see the doctor?" evoked rather different reactions. To the patients concerned, it invariably meant "Do you know today's date?" "Do you know where Valkenberg is?" "How long have you been in Valkenberg?" and so on. What the date was, and what weekday it was, became burning questions on which absolute certainty had to be attained. Such answers, it seemed, were necessary for the patient to prove that he was 'orientated for time and place'. (Observed in pre-visit patient-patient encounters.)

The psychiatrist himself was greeted on his arrival by patients excluded from his list. Their main query tended to be "when are you going to see me, doctor?" This was generally followed by promises that each one would soon be granted an interview, but not on that day. The

psychiatrist then entered the Charge Nurse's office, which had been transformed into an interview room, with a seat before the desk for the patient, a seat behind the desk for the psychiatrist and a seat on the side for the Charge Nurse. The latter would be ready to make comments, to answer the doctor's questions concerning patient conduct in the ward and to affirm or disconfirm the patient's own assertions about himself. It was the patient's task to ask for privileges such as permission to go on ground parole, town parole, garden work or library parole and to assure the doctor that he had earned this privilege by behaving himself in his present status and supplying good reasons for status advancement. (Observed in patient-psychiatrist encounters.)

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Sandy P told me about his interview with the psychiatrist as follows: "No; you see, I told the doctor last time I ran away I was sick, but I'm better now and I only want a chance to prove myself to them so they'll let me go home and see my brother. I promised the doctor I wouldn't run away again and he told me he would give me another chance, but if I tried to escape again I wouldn't be given any more chances."

Later I overheard him telling his 'chommie' (his buddy), "Well, if I do try to escape again I'll make sure they don't catch me, 'cause the doctor told me this is my last chance. I think if I run away again they'll certify me permanently."

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The patients who came out of the consulting room were quizzed by their friends - "What did he ask you?" - "What did you tell him?" - "Did you get parole?" These were standard questions. In this way, future interviewees would gauge the kind of questions they were likely to be asked, as well as their chances of being granted a particular request. "I'm also going to ask for parole. 'So-and-so' got it. I'm sure the doctor will give it to me too, if I ask him nicely." Comparisons would be drawn up on the basis of relative time spent in the ward and the kind of ward work the

requester was doing at the moment, and it was recalled what the doctor had told the patient at the last interview. It would be brought to his notice how the conditions he had laid down had been fulfilled by the patient in the interim. (Observed in patient-patient encounters.)

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"Hey Tom, guess what? I got ground parole."

"Jeez, you lucky bastard. How did you get it?"

"I'm lucky, hey? I told the doctor he promised me last time that he'd give me parole if I behaved myself."

"Did he tell you that?"

"Well, he didn't actually say so, but I told him he did and he believed me. The Charge told him I'd been working nicely in the ward, so he said if the Charge was still satisfied with my work I could start next Wednesday." (Patient-patient conversation.)

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Following the psychiatrist's visit, the ward would be literally 'transformed' for the rest of the day. With all the tension of waiting for the interview gone, even those patients who had been 'lying low' during his visit, who would habitually sit outside all day in their 'private' chairs, listening to their radios and leafing through magazines which they constantly carried with them (often rolled up and tied with string or old shoelaces) would call interviewed patients across to them, to ask about the outcome of the interview.

Discussions would ensue as to whose turn it would be next. Hard luck stories could be heard - promises unfulfilled ("he said he would see me next time") - fears of having been forgotten by relatives or the psychiatrists themselves, speculations about what one would tell the doctor next time, what request might be granted next time.

The nurses would join in the camaraderie with "You must be pleased about being able to go home next week-end". "Yes, staff. My sister said she would ask the doctor if I could come home for a whole weekend, but the

doctor said I should start with just Sundays first, and see how it goes."

With more 'serious' patients - the 'risky bets' - staff would make pointed jokes, such as, "If you feel like running away again, you better tell me first and I'll make you a sandwich lunch." Answered in the same half-joking manner, "No, staff. I won't try to escape again. I learnt my lesson last time. I want to be discharged now and go home properly." (Recorded from staff-patient conversation). Among themselves the patients would speculate: "He won't last long. The first afternoon he goes to town, they'll go to the 'X' hotel and pick him up drunk again. That'll be the end of his town parole."

"Hey, Johnny, did you tell the doctor you're going to go and beat up your sister again?"

"Nah, what. She's staying at my brother-in-law's place and I'm only allowed to visit them on Saturday afternoons. She's the one who's ... keeping me in this hospital. But her husband's all right. We'll probably go out for a drive and have a few beers then he'll bring me back again." (Recorded from patient-patient encounters.)

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Ward Status : Reactions to "perceived" demotion

In Hospital B, there is a road which separates the out-patient clinic and the so-called neuro-clinic from the remainder of the hospital wards. Across this road there is a bridge which links the two sections of the hospital to one another. This bridge came to assume tremendous symbolic significance to the patients in the neuro-clinic, such that, to be a patient in one of the wards 'across the bridge', was recognised as a definite social stigma.

Harold P had acquired a bad reputation among the hospital staff as a result of the 'inordinate' amount of attention he was paying to one of the female patients in the 'female section' of the neuro-clinic. As a result of the concern this attention was creating among hospital staff, Harold was asked to allow himself to be transferred 'across the bridge' to Ward Two, an all male ward, with - as the psychiatrist explained to him - "roughly the same

social status as the neuro-clinic". It was often used, he explained, as an overflow for the neuro-clinic when they had too many patients. In Harold's case (it was explained to him) his transfer was simply a question of the hospital's preference that he be treated in an all-male ward. Too great an emotional attachment between patients was more or less discouraged, as it could have adverse effects on those involved and on other patients as well.

"Hell, no," Harold said to me, "How can they send me across the bridge. Once they send you over there, that means you're mad. Hell no, I don't know what to do, man. Although I need treatment I wouldn't be able to face the world again if they sent me over there."

A choice was clearly put to him by his psychiatrist - either he went to Ward Two or he left the hospital. He decided on the latter course.

When I approached his psychiatrist to ask if I would be allowed to take him to his home that evening, I was told, "You can take him home, if you want to. That's your business. Once he's discharged that's the end of him as far as we're concerned. But why do you want to waste your time on him? He's a real good-for-nothing. He's capable of doing a day's work, but instead he stays at home and lives off his mother's pension; and when he comes here he just wants to chase after women. We offered him a choice to go to Ward Two, but no, it's all or nothing with him. If I were you, I wouldn't have anything to do with him."

It seems the psychiatrist himself was not aware of the symbolic meaning of the ward transfer, or, if he was, was not prepared to take it into account in his relations with Harold P. The latter's dilemma clearly lay in his fear of the stigma attached to 'demotion' 'across the bridge'. Such considerations, I was later to discover, were largely irrelevant to patients actually living on the 'other side'. One patient in Ward Two, whom I questioned openly about the difference between the two wards, said to me:

"No. There's no difference between the wards. It's just that they're on that side of the bridge and we're on this side. I know. I was a patient in the neuro-clinic before. We get the same food, the same treatment, everything. As soon as the doctor sees you are ready to go home you can

leave straight from the ward. Meanwhile there are patients in the neuro-clinic who are not allowed to leave. So what's the difference? There is no difference. We are just the same." (Recorded in Ward Two conversation with a patient.)

On the other hand nursing staff themselves would often jokingly threaten to send a patient "over the bridge", if he did not make his bed properly or perpetrated some other misdemeanour which gave staff extra work.

Requirements for a Comprehensive Understanding of Hospital Character.

It is only by observing the relations of constituent interactants themselves, that a total understanding of the overall structure and function of a mental hospital can be understood. For the sake of a clear theoretical line of approach, I am going to assume that the over-riding purpose of mental hospitals is treatment aimed at eventual 'cure' and social re-integration of patients into the extra-hospital society. As a theoretical variable, this purposive end may be considered as an 'independent variable', in terms of which all other activities can be construed as 'dependent variables.'

However, clearly, not all the activities in any organisation will be functionally related to this ulterior end. Therefore some activities can be considered as non-functional. Other activities still can be considered in terms of their obstructing, hindering or impeding the fulfilment of the institution's over-riding purpose. These can be considered as a dysfunctional.

At Hospitals B and C the activity called 'blocking' (polishing the floor by means of large felt-covered blocks on the end of the broom handles) was commonly put forward by the staff as 'work therapy'. At Hospital C one of the non-working patients (hence one presumably not benefitting from this type of therapy), told me, "When I just came to this ward, the staff tried to tell me I had to do ward-work if I wanted to be discharged. I just told them to off. I was a patient in Pretoria before. It's how you put your case to the doctor that matters, not what you do in the ward. You look at the floor polishers. Who are they?" (He named a few.) "All bloody feebs! Do you think they're ever going to be discharged? The feebs are the hardest

workers in the ward, and they're just the ones who are never going to leave this place." (Recorded in Ward Four.)

In Hospital B blocking would take the following form:

The blockers would push their blocks across the floor in a horizontal line, walking from one end of the room to the other. A patient 'overseer' would always be in charge of the 'blocking'. Such a role position would generally be filled by a long-term institutionalised patient, who generally tended to regard himself more as a member of staff than a patient. The overseer's 'orders' always tended to take a similar form, such as:

"Kom manne, Blok.' Block.'

"Ek wil 'action' sien",

and jocular remarks to individual patients who were slightly lagging in the action. For example, "Kom Johnson ek wil 'spirit' sien, " followed by laughter and humorous counter-remarks such as "Ou Manie wil 'n spook sien."

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"Kom Snyman, you're still a young boy, but you block like an old man already", rings out. All such remarks are followed by counter-remarks, accompanied by renewed effort on the part of all.

When the action falls, Manie apparently feels it to be his responsibility to start it up again. He urges the workers on as if his words are the embodiment of the action wanted of them, "Laat waai!' Laat waai! Laat waai! Laat waai! "

Tulleken P looks to see if his shoes are spoiling the surface as he sweeps behind the blockers. There is always one worker who walks behind the rest to sweep up as they polish. Manie says to him, "Tulleken, jy moet kaalvoet vee. "

"Wat? "

"Ja, al die manne in Ward 4 (a lower ward) doen hulle werk kaalvoet. "

"Nee. Ek is nie mal nie. " He looks around for agreement, laughs off the implications and returns to his sweeping.

"Kom. Daar's nog baie 'jobs'. Jy't net vir tien minute geblok, " Manie resumes his shouting.

Gradually the blocking slows down in pace. Remarks and mumblings begin. Soon general agreements emerge. "Ons is klaar. Kom ons loop."

* * * * *

The blocking is over. Blocks are put in the sun to dry.

* * * * *

To decide whether activities such as 'blocking' are functional, dysfunctional or non-functional one more distinction must be made. This distinction points to the actual functional alignment of participants. Such functional alignment can be gauged only by considering the subjective intentions of those involved in the activities themselves.

Merton (1957) speaks of 'manifest' and 'latent' functions. Manifest functions can be considered as those objective consequences contributing to the overall functional adjustment of the system which are recognised and intended by participating members. Latent functions, on the other hand, comprise those objective consequences occurring within the system which are neither intended nor recognised.

Looking at the position logically, it would seem reasonable to suppose that manifestly dysfunctional activities would be sanctioned and tend to be purposefully reduced, manifestly functional activities would tend to be encouraged, and manifestly non-functional activities would tend to be ignored up to the point where their over-riding presence would cause a displacement of functional activities, whereupon they too would be considered dysfunctional and tend to be purposefully reduced. Conversely, latent functions would, by definition, go unnoticed by controlling members of the organisation.

The existence of latent functions in social systems leads to the possibility of analyses of these in terms of their structural 'credibility', which in turn raises the question of their effect on the institution's general functional viability, in terms of the fulfilment of its institutional purposes.

The term 'character', used in the heading of this chapter, is used in the sense defined by English and English (1958), namely, "an integrated

system of traits or behaviour tendencies that enable one to react, despite obstacles, in a relatively consistent way in relation to mores and moral issues." In a similar vein, Riesman speaks of 'social character' as "that part of character shared among significant social groups." (Riesman, 1950) The notion of 'social character' permits us to speak of the character of communities, of classes and of professional groups.

In referring to the 'character' of mental hospitals, the same notion applies. In order for a mental hospital to function adequately, according to its purported social purposes, it would seem necessary for its participants to acquire the kind of character that makes them want to act in ways they will be obliged to act within the type of social system it prescribes. Yet this is to assume a priori the functional viability of the character of mental hospitals, more especially, their functional viability insofar as this reflects the permeability with which behavioural tendencies engendered in the hospital environment relate functionally to the behaviour tendencies expected and required of adequately functioning members of the wider community. This, then, is the crux of the matter. Functional alignment with certain 'desired outcomes' as they present themselves in the hospital may well lead to the type of patient colonization usually referred to as 'institutionalisation' - a recognised dysfunction of many mental hospitals. To expose such dysfunctional processes, it is first necessary to evolve a technique for investigating dysfunctional processes in staff-patient 'situations'.

In considering the role played by vocabularies of motive expressed by various reference groups in the mental hospital, and in relating these to the purported purposes of the hospital as a social institution, distinctions between manifest and latent functions become clear. Whether these functions are in fact functional or whether they are non-functional or dysfunctional is something that requires further individual consideration. In taking this line, due consideration is paid to Nagal's view that "unless subjective-aim-in-view is explicitly introduced as a special state co-ordinate, Merton's distinction between manifest and latent functions is vacuous, and all functions fall under the heading of 'latent functions'". (Nagal, 1969).

By introducing subjective-aim-in-view in terms of 'motives' and 'motive vocabularies', the character of various hospital processes is now open to analysis in structural-functional terms. (See Chapter Eight).

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CHAPTER III: THE ROLE MODEL - A PSYCHIATRIC PERSPECTIVE.

Situations and roles - normative expectations - situated role functions - rights and obligations - ritualistic adjustments - ego and alter aspects of roles - role validations and role commitments - granted and attained roles - validations in role of mentally ill person - demand situations - self-defining implications - demonstrations - metacommunicative messages - double-bind situations - cultural adjustments - moral careers - career contingencies - hospital implications.

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In the previous chapter, the form taken by certain reciprocal relations between staff and patients was described and demonstrated. In this chapter, relations between staff and patients are placed within a role theory context. The relevance of this context for an understanding of the therapeutic implications of staff-patient relations is discussed.

Situations and Roles

An individual normally expects that he will behave in a certain manner under regularly encountered conditions. He usually has rather definite expectations with regard to the conduct of other persons with whom he interacts. The significance of such expectations may be demonstrated by envisaging the opposite state of affairs - one's first day at a new and unfamiliar job for example. A person's behaviour is contingent upon his anticipation of how others will react toward him. The attitude and anticipations of others are inferred from subtle cues provided by appearance, facial expression, posture, mode of address and tone of voice, by comparison of previous and current behaviour and by the situational context within which the interaction takes place. Through long experience in familiar situational contexts, the processes of inference and anticipation are simplified for an actor by his automatic categorization of behaviour as representative of a particular class of distinctive behaviours. Behaviours

characteristic of situational contexts are termed roles.

Anticipations centring around role - behaviours of others are usually only correct and well established in previously encountered situations, where those involved have certain shared experiences in common. Each interactant shares expectations with regard to his own behaviour and the behaviour of others. Such expectations have a normative quality in that failure to comply with anticipated conduct usually meets with some sort of censure. Alternatively, unusual behaviour is contextually explained away by indicating its significance relative to other commonly experienced situations. Behaviour may in this way be transferred from one situational context to another on the part of some or all of the interactants involved. Roles may, in this way, be expanded to embrace situationally irrelevant behaviours which are yet understood by those involved and serve to ease the strain of too great an identification of collective individuals with their situated roles.

The function a role plays in a particular situation may be related to the goals, or motives, shared by interactants. The function of the role can also be related to the position of the role-player with respect to other role-players in the situational context. The expectations associated with a position specify particular conduct with respect to the occupants of other positions. Functional positions and counter-positions in a situation where interactants are co-operating to achieve a particular goal can thus be specified. These positions and counter-positions can in turn be related to certain rights and obligations which their occupants come to assume with respect to one another. When a client pays a medical specialist a visit, for example, he has a right to expect the expert attention of the specialist in the particular practice of his profession. The specialist, on the other hand, has an obligation to his client to give him the best attention he is qualified to give. There is a range of permissible behaviour which is defined by the context of the interaction, and each interactant is accountable for the way in which he fulfils the demands which the situated context places on his conduct. Having given the client his expert attention, the specialist in turn has a right to expect due payment for

services rendered. This role reciprocity is symbolically communicated and situated conducts can thus be spoken of as having a ritualistic quality, in that, in terms of expectations associated with role positions and the ability of actors to meet these expectations, each shows how worthy he is of respect or how worthy he feels others are of it.

Ritual adjustments

"Co-operative activity ... requires that the occupant of each status act towards others in a manner which conveys the impression that his conception of himself and of them is the same as their conception of themselves and him." (Goffman, 1951). For every social interaction a certain working consensus is taken as background; a certain social structure and behavioural norm is taken as a framework, within which individuals proceed to co-operate with one another.

In all group life four features typically emerge (Znaniecki, 1959; Sherif, 1954). These are:

- (1) The sharing of motives or goals;
- (2) The presence of norms setting boundaries on interpersonal relations,
- (3) The presence of roles which become stabilised, and
- (4) The emergence of a network of likes and dislikes of members for one another.

The theoretical recognition of such features within the social group provides a framework for conceptualising not only the bonds uniting collective individuals, but also for bringing about an understanding of the 'subjective content' of the other. The keys to such an understanding lie in the meaning of ritual adjustments, made by and large through inference. People tend to be aware of much more than they have actually experienced. Restraining and guiding influences tend to a large extent to be symbolically communicated, inferred, and encompassed. The other with whom I interact is not simply an object to be responded to but one with whom I act in common. This commonality, which forms a working basis in terms of which our interaction proceeds, receives symbolic recognition whenever our interactions are in need of being stabilised.

Consideration of Piaget's concepts of 'assimilation' and 'accommodation' may be of interest here, as far as their theoretical implications for role theory are concerned. Assimilation is the process whereby new features are coped with by means of established constructs, while accommodation is the process whereby an individual's constructs are modified to cope with new and unusual contingencies. Translating these terms into a role theory context, assimilation might be seen to refer to the way an individual copes with new situations by means of established role patterns, while accommodation refers to the learning of new roles, or the modification of old roles in order to meet new and unusual cultural expectations and contingencies.

A Demonstration :

On the occasion of my first meal as a patient at Hospital A, I thought I might simply walk up to a place at the tables, sit down, and begin eating as I expected everyone else would. However, I was unprepared for the rush for seats which I encountered and could not assimilate this cultural feature of patient behaviour into the style I had assumed I was going to adopt. My confusion was soon allayed, however, by one of the patients, Robert 'Zamfumf', who said to me, "Hey wena Mlungu. (Hey, European). Sit here. This is your place." Expectations regarding my behaviour as an 'alter' - a collective subject - thus seemed to have taken on timely definition. I soon noticed, however, that I was sitting in close proximity to the only two other Europeans in the hospital. These patients, as I later discovered, Zamfumf had taken under his wing (so to speak), because he believed himself to be a prophet of God, and, as far as he was concerned, Europeans were a 'chosen people' sent to bring the black peoples of Africa out of their ignorance, and were therefore deserving of his special attentions. An alter role as one of Zamfumf's 'chosen' (he also claimed to be God Himself) would have been an embarrassing one for me on both social and methodological grounds. It was a role position to which I could not accommodate myself. Not only was it personally distasteful, but I felt it would also jeopardise my

relations with other patients whose basic assumptions differed from those of Zamfurf.

Ego and Alter Aspects of Roles

Inter-relations between ego and alter modes of activity become clear in the above example. The 'ego' aspect refers to an individual's personal orientations and motivations, while the 'alter' aspect refers to those aspects of behaviour that reflect recognition of a set of public proprieties. The way individuals conduct themselves in social situations, be this behaviour motivated by personal attitudes or public circumspection, will form the basis of their "alter records" (Stoodley, 1965) - records of their meaning to others. In this way each individual in a social system is subject to both expectations and evaluations which cluster around automatic social reactions to role positions which he assumes. Social roles are "self-defining" (Goffman, 1961).

The bonds of mutual role engagement imply certain broad conceptions of persons tied by them. To engage in a particular activity in the prescribed spirit is to accept being the sort of person who lives in the assumptive world underlying the role.

Role expectations are thus also expectations regarding assumptions about what the world is like and how one ought to deal with it. The working consensus which releases common action in the group reveals a particular consciousness of group realities. To say that common purposes exist within a group is to say that perspectives blend and confirm each other. In this way, social meanings introduce order into the diversity of signals reaching group members, confining them to a range of cues in terms of which problems which arise within the group can be controlled and manipulated.

Theoretical encompassment of the relations between individual role-enactments and group role-expectations is made possible through analytical distinctions clarified by K. T. Erikson (1957) who identifies 'role validation' and 'role commitment' as complimentary processes in the establishment of social identity.

Role validation is the process whereby a group gives a person certain expectations to live up to, providing him with notions as to the type of conduct it considers appropriate or valid for him. Role commitment occurs when an individual adopts a certain style of behaviour as his own, committing himself to role themes that represent the kind of person he assumes himself to be, and best represent the social position he considers himself to occupy.

The ego aspect of an actor as 'self-affirmer' is thus constrained by his alter aspect, by his being an 'object affirmed'. So long as an actor is a participant in a social system he will never be free from the expectations accorded him as a public self. The collective individual is thus also aware of himself as an alter, constrained to act within situations structurally circumscribed by anticipated consequences for various social acts, his conduct being imputed with certain socially-defined motives specifically linked to the social system in which he is involved and the social role validated for him within it. A limited number of roles is open to any particular individual within the boundaries of a social system.

Sarbin (1969) considers the establishment of social identity in terms of an encumbant's acting out his role choices in such a manner as to make good his previously established 'granted' and 'attained' roles. In this way, the dimensions of social identity can be viewed as components of the role system within which the individual is required to act.

Granted roles may be considered as roles which one is expected to enact simply by virtue of the fact that one is a recognised alter in a particular situation. One is expected, for example, to fulfil the role obligations central to family and work relations in any social situation without expecting any special acclaim for this conduct. Non-fulfilment of these basic roles on the other hand is apt to receive the strongest of negative valuations. Attained roles, by contrast, are roles-by-choice, the performance of which opens the encumbent to rewards of social approval and prestige. These roles are not obligatory and their non-performance does not meet with strong negative censure. Examples of these are the role

positions of a successful athlete, a student who has passed an examination with honours, a good public speaker and so on.

A basic postulate of Sarbin's model is that human beings act in such a way as to locate themselves accurately in their social environments. This is an inferential process. On the basis of available cues, and of the individual's knowledge of the role system, he infers the role of others whose behaviour is consequentially relevant to his own and concurrently of his 'social self'. (an alter) engaged in mutual monitoring of certain social consequences with other alters. Since answers to questions concerning one's social identity lie in the nature of the role relations in which one engages, it is possible to look for the social bases of disordered conduct in terms of their social instability (Klapp, 1969), social impermeability (Goffman, 1961; Jourard, 1964), meaninglessness (Goodman, 1967; May, 1967) or their double-binding properties (Bateson, 1956; Laing and Esterson, 1964).

Sarbin (1969) speaks of the "perjorative labelling of 'mentally ill' " as a process of validating degraded role positions for a person unable to perform properly his granted roles. He sees this process as a vicious circle activity.

Legitimate opportunities for obtainin role-distance are absent when one's identity is composed exclusively of granted roles. Because of the nature of these roles, their performance receives little or no positive public valuation, while their non-performance receives strong negative censure. At a certain stage, Sarbin argues, the individual raises the question of whether the pay-off, in attempting to enact granted roles, is commensurate with the high degree of strain involved in their unsuccessful enactment. Validation in the role of a mentally ill person isolates one from the mainstream of everyday social life, but it nevertheless relieves one of the burden of having to 'prove' one's 'normality' in the face of a personally degrading alter record. It is in this context that the social function of the mental hospital, in stabilising normal conduct, is viewed. It is with these considerations in mind that situations in mental hospitals can be judged, relative to the manner in which they fulfil this function.

Situated Roles and the Medical Model of Mental Illness

Laing (1967) has argued against the continuation of degrading practices in the hospital context itself. He says, "It is wrong to impute to someone a hypothetical disease of unknown aetiology and undiscovered pathology unless he can prove otherwise. Treatment of a person as an object-to-be-changed rather than a person-to-be-accepted, simply perpetuates the disease it purports to cure." Similarly, Goffman (1961) speaks out against the hospital's posing of a dilemma to patients who wish to have their normality taken for granted, but are yet continually confronted with situations which are all potentially "test situations of their normality".

Sarbin (1969) proposes that the social conditions that promote degradation also retard the development of differentiated concepts and related constructual frameworks for modulating conduct. For this reason, the employment of socially impermeable techniques to reduce strain tends to be more extreme among degraded people. Behaviourists such as Wolpe & Lazarus (1966) and Ullman & Krasner (1969) regard disordered behaviours as maladaptive forms of coping, in the face of problematic environmental conditions and pressing social demand contingencies. Ullman and Krasner (1969) define a 'demand situation' as the "totality of cues which convey a particular expectation to the subject in regard to his own behaviour."

The structuring of expectations

Whatever type of therapy is employed, the patient's social relationships are certain to receive consideration, and directives relating to them must sooner or later be made either explicitly or implicitly. Bandura,

Lipsher and Miller (1960) have shown how therapists control their patients by (at least) rewarding them with approval and interest when they behave in the prescribed manner and 'punish' them by withdrawal of interest or other subtle forms of disapproval when they behave in a manner contrary to the therapist's objectives. Likewise, Rosenthal (1955) has shown how patients' revisions of their own values tend to change in the direction of therapists' values, even under so-called 'non-directive' therapy.

In his book 'The Divided Self', Laing (1964) gives an outline of the aetiology of schizophrenia in the role playing sense. Where the individual is constantly not presented with a clear and definite self-image or where his self-image is continually contradicted by others, he begins to live in an imaginary world to sustain an acceptable self-image or to create a new one. Laing says, "if this were possible, there would be no need for psychosis." The imagined advantages for what is felt to be the 'true self' are isolation and freedom from the infringements of others. The actual disadvantages are that this isolated self is unable to be enriched by outer experience, so that his 'inner world' becomes more and more impoverished. Since relationships of any kind are experienced as identity threats, he feels safe only in hiding and isolated. This becomes the basis of his social identity.

Goffman (1961) has described the manipulation of patients' self-concepts in mental hospitals. Firstly, role dispossession occurs. The patient is separated from all contact with his usual social environment so that he can no longer identify himself with roles he is used to playing. Property dispossession is part of this process. The patient is given a standard set of clothes to wear, his private belongings being removed into safe-keeping. Whatever the intent of the staff, such procedures as shock therapy and the administration of drugs lead inmates to feel they are in an environment which does not guarantee their physical integrity. In the system of administering punishments for undesirable behaviour and rewards for so-called 'insight and co-operation' the inmate may be reduced to further physical indignities, but he is nevertheless rewarded for increasing compliance, and so a 'cure' is effected by building up a new 'self'.

In his consideration of therapy as a 'relearning' process, May considers as one of its primary aims, increase in the patients self-awareness, or, "the capacity of the individual to treat himself as subject and object at the same time." (May, 1953). Therapy itself he sees as a process whereby an individual overcomes his previous unfortunate learning experiences which have resulted in a blocking off of awareness, curtailing of actions and the development of substitutive gratifications on less mature levels (that is, 'symptoms'). The goal of therapy, as he sees it, is clarified relatedness to one's self and to the other persons in one's interpersonal world.

Reflecting on his own specific brand of 'non-directive therapy', Rogers has the following to say of 'self-experience'.

"In the security of the relationship with the client-centred therapist, in the absence of any actual or implied threat to self, the client can let himself examine various aspects of his experience as they actually feel to him, as they are apprehended through his sensory and visceral equipment, without distorting them to fit the existing concept of self. Many of these prove to be in extreme contradiction to this concept of self, and they could not ordinarily be experienced in their fullness, but in this safe relationship they can be permitted to seep through into awareness without distortion." (Rogers, 1953)

Surely, one might be tempted to argue, when one is alone in one's own solitude, one might allow oneself to experience one's own feeling in a similar fashion? What is so special about the client-centred relationship? The answer to this question, I suggest, lies in the particular 'ego' evoked by the 'alter' of the therapist. To a large extent, the alter of the client-centred therapist is an alter of the client's own choosing. He nevertheless functions as one who "reflects back" (Rogers, 1953) what he considers to be important aspects of the client's experience, or, rather, what he (the therapist) considers the client should take up as important aspects of his (the client's) experience.

The client-centred therapist exists to a large degree in the personal world of the client, yet he exists there as 'himself' - not as 'the client' - so that he still mediates as a representative of the 'sane' world. Rogers indicates that the client in client-centred therapy not only learns to accept himself but actually to "like himself". But which 'self' does he

like? It would seem apparent that he likes the self whose social role, in therapy, the therapist has validated.

May sees so-called patient 'symptoms' as the individual's way of shrinking his world so that his self, as he experiences it, may be protected from threat, blocking off certain aspects of his environment so that he may be "adequate to the remainder". (May 1967). In a similar vein, Cummings and Cummings (1962) point out that what they call the "ego-damaged patient" is, in a sense, "deculturated". They see the goal of the mental hospital, in its dealings with him, as bringing him into sufficient relation with social life as to enable him to work out his own unique compromises between individuality and conformity. They state:

"The restoration of acceptable behaviour is particularly important for a mentally ill patient, because it helps restore to him the label 'normal', that leads to social acceptability. This in turn should allow a patient to attempt more difficult tasks and to develop stronger, more complex and more clearly differentiated ego organizations and greater ego ability." (Cummings and Cummings, 1962)

This is clearly in line with Sarbin's (1969) thinking about the relation between granted and attained roles. One cannot establish oneself in attained role positions until one's granted roles are taken for granted. In failing to achieve validation in an achieved role position one can always fall back on granted roles in order to 'save face'. "Consequentiality" (Goffman, 1969), in terms of expected outcomes, is reduced by spreading role identification into other areas of role competence, thus creating for oneself 'role distance'. By contrast, persons labelled 'mentally ill' are denied such techniques for acquiring role distance. Furthermore, their attainment of mastery over granted role performance is a painful process under normal circumstances, since their non-performance or poor performance of granted roles is simply socially unacceptable. Wide general acceptance of 'normal' standards makes the non-performance of granted roles socially inadmissible, since their performance indicates a ritual acceptance of normal standards, and their non-performance is thus likely to be viewed as rejection of accepted standards.

Bateson (1968) and Laing (1968) both point out that the nature of "the obvious" can be very difficult for people to see. This is because people are self-corrective against disturbance, especially where such disturbances appear to rub up against accepted standards of conduct. Such standards form basic points of orientation for the guiding and regulation of normal, socially acceptable conduct, and cannot themselves be put in question. Basic interpersonal accommodations are made through common adherence to such standards. Granted role enactments correspond to a recognition of these standards. Such standards are thus metalogical points of reference in cultural systems - basic assumptions not open to dispute. Expectations for their performance consequently remain as metacommunications which are implicit rather than explicit, giving precision to the meaning of manifest explicit messages. (Bateson et al, 1956)

Ullman and Krasner's (1969) detailed argument that behaviours traditionally called 'abnormal' are no different either qualitatively or quantitatively in their development and maintenance from so-called 'normal' behaviours, is given added force by Laing and Esterson's (1964) demonstration of the operation of the 'double-bind' in the family relations of schizophrenic patients. The 'double-bind' itself is a situation which results when the meta-communicative message contradicts the manifest message. Laing and Esterson argue that this pattern, if repeated, is schizophrenogenic.

In like manner, Cummings & Cummings (1962) point to the fact that certain mothers derive great pleasure from caring for dependent defective children. Outside efforts to help these children toward independence run up against learned patterns of dependent decision-making, which need to be countered within the subject's own family. Although they do not go so far as to call these mothers 'defectogenic' the type of vicious-circle quality they point to in these mothers' relations with their children is demonstrably similar in kind to the type of behaviour-maintaining patterns found in schizophrenogenic families.

Similar vicious circles may be perpetuated in mental hospitals by unwilling initiation of bizarre behaviour patterns by certain patients and/or staff members. These sequences are then perpetuated by subsequent

baiting of the subjects by both other patients, and also by staff members (occasionally).

In Hospital A, Mangis! P would fly into a rage on being told he was going to be "circumcised". He eventually learnt to cope with such baiting by ignoring the insult and asking for tobacco. His request was usually refused by the answer "Alikho" (There isn't any), after which refusal he would retreat to a less frequented part of the hospital grounds without fear of further molesting. His request "Awungitshel' igwayi" (I am asking for tobacco) became a standard opening verbal gambit whenever he was approached by anyone, staff or patient. At a later stage, a secondary sequence was brought into play by having him "praise the chief". Baiting, at this stage, took the form of demands that he "Bonga!" (Praise), after which he would sometimes be given tobacco and sometimes be asked to praise over and over until a show of temper was once again provoked. His conduct thus vacillated between isolated standing, or sitting, and 'tobacco request - praise demand' or 'praise demand - tobacco request' sequences. These behavioural sequences can thus be seen to have been mutually perpetuated as expectations, regarding contact between himself and others, became standardised along these lines.

As Parsons (1951) has pointed out, 'mental illness' both inside and outside the mental hospital is not merely a condition but also a social role. Inside the hospital, the functional relationship existing between patient and therapist tends to take on the following aspects:

Patient Role Characteristics:

- (1) Exemption from normal social obligations
- (2) Exemption from responsibility for his own condition
- (3) The obligation to co-operate with persons socially sanctioned to help him
- (4) General social pressure for him to return to a state of health as soon as possible.

Therapist Role Characteristics:

- (1) Permissiveness with respect to the patient's expression of wishes and fantasies that would not be permitted in normal social relationships.

- (2) Treatment of the patient as though he were not a responsible adult.
- (3) Conditional support and conditional manipulation of sanctions
- (4) Assumption of the social obligation to do all in his power to help the patient.

In this context, it is possible to discern the double-binding effect latent in therapist-patient and staff-patient encounters, mentioned by Goffman (1961). Thus the patient may face the dilemma of wishing his 'normality' to be taken for granted, while at the same time being constrained to play the role of a patient (a mentally ill person).

My assistant-staff wrote up the following account of a heated episode in a patient discussion on the prevalence of homosexuality at Hospital A:

"We can't afford to leave our homes thinking that we come to a hospital, but when we come here we are used as women at night by people like M, N, Q and G." (Names omitted)

"You, M! You say you are working but the only thing you know is to sleep with boys."

"It is not surprising," he carries on, "that you hit J today. He was playing with you, his lover, but you are in a bad mood so you hit him."

Mbingo S, a member of staff who was passing by, shook his finger at the speaker and warned him to keep quiet. But the latter refused.

"Yes!! Mbingo!" he shouted, "I will not stop. In this hospital when we voice our views you people say we are mad and you give us injections. Go and get one ready for me when I'm finished talking."

Cummings and Cummings (1962) use the term 'milieu' to refer to a "specifically planned environment". In their consideration of the value of various forms of milieu therapy, they assume throughout that patients who are restored to interpersonal and occupational competence are no longer ill. They state "----- we explicitly exclude the assumption that personality can be conceived of as pathological while behaviour persists as normal." (Cummings and Cummings, 1962)

In mental hospitals where certain maladaptive behaviour patterns are encouraged, or at least permitted, and where adaptive behaviour patterns can

demonstrably be shown to be actually discouraged, what can be considered as culturally-induced conduct results. In terms of the 'role' model, assumed here, the 'culture' of a hospital may be considered as "the sum of expectations for the roles of all members of a group plus the expectations for behaviour of members in general." (Hare, 1962)

Ullman (1967) notes that requirements for behaviour inside the hospital may be incompatible and even contradictory to behaviour expected outside the hospital. He points to the advisability of hospital staff deciding when individual patients have reached a point of diminishing returns, such that gains in terms of alleviation of residual psychiatric symptoms are more than negated by the process of disculturation associated with prolonged hospitalisation.

In speaking of the 'moral career of the mental patient', Goffman makes it clear that the 'moral' aspects of the patient's career which he refers to, are concerned with "the regular sequence of changes which that career entails in the person's self and in his framework of imaging for judging himself and others." (Goffman, 1961). An important concept here is that of 'career contingencies' - objective causative factors influencing behaviour in definite directions. Commitment to certain lines of conduct involves the subject in subsequent situations, which, because of the fixed and independent character of many institutional arrangements, irrevocably conditions certain other possibilities of his life. By and large the concept of 'career contingency' refers to the unanticipated consequences of involvement in certain undertakings, causing other persons to build up their activity on the basis of the subject's continuing in these undertakings - the 'alter records' he builds up in his relations with others.

Becker (1963) suggests that in looking at cases of intended non-conformity one ought to ask how the person manages to avoid the impact of conventional commitments. Parsons' (1951) observation of the characteristics of the patient-therapist relationship is important here, especially those aspects which deny the patient's responsibility for the 'symptoms' of his 'illness'. An important sidelight is cast on this issue by Sykes and Matza's (1951) observation that insofar as a deviant can define himself as

lacking responsibility for his deviant actions, the disapproval of others is sharply reduced as a restraining influence.

Goffman (1961) comments on the apparent "normality" with which patients conduct themselves at mealtime, washing time, time for tobacco ration handouts and so on, dropping their characteristic psychiatric 'symptoms' in order to attend to the business at hand. Braginsky, et al (1969) propose that the mental patient's admission and retention in the hospital are more a function of the "secondary purpose" of symptoms than their "primary purpose", commenting on Freud's (1936) recognition that "while symptoms might emerge primarily in the service of anxiety reduction, they later assume a more gratifying significance in their influence on the social world." For these authors, the importance of 'symptoms' lie in the part they play in controlling outcomes in social situations. They are considered as a form of social communication. Braginsky et al's objection to the concept of 'mental illness' is that it reduces recognition of the properties of interpersonal control present in so-called 'symptoms'.

This objection is extended, in this thesis, to the absence of recognition of behaviour-inducing properties of mental institutions themselves.

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CHAPTER IV : WITCHCRAFT, MAGICAL THINKING AND PSYCHIATRY -
SOME CROSS-CULTURAL MODELS OBSERVED.

Assumptions underlying roles - magical thinking - specialists - diviners - examples - inyangas (witchdoctors) - examples - specialist/client rationales - Hospital A - Hospital B - structuring interpersonal relations - inyangas - African Zionists - limitations of hospital paradigm - accountability - the mental hospital in a tribal-traditional setting - tribal beliefs and Westernisation - generation gap - cross-cultural exclusions - therapeutic rationale - constitutional accountability.

* * * * *

By virtue of the fact that role expectations may also be viewed as expectations regarding assumptions about what the world is like and how one ought to deal with it, situations which call forth certain role expectations may be scrutinised in terms of assumptions about the nature of the 'world' which they exemplify. Such constructions of reality may be termed 'models'. Model building (as a scientific activity) involves the use of linguistic symbols, along with the rules of their manipulation, to represent objects of experience and to organise these in a comprehensible order, so that, by symbolic manipulation, one may arrive at a representation of what has not yet been observed. The role model put forward in Chapter III is an example of such an activity. This model represents an assumptive 'world' in terms of which a social psychologist might approach the reality of a mental hospital for purposes of scientific study. Using the same theoretical model, various persons or groups of persons engaged in situated role enactments can be scrutinised in terms of the model of reality which they, in turn, can be shown to have assumed.

In Hospital A, which forms the focus of most of the remaining observations to be considered, a number of epistemologically disparate models of reality can be shown to co-exist, resulting in a variety of

possible considerations about the nature of the presumed condition of patients and views as to the best mode of dealing with it. These models are discussed below:

Magical Thinking and 'Specialists':

The fact that certain people think in personal terms and seek largely personal causes for their misfortunes can not solely and simply be put down to the fact that they have an 'inadequate' control of their environment. Practices which can be logically reduced to assumptions inherent in magical and personalistic thinking still need to be understood not only in terms of practical problems faced by collective individuals, but also in terms of the moral problems central to the living reality of the culture in which they live. (Wilson, 1951)

The basically peripheral treatment of the practices of witch craft divining and herbalism which follow are intended merely to focus on some of the mutual monitoring processes involved in the various situated encounters which these practices call forth and to draw attention to beliefs and expectations underlying these.

Distinctions can be made between herbalists, diviners and witchdoctors.

(1) Diviners.

Diviners are able to divine information concerning the causes of personal or family misfortune, but they do not themselves use medicines. The causes of misfortune may be construed either as personal or ancestral in origin. The diviner's function is solely to search out the causative agent and not to direct remedial action with which it may be combatted.

The use of diviners among hospital staff was frequent, but mostly covert. In some cases my assistants became confidants and only transmitted knowledge of persons, events and circumstances to me on the understanding that I would not openly pursue the matter.

Examples: (1) 'Vamna' (Listen to me) is a herbal mixture, whose effect is supposed to make the recipient to the one, who,

having secretly given this medicine to her lover - usually mixed in with food - is capable thereafter of making him conform to her every wish.

Moses S was most hurt by the fact that it was the girl he was actually in love with who had given this 'vamna' to him. It was not necessary, he argued, for her to use any such medicines with him, since he was already 'deeply in love' with her. Such underhand methods of gaining a man's attentions were only justified where there was no true love. In trying to console him, the friends in whom he had confided argued that, since he was really in love with her, it made no difference that she had used medicines with him, and only proved that she was determined not to lose him. Behind the scenes, however, they secretly agreed that it was not really the right thing to do, and backed this judgement up by citing cases of husbands, who, deeply in love with their wives before marriage, had turned against them after marriage, realising that they had been 'tricked' into marriage by having been deceived with love potions (mistakenly believing they were actually 'in love').

Other such known use of diviners occurred as a result of:

- (1) the death of a near relative,
- (2) the loss of an engagement ring,
- (3) another (different) case of 'vamna', and
- (4) loss of money.

Two of these were openly communicated to me, personally. They all involved hospital nursing staff.

(2) Witchdoctors and Herbalists.

Witchdoctors can be distinguished from herbalists by the fact that they have been 'called' by certain spirits to become 'inyangas', whereas herbalists have no vocation, but have only learnt the use of certain herbal mixtures to cure various ailments.

Witchcraft is concerned with 'supernatural technology', although witchdoctors are not precluded from using ordinary herbalistic measures which can be 'understood' by their clients. True witchdoctors are also herbalists. The converse is not true.

Being 'called' usually involves a time of psychological disturbance, and a number of patients had come to the hospital claiming to have been 'called' to become witchdoctors. Among these were some persons who were truly believed to have been called, while others were outrightly declared to be 'fakes'. The criteria, it seems, are best understood by specialists in these matters, who can discern between 'true calling' and mere psychological disturbance. The fact that being a witchdoctor is often connected with being in a certain family with a history, or line, of witchdoctors, does not conclusively prove anything either way; that is, it does not indicate that people in these families are more prone to psychological disturbance than people in other families (conversely, that there are more 'callings' in these families than in others) nor does it indicate that psychological disturbance in these families is more likely to be diagnosed as 'calling' than in other families. The latter is, however, a conjecture which may hold water.

One patient, Mkehla P, who had a sister who was a recognised witchdoctor was widely considered by both staff and patients to be a witchdoctor himself. Although he was not a diviner, he also claimed a certain ability to tell truth from falsity through the use of a small pocket Bible. On two occasions he called me aside and asked me a number of questions, looking intently at me throughout, and then opening his Bible to read at random a passage which the open page revealed to him. He would then shut the Bible and pronounce either "Inyaniso" (It is the truth) or, contrariwise "Unamanga" (You are lying) or more politely "Chahlakaniphila" (No, you are being clever), laughing and shaking his finger at me.

(In Hospital C, where I worked in 1965, an Afrikaner patient, who considered himself a sort of prophet, would likewise decide on the likelihood of certain events by opening his Bible and reading passages on the opened page. This practice known culturally as 'om die Bybel oop te slaan' (to open the Bible) seems to be widely used among less technologically advanced persons to enable them to make important decisions. Specialisation in this field, possibly boosted by a 'good memory' for correct prediction, and

the fact that 'successful clients return' would seem reasonably to lead to a claim to prophethood or divinership.)

Cultural Beliefs and Practices:

Kuper (1947) points out in her work on the Swazis, that "the co-existence of missionary and 'magician' has led to a weakening of the ancestor cult, but has reinforced belief in supernatural power."

In my experience, the same is also true of pharmacological developments. Here, no distinction is made between the methodology of medical scientists and that of witchdoctors.

Among patients who had been hospitalised for some time, ten out of twenty five, randomly selected and questioned by my assistant-patient, indicated, without provocation, on being asked how they felt the hospital was treating them, that they would like to leave the hospital in order to see if "African medicines" could not help them where "European medicines" had failed.

One patient, Clement P, whom I would be inclined to describe as 'paranoid', initiated a discussion among patients when he refused to take pills prescribed for him by the doctor, which were being handed out by African nursing attendants. "These pills are not pure", he argued. "The staff are mixing them with African medicines with the result that they are now very dangerous." (Recorded during a pill handout.) I noted that at least four patients subsequently hid their pills in their clothing or spat them out, at the next pill handout. As a result of this, the staff began checking that each patient swallowed his pills as soon as he received them. Their mouths were searched before they passed. Clement indicated to me that this just "proved" his suspicions.

Nor were these beliefs confined to the patients alone. Mike S, a staff member, explained to me that certain diseases were peculiar to the Swazi nation and that European medicines would be of no use in curing them. He pointed out six patients (who were long term patients in the hospital) to illustrate his case. "Every nation knows and can cure its own particular diseases," he told me. "This particular disease of the Swazis is caused

by insects in the head and shoulders. These are very small insects and they move about very fast and drive a person mad."

The way to cure this disease, he explained to me, would be as follows: The person so afflicted would be given a boiled mealie to eat and he would then be given medicines to take orally, while some of the same medicine was put into his anus. This had the effect of attracting the insects from the head and shoulders which would then feed on the mealie, at the same time preventing their escape. The subject would thereafter be watched until he wanted to defaecate. This was done into a pit. Boiling water would be poured on these faeces, which would contain the insects. If one of these insects escaped alive, the sufferer would 'run mad' until he died. If they were all killed, the patient would be cured. One of these insects would then be taken and burnt and its ashes incised into the scalp and shoulders. This would protect the individual against a recurrence of this disease in future.

In analysing the above procedure, we see that its possible failure to cure is as thoroughly explained as its possible efficacy in curing. This 'safety valve' explanation is apparent in other witchdoctor rites, as I shall demonstrate further on.

The average Swazi shares certain commonly held anatomical beliefs with his inyanga, on the basis of which certain treatment programmes are embarked upon. The existence of a 'worm' which each person is supposed to have in his belly, is one of these.

Nelson G, a well-known inyanga whom I had occasion to visit, told me, "Every person has a worm inside him, but sometimes the worm is not the proper length. Sometimes it is too short, sometimes too long." He then produced a book on internal parasites, illustrated with diagrammes of various parasitic worms with whose names, and the disorders they cause, he seemed thoroughly familiar. He proceeded to tell me after this how he dealt with the first-mentioned worm, which everybody has, should it be "too long", causing it to emerge from the rectum of his patient, counting off eighteen digits and then breaking off the end. At this point he would let the worm climb back up into the alimentary canal, now more or less the right length.

I asked him whether he treated mental disorder. He replied that he only treated certain cases. If a person came to him with a mental disease which he could not treat, he would tell him so immediately. With those he did treat, he would remove a worm or a beetle from their heads. He also showed me some opium and said that he would use it on a particularly wild patient, tying him up and forcing him to drink some with water. He only used the opium, he said "to calm him down" saying that "when he comes around he is still feeling the effects of the drug."

I asked him whether he knew of any other witchdoctors who treated mental illness, to which he replied, "No" (My assistant later explained to me that he probably did, but would never tell me of them, because they would be "competition" for himself.)

My assistant told the inyanga of a stomach complaint that he had. The latter gave him a purgative and told him to look in his stools for a leaf with five points. If one of the points was missing or the top of one was broken off, he should return for some more medicine. He was told that he might also see in his stools a small lizard, and, if so, he was to look at its fingers. If one of them was missing he would have to return for some more medicines. Nelson G explained that from this tip of a leaf or finger of a lizard a whole new plant or animal could grow, and medicines would have to be given until everything was out of the system.

The above example indicates again the 'safety-valve' in the inyanga's prescriptions, providing a rationale for possible failure of the medicine to cure the ailment.

Specialist-Client Co-operative Rationale:

Generally lacking from Matsapa Mental Institute, was the type of therapist-patient co-operative therapeutic rationale found in contacts between Swazis and their 'medical men' in the wider society. The absence of this co-operative basis in therapy was openly voiced by patients on a number of occasions.

- (1) Simelane P said to me "Ngicela discharge". (I am asking for a discharge). I was still a pretending patient at the time and so obviously in no position to initiate discharge proceedings, so I asked him what he meant. He said (in Siswati) "Because you can speak English. I am like a prisoner here. How can I ask the doctor to let me go? We can't even understand each other, so how can he see I am well now? You can speak to him for me."
- (2) Albert P explained to my assistant-patient, "This place is worse than jail. At least there you know when your term is up. Here we are just at the mercy of the doctor. Do you know what this sickness is? Only the doctor seems to know, but he can't tell you this or that is wrong. He just says 'you're still sick' and you must just take it or leave it."
- (3) Jameson P was overheard saying "I want to run away and if these staff-police chase me I can stab them. Yes. Me, I want to work and to go and see my mother. The laws of this place are no good. They can't put you in jail without you going to court. Where is the court of these doctors? "
- (4) I was speaking to my staff-assistant, Joshua, when I found Moffat S beside me. I winked at Joshua and changed the subject to food. When Joshua had left, Moffat said to me, "You see he is pleased you are talking to him now. The staff are stealing our minds, but they don't tell us what they are doing."
- (5) Nicholas B came over to speak to me. "The patients are going to be discharged tomorrow. And I think all of them came after me. What is that?", he wailed. "Look at us here. We are given the same uniform, and if you came yesterday or a year ago it makes no difference. How can we all be treated the same? We have not all got the same sickness."
- (6) Aaron P was sitting on the grass, his head recently shaved. "I see you've just had a haircut", I said. "Yes", he answered. I asked him when he was going to be discharged, then. "No.

I don't know," he answered, adding "I think it will be better for me to see a Swazi doctor." "Do you mean an inyanga?" I asked him. "Yes", he said. "How many people do you think would like to see Swazi doctors?" I asked him. "I don't know," he said, "but there are many. I think more than thirty." "Yes, because the black people who are keeping us here are wizards (abatsakatsi)", chimed in Moffat.

Problems of Co-operation and Communication in Hospital A :

During the month I was a pretending patient, neither the Superintendent nor the doctor had come into the patient enclosure to see the patients (3 weeks at that time). Some patients were becoming increasingly restless because of this fact, and, in my assistant/patient's ward, a discussion had broken out in which three patients there were the main complainants. (I should perhaps mention that this was a ward occupied mainly by improved patients - Ward 2. A number were in fact awaiting discharge.) Although the doctor visited the hospital twice a week, he did not enter the 'campus' (as we came to call the enclosed patient area.) Some patients were called to see him in his office instead. These other patients were convinced, they said, that if they could see the Superintendent he would let them out. They were equally convinced that it was the Head Nurse who was preventing them from seeing him.

The Head Nurse was, in fact, a sort of 'assessor' of the seriousness of patient illnesses. Since neither the Superintendent nor the doctor could speak Siswati, the Head Nurse was the main gatherer of information of patient history. He was also the 'interpreter' when patients and doctor (or Superintendent) actually confronted one another. Yet he was viewed by many patients simply as a "stooge" for the Superintendent. This impression was unwittingly fostered by both the Head Nurse and the Superintendent; by the Head Nurse, in that requests for discharge were often answered by assuring the patient that he would speak to the Superintendent about the matter, and by the Superintendent himself, in that he would personally announce their time of discharge to the patients, while the Head Nurse would remain out of the picture except to be present as interpreter.

The Head Nurse's role of "informer" was seen to be motivated by his relationship with the Superintendent, the latter being construed as a provider of information, while the former was looked on as a gatherer of information. When the Superintendent finally visited the 'campus' with the Head Nurse, the latter's position as interpreter was openly challenged by at least four patients who refused his services and struggled to make themselves clear to the Superintendent in broken English, preferring that he understand what they understood he understood, rather than that he understand a possible distortion of the facts rendered him by the Head Nurse.

A Co-operative Rationale in Hospital B :

The only thorough doctor-patient co-operative therapeutic rationale in the three hospitals studied was put into effect in the so-called "Neuro-clinic" of Hospital B, where I worked for two months in 1966.

Here the treatment programme included a gradual stepping up of stellazine dosage. When a certain peak dosage was reached, the patient was usually informed that he seemed to be improving, and that his dosage would be gradually decreased from this stage onwards.

Timothy P would frequently complain to me, "These pills have a deadening effect on one. They numb the brain. Surely one should be as alive and active as possible if one wants to get well." The nursing staff answered his complaint by explaining to him, "You see, it takes time for the body to accommodate to these drugs. Everyone feels like you do when they first start on the pills, but as your body gets used to the dose you'll begin to feel more active again. It's just a matter of your body getting used to the medicine and letting it take its proper course on your nervous system."

At a later stage in the programme the same patient was told, "You see the pills are now having their biggest effect. It's best for you just to rest and you'll see you'll soon come right. It goes like that. You have to get a little bit worse before you can get better again," (Recorded from patient-staff conversations.)

Patients in Hospital B were frequently heard encouraging one another and asking each other what their current dosages were, whether the dosage was going up or down, and how they were feeling. David P was overheard saying

to Timothy P, "They'll probably keep you on that dose now for about three or four days. At least that's what they did with me. Then they'll gradually lower your dosage and you'll find your brain clearing and all the mugginess going out of your head."

I myself had occasion to observe closely the changes in physiological and psychological condition of Timothy P, whom I was to 'special' (keep constant company) for two weeks.

At first he showed increasing concern about not being able to think clearly and made persistent attempts both with myself and other members of staff to find out what exactly was happening to him, whether or not this was the expected effect the pills were supposed to have, and if, by any chance, the doctor could not have made a mistake in the case of his prescription. This was followed by a stage of resignation to his state of sedation, together with acceptance of the staff's assurances that he was progressing to a stage where the pills were having the desired effects on him, that he seemed to be calmer, more at ease and relaxed, and that it was clear he was now settling down properly in the hospital. He nevertheless continued to make intermittent enquiries as to how much longer this large dosage was going to be maintained.

At this time I was relieved of my 'special' duties. I nevertheless continued to observe him with interest, and noted that, as his senses returned to normal, he made frequent attempts to speak to the psychiatrists. He was assured by them that he was now getting better and would soon be much better than when he first came into the hospital. A date was set for a formal clinical discussion of his case, where his condition would be publicly discussed with him.

In all fairness, however, I think I should include in my brief 'summary' of this case a more detailed account of the patient's background and of the form my own help took in getting him to 'adjust' to the hospital.

Timothy P was put under special observation because he had run away from the hospital. Ten days after his escape, he had been picked up by the police and returned.

He had originally been brought in by an uncle, not knowing his true

destination at the time, and had been persuaded, under pressure, to remain in the hospital.

Of his bizarre behaviour which finally got him committed to the hospital, he explained to me, "It probably looked crazy to other people and even I could see it was crazy, but my actions were always under my control and never once did I not know what I was doing. I only wanted to have a little fun, but instead people have taken the whole thing much too seriously. I just wanted to frighten some of the university students staying at the hostel - you know, to 'spook' them - but I suppose because they didn't know me personally, they thought I was mad and went to call the police."

He had left a responsible and well paid job to become a collector of shells and driftwood on the beaches, selling ornaments he made from these to various curio shops and living from this money, in addition to a small additional private income from money which he had invested.

"A human being is not a machine", he would tell me. "Once you have reached a certain intellectual level, you're no longer bound by mechanical rules which govern the lives of less educated people. Then the whole question of money and property and status no longer pushes you into doing things you really don't want to do. My family always wanted me to be a big shot - that is 'big' to their way of thinking - but they've really lost me for good now, by deceiving me into coming here. I don't know what they must take me for. If they think I'm not living their way of life, they take it as an insult to the whole family. I've got some good friends, one an artist who lives in ---- Town, another a writer. They appreciate me and what I am doing, so what else do I need?"

On asking my advice on what I thought would be the quickest way for him to get out of the hospital (legally), I told him, "Look. You'll have to take all I say to you in strict confidence." He agreed. "O.K. I promise I won't tell a soul."

"You're here because your family does not like your way of life, right?"

"Yes, but that doesn't mean to say I'm mad. I'm an adult. I've got control over my own life, haven't I? What right have they got over me?"

"Well, you know you were brought here because of the police having been called in, and your uncle is probably protecting your own interests in this way ..."

"I never asked for his help. I'm quite capable of defending myself if it comes to that. I didn't break any law or threaten anyone ... "

"Listen. This hospital is like a game of chess. You must try to see what's in your opponent's mind, what moves he's making in relation to you and what he expects you to do. They probably thought you were not so bad, but now you've run away you're a threat to the hospital. If you try to run away again, people are going to start saying the hospital can't handle its own patients and they'll certainly lock you up in one of the lower wards. "

"I'm not going to run away again so you can forget about that. Carry on with your ideas. "

"O.K. The thing is this. You're not going to get out of here until you've convinced both the psychiatrists and your family that you're going to live what they consider to be a normal life ... in other words, getting a good job again, stop collecting shells, forget about asserting your freedom. "

"But that's preposterous! Are you going to tell me to let other people dictate to me how I must live? People who don't even think the way I do, some of them never even been to university? If I'm crazy, they'll have to prove it to me first. When they do that, I'll let them tell me how to live, but they'll have a bigger job on their hands than they think. "

"So what do you think of what I've just told you?" I asked him.

"I don't see how it can affect my situation. This is supposed to be a hospital. If I'm sick it's their job to make me better. If I'm not sick they have to let me go. "

"How do you think they know when you're sick?"

"They're doctors. They're psychiatrists. That's their job. "

"Yes, but you don't know their job. I'm only telling you the things it will be best for them to find out about you. You don't have to commit yourself to this line forever, but if you want to get out I don't think you have a choice. I'm not telling you what to do. I'm only telling you, as a friend, what I think. "

Conversations like these took place on most days during the two weeks during which I 'specialized' Timothy P. He used to tell me at the time, "If it weren't for you, I'm sure I'd try to make a break for it again."

After he was taken off special observation, his relations with the psychiatrists and the rest of the staff seemed to improve, and there was no way of telling how he now construed my previous discussions with him.

One day, while I was preparing cottonwool swabs for injection purposes, he came and stood behind me and said, "That's the sort of job you should be doing. They shouldn't let you have anything to do with patients."

This patient's hospital stay included two rather gratifying sequels for myself:

- (1) Having worked in the hospital for two months, it was time for me to leave, and the patients were all bidding me farewell, including Timothy P. He apologised for having 'insulted' me, and told me how much I had helped him during the first few weeks. "If it weren't for you I don't know how I could have remained sane in this so-called mental hospital." Later he told me that the doctor had said he could be discharged in a few weeks and that he was going to get a job for a month or so, before going up-country to visit some friends. He said, however, that he didn't want to go back to his old job and thought he would be able to sort things out away from everyone in the Transvaal.
- (2) Whether or not he eventually left the Cape I don't know. I did, however, return to the hospital six months later and made some enquiries about him among the staff. They considered Timothy P one of the "miracle cases" of the hospital. Whether this was due to my own efforts to shift his perspective, or not, I cannot say with any degree of certainty.

Structuring Interpersonal Relations:

The absence in Hospital A of any judgemental criteria whereby patients could assess their own state of mental health, or conversely, criteria whereby they could demonstrate their own sanity to staff, I have already touched upon

in examples given of patient complaints here. Additional examples follow below:

- (1) A few patients were discussing with my assistant-'staff' the question of patient soccer. Caiaphas P said to him, "If only they would let the patients play soccer then we could show the staff who is mad and who is not."

- (2) In my assistant-patient's dormitory, three patients had begun collecting flowers from bushes outside and placing them in old cool-drink bottles. Jeremiah S, one of them, was asked the reason. He replied "It's because I want them (the staff) to see I know how to look after things. Then they can see I am not like these others here who can't do anything for themselves." He kept some magazines next to his bed as well, even though he could not read. A few days later I noticed the staff were scolding him and chasing him out of the dining room. I asked Ephraim S, one of the staff, why he was being scolded. I was told it was because he was making a nuisance of himself by hanging around in the dining room after the others had left.
 "But wasn't he helping to clean up the dining hall?" I asked.
 "He knows he's not in the kitchen work-group. No. He's still sick. He doesn't know what he's doing."
 I asked the patient, in turn, what he had been doing. "I wanted to show them I could work, but they just say I'm sick. That's all they can tell you here," he said to me.

* * * * *

In contrast to the unstructured nature of interpersonal relations at Hospital A, persons in the wider society, approaching witchdoctors for help in solving interpersonal problems, are given highly specific instructions with regard to interpersonal conduct.

- (1) In order to encourage Nelson G to speak freely about his profession (the inyanga I mentioned previously), I told him that I would like him to solve a certain problem with which I was personally faced. It seemed, I told him, that a certain person, who should by rights give me a job, was trying to chase

me away to seek employment elsewhere.

He asked me who that person was. When I told him, he informed me that the person was probably using medicines against me himself and these would also have to be countered. He brought out his box of medicines and began to explain their use to me.

Many of them were love potions of various sorts. He also had medicines for stomach ailments and for skin disorders. A lot of the medicines, he explained to me, were very bitter, and were, at the same time, very powerful. Others caused the stomach to run and made one vomit. He also had incense of various sorts to chase away evil spirits. His prize medicines, however, came from various parts of a large and rare eagle. Its crushed skull bones for determination, its heart for courage and ability to overcome the prowess of others, its wings to increase the speed with which various occurrences would take place, its claws for tenacity, and so on. He had medicines to make a woman love a man, medicines to make a man love a woman, to make one's loved one come hurrying to one's side, to make someone else dream about one, medicines to send a message to someone in unbelievably quick time, medicine to mix with ink so that the one who reads your letter will not be able to refuse your request, medicines to apply to one's face so that the judge will believe you when you tell the truth, other medicines for when you wished to deceive the judge.

He also knew treatment for people who wished to become successful in business. Among those he had treated were influential Europeans. However, he explained, he could only work positively and not negatively. When a certain Englishman had come to him asking him to separate his daughter from her fiance, an Afrikaner, he had refused. He only builds up, he doesn't break down. If he did, his power would be taken from him.

When I questioned him, he told me he was both a witchdoctor and a devout Christian. His power, he explained, came both from his medicines and from God, although, he emphasized, he was not a faith healer.

He then began to show me potions he was going to mix for my own problem, explaining, "This medicine will soften the heart. This one will give you power to make him believe in what you tell him ---" and so on.

He explained to me a certain way of applying the medicine - from

the hairline down the forehead to the tip of the nose, then above the eyebrows, taking care not to cross the centre line, as this would destroy the power of the medicines. The medicine should then be rubbed in and spread so that it is not visible.

Following this, I was given specific instructions as to how to behave toward the person I hoped to influence. I was to look straight into his eyes and be sure never to look down. "You must not smile until he does", he told me, "When he smiles you will know that you have got him in your power --- Never disagree with anything he says to you. If he asks you to do anything you must agree to do it, even if it is impossible. Afterwards you can give reasons why it would be difficult and point out the obstacles to him, but never refuse him anything. Never say 'no' and never say you can't do something."

In following his instructions, I found the application of the medicines (in the way he instructed) to focus my attention onto the centre of my forehead, more especially the place where the lines were not supposed to intersect. This in turn drew my attention away from other parts of my body that might otherwise have felt awkward - hands, feet, legs, arms, the angle of my head, etc. Looking straight into my adversary's eyes caused a certain amount of embarrassment but the smile which followed made my heart leap for joy. He was mine!

(2) Where 'missionary influence' is evident, such as in the take-over of inyanga functions by African Zionist groups, I found an equally explicit structuring of expectations with regard to my own feelings, as well as the influence I could expect to have on others, all tied together with specific preparatory and controlling behaviours I was to follow in order to bring about the desired changes.

I approached Mike S, the Zionist priest in the hospital staff, for some spiritual help in solving some personal problems.

He took me along to the homestead of a certain Zionist priest, who was aided in his work by a prophet (diviner). The latter would disclose the nature of the devotee's problems to him, while the former would conduct the

prayer service and pray over the devotee, 'laying hands' on him, and providing him with holy water, together with directions as to its use.

The Zionists interpret the salvation promised by Jesus "by water and the holy spirit" as being literally applicable, (that is, they do not interpret it 'symbolically', to mean the washing away of sins through divine grace and spiritual rebirth). The Holy Spirit is invoked by prayer, and holy water is given the devotee for directed use. He is enjoined to pray and at the same time to use the holy water, sometimes drinking it, sometimes applying it to parts of the body.

The ceremony in which I was the principal subject opened with a general introduction to all those with whom I was to participate. Men and women filed past, shaking my hand. The ceremony then commenced with spirited hymns, accompanied by clapping, in which all participated. The singing seemed to come from the depths of each person's whole being, everyone kneeling or sitting on the ground, bodies swaying so that hands seemed to fall naturally into their clapping.

Thereafter, the prophet approached me and asked me if I was sincere in coming to see him and whether I was prepared to place my full belief in the power of God. I answered that I was.

Unfortunately I did not have an assistant with me to help interpret what followed, but I gathered from Mike S afterwards that the prophet then enquired from him certain features of my complaint, after which he began to elaborate on his own assessment of my condition, bringing in notions of the all-powerfulness of God, His knowledge of all things and His lasting love of all His creatures, relating all these to my own problems. His speech was punctuated by "Amens" from the others present.

This was followed by more singing, after which Mike S and the other priest began to 'speak in tongues'.

After this I was directed to sit on a chair in the centre of the hut, where the Priest, his whole body trembling, laid his hands on my head and shoulders, and, invoking the Holy Spirit, acted (it seemed) as an instrument of God, through whom Divine Grace was flowing into me, his body barely able to contain the power it was transmitting.

More singing followed as I left the central seat and once more resumed my kneeling posture on the ground.

After the ceremony, I was given a bottle of Holy Water, which I was to apply to my whole body after washing, allowing it to dry on my skin, all the while thanking God for the help I was receiving, allowing Him to influence my thoughts and actions. The advice they gave me was - not to prepare what I was going to say beforehand but to turn my mind to God and let Him put the words into my mouth. This advice is scripturally grounded in Jesus' advice to His disciples; "But when they shall lead you and deliver you up, take no thought beforehand what ye shall speak, neither do ye pre-meditate: but whatsoever shall be given you in that hour, that speak ye: for it is not ye that speak but the Holy Ghost." (Mark, 13 : 11).

Limitations of the Hospital Paradigm:

Mike S told me that they had once tried to introduce prayer meetings into the mental hospital, but this had made some of the patients "go wild" and the Superintendent decided to stop the meetings altogether.

"You see", he explained to me, "Mr. Khasa (Superintendent) is not able to distinguish between patients who are mentally sick and those who are possessed by the devil. It is only we, who are spiritually aware in these matters, who can make such distinctions and take the necessary steps." He assured me that he would be able to cure "at least twenty per cent" of the patients at Hospital A, but added, "While I am here I am not working as a priest of God, but as a servant of the Government, so I have to follow their ways in these matters and not my own."

He nevertheless did manage to introduce some treatment measures for patients, which were successful in getting catatonic-like patients to become sufficiently physically aware of themselves to enable them to begin eating regularly. These patients were rubbed and washed down with cloths soaked in extremely hot water, followed by cold showers - such treatment with water being one of the methods used by Zionists with similar cases.

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Leonard S, a new member of staff who had not yet learnt to submit his motive vocabulary to the paradigm of psychiatric treatment procedures, was overheard saying to one of the patients at a pill hand-out, "These pills are not going to help some of these patients here, since they are obviously possessed by demons. A week of beating drums can bring them back to normal."

On a different occasion he said to my assistant-staff "Fate has decided for some of these patients to be witchdoctors."

* * * * *

Accountability:

Not only are Zionist and witchdoctor agencies more structured in terms of tribal-traditional folk-lore and background, but there are also ways and means for both specialist and client to recognise one another's genuineness and/or expertise.

The specialist himself is one of the people. The power he possesses is 'given' to him and does not originate in himself. Before entering my presence as practicing inyanga, Nelson G first put on his traditional tribal dress and inyanga 'insignia'. Before the start of the Zionist meeting, the Zionist priest and prophet put on white robes, on the back of which were large blue crosses, green sashes being tied around their waists. (I was informed by Michael S that the dress itself was not simply decided on, but was revealed by God to certain prophets. To another prophet it was revealed that the Zionists should carry staffs cut from a special kind of tree, which was itself very rare and could only be found after long fasting and prayer. The devotee would be informed by the Holy Spirit in which locality he would find this tree, and, having found it, he would cut his staff from it.)

Nelson G, the inyanga, told me that he was only allowed to use his power and specific gifts for influencing for the "good". If he used his power for evil ends, it would be taken from him. The Zionists, also, are only allowed to work "For the good of Mankind" - (Conversation with Michael S.)

In approaching the specialist one automatically has certain definite expectations in mind. The person one is to meet is a man like other men. If he is boastful, he is immediately shown up as a fraud, since nobody really possesses power of his own accord. It is invested in him through ritualistic procedure and adherence to specific lines of conduct and it comes from the spirits or from God. Although the power more often than not resides in the type of mixture of ingredients used, its efficacy will be lost if any of the following conditions do not inhere:

- (1) The practitioner is worthy
- (2) Ritual procedures are properly fulfilled
- (3) The client is worthy
- (4) The client does not wish to use the help he is given for purposes other than those he has revealed to the specialist.

Inherent in the statuses of specialist and client, the subjective intentions of both parties, and the proper enactment of ritual procedure, lies the constitutional accountability to which the interaction is simultaneously committed. There are always checks on the abuse of power. Nor is there any payment of fees or exchange of gifts unless, and until, the treatment itself is successful. Moreover, non-payment for successful treatment is thought (in itself) to incur misfortune or divine retribution.

The conditions laid down for treatment are combined in mutually recognised frameworks. Although the client does not possess direct knowledge of the nature of the specialist's own power, he is given a precise description of the effects he may reasonably expect in the course of events which are to follow treatment and/or the application of medicines or Holy Water. If the treatment is working, certain signs can be recognised. From the beginning, client and specialist understand and recognise the nature of their relationship, the contingencies on which effective co-operation rests, and an explanation of, if not how the treatment was to gain its desired effects, certainly a good reason why it should. If the treatment failed a good explanation would also be to hand. Payment or expression of gratitude rested on success. In the event of failure, the client was free to consult other specialists.

A conversation recorded by my staff-assistant between three patients

and a staff member about the wrongness of exacting money without successful treatment, went as follows:

"I was sent there," Ray said. "He did nothing to heal me but wanted R10 cash"

"Yah!" interjected Simon, "When my brother took me there, we found him under his favourite tree smoking snuff. He asked my brother to buy 5c snuff before he began with his work. He doesn't cure you. No! He tells you about your life history, some of which is true, then he tells you to go to a certain place where you will become well"

"I know him to own a bus," said Elias. "These people at times fail to cure such sickness but they want money all the same." (Recorded from a patient discussion.)

Reflections:

Accompanying tribal-traditional sentiment pervades much of what is still largely "tradition directed" national Swazi culture. (Riesman, 1950) At an annual assembly of Swazi Police, King Sobhuza, himself universally recognised as spiritual leader and head of the Swazi Nation, appeared at the parade dressed in full police regalia. He told the police force present, that, as the King of Swaziland, he was also the leader of the police force. Bearing the title the 'Royal Swazi Police', they should recognise at all times that they were 'his' police and should conduct themselves in a noble and upright manner befitting to their king (the personification of the Swazi nation) and the dignity of the Swazi people. By the same token, the people of Swaziland should respect and honour the police force which was at the king's own royal command and therefore at the service of the nation itself.

Limitations of Hospital Culture:

I have used the foregoing examples to illustrate what I consider to be certain central expectations regarding relationships between specialists and their clients among the Swazis. The example I gave of the King's speech to his police force similarly illustrates how, in seemingly untraditional spheres, certain broad power bases are alluded to, bringing wide tribal-traditional

contingencies to bear on everyday events, constraining the abuse of power by regarding its use as resting heavily on certain national-spiritual loyalties and allegiances. I have also used these illustrations to show their relative absence in the practice of psychiatry at Hospital A, and yet to show how these wider practices are brought to bear in consideration of hospital practices by both staff and patients. Hospital practices, themselves unaligned to tribal-traditional power bases and their accompanying mystical-traditional legitimations, are yet required to rehabilitate patients who come, by and large, from tribal-traditional settings.

The need for spiritual alignment between patients and their traditional customs was clearly recognised by the Head Nurse, who said to me, "We try to encourage the patients as far as possible to use traditional customs and means for coming to grips with their problems, as well as trying to help them understand what the hospital is doing for them."

Tribal Beliefs and Westernisation:

Pervasiveness of Witchcraft Beliefs:

To hold to the view that upper intellectual and business strata in Swazi society are unaffected by the theory and practice of witchcraft, is to misconstrue the situation. It is therefore not surprising that certain formally educated patients hold the ideas they do, regarding the origins of their complaints, for traditional beliefs and related practices still pervade the whole social system.

Illustrations: In General Culture

(1) A certain bank clerk in Mbabane confided in me, "This witchcraft business in Swaziland is what is keeping the nation backwards. Even well-educated people in commerce, although they know how to run their business, still go to witchdoctors in order to ask for help in their business dealings. It's terrible. You think you are dealing with an ordinary person, but behind the scenes he is using medicines to influence you."

(2) A secretary in one of the Government Departments warned me, "Don't think this witchcraft business is all superstition. Do you know that Swaziland is the centre of witchcraft in Southern Africa? They are experts here -

scientists! - I'm telling you. If you get in their bad books, watch out! We have seen many things happening here. So much so that if I had to tell you, you wouldn't believe me."

(3) In Mbabane, Gerhard H, an American student doing historical research in Swaziland had had two serious recent road accidents - one in an automobile, the other on a motor cycle. He was pointed to as one on whom African medicines were working, and he himself did not rule out the possibility that he had been 'bewitched'. "I wouldn't be surprised if some witchdoctor hasn't put a jinx on me," he told me. "I've been driving in metropolitan cities in the States which are twenty times as dangerous as any Goddamn little country road you can ride on around here, yet I've never had a smash in my life before. Now in one month I nearly kill myself twice, and both my car and my motor-bike are completely written off! You try and explain it."

(4) There were stories circulating widely, in popular talk, of two road accidents on the Mbabane - Manzini road in which a certain Eur-African girl had escaped both times, unscathed, while her escorts were killed outright on both occasions. "It's not her fault", I was told. "It's because she's been bewitched. Everyone knows she is dangerous now and she will never get a man as long as she stays in Swaziland."

(5) There was a story doing the rounds in Mbabane about a very attractive Swazi girl in a good Government job who was reputed to have been given medicines by former lovers, so that she too would never be able to find a husband.

Stories such as (4) and (5) pervade much of the small-talk of everyday life in Swaziland.

Illustrations among Hospital Staff :

(1) In Hospital A itself, during the time I worked there as a nursing attendant, a group of fellow-staff refused to come outside with me to investigate the whereabouts of some large fruit bats which were making characteristic metallic-sounding noises somewhere outside. "Don't be

too curious, especially at night", I was told. "Sometimes those things are sent and you are just looking for trouble going to see what they are."

(2) My own research assistant (a Zulu from Cape Town) told me he had promised himself he would kill a certain cat which kept coming to his window at night. "It's not an ordinary cat", he told me. "You will never see that cat in the daytime. I've looked and looked for four days now but I haven't seen it. I think someone is sending that cat to me, but it's not really a cat. It's like a bad spirit, so I've decided to kill it next time it comes here looking for me." When I expressed my incredulity at his beliefs, he went on to tell me, "You can laugh at me. I used to laugh at these things myself when I was younger. But I've seen too much --- seen things that have happened to me, personally --- to think there's nothing in it any more."

(3) Enoch S, one of two qualified nurses working in the hospital, told me that he did not believe in witchcraft, and added that as far as he was concerned it was just "superstition". On questioning my assistant, in an attempt to find out what percentage of the staff also considered witchcraft 'superstition' my two assistants, one of whom was a matriculant, scoffed at my credulity, adding, "I bet you any money that there is not a single staff member who does not believe in witchcraft, including the Head Nurse." To illustrate their point my assistants pointed out to me that the very person who had called witchcraft "superstition" was wearing a bangle of goat-skin on his forearm. "Why does he slaughter a goat if he doesn't believe in witchcraft? He's going to get married and the goat was killed to bring him luck. Some of them even put medicines inside those skins."

I suggested other members of staff who might not believe. Each time I was contradicted and evidence was usually to hand to back up the point. "His wife burns medicines in their room." "His child wears a 'protection' around his neck." "Why do you think he eats alone? He's scared someone will put 'muti' in his food."

Generation Gap :

There was a noticeable difference, nevertheless, between the customs and beliefs of the older and the younger generations in the hospital, many of the older generation's customs and beliefs actually being discarded as "superstitions", and only retained for the sake of showing respect.

Illustrations:

- (1) The 'S. U. T.' is an open-air 'pub', or, rather, a complex of about three to four houses where 'Jabulani' (home made beer) is sold in the back yards. Those who visit the 'S. U. T.' range through hospital staff, police, prison staff and S. U. T. (Swaziland Universal Transport) workers. The most popular pubs have record players and music is relayed outside for the enjoyment of the drinkers. The 'Jabulani' (literal translation - 'be happy') is sold in large round tins, or clay pots, and is passed around a group of drinkers. Friends and associates freely join the drinking group and the drink is passed around in a circle. If one wants some, one takes a drink; if one doesn't want any, one passes the tin along. At the end of the round, the pot either rests in the centre of the group or at the start of the round. When new jabulani is brought, it is poured into the old container to show that the buyer wishes it to continue among the same drinking group. Anyone invited to drink is expected to remove his hat and get down on his haunches to 'show respect' and to say 'thank-you'. Among older people, respect is also paid to the ancestors by pouring some jabulani on either side of the pot - "the emadloti (ancestors) must also drink," I was told by Shadrack S, one of the older men present. The youngsters tend to ignore this ritual, except when sitting with older, more conservative Swazis. "It's just an old custom", Duma S, a nursing attendant, told me. "The older people believe it will bring 'bad luck' if it is not done, but to us it is nothing. I mean, you can't do that if you go drinking at the King's Hotel in Manzini."
- (2) One evening, when all the patients were ready to go down to supper, a thunderstorm broke loose. Some of the patients were very frightened because of its intensity. The Head Nurse, who was there at the time,

told them, "If you are frightened you must do what you would do if you were at your own homes." At this, one of the older patients ran out into the rain, bit off a few leaves from a tree outside, chewed them in his mouth and spat them out in two opposite directions. This caused great amusement among the patients, since many of them had never seen such a ritual before. The Head Nurse explained to me that this was an "old custom", which he had not seen for many years, for protecting a household from lightning. It was rarely seen these days, he added.

- (3) Certain other beliefs and practices were not accorded wide recognition, although they were not called into dispute when brought up for discussion. Clement P, complained to my assistant-'staff' that he should not lean over him when opening the dormitory windows in the morning. "You never know who might be using medicines. If I am using them you will feel the effects, if you are using them, you will affect me. So both for your own safety and for mine I wouldn't like you to 'overshadow' me again." My assistant-staff thought he was probably correct and mentioned that he wondered if this was not the cause of the head-ache he had been having for the past few days.

Cultural Exclusion :

Just as laying of hands and conducting of prayer services were excluded from the activities of Hospital A (although three of the staff were lay preachers, or priests, of recognised churches), so also, needless to say, were diviners and inyangas excluded from participation in hospital life. They nevertheless played a prominent part in discussions at all levels - staff among staff, staff among patients, and patients among patients. Their efficacy as curative agents was recognised by both staff and patients, especially since the patients, in many cases, were construed, both by themselves and by staff, to be 'bewitched'. Discussions along these lines were rare among patients and staff, since they tended to undercut the logic of hospital procedures, but they nevertheless did occur.

(1) One evening a police van arrived from Stegi with two new patients. While the police were talking to the staff about the necessary documents needed for admission, a number of patients had gathered around the police van, which had been driven right onto the campus grounds.

"Hey, just look how fat you have become since you've been here", one of the policemen said to a patient. It was obvious from this remark that the patient had been brought in by this policeman. "And you ____! Do you remember how you broke the jail windows and we had to tie you up in chains and ropes? You gave us a tough time, hey? But you seem to have recovered now. That's good."

After talking to a number of the patients he turned to the staff and commented about the number of patients that come from Stegi. "Yah!" said Benson S, a nursing attendant, "That place really knows how to bewitch (ukuloya)."

(2) That same evening, Benson, Sumane, Aloysius and Brown, all staff members, were gathered together in a patient dormitory, discussing with some patients the nature of David P's "illness" (He could not bear to be in the company of a woman, or even to look at one.) Eventually they all agreed that he was definitely "bewitched" and that this particular illness could only be cured by a witchdoctor.

Among the patients, origins of their 'illnesses' were more often than not discussed in terms of 'witchcraft', although other major reasons given were 'drinking' and 'dagga smoking'. What Goffman (1961) calls the patients' "apologia" has the effect of establishing for a patient a defensible position among fellow patients concerning his particular fall from grace, leading to his present mental patient status. This is achieved through alignment with certain cultural notions which could reasonably explain the patients' loss of status, without loss of 'face'.

(1) Mnikwa S was questioned by my assistant-patient, in a casual way, as to how he came to be in the hospital. (At the time he was sitting against an outside wall, listening to the hospital radio). "I got mad in 1963 while

at school at St. Peregrines doing standard five," he explained. "My father died long ago so I stayed with his brother, who bewitched me because I was brighter than his own children at school. I was treated by witchdoctors from then until my relatives brought me in here a week ago."

(2) Sumane S, my assistant-'patient' and I were sitting on my bed in the dormitory playing cards. Makhoyana approached us to ask for a smoke. Rommel, my assistant-patient, took advantage of the position, and, before giving him some tobacco asked him how he came to be in the hospital. "No", he explained. "The police found me along the road and brought me here. I have been here a long time. I got mad while I was here." "I understand he is a Zionist and possessed by a spirit," Sumane informed us after he had left.

(3) One afternoon, my assistant-'patient' and I, returning from working in the fields with some other patients, found a lively discussion in progress on the campus. We joined in. Gideon S was telling his friends, "You saw my wife coming here. Yah! She came to tell me that one of those who bewitched me is dead. He died on Saturday. There are more than three. My son was given medicine by another one. That chap was knocked down by a truck and now he's crippled for life. The one who died, is the one who used to give my brothers medicines to kill me, because I am the only one in the family who has got cattle."

"Awu! Look at him", said Mshiyeni P. "He tried to get you out of the way, but now he is the one who will not have Christmas." (Laughter)

"They are all going to die onè by one", said Gideon. "I don't use muti, but I understand it in such a way that no one can successfully use it on me."

A convincing apologia would seem to be even more necessary after discharge from the hospital, for, as Enoch S, a nurse, pointed out to me "Being a mental patient, or having the reputation of having been mad, is a terrible thing. You can be among men at a meeting and when you try to say

something, they can just point at you and say 'Don't listen to this one, he was in the mental hospital.'"

Therapeutic Rationale :

To both staff and patients, as I have tried to demonstrate, the mental hospital is one agency among others for dealing with mental disorder. This, however, is rarely admitted to in staff-patient discussions, however, since it could be followed up by demands to be discharged and possible reports to the Superintendent that "such-and-such a staff has said I need to see a witchdoctor because this hospital cannot cure my sickness."

On a number of occasions, in Hospital A, patients' assertions that they were bewitched were outrightly put down by staff, with such answers as "No, you're not bewitched, you are mentally confused." (Recorded at pill handout.) Refusals to take pills because "European medicines cannot help me" were heard to be countered with "If you don't take these medicines how can the doctor in charge of you let you go," thus implicitly assuming the latter's expertise in the matter, without being obliged to demonstrate the validity of this argument.

Concerning the long-term effects of large Largactal dosages on long-term patients, a member of staff pointed out to me certain patients. "You see", I was told. "The doctor prescribes, but he doesn't come down here to see the effects. Some of these patients are too heavily drugged." I was shown thick cutaneous tissue on the bodies of these patients and a slowing up of muscular activity in the hands and fingers was demonstrated.

Questioning staff about repeated requests by patients to go home, I would more often than not be told "He is very confused today" or, "He is still sick". On the other hand, inter-patient quarrels, which were usually punished by injections, tended to be explained away by statements that these patients were "troublesome", and had to be "punished".

When Joshua, my assistant-'staff', first came to the hospital, it was explained to him by the Head Nurse that, "some of these patients are not driven to this (bad behaviour) through madness, but because they wish to take advantage." (Explanation as to why a certain patient was being denied breakfast, lunch and supper on a particular day.)

One member of staff, Benjamin S, took the same patient food the following week. He was locked in the security cells (known as 'Kulukhuthu') and when the food was brought into his cell, he tried to push past. He was pushed back by Benjamin, and, in retaliation, he pushed Benjamin. The latter then went for his throat, throttling him, hitting him four times and finally kicking his backside. Benjamin turned around to find that Joshua was watching him, and said "Some patients take advantage. What do you expect me to do when he pushes me around?" "He deserved it", Joshua answered, keeping his 'cool'.

In one sense, then, the hospital is not one agency among similar agencies, since it lacks much of what would generally be expected in the way of a co-operative rationale. Even the staff expressed open dissatisfaction with regard to the lack of direction given them by the Superintendent.

(1) "I have a certificate in general nursing", Enoch S told me, "but I can't see what I must do here with these mental patients. When I ask Mr. Khasa what I should do, he just tells me to 'carry on'. I'm 'doing fine' he says."

(2) Brown S told my assistant-staff that he had once asked the Superintendent what to do when the patients hit the staff. "You are not allowed to hit them back otherwise you will be in big trouble", he was told.

Brown went on to say how one day the Superintendent had asked him to fetch a patient whom he wanted to see. "I went back to Mr. Khasa" he said, "and told him the patient didn't want to come and that the patient was threatening to hit me if I tried to force matters. Mr. Khasa just stood up and said to the patient 'Come on, you, let's go'. When the patient refused to go he hit him, knocking him to the ground. He also kicked the patient and said to him, 'Come on. Let's go, you bastard.' I was wondering 'Hey what is happening here?' especially after what he had told me The patient was crying." Brown went on to relate, "I was shocked because this was the man who said we should not hit these people and he's hitting one of them himself."

Constitutional Accountability :

Not only is a common therapeutic rationale generally absent, but also absent is the patients' appeal to the hospital's constitutional accountability. The hospital may be responsible for them (and even to them) but this is a responsibility definitely outside their own control.

In comparing hospital procedures to those of the law courts (since such comparisons are often made by the patients themselves) it can be observed that there is still often a choice open to the accused as to whether he would prefer to be tried by a tribal court or by a court of law. The choice itself is often shaped by peculiarities pertaining to the different courts.

In the tribal courts, personal motives and other psychological factors are taken into account to a much greater extent than in the law courts. The accused might thus be declared innocent of a crime of passion in a tribal court when motivational and other psychological factors are considered as justificatory contingencies. In a law court, on the other hand, the crime is more or less predefined and the accused is either guilty or innocent. On the other hand crimes such as stealing are not so easily justified in a tribal court and their penalties are heavy. In such cases the accused might consider he had a better chance with a clever lawyer in a 'European' law court.

The mental patient in a mental hospital has no right of appeal. This is 'normal' in Western notions of the rights of the mental patient and is, in fact, built into the very structure of the 'medical model', as I have argued elsewhere.

Lack of Cultural Equivalence :

The lack of structuring in interpersonal relations at Hospital A was found also at Hospitals B and C (with the exception of the Neuro-clinic). This feature was accentuated at Hospital A by a lack of linguistic and cultural equivalence between therapeutic measures and assumptions concerning the causes and treatment of mental illness, which was not found at either of the other two hospitals. Such a state of affairs is a long way from the

'ideal' suggested by Sullivan of the psychotherapist as a 'participant observer'. This implies, that the therapist himself be committed to some picture of what he considers 'reality' to be and to some picture of what he thinks the community at large considers 'reality' to be, and that he observe the patient's behaviour in the light of these considerations.

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CHAPTER V : THE CONTEXT OF CONTROL - AN ORGANISATIONAL PERSPECTIVE.

Co-operative systems - self-defining roles - construct systems - embeddedness - the situational context of analysis - assumptive worlds - language categories - motive avowals - defensive lines - socialized expectations - norms - directives - cues - collusive staging by teams - contingencies and new possibilities - construct limitations of language codes - the therapeutic encoding system - ward re-organisation - Ward H - evaluation - contextual relevance, illustrations - integrative awareness and goal - directed conduct - the therapeutic content of drug dosages, E.C.T - situational content and conduct - identity implications - the expressive order - illustrations - the role of incentives - ranking orders - what do symptoms say? - patient symptoms in institutional context - what do therapeutic procedures say? - basic therapeutic questions.

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The indivisibility of control and consent makes it necessary to view formal organisations, such as mental hospitals, as co-operative systems. Within the mental hospital framework, staff and patients may be viewed functionally as participants in assigned positions in the co-operative system. These role positions tend to be self-defining, more especially in the case of the patients, whose life is lived entirely within this institutional framework.

The individual patient arrives at the hospital with at least some established habits and a related set of constructs. The functional relation of these habits and constructs to the reality of the society at large, as others understand and interpret it, is the concern of all involved with the patient relative to his being a patient. In the mental hospital, the therapeutic agents involved are landed with the task of realigning the patient's habits, and/or his system of constructs, with a socially accredited model of reality. The hazard faced by both staff and patients in mental hospitals, lies in the hospital's demonstrable propensity to depersonalise the

treatment of patients by assigning them to such institutional roles as do not take full account of the patient's own socially significant structural bases. These latter consequently tend to cut across and spill over the boundaries of institutional roles. Such structural bases, if not correctly construed, are likely to be seen as 'irrelevant' to the logic of the therapeutic system. A further hazard lies in the fact that institutionalised deviations may develop in the formal system, so forming therapeutically unrelated subsystems. Whether these informal subsystems endanger the logic of the therapeutic system or not, is a subject of individual enquiry. Such an enquiry can only be made once a set of criteria for judging the relevant issues has been made available.

Construct systems are likely to be embedded in the hospital's institutional organisation in two senses:

- (1) in the institutional structuring of a formal system of control, and
- (2) in the theoretical model on which the formal system is based.

The way in which organisational members reach decisions with regard to their own conduct gives the researcher a field for analysis in concrete individual situations. However, before such situational analysis is possible, the context of control must be scrutinised. The significance of individual events may then be defined by assessing their place and functional meaning in a means-end programme, to which the institution, as a purposefully planned organisation, can be seen to have committed itself. Once its purpose is clearly defined, attention may be directed to a set of derived imperatives necessitated by the function of its organised structure. Only then can the inhibiting consequences of various types of formal and informal structures be gauged.

Culture and Control :

Daily hospital contacts promote the growth of interpersonal sentiments. These inevitably tend to be built up, in mental hospitals, around hospital rules and procedures, so that the interpersonal expectations they engender are appropriate to the context in which they occur. Cummings and Cummings (1962) argue that hospital staff members should represent the non-deviant culture, although their training must enable them to tolerate deviant

behaviour as a temporary state, and, when necessary, to make sense of the patient's apparently senseless behaviour.

Parsons (1966) prefers to speak of social conduct as 'action' rather than 'behaviour', since human action is a purposeful implementation of behavioural sequences in symbolically patterned cultural settings. Such settings, referred to by Parsons as "action systems", encourage certain lines of conduct and discourage others.

Elsewhere in this paper I have defined culture as "the sum of expectations for the roles of all members of a group plus the expectations for behaviour of members in general", (Hare, 1962). For an actor to be socially competent in a particular situation he must be sufficiently involved in it, culturally, to be able to perceive and interpret it correctly. Socialisation - or resocialisation - under conditions of obscure or ambiguous communication might prevent the necessary differentiation of action sets, and related constructs, from taking place.

In Mead's (1934) theory of socialisation, the 'self' is seen as becoming aware of its identity in social contexts which validate certain roles as appropriate for it. The child first realises that it is a self when it sees itself in relation to and differentiated from other persons in its family. In extra-familial social contexts, the individual, as a public self, learns to commit himself to roles which differentiate him from others and establish him in role positions which he construes as more or less agreeably self-defining. From a sociological point of view, a functional relation can be discerned in social situations between a situated person's conduct, the motive he is prepared to avow for his conduct and that motive's likelihood of acceptance by individuals espousing a culturally limited set of acceptable social motives for various activities. In this way the assumptive world underlying a group culture becomes clear to a member of the group as his behaviour within it is evaluated and appropriately sanctioned.

Language categories, themselves socially built up and maintained, embody implicit exhortations to manifest collective purposes underlying their use. Evaluation of an actor's conduct has indirect bearing on public action in relation to him. Mills speaks of a "tradition of interpretation", which is

"the linguistic reflex of socially controlled behaviours" (Mills, 1959), Such a linguistic reflex, and the interpretative tradition underlying it, enables group members to assess the meaning of the conduct of any particular actor without personal knowledge of him. The language in which such inferences are couched expresses cultural agreement concerning the nature of social conduct.

Such an understanding of the nature of group realities is consistent with Kelly's (1955) view of the nature of personal constructs. Whether or not an individual's use of public constructs is found acceptable within a given cultural context, will depend on the level of acceptability afforded by the action system presumed to underlie their use.

In any social situation collective subjects act in terms of anticipated named consequences, and they discern other subjects' actions in terms of a particular vocabulary, which enables them to anticipate the consequences of various lines of conduct. There always exists, in any group, a more or less stable vocabulary of motives, which links anticipated consequences with specific conduct. Conditions are laid down for certain lines of conduct. Vocabularies of motive ordered to different situations stabilise and guide conduct and expectations for the conduct of others. Certain 'reasons' for certain lines of conduct are acceptable, others are not.

Publicly avowed motives may be placed under the heading of 'public constructs'. They are public justifications for personal actions, and may, in many cases, be unaligned to the actual reasons behind individual conduct. This is less a 'discrepancy', between conduct and conduct justification, than a distinction between two disparate activities, motor-social and verbal. What is a reason for one man's conduct may prove to be a mere rationalisation of another's. The variable is the accepted vocabulary of motives accepted by the group exercising control over the conduct of the individual concerned.

In mental hospitals there are two dominant groups, staff and patients.

There are also three dominant 'action systems' consisting of staff among staff, staff among patients and patients among patients. The degree of social permeability of the three action systems in relation to one another can be gauged by observing the consistency of motive vocabulary usage as one crosses from one group to another. Explanation for conduct which is encouraged may thus be viewed in terms of its meaning and justifiability within the social structure which encourages it; explanation for conduct which is discouraged is open to similar analytical treatment. The meaning of language lies in the behaviour evoked by it. The meaning of vocabularies of motive lie in the nature of the social structure in which they are embedded. Consideration of public constructs in terms of their controlling and socialising functions thus calls for an assessment of their use in terms of the axes of orientation they focus upon, as well as the behaviours which their situated use tends to evoke.

Diplomatic choice, and public avowal, of motives often resolves conflicts of an ideological nature. Achievement of the therapist's frame of reference by a patient may be construed by the latter as indicative that the patient has achieved appropriate 'insight' into his condition. Relevant here is what Goffman (1961) has referred to as the 'defensive line' which patients often assume regarding their own 'biographies'. Having been forced out of apparent alignment with central cultural values, the patient, in many instances, feels impelled to instate himself within an acceptable framework of public constructs, by illustrating the more or less tragic transitions of his own moral career within the action system it assumes. Such a defensive line Goffman has called the patient's 'apologia'. For a patient to be pronounced cured, he must, at least professionally, have renounced this self-respecting personal fiction in favour of the hospital's view of himself.

Illustration :

In Hospital A, Sifundza P had developed an elaborate tale to account for the train of events which had brought him to his present patient status. This tale was largely woven from his war experiences in the navy. He seemed to have assumed that his knowledge of navy life and of distant ports in the

world could not be disputed, and therefore a biography based on these facts could not be debunked. When, however, he was publicly asked by the Superintendent how he arrived at Hospital A, he could hardly disavow his 'navy' story, which had by now become central to his patient 'alter record'. He was subsequently told by the Superintendent "until you remember where you came from, you won't be discharged." (Recorded from public interview.)

A wide variety of publicly avowed constructs and related motive avowal mechanisms can be shown to vary in their 'permeability' with respect to their function as ritual adjustments which individuals need to make in order to accommodate themselves within culturally circumscribed action systems. What Mills calls the 'cultural apparatus' refers to those symbolic aspects of culture which can be mobilised for the fulfilment of certain social purposes. "Symbols", he contends, "focus experience; meanings organise knowledge." (Mills, 1950). Any establishment of culture means an establishment of definitions of reality, values and taste. It is also, as Mills puts it, "the semi-organised source of its characters identities and aspirations."

The principles of logic peculiar to any given culture are rooted in the meanings which prevalent linguistic categories assume within it. The function of language in social control lies in the fact that a symbolic utterance, as an event with meaning, produces similar responses in both the utterer and the hearer. Hence, for a mental hospital to assume meaningful proportions for a patient, and for the meanings which emerge from hospital situations to be of practical significance to him on his discharge, there should exist some sort of dynamic equivalence between his experiences within this socially disengaged therapeutic milieu, and those situations he can reasonably be expected to have to meet in his extra-hospital community.

In a mental hospital, for the expressive order prevalent in the wider society to assume dynamic significance, therapeutic procedures should involve an analysis of the patient's pre-admittance demand situations, followed by a translation of his problems in these situations into the logic of hospital life, through a partial reconstruction of his extra-hospital circumstances in the hospital itself, so facilitating a meshing of hospital demands with the therapeutic needs of the patient.

The Cultural Embeddedness of Constructs :

Consideration of Goldstein's (1962) conclusions about the strength and cultural applicability of hypotheses (Kelly's 'constructs') is relevant here.

Goldstein notes that the greater the strength of an hypothesis, the greater its likelihood of arousal in a given situation, the less the amount of appropriate information necessary to confirm it, and the more contrary information needed to disconfirm it. The smaller the number of hypotheses concerning a given event, the greater their strength will be. The more frequently an hypothesis has been confirmed in the past, the greater its strength will be. The larger the number of supporting hypotheses, or the more integrated the supporting system of hypotheses, the stronger the hypothesis will be. Finally, the more basic the confirmation of an hypothesis is to the carrying out of goal-striving activity, the greater its strength will be.

Stodgill (1959), paying careful and systematic attention to experimental results, has shown the way to a conceptualisation of group organisation using expectations (read 'hypotheses'; read 'constructs') as one of his core concepts. He relates Mead's (1934) position, that group organisation is based on a system of stable expectations which give predictability to the behaviour of group members, to Mayo's (1933) complementary observation, that the socialised individual is one who acts in accordance with the expectations of others. He goes on to state :

"A new member enters a group with a great variety of expectations already formed Those (expectations) that are related to the group may be realistic or unrealistic in terms of the ability of the group to reinforce them. However, Sherif has shown that groups tend to develop norms of belief, expectation and performance . . . Groups exhibit strong capabilities for structuring the expectations of members. The goals, norms, rules, traditions and rituals of the group represent such mutually reinforced sets of expectations Conformity to group expectation not only increases the predictability of the performance of individuals, but also facilitates the co-ordination of action, unity of goal striving, freedom of action, and integration of the group. "

When such formulations as these are applied to psychotherapeutic groups (be these two member therapist-patient groups or multi-member staff-patient hospital groups), they can hardly but be seen to supply the

necessary theoretical starting points required to assess the socialising power of such groups, and, by comparing mutual monitoring processes within them to similar processes with which the individual will need to align himself in the wider society, they also point to a means of assessing the possible stability of constructs engendered therein, with respect to considerations afforded by wider social expectations, and their power to support and consolidate the use of such constructs.

Frank (1959) has noted that, in two-person psychotherapeutic encounters, the patient's behaviour in his speech is subtly reinforced by the therapist's cues. Following Greenspoon's (1955) study on verbal conditioning, Krasner (1958) has commented on the relevance of these investigations for general psychotherapeutic practice, stating that all psychotherapy may be considered as to some extent "directive" in nature. Krasner states, "The therapist uses cues, often without his own awareness to modify, control, guide or manipulate the patient's verbal behaviour. This mode of subtle communication can probably be offered as a means of understanding how the therapist's own theoretical explanations of the dynamics of personality and of psychotherapy are transmitted to the patient." (Krasner, 1958)

Seen in this light, Frank's (1959) assertion that psychotherapy can work through cues of which the therapist himself may be unaware, can be reflected on with an eye to Krasner's (1958) view that the operant conditioning implicit in psychotherapeutic procedures can be made explicit, and hence "teachable", to a large degree. Relating such observations to therapeutic enterprises of a multi-individual nature, Goffman's dramaturgic approach in the exploration of implicit communication aspects of social interaction is especially noteworthy. He notes that "team-mates everywhere employ an informally and often unconsciously learned vocabulary of gestures and looks by which collusively staged cues can be conveyed." (Goffman, 1959).

Wherever such 'collusive staging' of cues can be structurally organised for purposive therapeutic shaping of patient constructs and related behaviours, it would seem desirable for therapeutic organisations to engage

in active teaching of such cues' practical effects. The conscious employment of role relevant cues and constructs will thereby lead to a greater functional integration of patients with therapeutically related role alters. The more such a structuring of cues in a therapeutically graded fashion can become a stabilised feature of staff encounters with patients, the less 'artificial' such staging would tend to become, being realised as a functional requirement of the staff role. Goffman's conclusion that, "The more unconsciously the cues are learned and employed, the easier it will be for members of the team to conceal, even from themselves, that they do in fact function as a team" (Goffman, 1959), is supportive of this viewpoint.

Fanon's (1964) insightful observations, in a different context, also shed light on these considerations. Of the 'unconsciousness' of various forms of racism, he notes: "For a time it looked as though racism had disappeared. This soul-soothing unreal impression was simply the consequence of the evolution of forms of exploitation. Psychologists spoke of a prejudice having become unconscious. The truth^{is} that the vigour of the system made the daily affirmation of a superiority superfluous."

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In evolving his exposition on 'the problems of the colonised', Fanon uses such terms as 'metaphysical guilt'. He excuses such terminology as follows: "These (terms) will be accurate to the extent to which it is understood that what is important cannot really be attained, or more precisely, since what is important cannot really be sought after, one falls back on what is contingent The urgent thing is to discover what is important beneath what is contingent."

In a similar vein, I point to certain hospital contingencies in order to illustrate their relevance to theoretically derived imperatives. In this way I endeavour to show how what is important may be related to what is contingent. The schema presented later on in this thesis (page 170) demonstrates how such a theoretical encompassment of these relationships can be accomplished.

Codes and Construct Encompassments

Research into the acquisition of cognitive modes in culturally disadvantaged children (Hess and Shipman, 1966), shows that the central quality involved in cultural deprivation is a lack of cognitive meaning in the mother-child communication system. The healthy growth of cognitive processes, they argue, is fostered in family control systems which offer a wide range of alternatives of thought and action, whereas such growth is constricted by systems of control which offer pre-determined solutions and few alternatives for consideration and choice. Such restrictions preclude opportunities for the child to reflect, to consider and to choose among alternatives for speech and action. They develop modes for dealing with stimuli which are impulsive rather than reflective, which deal with the immediate rather than the future and which are disconnected rather than sequential.

In Bernstein's (1961) view, language structures and conditions both what the child learns and how he learns, setting limits within which future learning can take place. He identifies two forms or 'styles' of verbal behaviour - the restricted and the elaborated.

(a) Restricted codes:

These are stereotyped, limited and condensed, lacking in specificity and exactness needed for precise conceptualisation and differentiation. Sentences are short, simple and often unfinished. Little use is made of subordinate clauses for elaborating the context of the sentence. It is a language of implicit meaning, easily understood and commonly shared. It is a language often used in impersonal situations where the intention is to promote solidarity or reduce tension. Much use is made of non-specific clichés, statements and observations made in vague general terms whose meaning is readily understood. The basic effect of the use of this code is that it restricts the range and detail of concepts and of information used.

(b) Elaborated codes:

These, on the other hand, are characterised by communication which is individualised and a message which is specific to a particular situation, topic and person. It permits expression of a wider and more complex range

of thought, discriminating both intellectually and emotionally.

All in all, restricted codes order constructs in terms of status control and in terms of ascribed role norms, while elaborated codes focus on social action in terms of the individual and his subjective intentions. In practice, the two codes can be viewed as opposite poles of a single dimension - restriction/elaboration of the meaning of the controlling cultural context.

The Psychiatric Relevance of the Encoding System:

Arguments for a more humanistic approach to the practice of psychiatry (May, 1958; Mowrer, 1964; Cummings and Cummings, 1962; Adams, 1964; Colarelli and Siegel, 1966 and others) all stress a more personalised approach to individual problems, less stereotyped and rigid than the kind of treatment meted out to patients in most psychiatric hospitals today. Naturally, there are obstacles in the way of change, among them a dearth of finance, training facilities, and staff, as well as the nature of present professional obligations and the felt threat to reputation of therapists professionally tied by these obligations.

Many of the practical problems of the implementation of more humanistic measures have been explored by Colarelli and Siegel (1966) in their four-year experiment on ward re-organisation in one of the lower wards of a mental hospital in the United States.

In the first year, they point out, their therapeutic resocialisation programme, whose essential aim was "to guide the patient's capacity for growth to the point where he could assume the social responsibilities he had abandoned or never developed," required that the aides themselves be provided with "informal individual consultation on request" in order to enable them to cope with the ensuing 'role confusion' resulting from the personalisation of the aide role. Thus, the authors note, the personalisation of patient problems required a like personalisation of the aide role such that the aides' initial lack of confidence in their ability to meet resultant role demands was accentuated by the patients' initial lack of confidence in the aides themselves. The aides were afraid to expose their own weaknesses, which were previously concealed within largely ascribed and restricted role patterns. Not only did

the aides need to acquire the confidence of the patients, but that of the doctors as well. In their turn, the doctors had to accept, and to a large extent rely on, the aides' own definitions of patient problems.

In the second year of Colarelli and Siegel's experiment, the nursing staff were found to be sufficiently stable and secure to tolerate critical questioning. Realistic goal orientation had replaced previous routine arrangements and aides were periodically questioned about each patient. The authors note that, at this time, a mutual appreciation of group structure had developed.

In the third year, however, the researchers felt that it was also necessary to build up an administrative structure consistent with the new goals and needs of the aide-patient relationships. Traditionally, the supervisee was considered competent only insofar as he was able to use the supervisor's own methods. "Consultant supervision" was introduced in order to cope with problems centred around "the personality and humanity of the aide". Within the framework of this supervision, the following features of the aide's duties and rights were recognised.

- (a) He was free to set his own goals for patients,
- (b) He could use any procedure to attain these goals and was not accountable for procedures used, only their results, in terms of the goals he had set.
- (c) The supervisor, in turn, was free to criticise, observe, inform, disagree and advise on procedures undertaken, and the supervisee was obliged to consider these ideas.
- (d) The supervisee was, however, free to accept or reject the supervisor's ideas.

All in all the supervisor was to be concerned with helping the supervisee to become aware of the patterns of his own personal style, while the supervisee was himself responsible for the consequences of this personal style in terms of its therapeutic effects.

One of the recommendations arising from this treatment programme was for greater communication between the aides and the social worker.

The ward programme for the fourth year included the following aims,

toward which aides were to strive:

- (1) Location and definition of the patients' private personal experiences, and a relating of these to his background, his characteristic behaviour, his general feelings, and his talents.
- (2) Grading of expectations and allocation of responsibilities in terms of interpersonal behaviour and general hospital expectations.
- (3) Provision of a milieu in which the patient could establish himself with stability and familiarity into a general routine.
- (4) Periods of special 'individualisation' in which patients would be singled out in order to attend to their more individual needs.
- (5) Encouragements to the patients to verbalise about personal feelings in relation to self and others and the teaching of related skills to enable patients to understand, control and effectively cope with their feelings.

Hence, we see that the Ward H experiment, in which the researchers were constantly aware of the changes they were producing and constantly refining their own approach in relation to these, started out by assuming that "making a positive value out of not knowing where you are going involves everyone actively" - which it probably does - and ended up with a therapeutic programme which related patient problems and activities to their social backgrounds, as well as to the logical implications both background and problems held for therapeutic intervention in the hospital itself.

In evaluating the outcome of this research, the authors used before and after psychological test baselines, analyses of discharge and readmission rates, qualitative assessment of physical appearance and behaviour, and the use of figure drawings - the latter allowing assessment of the patient's experience of his own body and identity.

Among the tests used, the BRL object sorting test is cited as showing general increased ability of the patients to conceptualise experience (expressed in increased ability to symbolise and verbalise experience and deal with it abstractly.) The authors state that there was a marked change from all-or-none type of responses to a capacity for restraint, a modulation of self, and a meshing with the environment. The patients in general also showed an

increased capacity for obtaining gratification and support from human interaction, a feature they had previously lacked.

A Q-sort analysis done on the aides showed a change in aide-patient relationships from predominantly "organisation-centred" to predominantly "person-centred" modes. They also showed a change from a more generally "custodial" to a more generally "therapeutic" approach to the patients.

The Context of Control : Illustrations from Hospital A:

(1) Joshua Sithole, my assistant staff, was told by a fellow member of staff: "We know how to cure the violent cases, but these others who are quiet and just sit around the place seem to get worse rather than better in this hospital."

On a later occasion, noticing that the doctor was prescribing larger sedative doses than before (for certain new cases), the same nursing aide pointed this fact out to my assistant-staff, saying, "You see, now the doctor is coming to his senses. I told you, this is the only way to deal with such cases."

It should be noted that any eruption of violence on the part of patients, unsuccessful escape attempts, stealing or shouting were all usually coped with by means of sedative injections and/or solitary confinement in security cells. Patients indulging in such behaviour were "taught a lesson" through "overdosing" - a large injection of largactal. (Colloquial staff terminology.) It was not unusual to see patients so sedated that they could not be roused to consciousness.

(2) The following incident was reported by J. Sithole, my assistant-staff: "I was playing cards with Duma S and Sumane S when Brown S arrived at 6.45 p.m. and said to Duma that Mkonta P needs a largactal injection so that he does not bother the night duty staff. Abraham S, who had just finished counting the patients said that he (Mkonta) was sleeping now.

Duma said, "It's better if he just gets 50 cc largactal."

Brown said, "Okay. I'll give him 100 cc's then he can sleep the whole night."

Duma remarked to me, "You see this night staff is complaining that we leave the patients violent and don't inject them."

Such strategies are clearly 'staff-centred', rather than 'patient-centred'. Justifications for them are culturally restricted, that is, unelaborated along mental health lines.

(3) Duma S, who had taken the trouble to learn off by heart all the drug prescriptions of the patients and would usually be the one, along with Enoch S, to hand them out to patients at the pill-handouts, once said to me: "Listen, Stanley, man, I want to ask you a favour. Haven't you got a book on drugs for me, because I would like to learn what effect these drugs are having on the minds of the patients. We are just told to give them so many drugs every day, not knowing what effects they are supposed to have on the patients."

I said to him, "What effect do you think they have?"

He told me, "Well, some are for epileptics. We know that it stops them to have fits. Others get largactal to calm them down. But we don't know in what way and how does it cure them. That is what I would like to find out."

His interest in patients as persons with personal problems was underlined by the fact that it was he who was the one to engage in pre-discharge discussions with patients, advising them not to drink too much, and, if they did drink, not to do so without eating as well, warning them against marihuana smoking and so on. It was noted that improvements in certain patients were greeted by such comments by fellow-staff as "We must tell Duma" or "Duma will be pleased". (Observed by myself.)

(4) The only comprehensive explanatory models of mental illness, encompassing explanations of its origins and cures, were derived from Zionist (a Christian sect) and witchcraft beliefs and practices.

When I questioned Benjamin S as to whether or not he thought it was a good idea to introduce witchdoctors into the hospital, he answered, "I think it would be a good idea, but not all the patients believe in it. Some of them believe in Christianity."

What he meant by this, it appeared from further questioning, was that he considered a great deal of the curative power of these agencies lay in the

part played by belief.

"I think a lot of these patients will never get better", Benjamin told me, "because they don't believe that these European medicines can help them."

This view was reiterated by Aloysius S who said to me, "Ya . . . because this is a mental illness. The patient must believe in the medicines, before he can get better. That's not to say the medicine is not working. It is working. But - at least I know it with African medicines - they won't work for you properly unless you believe in them."

(5) During the time I was a patient in Hospital A, one of the patients in my dormitory used to shake a home-made rattle practically all the time, day-in, day-out. When I asked Aloysius S about it he told me:

"I suppose he just likes the sound of it. It doesn't bother anyone." Then he added, after a few moments reflection, "I suppose it is a part of his sickness."

He was discharged a few weeks later and walked out of the gate in traditional tribal dress, still shaking his rattle.

(6) Staff members would commonly assert that certain patients, who were wont to talk to themselves or to curse aloud, were addressing those who had bewitched them. Others asserted that they were probably possessed by demons. The patients themselves naturally also drew on such constructs. Others, still, believed they had become sick in the hospital.

Augustine P told Rommel Mdwara, my assistant-patient, "I was at home. Police came to fetch me for a reason I didn't know. I fought with them and they took me to jail. From there I was brought here where this illness began."

Reflections:

The expressive order in the hospital context forms the starting point for all other considerations. Functioning as it does as an encoding system for encompassing, regulating and stabilising events in the hospital milieu, its relevance for therapy lies in its acting as an inferential system for guiding selective attention and perception in various situations. The use of one set of judgemental criteria over and against another is viewed as a matter of 'cultural' variation. The hospital's use of one set of criteria over and against another is viewed as a matter of professional commitment. The effects of inclusion and exclusion of cultural variants is therefore viewed in terms of the nature of these professional commitments and the ends to which they are directed.

Integrative Awareness and Goal-directed Conduct:

If one considers the exchange patterns, engendered by hospital requirements, as themselves forms of communication, displaying normatively regulated goal directives, then these exchange patterns can be scrutinised in terms of the therapeutic ideals which they exemplify. Conversely, such exchange patterns can be viewed from the point of view of their concealing or revealing their own purported functional ends.

However, the dynamic meaning of social structures needs to be understood in terms of the way in which they operate on other structures contained within them, and the way in which they, in turn, are operated on by these structures. The way in which an organisation functions, needs to be understood in terms of changes taking place within it over time. Insofar as an organisation is functioning in such a way as to systematically reorganise elements of subsystems contained within it (the hospital's function of resocialising its patients), the time dimension itself becomes an essential element of organisation since the rate of change of subsystems operated on must be systematically matched by organisational measures to take advantage of these changes.

Goldstein (1962) reports an investigation by Schlien, who compared patient improvement in two groups. In one group patients were told at the start of therapy that they would participate in twenty sessions over a ten-week period. In the other group patients were told that their treatment would continue until voluntary termination. Results indicated that patients receiving time-limited therapy reached the same level of improvement in twenty sessions as the other group did in an average of fifty-five sessions. Furthermore, at the end of the latter period, the group receiving time-limited therapy had maintained their level of improvement, even though they had been out of treatment several months. All patients were matched in terms of relevant demographic criteria. Measures of improvement and type of therapy used were the same for both patient groups.

Since effectiveness of therapy is so dependant on the type of awareness of those mutually engaged in this process, the function of constructs employed to guide and stabilise expectations cannot be over-estimated. The therapeutic use made of drugs and electronically induced convulsions, should, I feel, not be excluded from these considerations.

Drugs and the Therapeutic Context :

C.R.B. Joyce writes that doctors who insist that drugs alone can work cures are either "modest, overworked, or incompetent" (Joyce, 1966). He argues that if drugs are properly chosen with the patient in mind and given at the correct dosage, at the right time and for a sufficient period, the patient can be helped to re-establish contact with his environment, especially with some kind of therapist. His disturbed behaviour first has to be quietened, habitual behaviour patterns broken and aggressive attitudes diminished, or he may need to be driven out of lethargy or depression before this relation can be established. However, he adds, if some other human being does not take advantage of this physiological change, the drug is quite certain to be useless. Of the use of depressant drugs in mental hospitals, he writes: "A maniac quietened by a depressant but otherwise untreated represents an advantage to the society of the mental hospital, but it does not necessarily follow that the patient shares in this."

The James-Lange dictum, "Bodily change precedes emotion", points to the fact that physiological changes are inextricably linked with emotional changes. However, bodily changes which are induced without the subject's knowledge, tend to be viewed by him as having been caused by certain situations. This is because physiological changes within the individual are usually part of a comprehensive whole, which includes the interpretation of the stimulus situation, expectations of future developments in the situation and the action set which the individual assumes for guiding appropriate responses to that situation.

Cantril and Hunt (1932) and Landis and Hunt (1932) offer experimental support for this view. Their experiments showed that subjects to whom adrenalin was administered, giving rise to visceral changes similar to those experienced during excited emotional states, reported in some instances that they experienced 'emotion', in other instances that they did not experience 'emotion', and in other instances still that they felt 'as if' they were afraid or 'as if' they were angry.

Schachter and Singer (1962), considering the fact that the subject in these above-mentioned experiments probably knew the effects of adrenalin, came to the conclusion that, when the adrenalin caused tremors and palpitations, the subjects were, on this account, not disposed to treat them as cues of emotion, hence the qualifying 'as ifs'. In their own experiment, they misinformed their subjects about the nature of the drug they were to receive. They received adrenalin, but were told that they were receiving 'Suproxin', a 'vitamin supplement', and were told that they had been recruited in order to study the effects of this vitamin supplement on vision. Using subjects whom Schachter and Singer describe as 'uninformed', 'misinformed' and 'informed' as regards the 'side effects' they would experience while waiting for the vitamins to take effect, subjects were placed with stooges "who acted either in a spirited jovial manner or in a disagreeable and aggressive manner." It was found, using observation and questionnaire data, that the uninformed and misinformed subjects, were nearer in action and mood to the stooges than the informed subjects. It was concluded, therefore, that when a subject is in a changed physiological state for which he has no explanation he will label this

state in terms of the situation in which he finds himself. Conscious experience of 'emotion' appears therefore to be a complex experience which includes awareness of the stimulus situation and its significance, awareness of the contextual appropriateness of certain responses, and awareness of certain physiological changes occurring in the individual.

In endeavouring to answer the question 'what psychological changes can be brought about through the use of drugs?' it is interesting to note what Hays (1964) was able to say of the drug 'Largactal', the most widely used drug in Hospital A (80 percent of the patients receiving, on an average, over 350 mg. per day each). He says: "When it is successfully used in schizophrenia, it removes whatever symptoms of the illness exist, so that if these include overactivity it may be said to tranquilise, while if they include underactivity and inertness, it activates." In the same article he also declares that its introduction into mental hospitals resulted in improvements which were not confined to those who had received the drug. He writes, "The untreated patients benefitted from the altered atmosphere, as even the most withdrawn patients did in the distant past when chains were struck off or straight-jackets abolished."

Such statements as the above do not clarify the effects of the drug's use. Instead, what becomes clear, is a situation involving the use of drugs, in which certain physiological changes in individual patients interact with therapeutic expectations, exerting a dual influence on these patients, such that situational changes cannot readily be attributed to either alone. That largactal "depresses certain parts (of the central nervous system), the reaction being reversible", that "it also inhibits the central nervous system" and that "it has sedative, hypnotic, anti-pyretic, anti-convulsant and anti-emetic actions" (Sapeika, 1963) is not doubted. That these effects of themselves 'cure' schizophrenia is doubted.

The exchange system involving the use of drugs is thus viewed here in the context of the entire exchange pattern of the hospital. Somatic phenomena are seen as significant insofar as they constitute signs which are incorporated into, and encompassed by, the logic of the expressive order prevalent in the hospital, underlining, as it does, the meaning which such physiological changes acquire in interpersonal transactions.

'Electro-Convulsive Therapy' and the Therapeutic Context:

The same analytical context as elucidated above will hold for consideration of shock therapy procedures. Its use, based on its purported "calming" and "anti-depressant" effects (Hays, 1964), although lacking in any adequate theoretical grounding - "those who use these treatments do not do so on theoretical grounds (because no satisfactory explanation of their effectiveness exists) but empirically" (Hays, 1964) - was evident in all three mental hospitals studied.

'In loco' statements by doctors administering E.C.T. such as, "We don't know how it works, but I have a theory that it helps to break down the barriers of the central nervous system so that the other drugs can have better effect there", (Hospital B), "It's amazing how it sometimes works with them" (Hospital A), and "I find it works better with our Bantu patients when the treatment is given to them 'live' ", that is, without prior injections of pentathol (Hospital B), demonstrates the absence of explanatory models in terms of which patients themselves might receive assurance on the possible effects they might receive from the treatment.

The Context of Induced Physiological Changes in Hospital A:

Here, 'shock therapy' often took on aspects of a 'rite de passage'.

I was witness to an open discussion on the topic of who was going to be discharged first and why. The fifteen patients involved in the discussion eventually agreed that those patients who had been receiving E.C.T. would be the first to be discharged "followed by those who have recovered".

* * * * *

Tranquillising injections were often meted out to offending patients with the statement that the injection was being given "because you are troublesome" and "because we can see you are still sick". The two statements were often made to the same patient, even though nursing staff would differentiate among themselves between patients who were "sick" and those who were "taking advantage".

Situational Awareness and Conduct :

The issue being underlined here revolves around the question of to what extent, under what conditions and in what circumstances patients should be aware of behavioural changes which external agents are producing - be these agents inducing behaviour changes through the use of pharmacological drugs or through behaviour reinforcement mechanisms. This question in turn boils down to one which asks when and how patients are to assume responsibility for their own behaviour, and under what conditions.

Assuming that drugs modify central and autonomic nervous activity, a reduction or increase in such activity may be met in either 'adaptive' or 'unadaptive' ways. It is suggested here that such coping behaviour be regarded as a function of the patient's ability to recognise and respond to various demands made on him in the hospital, this being related to his previous experience in similar situations and his capacity, in terms of positive transfer, to modify his conduct or to learn new conduct under these physiological and situational conditions.

Since a large proportion of behaviour can, in any case, be construed as a function of neurological arousal, disappearance of 'symptoms' under sedation is only to be expected. However, the learning of socially more acceptable and/or more appropriate responses to the patient's general life conditions can hardly be said to be a function of increased or decreased nervous activity alone. It is more, as Mandler (1962), in his famous 'juke-box' analogy of emotion puts it, a question of both "inserting a coin and selecting a musical number".

Identity viewed as a Function of Situational Context:

The concept of identity must, of necessity, remain an elusive one, which elusiveness disappears once the situational context and an individual's place in it, has been defined. This is necessarily so because each individual's identity, seen as an experiential construct, is bound up with appraisals of himself, by himself, and by others. In like manner, the way in which an individual presents himself, in the identity he has assumed, is guided and stabilised by his judgement of himself and of others, of their

judgements of themselves and of him and of the consequences, in terms of interpersonal conduct, engendered by these mutual appraisals.

In culturally circumscribed situations, interpersonal conduct is guided by rules, norms and expectations. The process of construing a particular situation is a function of placing persons and things construed, within categories - patterns of inferred relationship. Such symbolic labelling at the same time provides the construing subject with certain directives for action. This process always involves both anticipation and evaluation. As long as new learning takes place, revision of constructs continues. As long as there is revision of constructs, there is reorganisation of conduct. The innovation implied by such reorganisation, relies, for its emergence, on the ambiguity of the situations confronted. It is only within such areas of ambiguity that new criteria of value can emerge and transformation of constructs can take place. Terminological shifts both necessitate and signal new evaluations of self and others, of events, acts and objects.

Strauss (1959), working in collaboration with Howard Becker, sees the importance of the latter's research on medical students in the implications held therein for the practice of psychiatry. Becker (1959) notes that physicians believe they can better diagnose certain illnesses when their patients are well educated. These patients are not merely more articulate, but give a more orderly and hence more satisfactory account of those symptoms which they judge as relevant to the doctor's concerns. Hence part of a physician's job would appear to be to teach patients how to report symptoms. How much more should this not apply to mental disorders, especially where the basis of the disorder is construed to be a problem in interpersonal relations?

Sullivan (1949) uses the term "consensual validation" to refer to the process whereby agreement is reached with a significant other, in terms of which co-operation with regard to mutual action and agreement concerning the character of self and other might be reached. He views interpersonal processes, occurring in interpersonal situations, as the proper subject matter of psychiatry, which perspective allows him to speak of "pathologies of interaction".

The manner in which Sullivan approached interpersonal problems with his patients was roughly as follows: He would find out in what situations the patient found himself thinking in terms of certain constructs. Then he would investigate what these constructs meant in terms of the function they served in the situation - how they were used, when, and for what purpose.

Sullivan viewed the therapist as "the alleged expert whose expertness shows itself, if at all, in uncovering the processes at work in the patient's relations with others." (Sullivan, 1940). Therapeutic growth he saw as dependent upon a series of insights into specific concrete situations.

Symbolic encompassment of one's world involves knowing how to act with respect to objects and situations construed. Where other persons enter into situations with which the individual must cope, his constructs need to encompass mutually agreed upon intersubjective meanings for cooperative conduct to be at all possible.

Where the world, within which one is living and functioning, involves a regularisation of conduct in terms of a pre-established set of role demands, as in the mental hospital, and where this regularisation of conduct involves a regularisation of sequential changes in role patterns, as the mental hospital should do in the 'sequential processing' of its inmates toward a state where they are ready for discharge, a series of predecessors and successors, should, logically, be identifiable. Other people have been in similar positions before and have had to cope with similar problems and others will be obliged to follow in their footsteps. In this way continuity is given not only to the group or organisation, but also to individual experience. The individual is, in this way, prepared for what is to come. He understands the passage of his career to this point and is aware of the imminence of the next transition. The attainment of a certain role-position in a hierarchy of role-positions may require that the future occupant has certain experiences and that his conduct meets certain standards of performance. The nature of the situations which the patient is required to confront should not distort or obscure the nature of this pattern.

Regarding the use of therapeutically ordered constructs in therapy, Sullivan has the following to say:

"Since psychiatry . . . is a science dealing with operational conceptions, its special referential language may well be derived from typical interpersonal action, which, from the nature of personality, must be identified with the common reportory language of the people concerned - which language however, insofar as it is made the special language of psychiatry, ceases to be common speech and open to any damned interpretations which appeal to the hearers; insofar as he (the psychiatrist) is a student of psychiatry, he has to learn the precise meaning of its terms" (Sullivan's emphasis.) (Quoted from unpublished lectures given by Sullivan by A.H. Stanton in "The Contributions of Harry Stack Sullivan". See References.)

Sullivan recognised the patient's right to hold onto his way of construing the world before giving it up to see what might happen to him. He saw the therapist's interaction with his patient as a series of "security operations".

In mental hospitals, where nursing staff can be seen as therapeutic intermediaries in the structuring of the patient's expectation in relation to the hospital- and later extra-hospital 'world', the staff themselves might become engaged in 'security operations' to protect their own occupational interests, in response to threats presented by anticipated consequences (from staff superiors) with respect to oversights and/or careless defaults. The following two sequences occurring in Hospital A, illustrate certain therapeutically 'mystifying' effects, as a result of the presence of occupational contingencies experienced by certain staff as 'threats' to their own continued employment. Although exceptional, they nevertheless point up certain mechanisms latent in hospital arrangements themselves.

Sequence A:

Elias P, the father of Gideon P, arrived at the hospital one evening, having been brought in by the police. His son greeted him - my assistant-patient informed me - "as if he were a stranger".

On the following evening, Gideon paid a little more attention to his father, lighting his cigarettes for him and sitting with him on his bed, the two of them exchanging a few formal words together.

Elias afterwards turned to my assistant-patient and told him that he respected him because he had some "English blood", and that he would like to smoke his pipe. Rommel (my assistant-patient) refused, and was consequently slightly rebuked for his refusal by Sifundza P, another patient and war veteran. Rommel replied that he was not being disrespectful, but that he did not let anyone else smoke his pipe.

It seemed as if Sifundza had wanted to engage in conversation with Elias, for the two of them exchanged formal greetings soon after Elias' respect had been expressively restored by this conversation. The two of them then began to speak about home affairs. Elias explained to Sifundza how one of his wives had been taken from him by another man and how he himself was arrested at his home by the police and brought to the hospital. All this time Gideon sat on Elias' bed, listening attentively, nodding agreement at times and showing respect to the old man, but not speaking.

Later on in the evening, at about shift-change time (7 p.m.) when Elias was sitting alone on his bed, he took out a tobacco pouch and rolled a cigarette out of some dry herbs, which he then began to smoke. The pungent odour of the smoke attracted the day-staff who emptied out his tobacco pouch to see if it contained intsango (dagga). Satisfied that it did not, they left him alone.

Shortly after this, he began to throw 'itinhloa' (witch-doctor 'bones') on his bed. Joshua, my assistant-staff, became interested and asked him what he saw in the bones.

He replied, "I'm just playing. In fact, I'm asking God to let me take my son out of here safe and sound."

Gideon was visibly embarrassed by this remark.

Elias then began to praise King Sobhuza. Rommel remarked at the time that the praises were "both correct and interesting". But toward the end he began to use vulgar words "as if cursing someone who had wronged him". (My assistant-patient's phraseology.)

After this he began singing "Somlandela Usithando", a 'traditional' song. At this time a number of patients, including myself, joined in the clapping and singing and a few of the staff who were just going off

duty came in laughing with merry approval. Others joined in the 'festival'. Madevu, a strongly-built and rather aggressive patient, at first tried to scoff at the proceedings, but later joined the group himself as the songs became religious in content.

Gideon, the son, who had been pretending to be asleep all this time, got up and walked out, seemingly embarrassed by the whole situation.

Since the gates of this block were being locked, I had to leave at this point, and, as I walked out of the building, I found Gideon sitting on the steps outside, his head on his knees and his arms folded about it. I asked him why he had left the singing, but he just shrugged and shook his head, not answering me.

It was soon all over inside, the old man being completely exhausted. Everyone went back to his own bed and Rommel and Elias spent the evening discussing 'lobola', the African marriage custom of cattle exchange between the bridegroom and the family of the bride on the occasion of their marriage, and women in general. The gist of the conversation boiled down to their common agreement that "The one and only hell is a woman". The conversation included a discussion about Gideon's mother who had run away with a shopkeeper.

It was during this discussion that Gideon vanished into thin air. At first Elias surmised that he must have gone to have a drink of water, or gone to one of the lower dormitories, but, on going to look for him, Elias found that he was missing altogether. He went to report the matter to the staff on night-duty, who were in the staff room at the time, engaged in a discussion of their own. These staff then also began looking for him, but could find no trace of him. They concluded that he had climbed through the wire above the outside passage, between the lower dormitory and the central toilets.

Later on that night, the staff came into Rommel's dormitory and injected Elias, who was sitting up in bed at the time. Rommel questioned Richmond S, the injecting staff, why Elias was being injected. He was told that it was because Elias had been responsible for his son's escape, having engaged the staff in conversation in the staff room, while his son, in collaboration with his father's plans, had escaped. At first Rommel thought he was joking, but by the time

morning had come it was apparent that the story had become the official version of the escape.

Arriving on duty, Joshua, my assistant-staff, came over to ask Rommel about the night's goings on, saying that the night shift had come to the staff dormitories with the story that Elias had helped his son to escape.

On reconstructing the whole episode we decided that the contingencies bringing about the 'scape-goating' of Elias (who was injected heavily every night for the next week), were as follows:

- (1) The staff were under threat of discharge if they could be held responsible for the escape of a patient;
- (2) Since they were on duty at the time they obviously would be held responsible, unless they had a reasonable alibi;
- (3) Since Elias had gone to report the escape to them in the first place - along with the obvious fact of their father-son relationship - there was circumstantial evidence enough for them to build up a strong case for their line of defence, so long as every staff member could be guaranteed to tell the same story.

The public motive - punishment of the offending party; their private motive - retention of their jobs in the hospital. (Joshua noted that Mr. Khasa had told him at the time of his employment: "If you are responsible for an escape I will have to fire you.")

Sequence B:

In the second example of 'scapegoating' to be considered here, the victim was perhaps more 'justifiably' accused. Nevertheless certain situational features permit description of the whole incident as an example of 'scapegoating'. These features are, briefly, as follows:

- (1) The position of certain members of staff was endangered by circumstances which could be accounted for as occupational oversights on the part of these individuals;
- (2) A patient was found who could shoulder the blame for the incident;
- (3) Institutional sanctions were used against this patient thereby reconstructing the sequence of events along lines which would elicit institutional approval.

Again the staff would be found blameless, a patient found responsible (in the context of his 'irresponsibility'), and suitable measures would be taken, which would, ostensibly, consolidate and promote the stability of the legitimate order.

The crux of the matter giving rise to the scapegoating sequence occurred between 10 a.m. and 11 a.m. on April 5th, 1970.

Benjamin S, a staff member, gave a set of keys to a patient called Danger P, in order for him to open the gate at the lower end of the 'campus' for Michael S and his 'boys', who were returning from the male staff quarters where they had been cleaning.

Danger claimed that he had given the keys to a patient nick-named 'Bungane' ('Bug') - a feeble-minded but willing patient - who in turn claimed that someone had taken the keys off him, although he could not remember who it was. In any case the keys were now missing and they, together with the culprit, had to be found.

Bungane was asked to point out the person who had taken the keys from him, but he claimed that he could not remember who it was. Through questioning him on all that had happened to him between the time he had been given the keys and the time they had been found to be missing, Benjamin and Michael reduced the number of possible culprits down to one, Samane P - an articulate and astute patient, who had spent some time in Johannesburg and was considered by the staff to have "vicious" and "criminal" tendencies, who would take 'no-nonsense' from those he did not like, but who was, nevertheless, kindly and generous to the more helpless kind of patient for whom he appeared to have sympathy. (When I finally left researching the hospital I gave the patients and staff a small aviary of birds. Samane told me that he was going to open the door and let them fly away - like he did to caged birds in European peoples' houses in Johannesburg - because 'no-one likes to be locked up'.)

It appeared that, as Bungane entered the building on his way to the staff room, he was met in the corridor by Samane "who passed a few jokes with him". (Samane's phrase.) Afterwards he remembered about the keys, but did not know where they were.

On the other hand, Mike reported that Samane had approached him outside and asked him if he wanted the keys. He had replied negatively, and said that at the time had had thought it rather strange that Samane had asked him this. Samane, on the other hand, explained that his request was in no way strange since he had seen Bungane in the corridor with the bunch of keys in his hand and then had seen Mike standing outside "as if he was waiting for something" (in fact he was waiting for the workers to put away their cleaning blankets, rags, brooms, etc.) and thought that he might be waiting for the keys.

On this day, the lower gates were not opened at lunchtime to allow patients to go down to the dining-room for their mid-day meal. Five patients who had been working in the kitchen all morning (since about 6.15 a.m.) were not considered suspect. All the rest were considered likely culprits. All were now becoming restless as the gates had not yet been opened to allow them to go down for their meal. Down in the kitchen, kitchen-staff and patient-workers had not yet heard about the missing keys and were becoming curious about the reasons behind the unprecedented delay.

Mike S addressed the crowd at the gates, telling them that no-one would receive any food until the keys had been produced. This was 'Strategy One'. But no keys were forthcoming. As the waiting game continued, and the crowd began to protest, first softly, then more loudly, Jonathan P began to threaten Samane P, the first accused, as the events leading up to this situation became known. Afterwards insults began to fly at the staff as the patients pressed demands for their rightful food.

Benjamin came over to speak to me. He told me that last time this had happened there was "a hell of a trouble" and that the Superintendent had threatened to discharge the responsible staff should any keys become "missing" in future. James P, a patient who was obviously very fluent in English, but who had thus far (since his admission) confined his utterances to endless self-questionings. - (What is the cause of the sinfulness of this nation of people, James? Who is to be the saviour of this world James? Why is it this person is listening to the words of one to be James, to be him in this world of saving?) - now shouted above the general hub-bub, "Bring

out the keys! That is all. We must have keys first, then we can go and eat!"

Reuben P was chasing 'Bungane' and threatening him to produce the keys - "or else"! Bungane eventually took up an embarrassed watchful position at the far end of the campus, from which he could run should anyone come to attack him. Brown S called to Reuben to call off his threats, since someone else must have the keys.

Jonathan P came up to me and said, "These police (a term used synonymously with 'staff' or 'mabalane'- 'clerks', to refer to male nursing staff) are not allowed by law to give the patients the keys. They just do it to get us into trouble".

Still no keys. 'Strategy Two': All the patients were lined up, irrespective of who they were, and searched by Brown S, who swore at them individually, treating each one, in turn, as if he were the culprit, although it was obvious from his tone of voice and the forcefulness of his threats that he had certain prejudices in this regard. In the meantime, Mike and Benjamin, together with Duma and Benson, were searching the buildings, turning over mattresses, looking in the toilets, under and in cupboards, inside books, behind partitions, on the roof, in the gutters, inside the drainpipes, inside crevices and in every conceivable place in order to find the missing keys.

Jack P came up to me, pleading, "Please open the gate for us. We want to go and eat".

"No", I told him firmly, "the other keys must be found first."

(I was drawing activity maps at the time and had a private key.)

As the search progressed, Jameson P, who turned most things into a farce, was standing alongside Enoch S and Brown S adding his own insults and curses to Enoch's as each patient was searched. ("Swine-a-ma-bitch" - he could be heard screeching in mock fury). After each patient had been searched he was directed to an enclosed area so as to prevent any passing of keys from unsearched to searched patients. Moshweshwe P was found to have a bundle of old rags, nails, bits of plastic and scraps of paper inside his shirt. The staff busily looked through it all, but, finding no keys, declared

him to be a "walking rubbish bin", and left him.

Austin and Albert approached me to open the gate with my own private 'research' key. I told them I had no authority to let them out and that Benjamin S would be in grave trouble were the keys not found. Albert asked me with forced humour whether there was not a special plane that could take Bungane overseas. When still others came to press me to open the gate, I retreated inside the buildings.

Enoch joined the search in the buildings, even going thoroughly through everything in the staff room, tins, duster heads, sterilizing basin and so on. All to no effect.

By 2.15 p.m. the patients were still standing around in small groups discussing the incident and complaining of hunger. Bungane was standing by himself. Danger, too, was fairly isolated at this stage.

At 2.20 p.m. Michael and Enoch decided to take the patients down to lunch. The gates were opened and all except Bungane trooped down to the dining hall.

Enoch said to me, "Did the patients tell him to stay there?"

I replied, "No, it was his own decision."

Enoch made no attempt to call him down and eventually he sheepishly came down of his own accord.

That afternoon the Head Nurse joined in the investigation. Benjamin and the Head Nurse cleared Samane's dormitory of patients and asked Bungane to point to the bed of the person who had taken the keys from him. He pointed to Samane's bed. The case seemed to be clinched, but the Head Nurse was not yet satisfied.

"Why didn't you say so before?" he asked Bungane. When the latter did not answer, he suggested, "Was it because you were afraid?"

"Yes", Bungane answered.

Samane was locked in the security block and denied supper, although he continued to protest his innocence, and no keys could be found to conclusively prove his guilt. The next morning he was denied breakfast as well. Being Monday, the Superintendent was on duty, and, on being told of the incident, he suggested that Samane be kept in confinement on half rations

until he confessed. After four days, having elicited no confession, and the keys not yet found, Samane was released, his guilt unproven. He told me privately that he had no resentment against the staff who were just doing their duty, although he was innocent. He told me that he did not resent Bungane either. He was just "simple" and "didn't know what he was saying." No action was taken against Benjamin.

* * * * *

Extra-ordinary events, such as the above two scapegoating accounts, might be seen as possessing merely anecdotal or partial value. Yet, when they are viewed from within the perspective which takes account of their embeddedness in everyday events, they serve to elucidate and clarify the very reality within which they stand as extra-ordinary and unusual. The degree of ease with which unusual events are incorporated into the overall pattern within which they occur, serves also to indicate the degree of their 'expectedness' - or 'unexpectedness', as the case may be - the extent to which they could have been predicted beforehand in terms of currently operative contextual variables.

The role of Positive Incentives in the Therapeutic Order:

The way in which, for example, incentive tobacco is used to build up patterns of exchange between staff and patients and the way in which these patterns attain symbolic encompassment in the therapeutic system is of utmost importance in considering the role they play in the therapeutic 'shaping' of role conduct.

In Hospital A, certain feeble-minded patients were forced to carry the blankets of incontinent patients in and out of the sunlight without tobacco payment, whereas the same patients were given tobacco at communal non-incentive tobacco-'ration' handouts. Patients were thus selected for this job by virtue of their utility value rather than because it was considered therapeutically desirable for them.

The therapeutic value of hospital work lies in the following possible

functions it could serve:

- (1) engendering social co-operation;
- (2) structuring role conduct in a purposive framework;
- (3) facilitating a positive attitude toward work and the advantages of co-operating in joint undertakings with others,
- (4) giving patients opportunities to resolve problems of an inter-personal nature within the framework provided by work roles;
- (5) providing patients with avenues of positive role identification;
- (6) providing patients with a means of assessing their progress toward personal and social responsibility, as more responsible roles are progressively validated for them, leading to eventual discharge.

That such uses were not made of hospital work roles was obvious from:

- (1) choice of patients for work roles according to their current ability and willingness to engage in such activity;
- (2) the fact that most kitchen-workers, garden-workers and staff-quarter workers tended to be, by and large, long-term patients, so that little, if any, relation was evident between ability to work and 'mental health', viewed as 'readiness for discharge', and
- (3) the fact that certain patients would underline their refusal to work by asserting that they were "non-smokers". Their argument was that on this account they could not be "forced to work".
(Witnessed by all three research workers.)

Both the concepts of 'work as therapy' and 'tobacco payment as therapeutic incentive' can be shown to have been absent.

Therapeutic Progress and the Concept of a 'Rank Order'.

I have argued elsewhere in this thesis that the absence of a rank order in terms of which patients may assess their own progress toward discharge, may well be interpreted as indicating the absence of a moral or therapeutic order in terms of which behavioural assessments might be made.

Dahrendorf (1969) sees the principle of inequality lying in the fact that men, as encumbents of social roles relate to dominant expectational principles, and to sanctions designed to enforce these principles. The presence of criteria for assessing and shaping behaviour in desired directions necessitates a discriminating application of sanctions (positive and negative) in order to clarify in a practical and unambiguous way, the manner in which patients must act in order for them to be able to claim responsibility for their own 'therapeutically approved' conduct - such responsibility functioning as a criterion of mental health. If this is not clear to patients at all levels, and if such responsibility cannot be assumed in good faith, communicated in a straight-forward manner, and its attainment appropriately recognised and communicated, either by incentive payment, increased freedom, reduced drug dosage or other hospital 'privileges', then co-operative activity with therapeutic intent seems difficult to envisage.

What do 'Symptoms' say?

Sarbin (1969) sees in psychiatric 'symptoms' the use of universal adaptive techniques to reduce strain arising in social situations. Such techniques, he notes, tend to be more extreme in degraded persons who characteristically lack the capacity for conduct modulation through the use of verbal controls. Violent and assaultive acts, he suggests, exemplify such unmodulated conduct. Syncretic attention deployment is logically unregulated and uncontrolled. The same is true of hallucinations. What has been termed 'acting out' makes use of the strain releasing power of unregulated motoric activity, so obviously lacking in well defined verbal and social control. Others, still, make use of the tranquilising features of sleep, or drugs. Delusional patients, on the other hand, reconcile contrary premises through the alternative avenue of reconciling logical contradictions by developing superordinate belief systems which tend to be messianic, fundamentalist and highly personalised. Such personal construct systems are generally socially impermeable, yet they tend to be self-perpetuating since their systematic consistency provides a framework for processing incoming

information in such a way that its delusion - maintaining function can only be disrupted through systematic intervention to counteract certain outcomes, on which the subjects' delusional system relies, for its continued maintenance as a coping technique.

Yet, as I have already argued, symptoms cannot be profitably viewed simply in terms of their function as strain- or anxiety-reducing mechanisms. They develop not only to reduce strain, but also to cope with demand situations which give rise to this strain in the first place. Symptoms can only properly be eradicated, therefore, by providing the patient with alternative means of coping with his situations - means of coping which are functionally more effective in fulfilling the patient's situated needs (and therefore equally, if not more so, anxiety reducing).

What do Therapeutic Procedures say?

Information collected on 'situational conduct - situation restructuring (reconstruction) - situational conduct' cycles is useful for providing a basis for understanding structural - functional relationships in the hospital context, and the effects which these relationships have on emergent roles and role-identities insofar as such information lends itself to a description of lawful relations (and relations to other relations) under prevailing cultural conditions. What is necessary for such a description to be possible is the prior drawing up of a conceptual schema comprised of categories which ^{would} enable one to identify certain recognisable events as representative of particular situations in which a particular set of relations (and the status of these relations with respect to a superordinate set of relations) holds sway. Such a conceptual schema, I would argue, will only be structurally credible if it enables an observer to ask, by means of its use, certain basic therapeutic questions.

In order to overcome 'symptoms' on a full-scale institutional basis, it would seem necessary to be able to describe institutional processes as independent variables against which patient behaviours can be assessed as dependent variables. However, since the conduct-shaping functions of controlling staff would seem to require systematic sequential re-organisation to keep pace with therapeutic improvements (manifested by individual patients), it might be best to endeavour to devise a method of describing situational variables with respect to the current conduct of staff and patients. ~~and~~

The following three questions may be seen as the basic therapeutic questions which need to be asked of any therapeutically - structured situation:

- (1) What conduct is demanded?
- (2) What motives are vowed to justify conduct demands?
- (3) What incentives are used to reinforce conduct demanded?

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CHAPTER VI : RESEARCHERS AND THERAPISTS AS PARTICIPANT OBSERVERS.

The researcher - conflicting role sets - contextual vs. ethnocentric insights - the therapist - patients as participant observers - transcendent constructs - identity implications all round - conflicting loyalties - the 'ethnocentricity' of the therapeutic perspective - resocialisation through transcending (ethnocentric) perspectives.

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In the preceding chapter, questions were raised concerning the conduct of controlling members of the therapeutic community. The context of control was considered with an eye to its 'meaning' for those involved in it. In this chapter, the interpretative role of therapists and researchers is reviewed with an eye to the meaning of their participation in the context of their professional involvements with those whom they are either treating or studying.

The Researcher as Participant Observer :

The problems facing a researcher in the role of a 'participant observer' serve to clarify and to throw into perspective problems facing the therapist - more especially if one assumes Sullivan's psychiatric perspective which places the therapist himself in the role of 'participant observer'. This perspective puts the onus on the therapist to define his own standpoint in relation to the society at large and in relation to the patient and to act as a mediator (between them), by enabling the patient to participate in socially acceptable social roles, while lending sufficient weight to his position to facilitate some sort of therapeutic collaboration with him.

The participant observer proper needs to be both a stranger and a friend among the people he is studying. It would seem that he needs to be both participant and observer at the same time. However, the conduct

implications of the role sets stranger/friend, participant/observer are in fact, mutually exclusive.

Jarvie (1969) suggests that the success of the participant observation method derives, existentially, from exploiting the situations created by the role clashes insider/outsider, stranger/friend.

If the participant observer identifies himself completely with those he is studying he may not be able to emerge from this immersion to the extent of his being able to objectify the situation. In developing loyalties, his vested interests will inevitably enter into his observations. Being an 'insider' gives one a privileged point of observation, yet the observation of a pure participant is in no way a privileged one. To the extent that he shares common goals with insiders, the participant observer will be able to take up a role position amongst them. To the extent that he lives outside their interests he will be unable to experience the effects of their living conditions on his own personal experience. As an observer, the participant observer's truthfulness needs to be 'ethnocentric' as opposed to its being 'contextual'.

However, the imposition of the medical model as an 'ethnocentric' theoretical perspective imposed on patient conduct merely results in numerous descriptions of 'symptoms', without accounting for the moral effects which the hospital organisation has on the patients (let alone the effect it has on the conduct and experience of the nursing staff!)

The Therapist as Participant Observer:

Most of the patients with whom I lived in Hospital A tended to be more or less ignorant of the ways in which the hospital wished them to progress, if, indeed, those occupying the roles of therapeutic agents had any clear idea of what 'therapeutic progress' in operational terms could mean.

Sullivan's (1940) position argues for at least a partial validation of the patient himself in the role of participant observer. Therapeutic effects are enhanced by the patient's participation with the therapist, (engaged in the process of investigation of situational phenomena).

Constructs used by therapists in the shaping of patient conduct can be described, as I describe them, as 'transcendental', in that they presuppose the kind of experience which the patient needs to have in order fully to grasp their meaning and significance for him. The term 'transcending construct' is used later on in this thesis to describe controlling constructs imposed by staff on patients, when such constructs succinctly bring about the resolution of conflicting positions assumed by the patient in relation to those demanded of him in the therapeutic situation. Every 'controlling construct' demands that the patient reconstrue his present experience and channel his conduct into lines which transcend the previous limitations of his capacity to embrace these constructs, that is, to commit himself to the logic underlying them. The paradigm of conduct possibilities encompassed by the logic of the expressive order, shared by therapist and patient alike, needs to be securely based in principles which have wide social applicability. Only then will patients be able to obtain any therapeutic advantage in learning to embody these principles in their own acts of situated construing and behaving.

Identity Implications all round:

The identity crisis facing a participant observer living among a group of mental patients, insofar as he shares the same conditions as they do, is essentially similar to the identity crisis facing the patients themselves. The same identity crisis is what Sullivan has asked the therapist to confront, as he faces the problems of his patients. Insofar as, in mental hospitals, nursing staff find themselves in the therapeutic role, the

same holds true for them. As therapeutic agents, these persons should, however, be in command of a transcending third perspective, which supplies the necessary conduct regulating constructs to enable the patients to grasp the insights offered by this perspective as solutions to their own situated dilemmas. The participant observer is essentially involved in observing other participants making predictions about their own situations and how to deal with them, hypothesising both their hypotheses and their conclusions (through systematically reconstructing their constructions of events). From the therapist's point of view, the patient is someone who needs to embrace the perspectives offered by situationally adequate constructs, if he is to be successfully resocialised. Such constructs need to be adapted to the specific patient in mind with due regard to his own particular circumstances, the transitions he has thus far achieved, and those he is yet logically committed to achieve. Hence, at each step, the therapist needs to offer the patient transcending constructs which will enable him to commit himself to roles which are either temporarily or permanently acceptable within the demand situation set for him by the hospital, in its 'resocialising' function.

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CHAPTER VII : PROBLEMS OF MARGINALITY - A TENTATIVE SOLUTION.

External and internal systems - integrating functions - resocialisation, disengagement, re-engagement - the grading system - role identification and role learning - the principle of self-help - the logic of psychiatric institutions - the illness metaphor - inherent logical contradictions - role strain - self-fulfilling prophesis - 'damned if you do, damned if you don't' - marginal role positions - overlapping vocabulary patterns - manifestations of role conflict - communication out of character - dangers - examples - transcending constructs - failure, dilution - 'reciprocity' - a derived imperative - a tentative solution to marginality problems - reward-centredness vs. cost-centredness - situated conduct 'meanings' - status advancements - hospital commitments and patient commitments, reciprocity - values - 'investment'.

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A Programme of Status Advancement:

In any co-operative activity, the interactants involved learn to commit themselves to role positions which the group as a whole validates for them, and which, in turn, fit the group's functional needs. These role-positions hold identity implications for those who occupy them. Individuals who commit themselves to group roles are generally obliged to accept the identity implications of these roles as accurate reflections of their social identities.

Elsewhere in this thesis, a distinction has been drawn between ego and alter aspects of social roles. This distinction throws into relief a distinction between private and public constructs. In group relations, functionally related individuals, viewed as centres of consciousness, or 'egos', encounter one another as 'alters', whose interpersonal attributes cluster around sets of public proprieties attached to their social roles. The public constructs relating alter roles to one another serve as frameworks for guiding and stabilising role conduct. These public constructs include a vocabulary of publicly avowed motives tied to the functional logic underlying co-operative focal role-positions.

The overt purpose of the mental hospital is resocialisation of patients. This may be divided into three stages - admittance, treatment and discharge. The patients are disengaged from the wider society for the purpose of their later re-engagement in socially accredited roles. For the institution to adequately fulfil this re-integrating function, it would seem necessary that roles required of patients outside the hospital be validated for them inside the hospital.

A system of patient grading inside the hospital would allow patients in the process of being resocialised to gauge the effects of their own conduct on the organisational culture, more especially, the effects of their conduct relative to the hospital's institutional commitment to eventually discharge them. A gradual status advancement in the external system, from the object side of institutional pressure, power and control, on to the subject side of such power and control could finally allow advancement into role positions where formal relations between patients and staff, in particular situations, are no longer applicable. Staff-patient relations, would, in this way, gradually assume the normal extra-hospital standards of conduct which lead to discharge. Such patients, as they advance into more 'socialised' role positions would constitute models of patient progress. They would thus have high identification value for lower ranked patients, conducive to role learning behaviour (Lippit, Polansky and Rosen, 1952; Mausner, 1954; Davitz, 1955; March, 1956; Deutch and Gerard, 1955). The advancement of mental patients into positions of power and social control would also serve to stabilise their own resocialised conduct, through the mutuality of expectations systematically built up through the structuring of action patterns in graded advancement of successive role positions. The patient's alter record is also enhanced at each stage of advancement, leading the patient into successive anticipation of new situational contingencies, appropriate to the next stage. Bales' (1945) principle of "self-help through helping others" can be seen to operate where the patient

moves into role positions in which he himself exercises a limited therapeutic role, so consolidating him within role positions in terms of which his own treatment may be terminated.

Some Dangers Latent in Current Hospital Practices:

K.T. Erikson (1957) argues that the patient is often persuaded by the logic of psychiatric institutions to attempt to engineer validations for himself in roles which the hospital provides for medical patients.

To establish his eligibility for this role, the mental patient must negotiate, using his 'illness' as an instrumentality, by presenting it in a form which the hospital staff will recognise as legitimate. Having achieved this validation, Erikson argues, the patient has no choice but to become sicker. He illustrates this assertion by means of the following personal observations:

"A patient was asked, 'Why did you do that?' His answer 'How should I know? If I knew these things I wouldn't be here!' reflects the values thus emerging in the hospital role pattern. Patients have been heard comforting one another saying, 'Of course you can't do it.' This process of 'giving up defences', is of course, presumed to be essential for successful treatment . . . "

Parsons (1951) writes that illness is a form of deviance which is culturally sheltered by patient-staff role structures. The sick role is not only granted out of sympathy for the mental patients' presumed condition, it is granted in implicit recognition that the person concerned is unable to carry out his normal duties. Role conduct validated for the patient role in mental hospitals can thus be shown to give rise to the type of situation which is open to description as a 'self-fulfilling prophesy!'

The concept of the 'self-fulfilling prophesy', derives from W.I. Thomas' theorem that "If men define situations as real they are real in their consequences."

Individuals respond to the meaning which situations hold out for them. Once some meaning has been assigned to a situation, consequent conduct, and at least some of its consequences, are determined by this ascribed meaning. Merton (1948) points out that continued pre-judgements of an out-group by a dominant in-group, leads to 'damned if you do, damned if you don't' consequences for their conduct.

Erikson's (1957) suggestion that psychiatrists would find it to their advantage if the state of 'being sick enough to need help' and 'needing exemption from normal social duties' were not articulated too clearly within the same role, finds common cause with Goffman's (1961) observation of the mental patient's dilemma of having to prove his 'normality', while at the same time being validated in the role of an 'abnormal' person. Where basic rights and obligations are clearly recognised by both sides of the therapeutic community, the nature of therapeutic progress could be clearly delineated within the context of progressive therapeutic demands, fulfilment of which would systematically void the patient of the possibility of negative evaluations and concomitant validations in the role of a mentally ill person.

Mills (1950) sees marginal role positions as displaying overlapping motive vocabularies in justification of conduct. By contrast, adequately-defined role positions embed actors within social contexts where motive imputations and avowals are more or less situationally prescribed. Mills writes that "Marginal characters belong to shifting and interstitial situations with different vocabularies of motive appropriate to them . . . Conflicts manifest themselves when vocabulary patterns have overlapped in a marginal individual and are not clearly compartmentalised in clear-cut situations." (Mills, 1950).

Principles of logic are basically the rules by means of which the meanings of terms are explicated. Where social control breaks down, common codes of linguistic response can be shown to have broken down also. Communication is then "out of character". (Goffman, 1959). The danger of such communication lies in its use leading to validation of role conduct functionally outside the paradigm supported by the inherent logic of the therapeutic system.

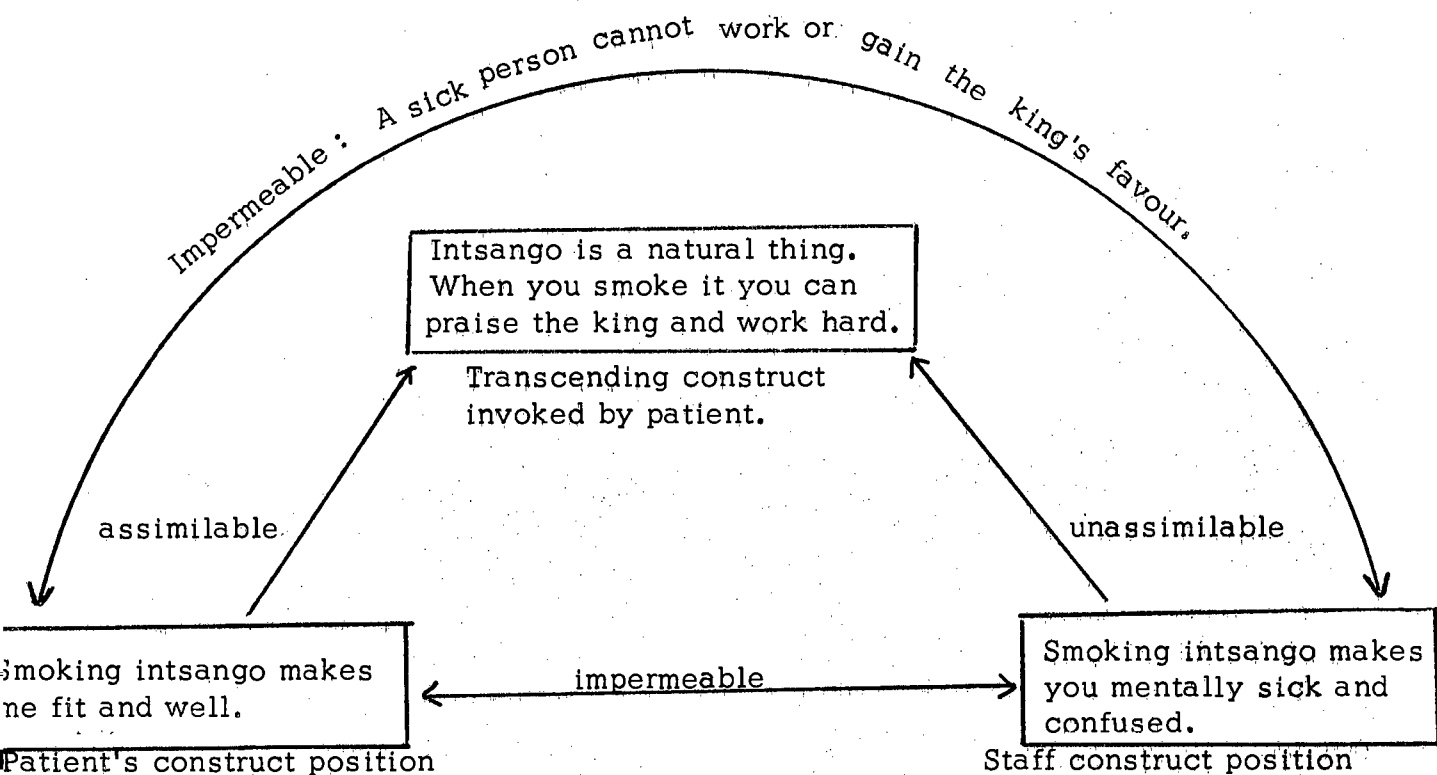
An example of this sort of situation is the case of a new member of staff at Hospital A, who had not yet aligned his motive vocabulary with the logic of the hospital's therapeutic procedures. He was overheard telling a patient, "I don't think these Europeans' medicines can help most of the patients here. Their disease is an African disease and only an inyanga can help them." (Overheard by R. Mdwara.)

Within the framework presented by the therapeutic system, staff cannot logically accord therapeutic superiority to alternative agencies. This would undermine the presumed 'expertness' of the hospital. The difficulty arises where such alternative agencies enjoy high prestige in the extra-hospital community. Positive improvements brought about by the hospital itself would, clearly, reduce patients' reliance on and hope in the therapeutic powers of alternative agencies.

An equally apparent danger lies in the prospect of dissuading patients from indulging in practices which enjoy a high degree of social approval outside the hospital and which may yet be potentially harmful to over-indulging subjects. The drinking of home-made beer, and the smoking of intsango (marijuana) are examples. The use of the latter as a work stimulant, as a cure for respiratory ailments, as a prescription to counteract the effects of orally-ingested poison, and in its use by certain diviners to arrive at a state of trance where certain perceptions are deemed possible, jeopardises too total a condemnation of its use.

The value of looking at therapeutically circumscribed situations in terms of the resolution of choice dilemmas offered by transcending constructs lies in seeing the conduct choices they prescribe, the consequences which these and alternative conduct choices hold out for patients and the logic of these consequences in the context of the institutional culture. As far as intsango smoking is concerned, it might be sufficient for the controlling staff to assert that its use is not permitted in the hospital, and that its excessive use can have deleterious side effects - a notion which would be readily agreed to in any case. By contrast, the following illustration shows how a member of staff took up an indefensible position with regard to this issue and so turned a personal prejudice into an issue which threw his expert opinion in

the therapeutic system into dispute.



The patient's transcending construct undercuts the logic of the staff's assertion. In attempting to put across a private, culturally-impermeable argument on a therapeutic basis, the staff member is forced to assume a marginal position in relation to his therapeutic role, thereby compromising his position. On the other hand, the patient's counter-arguments, and the transcending construct they invoke to dissolve the logic of the staff's position, are culturally permeable (in the context of the wider society.) The resultant situation can be described as 'diluted' (see next chapter).

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The position taken up by a member of staff may be described as being 'out of character', if its manner of presentation endangers the "reciprocity" (Gouldner, 1960) of staff-patient relations. A jocular mode of conduct, when subjecting a patient to an unpleasant situation (E.C.T. for example) would tend to deny the reciprocity of mutual concern and consideration between the interactants. Such conduct can likewise be spoken of as 'diluting' the situation, insofar as its possible therapeutic effects are concerned.

Goffman (1961) in his work on role distance, describes how doctors and nurses, working together in the operating theatre, engage in certain apparently role-irrelevant activities including humorous asides and gentle 'ribbing' of one another. He explains how such conduct effectively copes with the problem of achieving sufficient freedom from the stylistic cramping which total embracement of the 'surgeon role' would induce. In this way, he gains sufficient 'elbow room', as it were, to purposively commit himself to the task at hand. Such role-distancing conduct is, however, carried out in a doctor-patient 'back-region', since the patient is under anaesthetic.

A Derived Imperative:

As a therapeutic rule-of-thumb, such conduct as would interfere with patients' capacities to fully commit themselves to therapeutically ordered roles, should not be included in front region behaviour, since the total action system would not benefit from this inclusion. The character of constructs as 'co-operatively conducive' or 'co-operatively disruptive', must be decided through a consideration of whether or not these constructs can be shared by participants without compromising therapeutic aims and the logic of institutionally engendered roles related to these aims.

A Tentative Solution to 'Marginality' Problems:

Initial institutional restriction of patient behaviour provides staff with a means of rewarding co-operative activity and concomitant acceptance of the rationale underlying it. Therapeutically engineered 'resocialisation' leads to greater patient autonomy, that is, sociologically speaking, greater freedom from institutional pressure. Patients who achieve autonomous status will have assumed institutionally approved standards for modulating their own conduct. Providing they do not infringe hospital rules and regulations they will now be free to engage in activities which allow them to achieve certain institutionally prescribed goals, without threat of withdrawal of 'privileges'. Such patients can be described as 'reward-centred'. Their drug dosage will have been decreased, they will have relative freedom of movement, and, moreover, they will be free from validations in roles where full responsibility for

their own conduct is not recognised. By contrast, patients who are less aware of the cultural contingencies of the hospital in relation to their own conduct, may be described as 'cost-centred'. The meaning of their situated conduct in the hospital will not yet be clear to them, and this meaning needs to be elaborated in a manner which juxtaposes negatively valuated consequences for institutionally disapproved conduct with positively valuated consequences for institutionally approved conduct.

The 'reward-centredness' of institutionally empowered patients, can be expected to motivate them to approach all favourable outcomes within their range of power. The 'cost-centredness' of patients lower down in the therapeutic status hierarchy, limits their behaviour to the avoidance of conduct leading to negative sanction, at least until such time as reward-centred conduct becomes stabilised. With such a therapeutic programme set into operation, a point would at no time be reached in the career of a patient where the advantages of prolonged hospitalisation in terms of "alleviation of symptoms" be negated by the effects of "disculturation" (Ullman, 1967). As a patient's disordered conduct decreases, so his power to engage in conduct consonant with extra-hospital cultural standards of normality will increase. His marginality to both therapeutically-ordered and wider culturally-ordered role positions will therefore decrease simultaneously.

Initially only certain outcomes will be under the control of the patient. It can reasonably be assumed that the patient will modulate his conduct in such a way as to obtain better outcomes and avoid poorer ones. Positively evaluated outcomes can be said to be 'weighted' with respect to the patient's perceived control over conduct leading to them. As he learns institutionally patterned roles, so his ability to fulfil institutional commitments will give him the right to expect certain privileges contingent upon these fulfilments. The expectations of what the individual, as a patient, has the right to receive from the hospital may be called the hospital's commitments. Hence the more a patient is able to fulfil his role obligations, the more rewarding he should find the hospital's commitments in relation to him.

A value, to all intents and purposes, will not exist unless there is an institutional device through which it can be expressed. The power to create a sense of social values lies therefore with the controlling staff, who are

given a mandate to structure and control both situational behaviour and situationally embedded expectations for behavioural consequences.

Social experiences, of themselves, generate certain social needs. (Henry, 1956). These socialised needs are a function of the context within which the individual lives. The more a patient perceives his capacity to take advantage of social commitments in relation of him, the more he can be expected to enact roles validated for him which result in the advantages represented by reciprocal hospital commitments. Increased patient initiative, in enacting these roles, is thereby encouraged. The patient, in this way, enters increasingly into the subjective side of power and control, until he finally assumes role positions where less formal relations with staff hold sway. In this way, the patient's conduct 'investments' (Homans, 1951), gain for him 'idiosyncrasy credit' (Hollander, 1958), that is, the right to indulge in back-region informality with staff; a right not enjoyed by lower-ranking patients.

CHAPTER VIII : SITUATION ANALYSIS

Resocialisation and the moral order - knowledge and commitment - questions - motives and their functions as public constructs - structural mediation of motives - situations - the socialisation model - implications for mental hospitals - functional imperatives - setting the rule - mutual responsibility - accountability - three levels of analysis - classification of situations - practical application; demonstrations

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Studies of resocialisation exclude the question of the individual's relation to any moral order beyond an actually existing set of social norms and cultural values and their human agents. (Danziger, 1971). This being so, for the sake of theoretical clarity, a conservative rehabilitative approach to the problems of psycho-therapeutic resocialisation, in the mental hospital community setting, has been assumed.

The conduct of staff members, here, tends to be more elaborately structured and less ambiguously construed than that of patient members. Staff members are usually able to seek and obtain information relevant to their social roles (in the hospital) more easily than members of the patient group. The latter's motives are, to a large extent, held suspect and not only is their reasoning capacity consistently doubted, but the role constraints placed upon staff members themselves often cause them to falsify situational contingencies in order to cope with them within the limitations imposed by their nursing roles.

In looking at conduct exchanges between staff and patients, it is the staff's conduct that is given major consideration. The staff are the agents of resocialisation. The following questions are therefore raised with respect to their conduct:

- (1) What conduct is the staff member demanding of the patient?
- (2) What constructs are being used to frame and justify conduct demands being made on the patient?
- (3) What sanctions are being used to reinforce patient conduct?

The following statement by a staff member "You must take these pills because they are prescribed for you by the doctor who is responsible for you in this hospital" demonstrates the use of a motive as a public construct in backing up and justifying the demand that a patient swallow some pills. This motive illustrates to the patient a set of relations, responsibilities and obligations that surround the institution of pill-taking.

Mills (1940) sees motives as serving the following social functions:

- (1) They link consequences to specific conduct.
- (2) They frame situations in terms of socially acceptable goals and prescribe conduct for attaining these goals.

What is implicit in the above example is the relation between pill-taking and the attainment of a state of mental health which will lead to discharge from the mental hospital. The doctor is the social agent who is responsible for both the patient's medication and his discharge.

Motives invoked by nursing staff to legitimise their conduct and demands in relation to patients tend to be mediated in various degrees by the illness model of mental disorder, by organizational rules and by various moral paradigms shared by patients and staff of the same cultural background. (See chapters I, II, and IV of this thesis.)

The conduct of patients is assumed to be a consequence of their attempting to cope with demands made on them in specific situations. The term 'situation' is used to refer to "any environment of mutual monitoring possibilities that lasts during the time two or more individuals are in one another's immediate physical presence and extends over the entire territory within which such mutual monitoring is possible." (Goffman, 1968).

Personality is considered to be socio-culturally variable, developing in inter-relationship with its social environment. An individual's personal constructs and his sociality are considered to be inextricably intertwined. Berger and Luckmann (1967) argue that "social order only exists as a product of human activity." That position is likewise adopted here. Social order is considered to be a product both of past human activity and of the current human activity that sustains and perpetuates it. A person's construct system develops in response to the socially ordered situations in which his conduct is historically and culturally embedded.

A model of socialisation :

Any activity that is frequently repeated becomes cast into a pattern which can be economically reproduced and recognized by the actor.

Habits are formed. Choices are narrowed because the meanings involved in habitualized actions become embedded in the actor's construct system, taken for granted by him, and used to formulate his future actions. People recognise one another's habits. They also recognise and construe the meaning of the constructs others employ to make sense of their habits. When shared patterns of action develop between people, they typify one another's conduct. A watches B, he attributes motives to B's acts, and, seeing the actions recur, he typifies the motives as recurrent. At the same time, B may assume that A is also watching him and is involved in similar constructions of his conduct and its meanings. Mutual expectations develop so that each person is able to predict the other's actions. Concomitantly, interactions become predictable.

As A and B come to know one another over time they evolve a common 'culture'. Because they can predict one another's actions, their conduct can be objectified. It can be related to shared or unshared goals. Such objectification will occur at particular moments in particular situations.

If an outsider, C, enters the culture of A and B their customary habits may be questioned at some point and they might find it necessary to justify their conduct with reference to goals of which C is possibly unaware. Their institutional order thus develops legitimations which C will have to learn if he is to be socialized into it. If C utilizes a construct system incompatible with their own, they might find it necessary to develop sanctions in order to socialize him. The 'programming' of C's conduct follows, aligning it within a pre-established framework of means and ends. The institutions of A and B

thus claim authority over C's conduct, independently of the subjective meanings C himself attaches to any particular situation. His construct system thus stands in need of 'overhauling'. The culture of A and B, which developed independently of C's participation in it, imposes its socializing processes on C 'from above', as it were, whenever his conduct deviates significantly from cultural norms, neither seeking nor requiring his prior consent for this process to occur.

The more conduct is institutionalized the more predictable it becomes. Among persons socialized in the same cultural milieu, most of their conduct evolves within a common institutional 'set'. Whenever deviant behaviour appears, conduct control measures, developed to curb it, need ordinarily only be applied selectively and sparingly. On the level of meaning most conduct rules and constructs framing and legitimizing these rules will be taken for granted.

Mental hospital application of the socialization model :

Although mental hospitals are extra-ordinary social institutions, in that their sole purpose is the socialization (re-socialization) of a certain kind of social deviant, their principles of operation share much in common with other social institutions and are open to analytical scrutiny in such situations as are definitive of their manner of operation.

In order to understand an institutional order, analysis must proceed in terms of the 'knowledge' that its members have of it (Nagal, 1969). What is taken for 'knowledge' in the total context of the culture comes to be co-extensive with the 'knowable', or at least provides the basis for interpreting what is not fully known or what is not fully understood.

Knowledge about a society is knowledge in a double sense: knowledge of an objectivated social reality and knowledge of what is 'known' in that objectivated reality. The problem of cultural and logical coherence can thus be looked at on two levels: the level of socialization of roles and the level of legitimation of these roles.

What may be a 'reason' for one person's conduct may prove to be a mere 'rationalisation' of another's. The difference lies in the functional alignment of culturally related persons to goals being sought and to motives being espoused. In the resocializing context of a mental hospital this inevitably boils down to the relation of a patient's conduct to the control exercised by nursing staff over his attainment of certain goals.

Analysing institutional practices thus involves typifying actions and actors along certain lines. Not only specific actions, but also specific forms of action are typified.

Both self and other can be construed as performers of objective generally recognized actions which are recurrent and repeatable by appropriate actors. In therapeutically ordered situations a staff member or patient may construe himself in identification with objectivated social roles in that context. Afterwards, however, he will be able to re-establish role distance from his institutionally ordered conduct, in order to reflect upon it. By the process of reflection over a number of role commitments in a number of situations, he will be able to realize the idea of an institutional order. This is reflected in the integration of his institutionally ordered roles. These roles are thus themselves representative of the institutional order that defines their character. They derive their objective sense from the moral order of the

institution. Apperception of functional imperatives in the institutional order thus has controlling consequences for the conduct of the actors involved.

The process of establishing conduct conventions always takes place in the context of the question of who is 'setting the rule'. In the mental hospital framework certain situational appraisals by patients point to the need for aligning their constructs within it's social order. Such qualified questions as "Why should I work here? This is a hospital not a factory" and "Why should I keep taking these pills as if I am constipated?" reflect institutionally unaligned role assumptions. As such, they represent challenges to the institutional order in just the 'double sense' mentioned above. Both the required roles and the required motives for commitment to these roles need to be learnt. Constructs for realigning constructs have a special logic of their own. For the therapeutic system to function adequately, a consistently ordered bias needs to be written into conduct expectations so that they match previous construct transformations and both reinforce and extend their logical implications. Therapeutically formative constructs will either integrate one with another or transcend one another in such a way that their basic assumptions are only modified slightly, through embracement of a broader range of elements, which in turn, afford the patient a broader scope for control of his own circumstances and goal-directed conduct. Hence the patient's personal constructs must be accorded due recognition if they are to be transformed. This recognition is ideally inherent in the constructs invoked to shape the patient's future conduct. Another way of stating this is to say that the process

of construct transformation poses to the patient a choice which affirms his identity, firstly, as a person who is responsible for his own conduct, and secondly, (and derivatively) as someone who has the right to understand the consequences of his own conduct, the relation of these consequences to the conduct of others and the rationale behind the conduct of these others. A set of meta-rules is required for construct and conduct realignment: rules for making rules.

The Classification of situations

Therapeutic meta-rules need to take account of three levels of meaning in staff-patient conduct exchanges

- (1) the level of individual conduct (I do this, I understand the reason why I do it),
- (2) the level of conduct exchanges (I see you do this; I impute a motive to your conduct; I respond in accordance with my interpretation of your subjective intentions; you respond to confirm or disconfirm my beliefs about you), and
- (3) the level of the institutional significance of conduct exchanges (I think you do this because your role position has this or that significance for us and I affirm that I understand what this significance is).

A focus on situations involving staff and patients thus necessitates facing complex descriptive problems. Not only do classes of conduct stand in need of typification, but classes of conduct exchanges and classes of the institutional significance of conduct exchanges. Any model that

fails to recognize and integrate all three levels will be incomplete, because it will fail to take account of the feedback loops involved in sustaining and perpetuating institutionally ordered role conduct.

Level I : Classes of staff conduct

In looking at situations involving staff-patient conduct exchanges a therapeutic bias is assumed. That is to say, if it is the staff's conduct that is given first consideration, since it is the staff members who are, or should be, 'setting the rule' in accordance with institutional goals and functions. Staff conduct is looked at in terms of the demands made on patient conduct, the constructs used to frame and justify these demands and the sanctions used to underline them. The three classes of conduct thus typified are, demands, constructs and sanctions.

The questions posed are:

What conduct is demanded of a patient?

What constructs are invoked to guide and stabilise such conduct?

What sanctions are being used to shape patient conduct and constructs?

Level II : Classes of conduct exchange

Staff conduct is considered in relation to patient conduct. The emphasis is on the therapeutic value of staff conduct in its function of integrating patient conduct into the institutional order of the therapeutic

system. Recognition is paid to the need to reconcile patient constructs with those required for resocialization. The 'formative' nature of staff conduct is thus made central to its conceptualization. Staff conduct is viewed as 'shaping' patient conduct. Situationally embedded conduct exchanges take place. These exchanges may or may not be representative of the true institutional order. Exchanges of conduct are typified in terms of institutionally ordered roles. Every role can thus be seen, on one level, as representing itself, and, on another level, as representing the entire institutional nexus of conduct. Two levels of description are therefore necessary to define conduct exchanges: firstly, what the roles are in themselves, and secondly, what the roles represent relative to the institutional order.

In themselves, the roles may be either authentic or inauthentic. Relative to patient conduct, subsequent sanctions may either underline demands, reinforce conduct demanded and validate the usefulness of a construct supplied by a staff member (to stabilise and guide patient conduct); or, subsequent sanctions will undermine demands, inhibit conduct demanded and invalidate the usefulness of the construct supplied. The first effect is descriptive of authentic staff conduct. The second effect is descriptive of inauthentic staff conduct. The latter is double-binding and therefore subversive of the institutional order itself. The underlying question posed is: are situationally invoked constructs likely to prove adequate to the situation? In other words, are the constructs generated in a particular situation likely to be validated by subsequent sanctions? [

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Constructs derive their continuing significance and even their intelligibility from their utilisation in human conduct. Such conduct is typified here in terms of institutional roles. When individuals begin to reflect on their roles, the consequences of their committing themselves to these roles, and the further implications and ramifications of these commitments and consequences, they face the problem of binding the various rôle constructs together into a comprehensive whole. Such binding together of rôle related constructs may be facilitated or inhibited by the legitimations inherent in the controlling constructs of staff members. All constructs contain both assumptions about what the world is like and predictions based on these assumptions, (Kelly, 1955). Hence, 'staff constructs' supposedly aimed at resocializing patients may or may not be true representations of the institutional order of the hospital's therapeutic system. Staff rôles - and patient rôles in relation to them - ideally represent the institutional order in its totality. Such rôles are therefore of great strategic importance to the function of the mental hospital. It is for this reason that staff-patient interactional situations are given major consideration in the two sketches of hospital life in Chapters IX and X.

Legitimation 'explains' the institutional order and its functions in accordance with certain situationally objectivated meanings. The more truly a controlling construct, invoked by a staff member, reveals the institutional order in which it is embedded, the greater its epistemological strength. Epistemologically strong constructs not only tell a patient why he should conduct himself in a certain way, they also tell him why things are as they are. Epistemologically weak constructs fail to reveal the institutional order as it is.

The underlying question posed is: to what extent is the rationale justifying patient conduct demands grounded in the legitimate institutional practices of the mental hospital as a whole?

Level III : Classes of institutional significance of conduct exchanges

Conduct and construct exchanges can be seen as an integral part of the culture of the mental hospital at one level, but they can also be seen as cybernetic mechanisms actually 'governing' relations and role expectations in that culture at another level. All conduct exchanges can be viewed therefore both as products of and as agents of repetitive cyclical patterns.

If the institutional order of things has itself been falsified or not fully explicated in staff-patient conduct exchanges, this will have serious epistemological consequences. The seriousness of these consequences will depend on the degree to which misrepresentation has been stretched (alternatively, the degree to which representation is generally absent) and the degree to which such misrepresentation is reinforced by subsequent sanctions. We are concerned here not merely with staff construction of patient requirements in therapeutic terms, or with the mutual construction process and its consequences in terms of conduct exchanges, but with the construction placed on the entire therapeutic system, which supposedly governs the role requirements themselves.

Should a staff member's conduct in relation to a patient be both authentic and epistemologically strong, then the institutional order thus reflected in the situation will be a comprehensive representation of the true institutional order. Situations which exemplify such circumstances I have called "comprehensive situations."

Deviations from this ideal vary in accordance with the degree of misrepresentation of prescribed institutional functions and with the degree of reinforcement of such misrepresentations. Hence, situations in which the sanctioning process is unaligned to legitimations which could reveal prescribed institutional functions I describe as "unaligned situations".

A sanctioning process which underlines and reinforces constructs and conduct inappropriate to the means-end programme of institutional resocialization is clearly disjunctive with respect to the individual's embracement of the logic of the therapeutic order. Situations which embed such conduct exchanges I therefore describe as "disjunctive situations".

Finally, situations in which the institutional order is truly represented in construct legitimations, but which embody consequences which negatively sanction conduct demanded and therefore also negatively sanction embracement of the institutional order thus represented I have called "subversive situations".

The underlying question posed is: Is the situation comprehensive, unaligned, subversive or disjunctive with respect to the institutional order? In other words, is staff conduct situationally authentic and epistemologically strong, or inauthentic but epistemologically strong, or authentic but epistemologically weak or both inauthentic and epistemologically weak?

Application of the model :

The principles of classification described above are systematically applied to staff-patient interactions, ear-marked in the two sketches of hospital life, which follow in Chapters IX and X.

Below, some concrete illustrations of the process of situation analysis are given. The situations selected are chosen from the sketches themselves. The number assigned to the situation is the number assigned to it in the sketches themselves. In each case, the page on which the situation is portrayed is also given.

Situation 10 : page 208

Jameson P. walks up to the gate and addresses Mike S. as he comes in.

"Where is the European doctor?" he asks, "Because I want to go home to work and to see my mother."

"Yes", Mike answers him, not looking at him, "I understand you are wanting to be discharged."

"Yes, that's right", says Jameson, "When can I see him?"

"I am going to speak to him next time he comes."

"What do you mean? You are going to ask him to discharge me?"

"Yes, I said so", he answers, rounding the corner out of sight.

Conduct demand : Wait until the doctor comes next time and I will ask him to discharge you.

Construct : The doctor is responsible for discharge.

If you are well enough for discharge, a request will be put to him that he see you and discharge you. Therefore, wait patiently, and your patience will be rewarded.

Sanction : Discharge, conditional on a demonstration of patience and good conduct.

The patient's request to see the doctor (Where is the doctor? I want to go home to work and see my mother) is met by staff member's response that the request is a reasonable one (Yes. I understand you are wanting to be discharged.) The staff member's promise to speak to the doctor is inauthentic, however. It is queried as such by the patient (What do you mean? You are going to ask him to discharge me?). The staff member confirms his promise (I said so). In fact he did not explicitly say so. This partially confirms Jameson's suspicions about his promise. The correct channels are referred to. It is the doctor who discharges patients whom he examines and validates as 'mentally healthy'. Wanting to see one's mother, and to work are legitimate desires for a 'mentally healthy' person. The staff's constructs are, thus far, epistemologically strong. There are good grounds for believing them. But the consequences promised will not materialize. Therefore the staff's conduct is inauthentic in this regard.

The functional integrity of the therapeutic system is practically denied. The therapeutic significance of this situation is that it is 'subversive' of the therapeutic system as a whole. It's therapeutic status is described as 'subversive' on this account.

Following this situational exchange, Jameson P. turns his attention to 'King George', another patient. Suspecting that his request is not going to be met in practice, he postulates that this is because the obviously 'insane' behaviour of 'King George', and others like him, force the staff to disregard the reasoning and arguments of the 'sane' patients. This postulate is apparently confirmed by the subsequent conduct of two staff members whose verbal exchanges with 'King George' cast further doubt on the functional integrity of the therapeutic system.

We pass on now to consider the therapeutic status of the next ear-marked situation, involving 'King George', Benjamin S. and Enoch S. as the focal characters.

Situation 11 : page 209

"I am King George, the government", says 'King George'. "Anyone who does not respect his parents or who stays here eating the Government's food, not being sick, I am going to report to King Sobhuza."

"Oh, King George", says Benjamin S., who is sitting on the stone blocks with Enoch S. and Brown S. "Then there will be no-one left here and how can we get work?"

"Everyone must work in the fields or they will be put in jail", answers King George.

"Oh, you are the king, really", chimes in Enoch S., "The Lion."

"Lion. Lion matches", says King George, "Gi!"

Conduct demand : Act as if you were a king.

Construct : Since you have a king's power you can say what you like.

Sanction : Public praise and support for acting like a king.

A member of staff affirms the patient's construction of the situation as valid. (Oh King George, then there will be no-one left here and how can we get work?) 'King George' answers this question in the role of one who has authority (Everybody must work in the fields or they will be put in jail). Another staff member positively sanctions this verbal rejoinder and the assumption of power underlying it. (Oh, you are the king, really).

The effect of this exchange would be to make any validation of 'King George' in a patient role impermeable to the construct system in which his hypotheses are currently being validated. Any subsequent invalidation of his role as 'the king' and 'the government' will prove impermeable to this currently validated set of constructs. It is therefore epistemologically weak. Current validations will also prove to be ultimately inauthentic even though they are currently being reinforced.

The situated communications are thus disjunctive with respect to the therapeutic system as a whole. His conduct is reinforced. He continues to go "Gi!", as before. The therapeutic status of the situation is that it is 'disjunctive'.

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In Situation 16, a patient, Sigidla P., is validated in the role of a respected person in order to contrast conduct appropriate to this role with his own previous conduct, for which he has been reprimanded. (You must not be troublesome, Mkaya.) The implication is that, if he is troublesome, he will not be respected, in fact he will be locked in the security block. The staff have already called him a 'foolish person' in front of a patient whom he had provoked into attacking him. This behaviour is related to his previous good conduct at home.

Situation 16 : page 221

"You must not be troublesome, Mkaya (boy from my home town)", Benson S. tells him. "You know when you were living at home you were a respected person, because you knew how to behave and to see that nobody broke the laws. Isn't that right? Well now, you must show that you are a man who knows how to conduct himself in the world."

They stop outside Kulukhuthu. Sigedla is quiet for a long time. Then he says "Yebo".

"Uh-huh! You say so! That's good. We don't want to see you behaving badly."

Conduct demand : Behave respectfully with regard to other patients.

Construct : A disrespectful person must be taught respect. If you are respectful you will be respected yourself; if not, you will be punished.

Sanction : Mutual respect (Positively).

Social shame and punishment (Negatively).

The patient's conduct is recognized as troublesome. This is operationally defined in terms of respect and good conduct, not breaking the law and so on. The patient is led to the security block (Kulukhuthu), But he is not locked inside because he agrees with the staff's construction of the situation. He confirms his willingness to behave with decorum. He therefore does not incur added penalties. The staff's conduct as a controlling member of staff is authentic, this construction of the situation is epistemologically strong.

The situation as a whole can thus be described as 'comprehensive'.

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In Situation 17, a patient conducts himself in a socially undesirable manner. He receives what is considered to be appropriate punishment, but this punishment is not constructively related to his conduct.

Situation 17 : Page 221

Mike S. gives clean uniforms to young Petros and Vusmuzi. The latter starts to kick his old uniform around the staff room.

"Why are you kicking the uniform?" Enoch asks him.

"No, I just feel like it", he answers.

Enoch gets an injection ready and says to Vusmuzi, "Come".

"What is wrong?" Vusmuzi asks.

"Nothing is wrong. You must just have this injection", Enoch answers.

"Why?"

"Because the doctor prescribed it".

Conduct demand : Absent.

Construct : You must receive this injection because the doctor prescribed it.

Sanction : Injection (given for kicking a uniform around the floor of a room).

The patient receives an injection for kicking his uniform around the staff room. This is considered an appropriate negative sanction.

The staff member's conduct can therefore be described as authentic.

However, he has failed to properly justify this sanction to the patient.

He has, in fact, misrepresented it. He has denied the relationship between kicking the uniform and getting an injection. "I am giving you this injection because the doctor prescribed it" is an epistemologically weak construct.

The situation remains unaligned with respect to its functional significance in the therapeutic system as a whole. It can therefore be described as 'unaligned'.

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The functional meanings of the various situation classifications may be summed up as follows:

(1) Comprehensive situations (Authentic; epistemologically strong).

The controlling construct invoked by a staff member to shape patient conduct prescribes certain lines of conduct as appropriate and clearly delineates cultural consequences contingent upon adopting or rejecting the conduct prescribed. The rationale behind the construct's use is apparent and allows the patient to deduce institutional criteria which may serve as a guide to regulate his own conduct in the future. The construct is both comprehensive in the way it articulates therapeutic rationale, and fully explanatory in the way it demonstrates the application of this rationale in a particular situation.

(2) Unaligned situations (Authentic; epistemologically weak).

Epistemologically strong justification for staff conduct is lacking. Certain consequences are pointed to which are contingent upon certain lines of conduct, but no therapeutic rationale can be ascertained to underlie the expectations engendered. Such situations can be said to be 'unaligned' since the patient is not supplied with criteria for assessing the institutionally ordered value of his conduct.

(3) Subversive situations (Inauthentic; epistemologically strong).

When expectations are engendered for conduct consequences which are appropriately justified in terms of the existing therapeutic rationale and these consequences subsequently are not met in practice, the functional integrity of the therapeutic system is called into dispute. Situations exemplifying this state of affairs may be called 'subversive'. The non-discursive symbols of the expressive order are no longer a guarantee of the conduct for which they stand.

(4) Disjunctive situations (Inauthentic; epistemologically weak).

When conduct is demanded which cannot be justified with reference to the mental hospital's therapeutic rationale, constructs used to justify it will be disjunctive with respect to the therapeutic system as a whole. Alternative criteria to those applicable to correct hospital practices are embraced as guides to conduct considered to be appropriate. Such situations decrease the hospital's ability to cope with patients who may in future make use of them.

The situational classifications put forward in Chapter XI are not accompanied by explicit situational analyses, since these can simply be derived by applying the appropriate classifications to conduct exchanges. Demands, constructs, and sanctions will either be authentic and epistemologically strong, or authentic and epistemologically weak, or inauthentic and epistemologically strong or inauthentic and epistemologically weak depending on whether the situation is classified as comprehensive, or unaligned or subversive or disjunctive.

Situations 10, 11, 16 and 17 have already been fully and explicitly analysed and classified. Without burdening the reader with a full analysis of all thirty-four situations ear-marked in the following

two sketches for analysis in Chapter XI, it might not be inappropriate to give a limited analysis of eight more situations. This is done to give the reader some practice and feedback in utilizing the classificatory schema put forward and in getting the 'feel' of the implications of the model from which it is derived.

Situation 1 : page 183

(1.00 a.m.) Aloysius S. turns on the light, looks around dormitory five and goes out again. Everyone here is in bed and asleep. The only sounds are of Phopho and Vusmuzi, three cells apart in the Kulukhuthu, shouting a conversation along the passage to one another.

Having finished his round, Aloysius can be seen walking past the windows outside as he goes back to the staff room. He stops on the way and shouts at the two patients in Kulukhuthu, "Hey you two, shut up now. Why don't you go to sleep?" "Give us some matches, we want to smoke", they shout simultaneously. "Alikho matches (there are no matches)", he replies. "Hawu, wena, you are ill-treating us. We can't even have a smoke. This is worse than being in jail." "OK. I'll give you a light if you stop shouting." "We are only shouting because we have no matches", Vusmuzi replies with a stroke of genius. "Oh, Vusmuzi, uhlakaniphila (you are clever - derogatory sense). You're not crazy, man, you're a politician." He laughs. He returns, lights their cigarettes and goes back to the staff room.

- (a) Conduct demand : If your reasonable demands are met you must be quiet and sleep like the other patients.

Construct : Patients can expect to have reasonable demands met, on condition that they respect the practices of the institution.

Sanction : A light for cigarettes - (A reasonable demand).

(b) Staff conduct : authentic.

Staff construct : epistemologically strong.

(c) Situation : comprehensive.

Situation 3 : page 185

He (Simon) knocks on the staff room door.

"Yes?" says Aloysius.

Simon opens the door a fraction and puts his head around it.

"Please, I want a match", he asks imploringly.

"No. Get out," Aloysius shouts at him.

He shuts the door quietly, his body shaking in shamed laughter.

"Hawu", he says finally, shaking his head.

Inside, Aloysius says to the others, "These patients are just taking advantage of us. They keep asking for matches. We can't let them think we are running a cafe". Simon stands outside for a long time. Eventually he slowly opens the door again.

"Are you still there?" asks Michael S. "Come on, Simon, stop worrying us. Go back to bed" says Aloysius.

"OK, here", says Michael, lighting a match.

Simon quickly jumps inside and stands with bent knees in a gesture of thanks as Michael lights his cigarette. Then he quickly goes out.

"Poor chap", says Michael, "you must feel sorry for such a useless fellow." "Ya, well," says Aloysius, shrugging his shoulders in a gesture of indifference.

(a) Conduct demand : Shameless begging.

Construct : Absent.

Sanction : Eventual fulfilment of begging request.

(b) Inauthentic, Epistemologically weak.

(c) Disjunctive.

Situation 4 : page 186

(4.00 a.m.) Moses S. gets up to do the rounds. He unlocks the door of Dormitory One and looks around the room. All are asleep. Only Linford who sleeps on the floor (due to a bed shortage) is awake and talking to himself.

Moses goes over to Wilson's bed and draws back the covers.

"Hey! Come on. Don't you know how to look after yourself, that you must carry on like a small boy? Get up and take off your clothes. How can you live and sleep in the same clothes?"

"No, its just that I . . . "

"Shit! I don't want to hear excuses!"

Moses goes out closing the door, as Wilson starts to undress.

(a) Conduct demand : Behave like any adult. Undress before you go to bed at night.

Construct : Only small boys behave like that. You are an adult.

Act like an adult or you will be treated like a small boy.

Sanction : Verbal reprimand.

(b) Authentic; epistemologically strong.

(c) Comprehensive.

Situation 12 : page 210

When I was a staff member, we told him (Makoyana P.) if he stopped playing with his stones he would be allowed to go home. He did. Then Mike and Enoch told him if he washed himself and showed he was able to look after his appearance he would be allowed to go home. He did. But his pestering to go home seems to have been interpreted as a new feature of his 'illness', although his speech was now normal. "We must just watch him for a while", Mike S. told me, "to see if this is not just temporary." He soon went back to playing with stones and not washing. Proof. He is not yet well.

(a) Conduct demand : Stop playing with stones. Wash. Look after your appearance.

Construct : If you are able to do these things we will see that you are mentally healthy and you will be discharge.

Sanction : Conditional promise unfulfilled.

(b) Inauthentic; epistemologically strong.

(c) Subversive.

Situation 14 : page 216

A line forms. Josiah is at the kitchen door demanding more food. "I want you to fill my plate with food now. You can't be forcing me to take the pills and yet can't afford to give us some more food."

Shadrack tells him to sit down and wait. Then he goes into the kitchen and locks the door.

(a) Conduct demand : Wait and you will receive more food.

Construct : Your request is reasonable. It shall be met.

Sanction : Promise unfulfilled. No food received.

(b) Inauthentic; epistemologically strong.

(c) Subversive.

Situation 15 : page 217

(This situation is related to Situation 14, in that it is a logical continuation of it.)

Meanwhile Siqobolo, tall and thin, is at the kitchen door talking to Shadrack who gives him a plate of food. There is a rush now as the other patients also go to collect their extra food. Shadrack concedes and gives them some more. Brown, Benjamin and Mike discuss Shadrack's behaviour amongst themselves. (There seems to be a recognition of Siqobolo's clan relationship to Shadrack - both of them are 'Umtwanenkosis').

(a) Conduct demand : Expect and collect extra food if you are one of the clan.

Construct : Clan relationship supersedes the staff-patient relationship in some spheres. Some patient's needs are met as special favours.

Sanction : Food for a fellow clans-man.

(b) Inauthentic (total context).

Authentic (limited context).

Epistemologically weak.

(c) Disjunctive.

Situation 25 : page 275

I walk up to the staff room. Enoch is giving Jabulani an injection.

"I don't want an injection."

"You must have an injection."

"Why must I?"

"Because that is why you are here. It is to make you well that the doctor says we must give you an injection."

"Oh, you are going to hurt me with this injection now."

"No. We are not going to hurt you. This will make you better. Come - turn around."

Jabulani offers no resistance. He turns around and docilely takes the shot of largactal that Enoch pushes into him, then he ties up his trousers and walks out of the door, the torn strips of blanket still tied around his legs and his head.

(a) Conduct demand : Do not tear up blankets, tie strips around your body and run around the hospital grounds in this state.

Construct : Absent

Sanction : Injection of sedative (Largactal).

(b) Authentic; epistemologically weak.

(c) Unaligned.

Situation 26 : page 282

I recall a time when an old patient, Cornelius (now discharged) rebuked Enoch, who had said to me "You must not leave these patients

alone, they might try to escape." Cornelius had said to him, "Awu, Enoch, how can you insult us? We are old patients here."

(a) Conduct demand : Absent.

Construct : These patients might try to escape, therefore they should be watched.

Sanction : Public shaming.

(b) Inauthentic; epistemologically strong.

(c) Subversive.

SECTION B.

"Historical reality is to be located in the everyday occurrence, the immense ocean in whose vast dimensions everything unexpected and outstanding is drowned."

(Ortega y Gasset)

"What does it benefit thee to know the definition of a compunction if thou dost not feel it?"

(Thomas à Kempis)

FORWORD

The following two portraits of institutional life in Hospital A, from two different sides of the 'therapeutic universe', are attempts to evoke in the reader certain experiences - of sights, sounds, pressures and collective meanings - which exist for the patient and the staff member, respectively, as he discovers, rediscovers and lives within the logic of the institutional milieu - and some of its surroundings.

The two 'days' sketched here are recreations of situations and events recorded at different times during two months participant observation, and condensed against the background of two real days, recorded by myself and two assistants during a twenty-eight day continuous mapping record of patient activities. Life in the patient and staff 'universes', such as the reader himself might experience, were he culturally attuned to these surroundings, are reproduced.

Having been sketched with careful attention to cross-sectional and longitudinal detail, the experiences portrayed are at all times true to the substance of recorded data.

The situations which are ear-marked are classified, along lines stipulated in Chapter Eight, in Chapter Eleven.

* * * * *

CHAPTER IX: A DAY IN THE PATIENT UNIVERSE

A description: some initial impressions:

The area which my two assistants and I came to call the 'campus' (the fenced-in patient living quarters) is about as big as three rugby fields, and on it stand two H-shaped buildings made of asbestos, with steel windows and wooden floors. The campus ground slopes, permitting description of its two gates as the 'top gate' and the 'bottom gate'. Near the top gate there is a building made of brick with heavy wooden doors along an inside passage. These doors have barred windows in them. Behind these are the cells of the 'kulukhuthu' or 'security block'.

The campus itself is part of a large complex of similar buildings which used to be known as the 'St. George Barracks', headquarters of the British colonial army. The whole area is itself enclosed in barbed wire fencing, having one large entrance gate. The other barracks, listed in radius around the 'campus' comprise a male prison, the female section of the mental hospital, hospital kitchen and dining quarters, a T.B hospital, a prison staff training centre, a medical dispensary and the senior staff day quarters, male and female mental staff-quarters, and married staff-quarters. There is also a parade ground, used by the training staff, a soccer field, and a large area under cultivation by supervised mental patients.

As you walk onto the campus you notice there are grass 'lawns' around the buildings - except for the central portion between the two 'blocks' (called the 'yard'). In this foot high grass, footpaths trace patterns of interconnecting walks across the lawns. A certain bored amusement can be derived from tracing now one path, now another, now cutting across the slope, now walking around it, during the long patient mornings and afternoons. Some patients habitually follow the inside routes, others the outside. On the outside routes, one's attention is divided between events going on beyond the wire, if any, and patient activities, if any, on the inside grass. The inner routes pass through the midst of the patients. I myself preferred the inside paths, feeling too 'exposed' to the public - prison trainees, outside nurses, T. B. patients - on the paths tramped out along the wire.

Around the buildings are gravel borders on which there are blocks of cement or stones, used as 'sitting blocks'. There, familiar faces can be seen at different times of the day, patients tending to sit in the sun in the early mornings when the air is still crisp and cool and following the shadows of the buildings later on, as the sun beats heavily down.

As you walk into the campus buildings you are struck by the fact that there are only two doors opening out from each block. These doors are in wire covered passages which lead from the dormitories to the central lavatories. The top doors open out into the yard, the bottom doors onto the side areas. You discover that most patients prefer to swing out of the side doors from the dormitories, rather than walk through the lavatories. Consequently you find a greater percentage of lower dormitory patients in the side areas and a greater proportion of upper dormitory patients in the central area. But now the lower door of Block "A" is locked, since some patients escaped through the loose section of wire in the bottom corner, and there are no patients at all on that side at present.

Taps are running in the lavatory. You walk in, to see who is washing. No one, at the moment. A few taps are stuck. All day and all night they run. There are basins along the centre with hot water cylinders above them. Toilets on one side, showers on the other, a bath in the one top corner, a urinal in the other. You look at the toilets, some of the doors are missing. There is no toilet paper inside. (There is private paper only). "They won't find it unusual if you ask for things like toilet paper", the Superintendent had told me. "They don't use it most of them. They come from the bush." Not true. They may have 'come from the bush', but most patients did use toilet paper.

No towels. "I'll have to learn to dry in the sun like everyone else", you think to yourself. Rags, you discover, are precious things. You can dry yourself with a rag. You can use it to wipe your mouth and hands after a meal.

You see that the nursing staff has taken all your private clothes, but has left you with your handkerchief, a comb, your shoes and socks. None of the patients have jerseys. Oh yes, you notice one or two old khaki army jerseys with holes in them. Three of four patients wear big army great-coats. Most patients go barefoot. Standard equipment: one pair of shorts, one shirt,

a steel bed with mattress, two blankets, blue soap and toilet paper on request.

"Ah, well", you think to yourself, "may as well relax on the bed. Too hot outside. Nothing else to do." Several other patients are also stretched out on their beds. In one corner a game of ruba-ruba is in progress (played with bottle-tops on a lined board.) Two patients are playing; three others are watching. The players are shouting triumphantly, at each successful move. The other three watch more-or-less impassively. Those on the beds are undisturbed, lost in their own thoughts, or sleeping, or disinterestedly gazing at the corner group. Richard P comes in to beg for tobacco. You turn over to avoid his gaze.

* * * * *

MONDAY - 12 a.m.

It is a warm summer night. The outside gates are locked. Both gates of Block A are locked. The door of Dormitory One is locked. I am fast asleep in my own dormitory (Dormitory 5), and in the corner opposite me 'King George' sings a bugle reveille to himself. The sound stirs me. "Is that you King George?" I ask, half asleep. "King George. Barbeton-Mbabane. Underground," he answers and carries on singing softly.

Except for the sounds of heavy breathing, the night is quiet. Little 'Pilato' is curled up in the bed next to mine. 'Sergeant Major', quiet at last, sleeps next to him. Siqobolo, tall and thin, is stretched out sound asleep. At the foot of my bed is Caiaphas in his, and alongside him, Israel, his highly polished shoes under his bed. There are fourteen of us in all in the dormitory. Our ages vary from 19 to 75. Only King George and I seem to be awake now. Bingo S comes in, opening the door, switches on the light and looks at all the patients. "King George", he says. "Yebo (Yes)", King George answers (that is, "hello!") He switches off the light and walks into the next dormitory.

* * * * *

This 'come-in, light-on, check patients' routine occurs about five to eight times a night. Patients in Dormitory Eight sleep on blankets on the floor. They are mostly incontinent and their blankets are put outside during the day to dry in the sunlight.

* * * * *

In the corner of Dormitory Two, a cigarette glows in the darkness. Bingo S supplied a light to Mbulawa, on request, as he passed through on his rounds. The recipient now smokes quietly in his corner. Joseph P rolls his own cigarette, strolls across to him and stands next to his bed until he is given the lighted cigarette. He hands it back after lighting his own and walks out to the toilet to relieve himself. He walks back slowly, looking at the end of his 'smoke' to see if it is still alight. He quietly opens and shuts the door, walks over to his bed and sits down. His quiet solicitude guarantees him an uninterrupted smoke. His cigarette finished, he gets into bed.

* * * *

As Bingo S unlocks the door to Dormitory One, Petros P, who had been chatting with Victor on the latter's bed, gets up and walks over to Bingo, two Coke bottles in his hand. "May I go and get some water?" he asks. "Kulungile, hamba" (Sure, go ahead) he answers. Petros comes back with the two bottles filled with water. Victor says "Ngiyabonga ngam" (Thanks buddy) and they continue to chat. The light is on. No one complains. In the centre of the dormitory is a bucket for night urination. Most of the patients here are new arrivals and others not trusted to sleep in unlocked rooms.

* * * *

In Block B, Albert is having a shower. The free-est patient in the hospital, he spends his days unsupervised in his own workshop, fixing leather shoes and handbags for the female staff and metal pots for the kitchen, giving haircuts to the male staff and doing carpentry for the supervisor. With money gained from these labours he has bought himself a radio, some woodwork tools, his own clothes. Having been transferred to the mental hospital after a term in prison, Albert refuses to wear the hospital uniform. "If they want to put me in a uniform they must send me back to prison," he says. He has his own room which he locks in the daytime. He dries himself with his own piece of cloth and goes back to his room.

* * * *

Kulukhuthu (the security block) is quiet. Except for the two end cells, two persons share each cell. Phopho and Ray are sleeping alone. Mbutyulwa and Johannes, Vusmuzi and Gwayi, Zondo and Jabulani are

sleeping two in a cell. All are asleep on blankets on the cement floor.

* * * *

1 a.m.

Aloysius S turns on the light, looks around Dormitory 5 and goes out again. Everyone here is in bed and asleep. The only sounds are of Phopho and Vusmuzi, three cells apart in the Kulukhuthu, shouting a conversation along the passage to one another.

Having finished his round, Aloysius can be seen walking past the windows outside as he goes back to the staff room. He stops on the way and shouts at the two patients in Kulukhuthu, "Hey you two, shut up now. Why don't you go to sleep?" "Give us some matches, we want to smoke", they shout simultaneously. "Alikho matches (There are no matches)", he replies. "Hawu, wena, you are ill-treating us. We can't even have a smoke. This is worse than being in jail." "O.K. I'll give you a light if you stop shouting." "We are only shouting because we have no matches," Vusmuzi replies with a stroke of genius. "Oh Vusmuzi, uhlakaniphila (you are clever - derogatory sense). You're not crazy, man, you're a politician." He laughs. He returns, lights their cigarettes and goes back to the staff room. Phopho and Vusmuzi sit against the walls of their cells, smoking. Gwayi kneels on his blankets and watches Vusmuzi. The latter eventually passes him his cigarette which is nearly finished. He takes three long draws and passes it back to him, his left hand still touching his right forearm in a gesture of thanks. Vusmuzi indicates that he can keep it and turns over to go to sleep. Gwayi now sits back against the wall and smokes the last of the cigarette at his leisure.

* * * *

2 a.m.

Dormitory Five is quiet. In the darkness Frank gets up and shuffles out to relieve himself.

There is a knock on the locked door of Dormitory One. Moses S, the third of four nurses on duty tonight opens up the door.

"Yes, Abraham, what is it?" he asks.

"No staff, you must tell these two to keep quiet. I can't sleep."

Wilson, who sleeps next to Abraham is on the other side of the room, sitting on Victor's bed. Ngwevu, two beds away is reading. "He's lying staff", shouts Wilson, "we are not keeping him awake. He just wants me to go to sleep again so he can steal some of my tobacco. I caught him just now, that's why he's complaining."

"Don't believe him staff. Look, I've got my own tobacco." He shows Moses a rolled cigarette.

"Yes, you bastard, that's my tobacco which you have stolen."

"Come", says Moses. "I'm not interested in your tobacco. You can't keep the other patients awake at night. Don't waste my time."

Petros walks across to Moses with a rolled cigarette. Moses gives him a light. He goes back to his bed. Wilson runs across with hand raised in mock attack on Abraham, and jumps into bed. Abraham ducks him and walks across to Petros to get a light.

He gets back into his bed and Wilson asks him for a smoke.

"How can I give you a smoke. You slander me to the staff and then you want favours."

"O.K.", says Wilson. "Don't think I'll help you out next time you want something from me."

Abraham carries on smoking without comment. When he is nearly finished he leans over and nudges Wilson. "Here you are", he says. "Don't come back and tell me I don't share my things with you."

"When did I say that?" says Wilson pouting. "You know we always share everything inasmuch as you now take advantage of me by taking what I don't even give to you."

"You are right, my brother, but don't let your kindness weigh on our friendship."

"Ah, come on. Now you're twisting things again." They both laugh.

* * * *

3 a.m.

In Dormitory Four, Simon climbs out of bed with a 'stompie' (a butt of a cigarette) in his hand, and looks around the room. Everyone is asleep. He walks across into Dormitory Three. Here, too, everyone is asleep. He

stands at the door for a long time, watching for a movement or a glow of a cigarette. Slowly he turns and walks through the lavatory to Dormitory Two.

"What do you want? Get out!", Brown P hisses at him.

"Oh please give me a light." "Go to your own room. What do you come here for? You just want to steal. Get out!"

"Hawu", says Simon, shaking his weary head.

He knocks on the staff room door.

"Yes?" says Aloysius.

Simon opens the door a fraction and puts his head around it. "Please, I want a match", he asks imploringly.

"No. Get out", Aloysius shouts at him.

He shuts the door quickly, his body shaking in shamed laughter.

"Hawu", he says finally, shaking his head.

Inside, Aloysius says to the others, "These patients are just taking advantage of us. They keep asking for matches. We can't let them think we are running a cafe." Simon stands outside for a long time. Eventually he slowly opens the door again.

"Are you still there?" asks Michael S. "Come on, Simon, stop worrying us. Go back to bed." says Aloysius.

"O.K. Here", says Michael, lighting a match.

Simon quickly jumps inside and stands with bent knees in a gesture of thanks, as Michael lights his cigarette. Then he quickly goes out.

"Poor chap", says Michael. "You must feel sorry for such a useless fellow". "Ya, well", says Aloysius, shrugging his shoulders in a gesture of indifference.

As Simon walks through the lavatory he passes Jackson P who bars his way and demands (rather than asks for) his cigarette. "Hayi, cha" (No, no), says Simon, walking around him. He goes into his dormitory and sits on his bed, smoking. Josiah, who sleeps next to him is awake now. He looks at him but does not request a smoke. Jackson walks in, ignores Simon and gets into his own bed. Simon finishes his cigarette and laughs in a high-pitched chuckle. Suddenly his expression changes. He shakes his head with a

despairing look on his face. "Hawu, maja. (Oh fellow's) I want to go home", he laments, and sighing, covers himself with his blankets.

* * * * *

4 a.m.

Moses S gets up to do the rounds. He unlocks the door of Dormitory One and looks around the room. All are asleep. Only Linford who sleeps on the floor (due to a bed shortage) is awake and talking to himself.

Moses goes over to Wilson's bed and draws back the covers.

"Heyi! Come on. Don't you know how to look after yourself, that you must carry on like a small boy? Get up and take off your clothes. How can you live and sleep in the same clothes?" ... "No, it's just that I"

"Shit! I don't want to hear excuses!" Moses goes out closing the door, as Wilson starts to undress.

* * * * *

We follow Moses into Dormitory Two. Mbulawa passes him at the door and walks across to his bed, smoking. Gwebu greets Moses "Sawubona, poyisa!" ("Hello, policeman", that is "staff")

"Hello, Gwebu", Moses replies.

* * * * *

In Dormitory Three, a patient we came to call 'Set Square' (because of his habit of walking, stopping, turning at right angles and walking on again) is standing next to his bed and looking out of the window. As Moses enters the room, he turns to look at him, turns round again, tucks a slip of blanket under the mattress and continues to stand looking out of the window.

* * * * *

In my dormitory, pudgy little Solomon walks in (from Dormitory Eight) strolls straight across to King George's bed and asks for a light. King George has placed two open cupboards against one another, forming one large closed cupboard. He opens them up and gives Solomon a box of matches. Solomon lights his cigarette while King George sits up in bed. Solomon hands his matches back to him and his lighted cigarette also. King George takes three long leisurely draws on it and passes it back to Solomon.

Frank gets out of bed and shuffles across to Solomon, asking for a light.

He holds out his hand for the lighted cigarette. It is refused him. No words are spoken. Solomon holds out his hand for Frank's cigarette. He hands it to him. Holding his lighted cigarette in one hand, Solomon draws on Frank's cigarette, lighting it. He inhales twice on it, while Frank waits. He hands it back to him and walks out of the room.

* * * *

In Dormitory Six, Robert, who is blind and has no nose, is sitting up in bed, talking to himself. Maceda, a 'favourite' institutionalised patient (among the staff) is also talking to himself. He walks over to Majombolo, asking for tobacco. The latter, who is awake, does not even deign to answer him. Maceda laughs and talks himself out of the room as he wanders across it, holding his pants up with his left hand, his face greasy, white scratches etched in the dirt on his legs.

* * * *

Dormitory Seven is empty except for Samson P who sleeps in one corner on a mattress. He is crippled. Rumour has it his back was broken during shock treatment.

* * * *

Solomon walks into Dormitory Eight, smoking. He sleeps on a blanket between two feeble-minded patients, Mkwena (ever-smiling, ever-laughing) and Ephraim, a patient who constantly irritates and teases other patients to the amusement of both of them. Mkwena has moved up next to Ephraim and is snuggling against his body. Solomon walks over and kicks him.

"Move over", he says.

Mkwena does; and fast! Solomon gets in between them. Ephraim sits up and looks at Solomon with big blank eyes, his right hand opening and closing in agitation.

"Why do you let him sleep in my place?" Solomon asks, moving his cigarette near Ephraim's face. Ephraim leans over to get out of the way of the burning end. Solomon turns over to Mkwena and says to him, "This is my place. If you try to sleep here again, I'll throw you out." Mkwena looks away, stealing glances at Solomon to see if the latter is going to hit him. Solomon coughs. His fat little body strains with the effort. He stops coughing and carries on smoking, looking ahead of him.

* * * *

5 a.m.

The sky is already getting light outside. The doors of Dormitory One are unlocked for the day. Victor and Gwevu get out of bed, one with an empty Coke bottle, the other with an empty tin, to get some water to drink. Both of them are tremendously active during the day, Gwevu working in the fields harder and longer than anyone else, and Victor constantly performing, dancing, doing somersaults and generally clowning, to the amusement of onlookers.

* * * *

In Dormitory Two, Mbulawa is smoking in his corner and Joseph in his. Joseph is talking to Moses P, who is smoking on the bed next to his.

"You know when I was in this hospital before", he says, "they used to call me Joseph the Dreamer because I am always having a dream about something or other. Well, you know, God says that some people will have the gift of dreaming and to other people He has given the gift of interpreting dreams. Well, anyway, I had a very strange dream last night about a dog that flies." He laughs. "Did you ever hear of such a thing? And this dog came to sit in front of me and to talk to me about himself"

"Is it not your isiduko (clan animal), Joseph?" asks Moses P.

"To some people it is a clan animal. But not to me. Maybe God or an angel wants to give me a message through this animal."

He laughs.

Moses says to him, "It's not a small thing to have dreams. Sometimes they can give you an answer to why you have become what you are today."

He gets up and walks out to the toilet. Joseph follows him. The two are talking as they go.

* * * *

Set Square (Muntuwani) is still standing next to his bed in Dormitory Three. Pikenini, whom we called 'Abdal' because of his habit of praying aloud in barely intelligible language, is smoking with Samson on two corner beds.

* * * *

In Dormitory Six, Majombolo is smoking a cigarette. Solomon comes in to get a light from him. Mafanyana who sleeps next to the door walks

unsteadily across the floor to get a light also. Saki gets out of bed and stands at the foot of Alfred's bed, next to Majombolo.

"How's it, Alfred?" he asks.

Alfred looks at him but does not answer him. Saki looks around about him, goes over to his bed and gets a cigarette stompie to light. He walks over to Majombolo who shows annoyance. Has Saki not seen that two people have already lit up from his cigarette? "There!" he says loudly to Saki, pointing at Mafanyana.

Saki walks across and stands next to Mafanyana who leisurely puts his cigarette to his mouth, takes a long draw and passes it to Saki without looking at him. He lights up and passes the cigarettes back to him, then walks across to Alfred's bed, and sits down on it. He looks at Alfred with a mocking glance as if to say "you're not getting any smoke from me."

Alfred jumps out of bed and gets Saki in a head-lock wrestling grip.

"O.K. O.K.", he shouts handing him the cigarette.

Alfred smokes it right down.

"Hawu Alfred, you are finishing my cigarette!"

Alfred hands it back to him. Saki takes it and tries to kiss Alfred on the face, but the latter pushes him onto Zamfumf's bed. (Zamfumf, 'Beard' a nick-name.)

"Voetsek!" shouts Zamfumf, ignoring Alfred, who climbs back into bed and looks at Saki with a dead-pan expression on his face. Saki walks to the door, looking back with an embarrassed grin on his face. At the door he stops and shakes his fist at Alfred. Alfred pretends to get out of bed and chase him. Saki laughs loudly and runs around the corner.

"That youngster is going to get a hiding in here one of these days", Majombolo says to Alfred.

"Yes, we must teach him respect", says Alfred, a quietly amused smile playing on his face.

No-one else pays the slightest attention to these goings-on.

* * * *

In Dormitory Five a sudden shout wakes me up.

"Vukani, madoda! Kusile, Madoda! (Wake up men! The dawn has

broken, men!)" shouts 'Sergeant Major', who has just returned from washing his face. He is one of the kitchen-workers, now getting ready to go down to do his day's work.

"Ah, bugger it!" says Caiaphas. "I'm not going down today. I've had enough of that bloody shouting drunk. (Shadrack S)" But at ten to six, when Moses B comes to fetch him from the kitchen, he just gets dressed and follows him down without a word of protest.

* * * *

6 a.m.

There is a lot of movement now. Some of the patients are getting dressed. Others are looking around. Israel realises that two or more pairs of eyes are on' him. He puts on his clothes, his socks and polished shoes and goes out to fetch the broom. This is his morning for sweeping. It is an unspoken rule. Each man gets his turn to sweep.

* * * *

Outside, on the lawn, a patient whom we came to call 'Shumayeli' (Preacher) walks around with an open book in his hand. He is illiterate, but pretends that he can read. "I was not taught in school", he explains if asked, "I was given the gift by God." Some non-literate patients believe him; literate ones merely ignore him. Having suffered from bilharzia in the past, he believes that the blood which flowed with his urine at that time was a sign from God that he had been appointed to preach His Word.

"The people must all get up and go to work in the fields! The men must build dams and plough with oxen in the fields! All those who are too lazy to work will be punished by God, because they have not listened to his commandments that you must work in your fields or there will be no food and we will all go hungry." He whistles loudly. "Where are the oxen? It is time to harness them for ploughing."

A patient whose name is 'Sigidla' (meaning, literally, an ox with one horn bent downwards and one horn curving upwards) comes around the corner and bellows like a bull. The two of them put on a pantomime, to the amusement of a group of patient-onlookers standing nearby. I watch them through the window. 'Prehistoric' walks past, head bent, looking for cigarette butts.

Sigedla, his one arm raised above his head, the other turned downwards and outward at the elbow, paws the ground with his right foot.

"Bonisa amandla, Sigedla! (Show your strength, Sigedla)". He is urged on.

Sigedla simulates a bull bellow. There is laughter. Shumayeli whistles him on.

* * * *

Just then Ephraim walks into the room, walking on his toes, hopping from one leg to the other, flexing and unflexing the fingers of his right hand, and opening and closing his mouth. He advances into the room, looking around him as he does so.

"Sawubona", he says to 'Makhubukubu', an old patient paralysed on one side of his body. As he greets Makhubukubu, he pulls him by his shirt sleeve. Makhubukubu, who is making his bed, hobbles around it to get hold of a short stick.

"Hamba - Dlala nabafanna pandle. (Go and play with the youngsters outside)", Dingaan says to him.

Ephraim takes Makhubukubu's washing and drying rags hanging over the steel frame at the foot of his bed and throws them on the floor. As he runs out of the door, he bumps into Saki, who pushes him into the centre of the room.

Siqobolo, tall and thin, jumps out of bed and runs over to beat him, taking the broom from Israel who is sweeping the floor, but Aaron, a Zulu from Natal, runs over and holds the broom, laughing "Baleka! (run)", he shouts at Ephraim. But Ephraim is trapped between two beds now and Makhubukubu advances on him, beating him with his stick. "Uyadelela! Uyadelela! Uyadelela!" he screams at him over and over.

5 { Aloysius, attracted by the noise, comes running over from Block A and holds the two of them apart. He takes Ephraim outside and lets him go. The ward returns to its previous calm.

* * * *

In Dormitory Six, old Mafayana is making his bed, Jeremiah P is talking to himself, Qaguqagu is sweeping, and Majombolo and Saki are

sitting on their beds eating some cheese which they saved from last night's meal (or swopped with some other patients who don't eat cheese.)

Sunday nights are my personal favourite. Instead of getting half a loaf of dry bread and a bowl of the usual (unbelievably insipid) soup, we get a cup of coffee, half a loaf of bread and a chunk of cheese (or a spoonful of peanut butter on the bread.) This weekly coffee is a treat beyond description. At this time some of the more 'winning' patients are running around collecting armfuls of cheese from non-cheese-eaters, reminding them of free tobacco gifts given earlier in the week and promises of their Sunday cheese. Alternatively, they walk around with a handful of tobacco for on-the-spot exchanges.)

* * * *

Victor is sweeping the floor in Dormitory One and Abdal in Dormitory Three. Abdul sweeps every morning, as a result of which he claims a certain control over the whole 'territory' of the room. Usually sitting most of the day on his bed, he turns to give an ugly threatening stare to anyone who enters the room and continues to stare at anyone who is not a sleeping member of the dormitory. Even Ephraim is wary of coming in here. As soon as he enters, Abdul says to him "Get out!" advancing on him with his broom. He watches any 'stranger' the entire length of his sojourn in the room and reports any 'fingering' of other people's possessions to the owner on his return to the dormitory.

* * * *

Patients from Dormitories Three and Four are walking in and out now, as it is nearing seven, and some of the day-shift staff walk down and shout to everyone that it is time to get up. Johannes, James and Mdlandla are sitting naked on their beds, waiting for the shower water to dry off them before they put their clothes on. 'Zamfumf' walks into Dormitory Four with a wet rag in his hand. He goes over to Jakobus P's bed, one of his two abelulungi (Europeans) and says to him, "Kom Jakobus. Dis tyd om op te staan".

Jakobus, all skin and bones, with a straggly beard and peering old eyes, wakes up, and Zamfumf wipes his face and hands with the cloth.

* * * *

Down in the kitchen, the morning porridge is already boiling in a large cauldron. Ninevah P is sitting on the side drinking his 'tea' with a half-loaf of bread and some Sunday cheese. (This 'tea' is a kitchen speciality made from brown sugar added to hot water. Only kitchen workers have access to the sugar.)

Godolwendlovu (Sergeant Major) is sitting on the floor talking incessantly to himself as well as interjecting his own conversation with numerous 'mm's" and Uh-huh's" after which he starts up again with "Manje . . ." which is the equivalent of "Yes, but now"

Outside Moses P is reading his Bible as he sits on the ground.

Caiaphas, his tea finished, walks into the kitchen and says to Godolwendlovu, "Sergeant Major". To which the latter answers "Yebo, baba, Major Sergeant."

"Signorita, aqua vita, gogo baba, maja Italiana", says Caiaphas.

"Mm-mm. Signorita aqua vita gogo baba maja Italiana, baba. Senorita gogo baba", Sergeant Major replies.

Ninevah and Caiaphas burst out laughing.

"O, Sergeant Major", saya Caiaphas.

"O, Sergeant Major!" replies Godolwendlovu, also laughing, although it is not a joke to him - but he seems pleased to have someone join his conversation. He keeps on talking uninterruptedly, 'saluting' Caiaphas in a manner which resembles the way in which Richard P (a deaf patient and Zamfumf's second 'Unlungu') gestures his request for tobacco. Petros P is outside smoking.

Only Caiaphas is a fairly recent patient. The others have all been in the hospital from two to four years. Caiaphas is now going into his third month and is burning with impatience to leave the hospital.

* * * *

Shadrack S, late this morning, tramps across the football field from the married quarters and greets the patient-workers as he walks through the yard into the kitchen. "Good morning, gentlemen. Good morning, gentlemen. Come on now. Come on. Work to do please. Work to do." He unlocks the pantry door, bangs the enamel food bowls on the table and says to Caiaphas, "Come on. Put them out. Put them out." Petros takes up a pile and walks

into the dining room, more or less ignoring Shadrack. "Why do you have to start giving orders as soon as you come in?" asks Caiaphas.

"Please, my good man. Be so kind as to put these bowls out, will you?" says Shadrack.

"You're a bloody maniac. I don't know why I work with you", says Caiaphas.

"Thank you. Thank you, gentlemen", says Shadrack, walking through to the store-room to get the day's supply of sugar.

* * * *

7 a.m.

The day staff arrive in dribs and drabs. Benjamin and Mike are already in. Benjamin is reading the night report, at the staff table, written by Michael S. His reading spectacles on, he is bent over the table where the night-report book is lying. Outside, the chain at the top gate is given a few vigorous rattles. Sigedla runs down to the staff room window to get the keys from Benjamin, who has taken off his glasses to see who is at the gate. Sumane, Benson and Enoch come in, taking the keys from Sigedla as they walk around the entrance of Block A. Brown S, who has walked across the football field from the married quarters, rattles the chain at the lower gate. Enoch throws the keys to Sumane S, who goes to open it for him.

* * * *

Jackson P, down in Ward Four, has just rolled himself a cigarette and is now methodically folding his tobacco up in some brown paper, folding each section over slowly but vigorously so as to make it lie flat in his top pocket. He walks into Ward Three to get a light from 'Tension', a fellow garden-worker. He hands the cigarette back to Tension and walks at a slow leisurely pace out of the room and through the lavatories. He is a broad-shouldered strong man (one might even say 'strong-man'). He is moreover his 'own' man. He knows nobody is going to stop his walk to ask for a draw on his cigarette. He walks slowly across the campus, through the lavatories in Block B and out the other side. He walks around the corner and leans against the wall. He bites his mouth, flicks the ash off his cigarette and lifts the cigarette to his mouth. If no-one had disturbed him on his journey to this

part of the campus, he is even less likely to be disturbed here now, in this underpopulated back region, peopled in the main by feeble-minded, passive and old patients. He inhales deeply and blows the smoke down in front of him, looking at the ground.

* * * *

There is only one patient in Dormitory One now; three in Dormitory Two, including Mbulawa and Ngwevu from Dormitory One (who is sweeping there), four in Dormitory Three (including Samson, who is drinking yesterday's porridge (mixed with water and called 'makewu' in this state) from his private tin); three in Dormitory Four, including James P who is talking loudly to himself as he sits on his bed; one in Dormitory Five, a white-haired old man, John P, who is lying on his bed, his eyes closed and is talking to himself.

Mike S walks in and stands at the foot of his bed watching him.

John opens his eyes and sits up in fright.

"It's O.K., old man. I just wanted to see if you were all right."

"I'm all right, yes", says John.

"Well, its not time for breakfast yet. You can rest a little longer still."

There are six patients in Dormitory Six including Philip P, an epileptic patient (who is sweeping), Robert, who-has-no-nose, is under the blankets as usual. He spends ninety-nine percent of his time here. Dormitories Seven and Eight are empty.

* * * *

In the staff room Sumane, Mike and Benjamin are talking about yesterday's soccer match in which Sumane and Mike played.

Makhubukubu knocks at the door. Benjamin opens the door and finds him there, gesticulating and explaining in his stroke-affected speech that he needs some ointment for rubbing on his back.

"All right Makhubukubu, come back after breakfast and you can get your medicine."

"Enoch (a qualified nurse) probably knows what he uses", he says to the others, who briefly agree with him and continue to talk about the soccer match.

* * * *

Thirty patients are variously sitting or standing along the outside wall of Block A. The air is cool now, after sunrise, and the patients are warming themselves in the sun. None of them are talking except Jameson, the campus humorist, (from Ward One).

"Hey wena, Mlungu, Stanley, my brother, what is this place?" he says to me as I walk across to him. "This is a mental hospital, is it not? Yes, it is a mental hospital. All these patients, all bloody masimba, bloody shit! I am not sick. I am not mad. I can work. You know, Stanley, you know Dlamini (the Head Nurse)? He is not a doctor. Why does he keep me in this place? Why does he not let me go and speak to the doctor to let me go home? I don't know. You know if the European doctor sees me he will let me go home. What does this Umtwanwncosi know? He doesn't know."

Just then Sumane S walks across the yard. "Hey wena, poyisa." Jameson shouts at him, striding across the yard, now in form for some fireworks. "When are you going to let me go and see the doctor. You swine-a-ma-bitch."

"Jameson, do you want a hiding? Who do you think you're talking to? Swine-a-ma-bitch yourself."

Jameson turns around and does his 'ape dance'. A few of the patients snort. No one is really amused. Sumane shakes his head and walks on.

* * * *

In the lavatory of Block B, Madevu P and his 'gang' are cleaning the toilets, the basins, the showers and the floors, using soap, scrubbing brushes, buckets of hot water and hard brooms. Madevu is not doing anything himself, except to shout orders at the others. David ignores him, going about his job systematically. Bungane and Mnikwa do likewise. It turns out that Madevu is shouting mainly at Naftal, who is working slowly in a sort of submissive defiance, and Linford, who seems really frightened and is running around with a bucket, laughing nervously. Madevu runs up to Naftal as he pours hot water on the floor ('Shumayeli' sweeping it to the exit) and beats him on the back with his hand, "Not there! There!" he shouts at him, "Can't you see, what you're doing? Get some more water."

"Why do you push me around?" Naftal asks him, holding his hand.

"If you want your tobacco you must work for it", says Madevu, who hits him in the side and pushes him to the bathroom.

"Come on! Gijima! Gijima! Gijima! Pour here! Sweep it out! Sweep it out!" He shouts. When the job is finished they all troop across to Block A, put the brooms, buckets and brushes away and stand outside the staff room for Benjamin to write their names down. Madevu points to them, calling out their names to him.

* * * *

Behind Kulukhuthu (now empty), Set Square stands, as if to attention, his feet together, his hands against his sides, head in the air looking straight ahead. On the gate side of Kulukhuthu are four patients, gazing out through the wire - Daniel, Abraham, Zondo and Mangisi.

* * * *

Aaron, Simelane and Durban are having an unusually lively discussion, no doubt prompted by Aaron's high spirits at having been informed that he is to be discharged this morning. It is about snakes which they have encountered at different times. Ngisane stands to one side and smiles as he listens to them, saying nothing. Aaron is describing how one must always hit a snake "down and across" if one wishes to kill it without being bitten.

The bell goes for breakfast. It is 8 o'clock. The crowds converge on the gate. I walk down with Durban who says to me, "There are three patients being discharged this morning. One of them arrived after I had come here already", adding, "they refuse to tell me when I am going. Is it not criminal to do this to a human being?" He laughs. "What is it to be a human being in this place?", he asks me. "Do you know what! Do you know what I am?" He stops. "I am the first person singular."

"That's the bloody truth", I tell him, feeling as if we have suddenly grasped together the whole essence of the hopelessness of being a patient in a mental hospital. We laugh. I put my arm across his shoulders. "The first person singular", he repeats, and we burst out laughing all over again. Then it's all over and we walk into the crowd.

* * * *

8 a.m.

Benjamin has unlocked the gate and is standing next to it holding the chain which keeps the two gates together. Makhubukubu is next to him, holding in his hand a tin, into which he will scoop most of his porridge (to eat in the dormitory later). Augustine, the cripple, is also right at the gate. Around them are twelve old men and Mandoviyane, another younger cripple. It is Benjamin S's job to keep the younger, pushing patients out of the front section, to allow the crippled and the elderly patients to go down first.

"The old men must go down first, followed by those who are strong", shouts Sigidla, who straight away covers his face with his hands.

"Oh Sigidla", says Benjamin, laughing. "I think we must put you in charge of this army."

"Yebo baba (Yes, father)", says Sigidla, who shouts again, smiling embarrassedly this time. "The young men must wait for the old men to go down first." Benjamin S and quite a number of the patients are laughing now.

"Sigidla bonisa amandla!" shouts Shumayeli who steps out alongside Sigidla. Sigidla bellows loudly, then covers his face. There is general laughter now, but it is soon over as the patients are becoming impatient to go down to eat.

Solomon has pushed to the front. "No. You stay on the side", Benjamin pushes him away.

Brown S has been standing outside of the crowd all this while. Now Sumane S and Benson S walk down together from the staff room and are passed on the way by Abraham P and Joseph, 'the Dreamer', with the two trays of pills, followed by Wilson P, who is carrying the medicine book. They are followed, in turn, by Enoch S and Mike S who locked up the room after them. Patients who carry the pills and medicine book are the first to be let down. Once they have entered the dining room door, the old men are let down. There is a rush as Makhubukubu and Augustine hobble out in front of the rest. They enter the dining room along with the other sixteen 'first batchers', sit down and begin eating.

As soon as most of the first batch reaches the door, Benjamin gives the word and the rest of them go down. Those in front run to get to the door first. The less keen ones merely walk down. They all stand in a queue outside the dining room door. Benson is at the door to see that everyone is in the queue before they are let in. There is another rush as the first ones run in either to grab spoons and also a limited number of seats available. Some patients, however, prefer to sit on the ground and eat. Others also prefer to eat with their hands rather than with spoons. Neither mode is considered in any way more 'prestigious'.

* * * *

Zumfumf sees that his two 'Europeans' are seated near him, then blesses himself and says grace, very loudly. Two other patients also say grace before sitting down to eat, but silently, to themselves.

* * * *

Benson S and Sumane S stand and talk at the door. They see that no patients go out without taking their pills and no patients who are not trusted to return to the campus will go up without permission. Enoch and Brown are at the medicine table. Each patient who passes it is given his ration. Augustine P is the first finished. He picks up his white stick and hobbles out of the dining room, gulping down his pills (100 mg Largactal), which Enoch hands him at the table on his way out. Mike and Benjamin lean against the wall, talking to one another.

* * * *

Madevu gulps down his food and is the first at the kitchen door. Shadrack ignores him. He steps inside. "What you want? You are not allowed in the kitchen." He pushes him out and slams the door behind him.

* * * *

As the patients finish their porridge they line up for pills. Moses P and Petros P collect the empty plates and take them into the kitchen, where Sergeant Major is washing up, talking to himself all the while. Shadrack now comes to the door again. A number of patients have collected there for second helpings.

"Some more? Some more? Ha, Ha" says Shadrack. "All right, all right. Give me your plates. Give me your plates."

He takes the bowls and scoops porridge out of a rubbish bin which serves the purpose of a porridge container (thoroughly washed and cleaned, naturally),

"Thank you. Yes? Thank you. Come to Shadrack. Are you still hungry? Ha, Ha! Shadrack will give you more."

Shadrack's mock jollity is over as soon as he is finished giving extras to the surrounding crowd. Any late-comers he seems to think do not need extra food. "Finished! All gone." He tells them. They converge on those who have second helpings and force them to share with them.

"Why must Shadrack carry on like this? He's turning the patients into pigs", Benjamin remarks to Mike. "But when we complain to Dlamini (the Head Nurse) he always sides with Shadrack that the kitchen is his (Shadrack's) responsibility."

"Yes", agrees Mike. "The patients will forget their manners in this hospital."

* * * *

The eating quarters are in two sections. One for eating, and an ante room, into which most of the patients return after having their pills. It is a sort of after-meal queueing-area to go back to the campus. Sumane is now standing at the narrowing between the two sections. Amos tries to slip through without taking his pills. Sumane S fails to notice him, but Madevu P walks up and collars him.

"Why don't you have your pills?" he demands.

"Hey wena", Amos replies, "leave me alone or I'll kill you."

Madevu lets him go, but Sumane has noticed. He calls him back.

"Have your pills, Amos", he says to him, pulling him gently by the shirt sleeve. He makes no protest, goes straight over and takes his 100 mg. Largactal. (He has been in the hospital for three years on the same dose - 100 mg. 3 times a day.)

"Why all this fuss about pills as if I am constipated", he says, putting down the glass and walking into the ante room where, ignoring Madevu, he leans against the wall.

* * * *

Petros the kitchen worker walks up to Mangisi in the queue (as he goes about collecting plates.) "Mangisi. Siyokunquma wena. (We are going to circumcise you.) "

"Nquma bani? (Circumcise who?)" he shouts, not looking at Petros.

"You. Come", he pulls him by the arm.

"Yeka. (Leave me)" shouts Mangisi. "Angitshel igwayi. (I am asking for tobacco.)"

"What is in here?" Petros asks, taking some paper from Mangisi's pocket. He opens it up and shows Mangisi the tobacco. "Give it to me," says Mangisi, who seems himself surprised at seeing the tobacco.

"Give it to me", says Petros.

At this stage, the queue has moved up and Mike goes over to Petros, saying to him, "Give him his tobacco, now. Come."

* * * *

Mangisi rejoins the queue and, having had his pills, walks toward the door.

"Mangisi! Today we are going to circumcise you", Benson S. says to him stopping him at the door. Mangisi pushes him away, cursing his mother.

"Male benyoko", he shouts.

Benson laughs and lets him go.

* * * *

Joseph S, the garden staff, waits outside the exit door. As the others go up to the campus, Tension, Enoch, two Jacksons, Gwevu, Alfred, Dlozi and Mpaseka wait around the corner. They all go round to the store room and collect spades. Mpaseka takes a sickle. The kitchen workers pile outside too. Joseph gives everyone (kitchen and garden workers) a good helping of tobacco before they start work.

* * * *

Back on the campus, Mike S collects his 'boys' together - Joseph Dreamer, young Petros, Bungane, Mbulawa, David and Daniel. Armed with buckets and brooms they head for the male staff quarters.

* * * *

9 a.m.

The female mental patients are now in their dining hall. One of the female nurses is in Albert's workshop, asking him if he will fix a pair of leather shoes for her. He agrees to do it. (Albert does not eat with the other patients, but eats in his workshop, fetching his food from the kitchen himself.)

* * * *

The door leading from the kitchen to the female dining quarters is closed. The male patients (kitchen workers) are just finishing the bowls and are stacking them in the pantry. Sergeant Major and Ninevah are washing up. Sergeant Major looks through the kitchen window and through the dining room window (corners on) watching the women eating. He is still talking to himself. The male patients do not collect the female patients' dishes. The female staff bring the bowls in.

"Hello my darling", Caiaphas says to Victoria S.

"Hello, my sweet, when are you going to take me out?" she says teasingly.

"I'll be there tonight", says Caiaphas.

"Oh, but I waited for you last night and you never came."

"I've got a plan for tonight. Shadrack is lending me his suit and I'll take you to the King's Hotel for drinks."

"Uh! Uh! Is my girl-friend leaving me for another man?" says Shadrack, "Sorry I can't allow that."

"Since when am I your girl-friend? I have accepted Caiaphas."

"He is a patient. He won't be the one to fetch you in my suit."

"But you are also in jail because you are a married man."

"Ta! Thank you!" says Shadrack, "but I am ready to have another wife."
(He is not a Christian.)

"Yes, but it won't be me", says Victoria, mockingly.

"Ha ha" answers Shadrack, not to be outdone. "You are still in the back of the queue."

* * * *

Up in Dormitory Two, Madevu, with the tobacco ration which Benjamin has just given him, walks into the dormitory with Durban, Abraham and

Mnikwa, to play crap dice.

"You must play outside, Madevu", Sifundza says to him. "This is a clean house and we can't have people bringing dirt in here. This is not a casino."

"Who does this dormitory belong to? I can come in here any time I want to."

"Yes, but not to gamble. There is lots of room for that outside."

"You must play outside. This is not a casino. Who is going to arrest you when you try to fight, losing all your money? Go outside", Jameson chimes in.

Madevu is about to protest again, but, seeing Sifundza approaching him, and more interested in his dice than in an argument, he says "O.K. let's go outside."

They take a dust-bin lid with them (on which to place the tobacco stakes). A throw of a six-five combination gives the winner tobacco, likewise a 'snake-eyes' (one-one) combination. 'One-two' or 'seven' combinations lose the thrower his stake. The first throw gives the thrower his 'male' and he must repeat this total in order to win the stake. He may have as many throws as he likes, but as soon as he throws a 'one-two' or a 'seven' combination, he loses his stake and the right to continue throwing. His opponent then gets a chance to throw the dice and to take on the next in line. Throwing the dice is an elaborate procedure. The ground in front of the thrower is cleared, and, while the dice is still in motion, the desired combination, or some other general encouragement, is shouted.

Madevu takes up the dice and shakes them in his hands for about ten seconds, then he rolls them shouting "Uh! 5-6 Joburg line!" (11 is also a winning total). He throws the number eight, picks up the dice, rolls them between his palms, shakes them in both hands and throws them.

"Uh! Matsapha High School! J.C.!" he shouts.

He throws two and three. The procedure is repeated.

"Uh! Five-three!"

"Uh! Four-four."

"Uh! Matsapha High School. J.C.!"

He throws a six-two combination. Grinning, Madevu picks up his dice, scrapes all the tobacco into one hand and places it in his top pocket. The next in line places his stake alongside Madevu's.

"Ha! Such a small pile!" says Madevu, hands on hips.

"Its not small! It's the same size as yours", Abraham protests.

"Next one", shouts Madevu.

"You have got so much tobacco", objects Abraham.

"Do you want me to reduce my stake to your size," Madevu counters.

"All right. There!" He adds some more.

Madevua begins to shake his dice. There is a crowd now, watching. Madevu crouches, looks around the crowd and throws, jumping in the air "Uh! 6-5. Joburg line." he shouts.

"Ngiwinile" shouts Abraham ('I have won')

Medevu has thrown a 'seven'. Abraham scrapes all the pieces together, putting them carefully in his top pocket. Mnikwa moves his stake across the dust-bin lid next to Abraham's.

"I am next", says Madevu, taking a big stake out of his pocket and placing it on the dust-bin lid.

* * * *

On the other side of Block B, Augustine is talking to himself as he sits against the side of the wall. He sees Ephraim walking around looking for some 'action', Mkwena following him like a shadow. He picks up a stone and goes back to his seat.

* * * *

An old ex-soldier, whom we came to call 'Captain', is helping Majelimane out of his room into the sunlight. Majelimane is wet from his own urinations. Captain has washed him as best he could and is now helping him out into the sunlight. Mejelimane is the oldest patient in the hospital and is nearly blind. He always walks in a crouched position and traces the walls with one hand as he walks, grunting all the while "Uh! Uh! Uh! Uh!" endlessly. Perhaps the sound helps him better to locate objects about him. Captain wears an old military hat and an old army great-coat with a 'Legion of Mary' medal on the lapel.

He has asthma and wheezes constantly. He always salutes the staff members, and is dignified in his bearing and conversation with other patients. He has voluntarily taken on the job of cleaning and caring for Majelimane and demands tobacco for it at the handouts.

* * * *

Ngisane walks about, collecting the empty metal plates from old and disabled patients such as Majelimane, Robert and Samson who do not go down to the dining room to eat, but instead have their food brought to them by Ngisane and Saki (before the majority are allowed to walk up).

* * * *

Mavayana, another old patient, recently transferred from a mental hospital in the Republic, is also on the side, and is pointing to the ground, speaking to himself in a whisper.

* * * *

In Dormitory Seven, Samson is sitting alone on his bed in the corner (as usual). In Dormitory Eight, Johannes, from Dormitory Three, is sitting on a piece of paper on the floor. All day, every day, except for meals, he sits there. His uniform (which he washes himself when it gets any dirt on it) is immaculately clean. His back is to the door. He faces the corner. No-one else is in the dormitory. All the blankets were moved into the sun by Solomon, Mkwena, Ephraim and Umfanazana (a gentle, passive, quiet youth, who spends his days sitting on the steps leading from the lavatory to the lower dormitory) under supervision of Benson S. None of these patients are rewarded for this daily duty.

* * * * *

In one of the now-empty open cells of Kulukhuthu, King George is talking and singing.

"Eh! Jesu, one. King George, two. One ... two, Jesu, King George. Uh-uh-uh-uh-uh-ih-uh-uh-uh urr!". (A fan-fare)". The sounds echo and ring in the cell.

* * * *

In the field, Jackson, the strong-man, and Alfred are clearing the weeds away at some distance from the others. They work slowly. Every few minutes they stop.

"We mustn't go too fast. This work is our tobacco. When we finish here, we will get nothing", Jackson says.

"Those others are going too fast", says Alfred.

"I'm going to inspect the fence when we get that far", says Jackson. "I have been here long enough now. It's time for me to escape."

They carry on. At ten-fifteen it is all over. They go up to the store together and smoke at their ease.

* * * *

Alfred walks down to the others, leaving Jackson behind. Ngwevu works by himself, not talking to anyone, really 'putting his back into the job.'

* * * *

Lower down in the fields, Dlozi, Tension, Enoch and the other Jackson are turning over the soil while Mpaseka, a withdrawn Sotho man of about thirty-five, is cutting the high grass and weeds ahead of them. They shout to him to hurry up. (He speaks no Siswati).

Suddenly Enoch stops working, throws back his head and breaks into a peal of laughter. Everyone ignores this. They carry on working slowly. They all stop to rest.

Tension shakes his head. "Heyi, man! Why must Mfundin be so lucky!" (He was discharged last week.) "A few days ago he was with us here. Now he is far away somewhere enjoying himself."

"Yah", says Enoch resignedly. "He was lucky. Why not one of us? Why not me?"

"His uncle came to fetch him", says Tension.

"My family has forgotten all about me," says Jackson.

"Some people are lucky," says Enoch in conclusion.

* * * *

Alfred arrives and stands next to Dlozi. "Go and cut the grass", he orders him, threateningly.

"No, what! I am finished with my job now."

"Go on, do what I tell you", Alfred says, pushing him.

Dlozi picks up his spade and angrily threatens to beat Alfred.

"No, I'm only joking. I'm sorry Dlozi", Alfred says to him, but as soon

as Dlozi has turned his back he takes off his belt and begins to beat him with it.

"No, Alfred, No! I'm sorry! I'm sorry! ", says Dlozi.

Alfred threatens him, holding the belt high and bringing it down on Dlozi's legs. He stops only when Dlozi promises to kiss him on the mouth.

* * * *

They all stop work, no-one commenting on this behaviour, and walk up to the store room. Alfred and Dlozi are holding hands. At the store-room-kitchen complex Moses P is eating 'ingoloyi', burnt porridge scourgings. The garden workers put their tools away. Moses goes into the kitchen to fetch some ingoloyi for the garden workers. From now until twelve o'clock they will sit around smoking and waiting for the lunch bell to ring. Alfred and Dlozi sit together in a 'dominator-submitter' relationship. Mpaseka sits alone in his isolation; Jackson also sits alone. Tension, Enoch and the other Jackson sit a few feet apart from one another, occasionally conversing.

* * * *

10 a.m.

Mike S returns with his boys from the dormitories. Bungane is carrying the buckets, Mnikwa the brooms. Mnikwa is also carrying an empty Coke bottle, which he picked up in the men's quarters.

Behind them follow Sumane S and Benson S. These three staff (including Mike) have taken their tea break now - (half an hour), while Enoch, Benjamin and Brown took their's from 9 to 9.30. Mike S took his tea break while his 'boys' were busy. Joseph and Petros helped to wash the Matsapha Soccer Club jerseys.

These jerseys are all hanging on the line outside the male quarters. (The jerseys, presented by the Red Cross to the staff and patients for internal use have found their way into the Matsapha team in the Swazi national 'knock-out' competition.)

* * * *

The patients rattle the chain. Everyone waits for the gate to be opened. Benson urinates in the corner between the wire and the adjacent day-staff building.

As they passed along the road two Europeans - the head of the prison-staff training school and the chief chemist of the dispensary - arrived together, to have their morning tea with the Hospital Superintendent.

"Next time she comes we must just put her in Duma's room and then tell him she's gone," Benson shouts back to Sumane.

"Ho! He'll spend the rest of the night trying to get rid of her", says Sumane.

"Or running away from her", adds Benson, laughing.

Mike S is older than these two and does not enter into this conversation of their's. They are discussing an ex-girl-friend of Duma S, who was looking for him the night before. Because it is none of their business, the patients do not look at the conversationalists either.

* * * *

Sigedla is standing at the gate on the inside, holding onto the wire and watching those who are waiting to come in. There is no-one in the staff-room. As Benjamin walks around the corner, Sigedla runs down to fetch the keys from him.

* * * *

Jameson walks up to the gate also and addresses Mike S. as he comes in.

"Where is the European doctor?," he asks, "Because I want to go home to work and to see my mother."

"Yes", Mike answered him, not looking at him, walking down. "I understand you are wanting to be discharged."

"Yes. That's right", says Jameson, "When can I see him?"

"I am going to speak to him about you next time he comes."

"What do you mean? You are going to ask him to discharge me?"

"Yes. I said so", he answers, rounding the corner out of sight.

"This staff is telling me a lot of lies", Jameson says, looking after him and turning to address Gwayi, who is sitting on the ground nearby. Gwayi smiles embarrassedly, looking at the ground.

"Bloody shit, kak", says Jameson (meaning Mike S). He turns on King George, who is standing nearby going "Gi!" and pointing to the sky. "It's

10

because of bloody mad people like you going 'Gi! Gi!' all day that we are kept locked up in this place." Sifundza P, Joseph P, Wilson, Abraham and Victor, who are nearby, all laugh at this remark.

"I am King George, the Government", says King George. "Anyone who does not respect his parents or who stays here eating the Government's food not being sick, I am going to report to King Sobhuza."

"Oh King George", says Benjamin S who is sitting on the stone blocks with Brown S and Enoch S, "then there will be no-one left here and how can we get work?"

"Everyone must work in the fields or they will be put in jail", answers King George.

"Oh you are the king, really", chimes in Enoch S, "The Lion".

"Lion. Lion matches." says King George. "Gi!"

* * * *

Time drags on. There is no work being done either by staff or patients now. Everyone is 'waiting'. Only Gwevu is still at it in the fields.

In Dormitory Six, Robert, the blind patient, is lying in bed, his head covered with blankets. Richard, the deaf patient, lies in his bed, two beds away. In Dormitory Five, Siqobolo, tall and thin, lies stretched out on his bed. Frank smokes on his bed. In Dormitory Four, Josiah lies on his bed. In Dormitory Three, a patient we came to call 'Red Indian' (because of his expressionless face and orange coloured skin) lies in his bed facing the wall. If undisturbed he will lie here all day and all night, only getting up to go down to the dining room for meals. Like Johannes, he always keep his body clean, but his clothes are always creased, more than anyone else's. His hands are as small and soft as a young girl's. Amos and Petros sit on their beds in Dormitory One. Solomon, Mbulawa, Abraham and Wilson sit on Abraham and Wilson's bed, talking amongst themselves. The discussion revolves around jobs and education - the scarcity of jobs in Swaziland and the ease with which one can get work in the Republic of South Africa. Abraham is talking about his job in Preotria and how he was 'endorsed out' for not having a permit to work there. He says he would like to go back to school to become a doctor (he has only passed his Standard Five). Solomon discusses the number of people without work in

"Stwashini". Wilson is quiet through most of the talking. (He has a Junior Certificate.)

* * * *

A radio is playing outside. The speaker is perched on top of a high wall separating male and female sections of the hospital. It is relayed through from the senior-staff day-quarters. Jacob, a feeble-minded patient, is dancing to the music, clapping his hands and lifting his legs high in tribal dance style.

Makoyana walks across the lawn, talking to himself and playing with some stones, in his right hand. Asked why he always has these stones with him, he will tell you they are just to give him something to do. Like Enoch P he also breaks into what would in more appropriate circumstances be described as a 'delightful' peal of laughter. I feel sorry for him. Like myself, he does not seem to have the ability to relax, although he does seem to have made some advances toward keeping himself occupied, by playing with his stones. "Ngiyazitibazisa" (I keep myself busy with them), he told me. Yet this ability to amuse himself with his stones is interpreted by the staff as a definite feature of his illness. He believes his 'illness' started in the hospital. Some of the staff believe he has been cursed.

(When I was a staff member, we told him if he stopped playing with his stones he would be allowed to go home. He did. Then Mike and Enoch told him if he washed himself and showed he was able to look after his appearance he would be allowed to go home. He did. But his pestering to go home seems to have been interpreted as a new feature of his 'illness', although his speech was now normal. "We must just watch him for a while", Mike S told me, "to see if this is not just temporary." He soon went back to playing with stones and not washing. Proof. He is not yet well!)

Abednego is around the corner, smoking the butt of a hand-me-down cigarette. He sees Makoyana approaching and walks quickly up through the grass to the path along the wire. Makoyana follows him, demanding a draw on his cigarette. Abednego inhales as he walks quickly away from him. Just when Makoyana has reached him and is about to grab hold of him violently, he turns and hands Makoyana the last of his cigarette. Makoyana takes it

from him and Abednego walks across the lawn away from him. The former has the reputation of turning violent when his request for a cigarette is not met.

* * * *

Zamfumf and Gwevu are playing ruba-ruba in the yard. Zamfumf is good at it. Every time he wins he makes the sound of an explosion, wipes the 'dead man' off the board and laughs loudly.

Saki, Simelane and Durban, who are sitting nearby, start to discuss Zamfumf with some resentment. (The three discharged patients have already left amid shaking of hands and a crowd gathered at the fence.)

"Why were they discharged? I want them to stay here with us," says Saki.

"I suppose you would stay here if you were discharged", Durban says to him.

"Who would want to stay in this place?" Saki asks, rhetorically.

"There he sits", says Simelane, indicating Zamfumf with his head and eyes. (Zamfumf has been discharged three times, but he refuses to leave.)

"Zamfumf! Why don't you go home, since you have been discharged?" Saki shouts at him.

Zamfumf looks at him with a blank expression on his face, then he looks at the others, who are also watching him. He goes on with his game without comment.

Saki gets up and walks over to him. "Why don't you go home? You think you can just live here without working. You are lazy to work."

"This is my home", Zamfumf says to him, "I am not mad. But you must stay here, because you are mad."

"Am I mad?" Saki asks him becoming more and more angry. "And what about you? It's because you slept with one of the young wives of your father that you are afraid to go back to your home." (This is a popular rumour about Zamfumf.)

"You lie", he shouts at Saki, getting up from his sitting block and advancing on him to beat him. "I'll fucked up you", he threatens him in English.

"Yes. You are angry because I tell everyone the truth about you," says Saki, running away.

Jameson turns to the other two, "He is mad. How can an ordinary person stay here after he is discharged?" He gets up from the board and walks inside to register his disgust.

* * * *

11 a.m.

Caiaphas is in the workshop with Albert. They are leaning across the workbench talking together, quietly. There are long pauses between each sentence.

"I think I must try to write to my old boss while I'm still in here and see if he will give me a job in the garage where I used to work before", says Caiaphas.

"It is difficult to go out of this hospital without a job", Albert agrees with him. "At least if you are in jail you know you can leave with some little money to live on while you are looking for work."

"Do you think the doctor will let me send a letter to my old boss?" Caiaphas asks.

"He will let you, but I think its better to go and see him yourself. He will not believe you are not mad if you write to him from the mental." (That is, the mental hospital.)

"Yes, I think you might be right. In any case, I might be here another two weeks or maybe two months."

"Its terrible", Albert says, "I can hardly believe my own misfortune. My prison term is long finished, but the Government wants to keep me here still. I wish I could go back to driving trucks again, but I will have to get a new licence and I don't know if I can pass the test after all this time."

Next to Albert's room is a room where five female patients and a female nurse are weaving grass mats. (Albert occasionally talks to the nurse, but has no social contact with the other women.)

Shadrack comes to look for Caiaphas. It is time to dish out the lunch.

"Kunjani (How are you?) Albert?", he says to the latter.

"Lungile. Kunjani wena? (I am fine and how are you?)"

"Ngikhona" (literally "I am here", figuratively, "I am as well as you see me"), Albert answers. They shake hands. Albert touches his right

forearm with his left hand to show respect. Shadrack bends forward slightly to show humility.

"Sawubona, Mama," he says to the nurse working with the patients next door.

"Yebo, Shadrack", she answers.

"We are preparing the tables now", Shadrack says to Caiaphas.

"All right. I'm coming to help you", says Caiaphas. Shadrack walks out to go to the kitchen.

"O.K. 'buti' (Brother) Albert, we shall talk again this afternoon."

"All right, Caiaphas", Albert answers.

(Shadrack would never boorishly interrupt a conversation without showing the customary respect to those who are engaged in a serious discussion.)

* * * *

Up on the campus most of the patients are either resting in the shade of the buildings, or are inside, on their beds. Robert P, another deaf patient, is standing at the gate looking around with a worried expression on his face. He walks up to Mike S and Benjamin S who are talking together in the shade.

"Ngilambile", he says, pointing to his stomach and holding out his hands as if to ask "Has the bell gone yet?".

Mike S points at his own stomach and opens his hands as if to say 'stomachs are still empty', then points at his watch and down to the kitchen as if to say "it is not yet time for food; they are still busy."

Robert turns around, walks across the yard and stands at the corner of the opposite building, looking at the kitchen.

* * * *

Further up in the yard, Ephraim is teasing Jacob. Mkwena is nearby, turning his head to one side and laughing half-heartedly, as if in anticipation of greater excitement.

"Imfene! (Baboon)", he mocks Jacob, the latter pouting and pretending to ignore him - "Imfene!" he says again and pushes Jacob.

"Hey! wena!" Jacob screams, and, picking up a rock, chases him across the yard. "You damn-fool", he shouts (in English).

As Ephraim gets to the corner he bumps into Robert, who has not heard

him approaching. Thinking that the latter is trying to be 'funny' with him, he lays into him with all his might.

Mike S runs across to stop the fight, pulling Ephraim away, while Benjamin tries to calm Robert down. The latter nearly lays into Benjamin as well, but then recognises who he is and tries to tell him that Ephraim has attacked him.

13 { Mike S leads Ephraim up to the kulukhuthu. Were it another patient, he would probably be given an injection for interfering and causing trouble with other patients, but Ephraim is thought not to be able to discern events in their proper perspective so he is spared an injection and merely locked in the security block for the rest of the day.

"You damn fool", Jacob shouts at him, as Ephraim is lead to his fate. He takes no delight in this turn of events. It seems as if Jacob sees no 'poetic justice' in this. He leans against the wall and continues to look downcast and miserable even after Ephraim is locked away.

* * * *

The bell rings for lunch. Everywhere patients stand up almost immediately and begin to converge on the gate. Old men come down trying to push their way to the front. Some of them appear to be trapped on the outskirts of the crowd.

As Wilson, Solomon, Mdelwa and Abraham walk down with the books and medicines, Mike S and Benjamin S stand up and walk across to the gate. "Make room for the old men", they say as they walk through. The crowd looks about and leaves spaces for old patients to get to the gate. Enoch S follows the carriers down. Brown S, Benson S and Sumane S amble down as well. Brown throws the keys to Benjamin S at the gate.

Carriers, old men and cripples go down. The rest follow. Sumane, Brown and Benson walk along the road to the barracks to have lunch. Brown walks across the field to the married quarters. Sumane and Benson walk up to the single quarters.

* * * *

12 p.m.

I sit down at the table with the rest and look into my bowl of cold and dry mealie porridge covered with a watery gravy in which there are a few spinach-like green leaves. The table is smooth and clean to the touch, having been washed down after breakfast. The bench I am sitting on is likewise smooth and clean. Next to me is Zamfumf, next to him Jakobus, opposite Jakobus, Richard.

Zamfumf says to me in English, "Ya, you come back to me? You mustn't give your food to these Swazis. You must give it to me. I will look after you, I look after the Europeans. The Swazis hate the Europeans. I look after you."

I have an 'experiment' in mind. I call Durban across to sit opposite me and give him one chillie which I picked in the garden.

"Why do you call him? I don't want him to sit here", Zamfumf says to me.

"Who the hell asked you what you want?" I say to him.

Durban gets up to go away, but I restrain him, holding him by the arm. "Sit, man. Where are you going? Don't you know he thinks he's God already? Do you want him to think you also believe it?"

I eat as much of the mealie-meal as I can, having spiced it up with bits of chillie. I pass what is left in my bowl to Durban. Zamfumf looks at me. He has already finished his and is sharing Jakobus' share with Richard. Durban finishes half of my left-over, but then stops, fanning his mouth.

"Its too hot", he says.

I take the bowl and pass it to Zamfumf.

"I don't eat food from a black man", he tells me, "only from a European."

I get up and walk away, feeling a bit of a rat at having 'set-up' Durban in this way. (I did not know exactly how it would work out, but I knew I could arouse some sort of 'action'. "All in the interests of science", I say to myself to appease my conscience.)

"You don't eat black people's food? And what are you?" Durban asks him.

"I am a European", Zamfumf tells him.

"Yes, you like to play European so you can steal the food and tobacco of these Europeans. Do you think we are as stupid as you, that we can't see what you are doing?"

"Get away from this table! You don't belong here", Zamfumf shouts at him, punching him in the face.

Durban gets up and tries to punch him across the table but Zamfumf has moved out of reach. Durban rushes around the table and lashes out wildly at Zamfumf. All eyes are on the two of them. Nobody moves to intervene. Even the staff are standing still, watching in anticipation. A full half-minute goes by before Mike S goes over to stop the fight.

"I get so excited. I get so excited", says Durban, explaining the ineffectiveness of his attack to onlookers.

Abraham, Saki, and Mbulawa go up to Mike S saying to him "Why did you stop the fight?" "Why didn't you let them fight it out?"

Mike S replies, "We would all like to see Zamfumf get a hiding, but we also have to do our job here. This is just not the time and place for it to happen."

The three patients walk away, talking and imitating Durban, following their imitations with straight rights and uppercuts that would have sent Zamfumf rocking. There is quite a hub-bub, a most unusual-for-the-hospital spontaneity of chatter and laughter. Zamfumf, although the butt of it all, laughs stoically and says to all and sundry, "Ya! I teach him."

"It's all finished now gentlemen", says Benjamin S., "Come, have your pills."

* * * *

A line forms. Josiah is at the kitchen door demanding more food.

"I want you to fill my plate with food now. You can't be forcing me to take the pills and yet can't afford to give us some more food."

Shadrack tells him to sit down and wait. Then he goes into the kitchen and locks the door.

Eventually Josiah, and others waiting for more food with him, go down for pills, walking to the medicine table. Josiah walks past it. Nicholas P, Sigedla P and Brown S go to get him. He ignores the other two and threatens Brown S. At the table he says to Brown "I'll kill this damn table just now. What the bloody hell do you think you're doing by not giving me some more." (That is, some more food). He drinks his pills.

15 { Meanwhile Sigobolo, tall and thin, is at the kitchen door talking to Shadrack - who gives him a plate of food. There is a rush now as the other patients also go to collect their extra food. Shadrack concedes and gives them 'some more'. Brown, Benjamin and Mike discuss Shadrack's behaviour amongst themselves. (There seems to be a recognition of Sigobolo's clan relationship to Shadrack - both of them are "Umtwanenkosis").

After Josiah has finished his 'some more' he comes rushing into the waiting room. "Any Mabalane(one who can write - literally, a 'clerk'; another name for a staff member) who thinks he can stand a fight let him come here and I'll show him." Mike S who is standing at the door restrains him from going out. "I'll hit you - I'm telling you", he says, then sits down.

* * * *

When all have finished taking their pills the patients walk up to the campus. The chatter resumes now in the open air, arms flying - imitations of the fight. Then the gate is locked and the dullness of hospital life returns - sitting in the shade, sitting in the sun, lying on one's bed.

* * * *

Dlamini, the Head Male Nurse, opens the top gate and walks through the campus on his way to lunch in his own quarters. Sigobolo approaches him and says, "It is your duty to write to those who don't know their homes and have been transferred here from the Republic, so that they can be claimed."

"I take care of the patients given to me. Those who want to claim their relatives here should come and do so. I can't be running around looking for their relatives and chiefs to come and claim them. Many may be left here because their relatives can't afford to have them at home for many reasons

such as food, sickness, poverty and so on. Heyi wena, Mdwara! You explain to him for me I must get back to work just now". Finally he refers the matter to my assistant-patient and goes out of the bottom gate.

1 p.m.

The female patients are now walking up to their quarters. Sigedla, Abraham and Wilson and others are watching them through the wire fence, day-dreaming.

"You know people", says Abraham, "Dlamini should just let them come and sleep on this side for one night. Then all our frustrations will be over."

"That will never happen", says one of the by-standers. "They will become pregnant and their children will also be mad, then who will look after them?"

* * * *

Up in the top corner of the campus, Elias, Siqobolo, Marcus and others are having a conversation.

"This person", says Marcus, "brought medicine from an inyanga. He would get corrugated iron from a shop without paying for it. Today he has a wonderful building. He has got 'tywala' (alcoholic drinks) from bottle stores in the same way ...

"One day two 'tinghungqula' (birds used for witchcraft) came to his kraal and played around there, and the whole side of his body was paralysed."

"I know this chap", remarks Elias, "His wife today is the worst whore I've ever seen. You can pay this chap money to go and sleep with his wife. He would agree to it. He is even paralysed in his sexual organs."

"Why was he bewitched?" asks Victor who has just joined the conversation.

"Its because he used to kill people by bewitching them", Marcus carries on. "Then he would take their wives and cattle. One day he killed a fellow who had medicines also. So even in death he managed to take revenge."

The conversation turns to cattle and car accidents and whether or not some of these accidents are not also caused by witchcraft.

* * * *

Sumane S has gone down to Dormitory Four and is sleeping on one of the patient's beds. Benson is sitting in the yard, leaning against the building in the shade, resting. Brown is in the staff room, sitting at the table, his head resting on his arms. The other three staff members are now off for lunch. It is a sweltering hot day. Most of the patients are on their beds, resting and sleeping.

* * * *

Elijah P is sitting against the dormitory wall by himself. A gentle, slightly effeminate young man, his only speaking companion appears to be Moses, the kitchen-worker, who comes up to the campus in the evenings and has a chat with him. A favourite pastime of theirs is to count the number of a certain type of bird (egrets) which pass over the hospital in the evenings.

* * * *

It is in this time of inactivity (1 p.m. to 2 p.m.) that Makhubukhubu usually takes his shower. He is in the bathroom now, showering.

* * * *

Having no beds to lie on, most of the patients from Dormitory Eight are out on the side lawn. Mangisi is in Dormitory Six, sitting on another patient's bed. The latter has just rolled a cigarette, and, not wanting to be pestered by Mangisi, goes and lights it from Alfred and walks outside.

* * * *

Abraham is down in Dormitory Three, sitting with Tension, whom he is asking for a smoke. Abraham, Tension and Enoch are talking together. Sigedla comes in and sits down opposite them. He is a non-smoker. Abdal looks at him for a long time, but says nothing.

* * * *

Sigedla, who walked in just as Abraham was saying how he wanted to take revenge on someone outside the hospital, begins to talk about a certain man who killed his brother's 'impaka' (an animal used by witches to send medicines to different places.)

"How does he expect me to like him when he has killed my brother's 'impaka'?" he asks. "Impaka is as good as a child at home. Sometimes you will even sacrifice your own meal for it or feed it with bananas. I

found this man in the forest killing it. I thought of sharpening my spears and having a fight with him, but I changed my mind because they will think I am mad."

"What sort of animal is an impaka?" Abraham asks, interrupting him. He looks at Abraham a long time then answers, "Don't you know a baboon?"

"Yes", answers Abraham.

"These animals must be treated with respect", Sigedla carries on, describing how they should be treated.

He soon breaks off his conversation (as suddenly as he started it), and walks out of the room.

The three seem not to know whether or not to believe him.

"He is a jolly chap. He knows how to talk and most of what he says is interesting", says Tension.

Abraham agrees. Enoch says nothing.

* * * *

As Sigedla walks out, Reuben walks down through the toilets to his dormitory. It is almost ritual for him to stop in the wire covered passage between the toilets and the bottom dormitories and shout something to unknown persons. Today he begins shouting: "Ngikuthumele empini ngeflayi-mashini. Liphi lesaka lami sentsango? Ngitamhlabisa nabanesi abemitsise. Lomunye umfati ngitambeke kwa Lukhele angiphekele emahewa ... (I sent him to war in an aeroplane. Where is my dagga bag? I'll put him with the nurses which he'll make pregnant. I'll put one of these women in Lukhele's home to make me mahewu.)"

At this stage Sigedla interrupts him by saying "Unamanga, man! (You are lying, man.)"

Reuben is furious and begins chasing him, in order to beat him. Sigedla runs out into the grounds, laughing. Reuben's shouting attracts Benson and Brown who give chase and restrain Reuben who is now holding a brick in his hand. Reuben is told not to take seriously what a foolish person like Sigedla says to him. Sigedla is led away by Benson in the direction of Kulukhuthu, Reuben still cursing and threatening him as he goes.

16 { "You must not be troublesome, Mkaya (boy from my home town)", Benson S tells him. "You know when you were living at home you were a respected person, because you knew how to behave and to see that nobody broke the laws. Isn't that right? Well now you must show that you are a man who knows how to conduct himself in the world."

They stop outside Kulukhuthu, Sigidla is quiet for a long time. Then he says "Yebo".

"Uh-huh! You say so! That's good. We don't want to see you behaving badly."

It is left at that. The two of them are old patients. The staff know that it will all stop there.

* * * *

2 p.m.

Benjamin, Mike and Enoch return from their lunch-break. Soon afterwards, patients are being gathered for the afternoon wash.

"Time for washing!" the shout goes up. Most of the patients in Dormitory Two do not move, neither are they molested. Most of them have already showered today and do not wash with the "masses", as my assistant-patient used to call them. Only Leonard is singled out by Mike.

"Come on, Leonard. Go and have a wash."

Benjamin S goes down to Dormitory Four and gives out the word. Simon, Josiah and Owen troop through to the showers. James is already there.

* * * *

17 { Mike gives clean uniforms to young Petros and Vusmuzi. The latter starts to kick his old uniform around the staff room.

"Why are you kicking the uniform," Enoch asks him.

"No, I just feel like it", he answers.

Enoch gets an injection ready and says to Vusmuzi, "Come".

"What is wrong?" Vusmuzi asks.

"Nothing is wrong. You must just have this injection", Enoch answers.

"Why?"

"Because the doctor prescribed it."

"O mayibaba", says Vusmuzi, turning around to get his injection (150 mg. Largactal).

"I want to sleep alone", says Vusmuzi as Enoch takes out the needle.

"All right", Enoch answers, "Go and have a nice rest now."

* * * *

"Come, old man", says Benson, pulling Mavayana in the direction of the showers.

"Mkwena, why aren't you washing? Where's my stick?"

Mkwena runs laughing to his dormitory, takes off his clothes and runs to the shower.

* * * *

In Block A, Sumane is supervising the washing. Abraham is soaping and washing Kanyezi. Victor is cleaning Linford. 'Red Indian' does not seem to have washed very well, but has just stepped out of the shower and ducked out of the door to go, dripping, to his dormitory.

A large number of patients are standing around drying off ('drip dry') next to the basins, then putting on their shorts and going out to stand in the sun.

* * * *

Joseph S, the garden staff, walks through the lavatory to collect his garden workers. Their reaction on seeing him seems out of place. Instead of lethargically rolling out of bed, they almost jump out and follow him out of the door at a brisk pace, through the lavatories, out of the top door and down to the gate.

* * * *

In Block B, Benson is busily washing down patients. It is a job to which he is obviously dedicated. A large number of patients are in the showers. Each patient is thoroughly cleaned before he leaves (or seen to have cleaned himself.) Solomon and Saki are helping with the washing. They are using smooth stones which act as scrubbing brushes to scrub the patients bodies, especially their legs and feet.

"Jeremiah! Daniel! Where are you going?"

Daniel turns back and walks slowly into the shower again.

"I'm finished washing", says Jeremiah.

"Come on, you only wet yourself. Did you use soap?"

The nervous old man stands timidly while Benson S lathers him all over, 'stoning' his feet, massaging the soap into his scalp, then leading him into the heavily pelting shower.

"There you are. Now you're washed", says Benson.

"Enkosi! Enkosi!" says the old man, grinning nervously as he comes out of the shower, tripping up the passage to his dormitory, hopping on the balls of his feet as he dries off next to his bed.

* * * *

The showers over, calm reigns once more. Time must be passed from now until the next meal at 4 p.m.

* * * *

3 p.m.

Down in the kitchen, the workers are starting to get up from their resting places. Moses is in the yard, singing hymns to himself. Petros is around the corner, smoking in the sun. Godolwendlovu sits asleep in the kitchen. Shadrack S, Ninevah and Albert are talking together in the female dining room. Caiaphas is sleeping on a bench inside. (The kitchen workers are not allowed to go up to the campus during the afternoon. This is a 'kitchen rule'. "Why not?" I asked, during a brief spell as kitchen-worker. "No, it's just a rule", I was told.)

In the fields, Simon and David seem to have joined the other garden-workers, yet they are hoeing in a separate field. They are, in fact, working the field of Brown S. This is a recognised legitimate practice. Each staff member is permitted to work a field for his own food needs. Brown 'pays' them each 25c per month, as well as giving them the ordinary tobacco ration. "Because it is more than hospital work", he explained, "they are also doing me a favour."

* * * *

I walk into my dormitory, feeling weary and wondering what use I am to anyone in the world, wondering whether I will ever be able to sort out and describe with any exactness, the 'reality' of patient life - being neither an integral part of the patient community nor a detached observer, and

suffering from a peculiar moral deprivation, not being subject to the hopes and fears of my 'fellow-patients', nor having any objective scientific criteria whereby I can judge the 'usefulness' or 'validity' of my constant observation and description of events.

In the midst of this quandary, however, the whole set-up seems suddenly to take on aspects of an 'interior revelation'. I 'understand', as intimately as if I were a patient, my own identity as a mentally disturbed person in this self-contained world, a world in which there are no guidelines, no moral groundings on which to base my existence and to choose one path rather than another, to engage in one activity rather than another. My anxiety seems to be "free floating" (in the Freudian sense), unattached. The only thing I want to do is 'something', I want to do something, and to say to everyone "Look THIS is what I am!" What I felt most like doing was having a bloody fight with someone - to protest. To say "Look I AM NOT THIS."

While I am having these thoughts Benson S wanders in and out of the room.

"Congoless (that is Congress (Congress Party))" Siqobolo says to me.

He had named the enemy - the one who was to be blamed for this state of the world, of Swaziland, of the hospital, of himself. Being a member of the Mbvokodvo Party (the ruling party), he holds fears that there is a subversion underfoot. It is to be found everywhere. Even here in the hospital. People could now be divided according to their political allegiance. Were his thoughts far fetched? Not at all. Someone surely was to blame for this state of affairs. The government, being a good government, could certainly not be blamed, yet this nameless and faceless meaningless imprisonment continued. Nor was there contact with the outside world. Therefore agents were working here, within the hospital. All logical enough!

The staff were free to move around, to joke, to laugh. Their freedom of action seemed to exist at the expense of our own. Because I was under their control and at their 'disposal' they were free and I was not. I had a vague feeling that this was not quite correct, yet it would be comforting to believe that it were correct. How patiently, how 'hopelessly', the other patients seemed to have accepted their lot.

This sociological exercise of my imagination, was now over. I returned to my 'identity' and I was envious of some of my fellow patients. The way they had established a 'meaning' here, which was denied me - Makhubukhubu cursing and threatening those who did not respect him; King George with his self-praises and realisation that he was in fact in command of the whole 'scene' - Jesus and King George - two, yet one; Siqobolo who was out to protect himself from the wiles of the Congress Party; Sergeant Major with his ever-interesting self-conversations ever-agreeing with his own thoughts, ever-revealing old-yet-new ideas to himself; little 'Pilato' with his 'respect' and 'manners', begging for cigarettes, then jumping mischievously into his bed to smoke them with private glee; Israel with his polished shoes; Caiaphas with his complaints and involvements in the kitchen; 'Tamatisi' constantly shaking his rattle; Jacob ever looking for 'action'; Sigidla with his ability to walk into any conversation and partake of it, adding his own comments and stories, without giving offence. Yet all this was within a world within a world, a dream within a larger dream.

Determined to press my thoughts to their conclusion, I picked up a piece of paper and wrote the following poem:

In my own time,
 Searching myself for the right
 thread of tension
 to sustain my flight,
 I return to the place
 I started from -
 Only to leave again -
 the emptiness not holding me!

The emptiness not holding me,
 I turn my resignation, inside,
 Out.
 I remain,
 Where nothing holds,
 holding to nothing;
 Nothing holding and holding me.

I lie back on the bed, exhausted. So there it is. I too had 'done my own thing'. I was fulfilled. I had discovered my own meaning. I was the one who was deciphering 'the void' and I myself was a cipher of it. When the bell rang for supper, I walked down to the gate 'on clouds'.

* * * *

4 p. m.

Blind Robert, Majelimane, Samson the Cripple, and Ephraim remain on the campus, the former three as a general rule, the latter because he is locked in the security block. Also remaining behind are Vusmuzi, who was injected earlier (and is now asleep in an open cell in Kulukhuthu), and James, who has been injected during the last hour.

I stand among the first fifteen in the dining room door queue, as the stragglers walk down from the gate. Joseph-the-Dreamer is allowed to go to an adjacent toilet to wash his hands before eating.

"O.K., Gentlemen", Mike says. There is the usual rush inside for spoons and large helpings.

(It's always 'Gentlemen' when permission is given to patients to do something they want to do, I muse; one of the 'niceties' not likely to be thrown back in the face of the staff member as an attempt at 'social manipulation!')

* * * *

King George has a special place in the corner, probably the only 'official' seating arrangement in the hospital.

I decide to sit at the centre table. I find myself in the company of Pilato, Amos, Phillip and Elijah. Although they are not strangers, I feel strange in their company. They shift about uneasily, probably wondering why I have come to sit here. The movements are slight - or is it merely my own uneasiness? No. I miss the 'hello-as-usual' nod which accompanies my sitting at more-frequented-by-me tables. It is like the difference between walking into one's own dormitory and walking into another dormitory. You feel that there are eyes on you, making you self-conscious. This is accompanied by a slight lull in the general conversation (even if only two people are actually speaking at the time.) Certain proprieties need to be recognised. You can't just sit on the end of someone's bed without some good excuse. You can't just walk up to acquaintances, even good ones - in whose company you would often find yourself, outside the dormitory - and sit down on their beds and start light conversation. Sigedla could do it, but then he was a bit of a 'card', a "jolly fellow". When he sat on your bed he would cover his face

with his hands like a shy young girl in unfamiliar company, then, slowly taking his hands away from his face, he would begin to talk to you about something 'extra-ordinary' - (it would have to be wouldn't it? What ordinary conversation could be struck up between strangers? And Sigedla, remember, is a non-smoker) - looking at you, out of the corner of his eye.

On one occasion he opened such a conversation with me, in this way, by saying, "Ligwayi liyalinywa nepampentsis, nemahabula nakonke. (Tobacco is farmed and peaches and apples and everything.)" So it is in the dining room seating arrangements. Even the rushed-for seats are in a small area (I subsequently note) and the spoons which are snatched up are grabbed as one rushes to seats in this area.

* * * *

Cold, watery, pea-green insipid soup with half a loaf of bread stuck in it. Patients like Maceda would munch into the soggy bread and drain the soup from the bowl. Those sitting opposite the old men would sometimes try to pinch some of their bread. Those who chose to sit on the floor usually ate at a more leisurely pace than those sitting at the table.

* * * *

One's food and one's bed are nobody else's property. Only the most unmannerly of patients would dare to abuse one's private right to them, and there is no need to show mercy to transgressors. Even the most vicious defences of one's rights in these areas are countenanced by the staff.

* * * *

Passing Zamfumf, Shadrack asks Jakobus (Zamfumf's 'European') if he has finished eating. He nods assentively. Shadrack picks up his plate and walks off with it.

"Sulu benyoko" Zamfumf shouts at him, abusively. "You know this is my European. He gives me his food. You like to drink tywala then you just do what you like with other people's property." Shadrack walks off, not answering.

"What's he carrying on about?" I ask Shadrack, pretending I don't understand.

"Zamfumf has been discharged four times, but every time he refuses to go home. He thinks he can do what he likes here. I'll give him a hiding one

day when there are no superiors around. He is very troublesome", he explains.

Sumane, Benson and Enoch are laughing at Zamfumf. Durban walks passed him and says. "Ya, Zamfumf! They are teaching you not to steal food."

"I'll fucked up you," Zamfumf tells him in English.

"Here", Durban says to him, half to placate him, half to tease him. "Here is some tobacco for your Europeans. You have probably smoked theirs already."

"I don't need your tobacco", Zamfumf says, turning away from him.

"I'm sure you don't. You've got your own supply", Durban taunts him.

"I know what I am doing", says Zamfumf. "You are stupid. You don't know about God and Europeans, but I know what I am doing."

There is a roar of laughter and disapproval at this. Zamfumf takes Jakobus by the hand and leads him into the waiting-room.

"Come Richard", he shouts at Richard P, beckoning to him. Richard looks uncomprehendingly at the on-lookers (being deaf and not having heard the verbal exchanges) and follows Zamfumf.

* * * *

At this time, Jameson, who is lining up for his pills, gives his 'Bull cry', a derisive "Ho! Ho! Ho!", his arms bent at the elbows, leaning forward and stepping from one leg to the other. "Bloody swine-a-ma-bitch" he says, indicating with his eyes to Sumane that he means Enoch S. The latter ignores him and Sumane stares blankly at him.

"Why do you do it?" I ask him, laughing with mirth at the whole spectacle. "No, its just my way of playing" he answers, "I do it even at home."

* * * *

Shadrack gives six plates of food to Saki, Ngisane, Jack and Naftal. The latter is not a regular, but has 'jumped in' to take advantage of the extra patients who are on the campus. Ngisane takes food to Majelimane and deaf Robert, Saki to Samson. Jack takes food up to Ephraim and Vusmuzi. Naftal takes his food to James, but, finding him asleep, sits on one of the

beds and waits for some others to come up, while beginning slowly to eat James' samp himself. (No soup is taken up to the campus.)

* * * *

Back at the dining hall the 'wait' in the waiting room is long and eventless (as it normally is). Now and then patients push through the crowd to get a light or to stand next to someone else, who is smoking. Most patients stand or sit, looking at the floor, not concerned with their neighbours. These long waits are just another part of the routine.

Living in a closed community very little happens that the next man does not know about. Consequently conversation is severely restricted. I should think it fair to say that at the 'average' moment in time only about five percent of the population is conversing. At long last everyone seems to have had their pills. The door is opened and everyone files out.

* * * *

Garden workers file around to the yard to collect tobacco rations. King George is there to..

"Oh Marabi, do you also want some tobacco?"

"Yes. Me? I am here for the Government."

"Well, we are all here for the Government are we not? But the rest of these people have been working in the garden and the kitchen and that's why they are receiving tobacco. But you were not there."

"I work in the garden. You lie! You know I work in the garden. You can't refuse me tobacco", King George says angrily.

"All right", says Joseph S, "I'll give you your tobacco, but then I want you to do a special job for me? Will you do it?"

"Give me the tobacco first."

"Here you are. Now I want you to take this watering-can and water the seedlings over there."

King George does as he is bid and continues to water until he is stopped by Joseph. "Thank you very much, Marabi, now you have really earned your tobacco", says Joseph.

"O.K." Marabi raises his index finger and walks slowly away, smiling to himself. Joseph watches the wiry little figure of this old man with white

hair, slowly walking away. Just then he turns and says to Joseph, "I'll come and water for you tomorrow."

"I'll be very pleased", Joseph answers.

"Okay", he says again, and walks on.

* * * *

The line of patients trails up to the campus. Jakobus is already up in his dormitory being one of the old patients (allowed to go up before the rest). Zamfumf walks toward his dormitory with Ruben, the two talking about 'money'.

"Let's go", Ruben is saying, "and I will tell the women to bring me ten pounds (old currency). They will bring it back very soon."

"Don't tell me about ten pounds. I talk in hundreds", Zamfumf answers him.

"Come. Lets go and you will see", says Ruben.

The two walk through the toilets together, but Zamfumf carries on after Ruben has stopped, going into the latter's dormitory to wash old Jakobus' face, before he goes to sleep. He does this, puts him under the blankets, sweeps up around his bed, and, crossing himself, says the 'Credo' in Siswati.

Everyone takes this performance for granted, just as they take for granted Ruben's shouting to his imaginary wives.

"Bring me Boxer and ten cents matches! Don't forget to give Duma my ten pounds! Do you hear? If you don't send it, I'll send you all to the army." shouts Ruben.

Nobody looks twice at him as they walk past him in the passage.

* * * *

Meanwhile in Dormitory Four, Naftal has called Tension and Enoch to come and share the food with him. Solomon and Philemon have noticed the 'action' through the window and rush in to grab their share. Saki has also come in now and is competing with them for his share of the food.

A number of other patients are gathered outside the window to witness the unusual spectacle. Afterwards David P was heard to remark, "I was so angry. I was so very angry. I wanted to rush in and beat them all for fighting

like that over food. But I just restrained myself because the staff would probably inject me, saying its none of my business."

Saki comes out when the food is finished and says, "The staff must be told about this. This is not the first time this has happened with Naftal", although he himself was involved in the consumption of James' food.

18 { Saki reports the incident to Brown S, who simply says, "That's none of my business. Shadrack must see that responsible patients are given this food to bring up."

But Shadrack does not see this side of it. How is he to know? I feel angry, myself, now, and go down to grab Naftal by his shirt, demanding of him, "Why did you take James' food?"

"He didn't want it. He will get food tomorrow", Naftal answers placidly.

"But you had no right to take it. Its not yours to eat."

Naftal says nothing, but looks at me as if he doesn't understand a word I am saying. A few patients start to chuckle derisively and by now I think I am over-selling myself, so I just leave him and walk out, standing for a while around the corner. I listen self-consciously to hear whether my exit will be greeted by scoffing.. It is not. A few toned down murmurs seem to indicate something of a consensus regarding the appropriateness of my expressed outrage. I walk up through the toilets, feeling rather as if I have in some way asserted some of my own rights as a patient. At least Naftal would not try it with me, if I were ever in James' position. Anyone who now espouses Naftal's action as being in order is potentially open to abuse. I still feel irked by the whole incident 's hollowness.

* * * *

5 p. m.

The bottom gate is rattled. It is a prison staff member from next door bringing seven prisoners up to receive first aid. At this time Enoch S and Benjamin S are giving out constipation and headache-flu potions and pills to a few patients, while Brown S is outside calling patients' names, individually, from a long list of those who have done odd duties and are about to receive tobacco payments. Brown's 'performance' is generally

disapproved. Comments such as "Get a move on!", "What's all this?" and other sarcastic murmurings are in the air, but Brown pays them no heed, giving each man his tobacco with great ceremony.

"What's he think he's doing?" Abraham says to Simon, "handing out tobacco as if it's his own property."

"Ya", Simon agrees, "He's damn stingy but he pretends to be generous with Government tobacco. What does he think we are, a lot of beggars?" A rhetorical question.

* * * *

The prisoners wait outside the medicine room while Mike has a friendly chat to the prison staff. Enoch is pleased to be doing some 'real nursing' and is doing a thorough job of cleaning and disinfecting some very minor scratches which some prisoners have brought to have attended, applying Gentian Violet ointment on the abrasions when the cleaning is over.

* * * *

A few of the prisoners are openly asking for tobacco from patients. They are generally ignored. Ngisane seems to know one of the patients and is talking freely with him. Surrounding prisoners show open interest, surrounding patients guarded interest in this conversation. Tension passes by, ignoring them, smoking. Some prisoners are very adept at learning patients' names. Tension is asked for a smoke, by name, but shakes off the requesters, ignoring them completely, as he walks through.

Joseph says to one requester "How can you ask us for tobacco? How can you ask us for tobacco? Are we not also prisoners? You prisoners get even more than we do, but you still ask us for tobacco, not bringing over any yourselves."

"No. I'm just asking because I forgot my tobacco on the other side", the prisoner explains.

"You better not forget it", Joseph tells him, "and next time you come over don't forget that I also need tobacco and see if you can give as easily as you ask."

"Heyi!" exclaims one of the onlookers to this exchange. "Maja! We

think all these people are mad, but some of them have got more brains than we have."

"Ya," says Joseph, retracking in his steps as he hears this remark. "We are here because they don't give us a trial in court, but you are in jail because you failed to defend yourselves in the law." He walks away before anyone can answer.

* * * *

At the top fence Madevu is collecting some food from his 'girl-friend', who is a patient at the TB hospital (which is about 100 yards away from the top fence, also in some converted barracks.)

"You are just ignoring me these days", she tells him, "I won't give you any more food if you keep on playing dice all the time."

"But Sweetie, you know I love you. When I get out of here I'm going to marry you and take you to my home and make love to you."

"Mnakethu (my brother)" she says, "You are still just mad. I don't think they will ever let you out of this hospital."

"What? They said they will release me next week. Then I'm coming to take you."

Quite a few other patients are at the fence now. Saki says to Madevu, "You will have to share this wife with me. Look I've got nothing."

"You can have my sister", Madevu says and giggles mischievously.

The girl runs away now and Madevu shouts after her. "Don't forget I will come to fetch you! You must be ready."

"All right, love", she shouts back.

"Where are the cattle? We must see the cattle." Some of her companions shout from the TB quarters. Madevu takes the food inside to his dormitory, covers it over with a cloth and puts it under his bed to eat it later when there will be fewer scroungers around, and when he can get some sugar to mix with it.

* * * *

Mike S walks into Dormitory Two and discusses with Sifundza, Moses, Jameson, Madevu and Mbulawa the question of another patient coming in, to fill the bed of one who has been discharged.

"Give us someone from next door, but don't bring anyone in here from those lower two dormitories", says Sifundza.

"I was thinking of Petros or Amos", says Mike (actually he used their surnames.)

"Petros is better", says Sifundza. It is settled.

He is brought in with his blankets and begins to make his bed, a number of these former-mentioned patients watching him.

When he is through, Sifundza says to him, "We are pleased you are here, and we hope that you will behave well. You see in here we want no' homosexuals and no noise-makers. You must sweep when your turn comes. No stealing of tobacco. You must respect the old men, and if we say 'close the door' you must know that trouble begins and someone -usually from outside - will be given the works." (This is more a threat to outsiders who come in - especially friends of Madevu, with whom the latter sometimes 'romances' on the bed, than something which is carried out in practice.)

Petros sits down on his bed, rolls a cigarette and shares it with Sifundza, Moses and Jameson.

* * * *

At 5.20 Benson takes Ephraim out of the Kulukhuthu and leads him around to help bring in the blankets to the 'incontinent' ward - Ward Eight. He is helped by Solomon, Kanyezi, Mkwena and Umfanazana..

* * * *

5.30 Benjamin S and Enoch S remain behind while the rest of the staff troop down to the soccer field with about twenty patients.

Some of the new ones are refused at the gate. Madevu speaks to Sumane to let him go down to the kitchen for a moment. His request is granted and he is off to make a deal with Caiaphas, who will share his food if he brings some sugar. I walk through the kitchen as the deal is being made, having told Mike S that I left my "cloth" in the dining room and wanted to fetch it. Madevu goes out and I manage to scrounge some 'tea' (brown sugar and hot water) off Caiaphas.

'Jumping Jack' stares at me with open hostility throughout the exchange. ('Jumping Jack' is Petros' nickname. I shall use it to avoid confusion with Petros P, now in Ward Two.)

Sergeant Major says "Oh look at this person. He likes to drink tea.

Yebo Baba. Yes, he likes to drink it. He is finished drinking it. Manje ... Yebo, Baba ... Ngiyabonga, ngiyabonga". I shake him by the hand, and, turning to Jumping Jack, say to him "Oh I see everyone is very happy in the kitchen. Next time I come here we'll all have a party together."

Jumping Jack walks up to me and says, "You are not allowed in here. You do not work in the kitchen. I won't let you come in here again."

"O.K. Caiaphas. Thanks, hey. Come and play soccer with us." I say, walking out, thinking to myself, "Boy, oh boy, nobody's going to 'crash' this little clique very easily."

* * * *

Victor, Simon, Petros, Gwayi, Jabulani, James, Fuyaya, Shumayeli, Jackson, Moses (from Dormitory Two), Sigidla, Moses (from the kitchen), Phillip, Edward, Pilato, Josiah, Bungane, Durban, Joseph, Danger, Abraham, Petros, and Madevu are in a line with staff members Sumane, Mike, Benson and Brown. Also running onto the field now are Titus S, a kitchen staff, and Moses, Duma, Bongane and Michael, other staff members not on duty today. Joining us also are two small sons of Shadrack, and Jameson and Dlangamandla, two TB staff (who are also official members of the Matsapha Soccer Club.)

They all line up and Sumane counts, "One, two, one two; one two; one two; ... " down the line, dividing all present into two teams. At this stage I run onto the field, Caiaphas walking on also, behind me.

"He's coming! He's coming! He must play with us", says Pilato. My heart beats with secret joy that Pilato should thus acknowledge me as a friend in front of everyone.

The play begins. Shadrack and Albert watch from the side. Although a soccer player, Albert has told me that he will not play as long as he is a patient.

I am not much of a soccer player myself, having no foot-control over the ball, but at this stage I am still fairly fit and manage to make a few breaks by kicking hard and running hard, rather than by dribbling my way over the field and passing back and forth to other players. I rush at Sumane who is dribbling down-field and by a fluke manage to get the ball away from him and kick it as hard as I can to an empty space of field. As I run after it Moses P shouts

"Wind away!" which afterwards became my nickname (though in later days, as a member of staff, I was not sure whether this didn't apply to my constant exhaustion on the field.) It was Moses, the kitchen-worker who gave most of the players their nicknames. 'Pilato' was one; 'Usatile, zinduna zilambile' applied to Titus the kitchen staff (who had a powerful kick which nobody else could match during a game). It means "You are satisfied (with food) but the other chiefs (i.e. staff) are hungry."

* * * *

Before I was admitted as a patient, Joshua reported to me that Caiaphas and Durban had said to him one day "The staff should let the patients play soccer, then they would be able to see who was mad and who was not, and discharge the better ones." Staff and patient soccer was thus a newly-introduced thing. Most of the patients were good, some very good soccer players, well up to, and exceeding, in some cases, the expertise of the staff.

* * * *

All tensions vanish on the soccer field. Formal patient-staff social restraints are lost in the enjoyment of the game. Soccer-days leave me calm and relaxed. Non-soccer-days leave me disgruntled and frustrated.

* * * *

Back at the ward Makhoyana, Abraham, Sigidla and Wilson are watching the play through the wire fence.

* * * *

In the staff room, Enoch and Benjamin are writing separate 'day' reports - one for the Ministry, one for the Hospital.

"Who else was injected today? Oh yes, James."

"Yes. James" Both write - "James still confused. Care given".

"Ephraim troublesome. Locked in the security block."

* * * *

Jacob has been given some rubbish to throw into the rubbish bin. He takes it and throws it in. Mangisi goes over to the rubbish bin and searches through its contents.

* * * *

Captain has just put Majelimane in his room and covered him with

a blanket for the night. He walks through the toilets and looks into the window of Dormitory Two, as he enters Block A. He sees Makhanya and decides to go in and talk to him.

Makhanya is an old man, like himself. He addresses him respectfully and says to him "Thokoya endaweni" meaning "I hope you will be happy, here, in this place."

Makhanya tells him about the spirit which he had and says that he should be treated by witchdoctors rather than the hospital.

Elias joins them and they discuss about their homes, how cattle, goats and fowls are raised, and about their wives.

* * * *

6 p.m.

All the dormitories are quiet.

Alfred, looking for something to do, comes into Dormitory Five and says to Dlozi "What were you doing with Saki?"

"Nothing, Alfred, man."

"Why do you always beat this boy?" Dingaen asks from across the room.

"He is my wife. I have a right to beat him," Alfred replies.

The remark raises a few laughs.

* * * *

In Dormitory Three, Abdal, who has just finished sweeping, sits on his bed and says his prayers.

"Look after the people who are suffering here, My Lord, My Lord

"And those who travel in aeroplanes, My Lord, My Lord

"And those who come from Durban, My Lord, My Lord

"And those who ride on bicycles, My Lord, My Lord"

* * * *

Red Indian sleeps in his corner bed; Pencil sits on his, talking quietly to himself; Rub-a-dub is sitting on his bed rubbing his legs and talking to himself; Johannes has just come in from a shower and is standing at the side of his bed while the water drips off him.

* * * *

Abraham, Wilson, Mbulawa, Gideon and Makoyana are all sitting together, talking with Mike S, Benjamin S and Brown S. Albert P walks across the yard, playing his mouth organ, and joins the group.

Ray walks past and says to Albert "Let me play it."

Albert politely refuses him.

After a short discussion about Ray being a nuisance Albert begins playing "Jesu wami usaphila". The rest join in, singing and humming, staff and patients alike. Shumayeli, who has also joined the group tells Saki to "Shut up" when the latter asks Albert to play a traditional dance song, "because yesterday was Sunday and we had no Church."

Minutes later Edward appears with a book in his hand and begins preaching about repenting. "Kholwani. Jikisani izinhlizio yenu bkekisa ku Jesu ngoba usuku lokuya kwakhe asikwazi (You must all believe. Turn your hearts about and give yourselves to Jesus so that he will know you in the coming darkness . . .")

Shumayeli takes the book himself and begins preaching. Soon the singing fades and Edward, taking his book back from Shumayeli, walks away. Albert begins to play a tribal dance on his mouth organ. Shumayeli continues to preach, emphasizing the fact that Sundays must be kept holy. Ray begins complaining about having to sleep in the Kulukhuthu, but Wilson and Shumayeli tell him that it is "serving him right".

"It is ten to seven", says Mike, looking at his watch and telling the small group to go to their sleeping quarters, because "It is time to count". They all disperse, getting up slowly and moving away in two's and three's.

* * * *

Jacob comes out of Dormitory Two and says to Benson S "Oh, wakits! (our one) I like pineapples." (Tomorrow the Red Cross ladies will come to the hospital and give out pineapples to all the patients.)

* * * *

Enoch P stops Albert, as he walks to his dormitory, and asks him for a light.

"You must come in now". Mike S says to him.

"Yes I am just getting a light", he answers.

Albert has a cigarette lighter and can therefore always be relied on to light one's cigarette.

* * * *

Enoch walks back into Block A, and, just before he gets through the gate, he throws back his head and gives out with one of his 'delightful' peals of laughter, then carries on walking.

"Heyi wena", says Jacob who is standing in the corridor. He laughs with Enoch and grabs hold of his arm, to share the laughter with him.

Enoch gives him one tremendous 'belt' across the ear and carries on walking to his dormitory, as if nothing had happened, - preserving his solitude.

Jacobs howls with pain and runs to his dormitory stamping his foot in rage. The other patients decide to bear his howls in silence. Only Moses P comments, "Heyi, this boy! One minute he's laughing, next minute he's in tears."

* * * *

(The above incident reminds me about an incident involving a young feeble-minded patient in Hospital C. I commented to a hardened old institutionalised patient how this new patient brought new life to the ward.

"He won't last long", I was told, resignedly. "You wait another few months. A punch here, a slap there. He'll soon be like everyone else, sitting around by himself not saying a word to anyone.")

* * * *

Benson and Sumane finish their counting. All present and correct. No escapes. No new patients. Aaron is back, however, and this must be recorded.

* * * *

7 p.m.

Back in my dormitory (Five), Aaron is sitting on his bed smiling broadly and telling of his experiences outside, that day. Everyone else is settled down in his own bed expecting to be entertained. The reason he is back is that he could get no transport, nor could any be hired for him, by using Government funds. Once discharged a patient is no longer Government responsibility. He will have to remain until a patient is brought in by the police from his area. Then he will be given a free lift back in the police van.

* * * *

Night-staff on tonight: Michael, Aloysius, Moses and Nene. Michael seems a little intoxicated, but it's hard to tell since he always speaks in a slow drawl, a smile playing on his face, his eyelids drooping.

Michael and Nene are doing the rounds, counting. (A night-shift count always follows a day-shift count.) They walk around the beds looking at each patient and greeting him as they go by.

"Oh Aaron, are you back again? What happened?" asks Nene.

"No. There was no bus for me", Aaron answers.

"I see, yes. You must wait for a police van to come and take you home."

"Ya. They will fetch me."

"Well at least you are lucky you are not a patient any more. Just a visitor," says Michael.

"Too mush! (that is, 'too much'; that is 'very lucky!')" he answers.

* * * *

"Yebo, Dlozi".

"Yebo".

* * * *

It is as if each patient is waiting his turn to be greeted now. The whole thing looks like an artificial performance. These are the most gratuitously exchanged greetings of the day. Each patient seems to be acting out at least five times his usual responsiveness. They lean forward. They smile as if pleased and honoured by these encounters. As soon as the staff members have passed, a look of resignation returns to their faces and bodies.

* * * *

"So Israel, are you still here? I thought they were going to discharge you today?"

"I wish they would. I'm ready to go now. I'm tired of this place. I think they must discharge me soon. I'm here nearly two months already and I don't see how they can still keep me since I'm not sick any more."

"Yes, well, you must just wait till the doctor can see you", answers Nene.

* * * *

"Hello, Mr. Caiaphas".

"Yes, Caiaphas, I don't think you'll be long here either. "

"I'm trying to see the doctor, but they seem purposely to pass me by each time. "

"He'll see you next time. Don't worry. "

"I hope so. "

* * * *

"Hello, Mr. Stan", says Michael to me.

I feel myself stiffen. The tension is real. It is my turn now. My special moment of attention!

Myself: "Hello, hello. How are things? How are things?"

Michael: "Oh, same as always", I nod three, four times. (Same as always, I think to myself. Oh how I long for that 'always' of yours. How precious that 'sameness' of your life feels to me now.)

Nene looks at his list. "Hello Mr. Charles", he says to me (My names are Stanley Charles. No-one ever attempts my surname.) "How are you enjoying the hospitality of the hospital?" he asks (showing off his knowledge of English.)

"It could be worse", I answer. They pass on. "I tell you what", I say to Nene, calling him back, but feeling by now that I've really missed my cue, "I'm learning the patience of a patient. "

He doesn't get me! It's useless. Why didn't I just keep quiet?

"You mean you're learning to be a patient?" Mike asks me. (Do they know I'm not a real patient? Do they think my whole 'being' here is just an act? a pretense?) I shrug my shoulders and open out my hands, thinking at the same time how "Jewish" this gesture must appear - in a stereotypical sense - remembering in my mind's eye Sartre's essay on 'Authentic and inauthentic man', and my feeling of having been betrayed and scandalised by his conclusion.

". . . . This is naturally interpreted as meaning that the Jew does not sincerely desire to be assimilated and that, behind a feigned adaptability, there is concealed a deliberate and conscious attachment to the traditions of his race. The truth is exactly the contrary: it is because he is never accepted as a man, but always and everywhere as the Jew that the Jew is unassimilable." (Sartre, 1948)

Unassimilable! Unassimilable! Damn you, Sartre! You're a bloody Judas! You've betrayed your fellow man! I remember thinking all this at the time. The thought hits me again now. Was it Sartre's purpose to 'nauseate' his readers by this conclusion? I can never be 'cool' when I think of this essay. It's the same loss of 'cool' I feel now with Michael's questioning remark. Or was he just trying to paraphrase my remark?

* * * *

They pass on.

"Yebo mnumzana", says 'Pilato' as he is greeted, rocking back and forwards on his bed, holding his knees, smiling, his eyes lowered,

"Poor little bugger", I think to myself.

* * * *

"Oh, Sergeant Major."

"Yebo. Sergeant Major. Mm! Mn!" Michael returns his salute, jokingly.

* * * *

"King George - Jo'burg. Underground". They have not greeted Siqobolo, who lies back in his bed ignoring them.

"Ya! i Golide (gold), Underground!" says King George, laughing, in reply.

* * * *

They pass on quickly now. Too much time is being spent in this dormitory. Both count quickly "14?" "14" They walk out.

* * * *

There are seven people sleeping in the Kulukhuthu tonight. This is not really punishment; just shortage of beds. Gwayi is down in Dormitory Four. Otherwise the sleeping arrangements are the same as last night. (But two people have left the hospital? Oh yes. Linford has been given a bed now in Dormitory One.) Phopho, Ray and Vusmuzi are sleeping alone. Jabulani and Zondo share a cell.

* * * *

"Aaron is back", Saki announces to Nene and Mike, as they enter through the door of his dormitory.

"Yes, he's back", says Mike, without explanation.

"Kuncono (that is better). . . . How can he go, when I must stay here?"

Zamfumf laughs from the corner. "They won't let you out because you are still mad." he shouts.

"Zamfumf, you are very foolish", Nene says to him.

Saki looks at Zamfumf, then at Michael and Nene. Michael shakes his head incredulously "Hey man! That Zamfumf is another chap", he says.

They begin counting. Maceda walks up to Michael with the butt of a cigarette.

"Bhemisa! (Give me a light)", he says.

"Wait, Maceda", says Michael, trying to count.

"Bhemisa, man! Wenzani? (What are you doing?). Bhemisa, kuphina metshis wakho?" Macedo advances on Michael demanding a light in an angry voice, then stopping in front of him and laughing as if it is all a terrific joke.

Michael can't restrain himself. He, too, begins laughing, as he takes out his matches. "Oh, Maceda! How can we teach you manners?" He lights Maceda's 'smoke' and the latter simply turns around and walks off.

"Maceda! Bonga!" Mike shouts at him ("Praise", i.e. "say 'thank-you'.")

"Ngiyabonga. Ngibemisiwe, kumemezwe", he mumbles, laughing. (Thank you. I am lit up, now he shouts at me.)

"Come. 17" says Nene and they walk out together.

* * * *

How can the night-staff afford to be so friendly? I muse. Oh yes, I see. Very little contact. No need to pressurize or persuade anyone to follow certain lines of conduct. No possibility of being pestered to make contact with the doctor on behalf of patients. Gates locked, pills eaten, doctors off duty; a long eventless night ahead. I sigh.

Albert, who only returns at night, shows a similar degree of friendliness on his return to contact with the patient world. There is a knock at his door.

"Ngena (come in)", he says.

It is Pilato, with a piece of paper in his hand. He comes in and kneels

on the floor as Albert gets out his tobacco bag.

"All right, sit on the bed", Albert says to him.

He does, his hands rubbing his knees in eager anticipation and nervousness. Albert rolls his cigarette. Pilato reaches out to take it, but Albert takes out his lighter and lights it for him. Pilato again rubs his knees, smiling nervously. Albert hands this cigarette to him. Pilato's face is suddenly serious. He takes the cigarette and draws on it two or three times, watching the end. Seeing it is alight, he gets up to go outside, saying "Ngiyabonga. Enkosi." (Thank you, Thank you.) But Albert restrains him.

"Wait, our young man", he says, "sit down for a bit. You mustn't be in such a hurry."

Pilato sits down. "Do you want some cheese?" Albert asks him.

"Yebo mnunzana (Yes, sir)." He takes a piece, which Albert cuts from a larger piece, wrapped in some newspaper.

Albert lights up, himself. "How many goals did you score today?"

"Two goals".

"Yes. You know how to play."

"Yes, sir."

They sit for a long time without talking.

"All right, Pilato", says Albert.

"Yebo, enkosi", says Pilato, and, crouching, he walks quickly out of the door, strides across to his bed, looking neither left nor right as he walks across the floor, and climbs in, under his blankets. He sits, smoking, looking down at his blankets. No-one asks him for a smoke.

* * * *

In Dormitory Four Ruben and Ninevah pass a few comments to one another, as they sit in adjacent beds, smoking. Durban is sitting with a box of matches and a blade, cutting each match, lengthwise, into four matches.

* * * *

In Dormitory Three, Tension smokes in bed. Enoch walks in from the toilets and lies down. In Dormitory One, Abraham is writing a letter home. Everyone else is lying quietly, eyes closed, or looking at the ceiling.

* * * *

8 p.m.

Caiaphas calls Sergeant-Major over to his bed, offering him some tobacco.

I ask him "Sergeant Major, what is a 'man' in Italian?"

"Signor, baba."

"And water?"

"Aqua. Aqua pura, baba."

"And how do you say 'Good evening'?"

"Bona sierra, signor, baba."

Godolwendlovu was in the last war and was stationed in Italy. He seems to have retained quite a substantial vocabulary of Italian words. My own knowledge of Italian is now exhausted.

"What did you get when you were in the army, Sergeant Major?"

Caiaphas asks him, winking at me.

"Ukudla, namahala; na-kofu, namahala; naswekile, namahala; na-tamatis, namahala; na mahewu, namahala" ... (Namahala means "for free" - each article is followed by the qualification 'free' or 'for nothing'.)

Caiaphas begins to say "namahala" with Sergeant Major each time, Sergeant Major answers him "Mm-mm, namahala". Caiaphas seems to feel he has something going with Godolwendlovu. This is a sort of a 'show' he is putting on for Israel and I. Caiaphas is laughing. Israel looks at Godolwendlovu with what appears to be an expression of pity on his face. Pilato is under his blankets facing the other way.

* * * *

Ray begins to shake the door of his cell in the Kulukhuthu and to shout for the nurses. Aloysius S goes out to ask him what he wants.

"I want to go to the lavatory. Why must I shit in this bucket and sleep next to it all night if you are not punishing me?" he whines.

"All right. Yes, you are quite right. You can use the one here." The door is opened. He walks down to the lavatory at the end of the passage.

"Hey wena, poyisa", Popho says to Aloysius, as he passes the former's cell. "Switch off the light in this passage. I can't sleep."

Aloysius has granted the first request. The second, too, sounds

reasonable. "All right, I'll switch it off." He waits for Ray and then leads him back to his cell.

"Why don't you leave my door unlocked so I can go to the toilet when I want to?"

"No. I can't do that. I've just told Phopho I'll switch off the lights and we won't be able to see what's going on if the doors are open and the light is off." (The Kulukhuthu is situated opposite the staff-room window.)

"I'll kick this door down if you lock me in here."

"Listen. Don't start to be troublesome. If you start to be troublesome I'll have to give you an injection."

"I'll hit you", says Ray as he is locked inside, "before you try to inject me."

"I wouldn't advise you to try it. I'm a boxing champion", Aloysius tells him.

Ray is a youngster of about eighteen years, still at school. Aloysius takes his threats lightly. Furthermore Ray is a new patient.

"I'm not scared of you."

"Come on, Ray, man. Take it easy. You've done what you wanted, now what more do you want?"

"I want to leave this hospital. I want to see Father Allard (a teacher at his school)."

"How can you go out? You are still sick. When the doctor sees you are well he will let you go."

"I'm all right. I want to go tomorrow to see Father Allard."

"Well I'm leaving you now. I'm going to switch off the light."

"Give me some matches."

"Have you got a cigarette? I can only give you a light."

"Yes. I've got a cigarette."

"All right. Wait. I'll get some matches."

He goes down to the window and says to the nurses inside, "Have you got any matches?"

"Here you are". Moses hands him a box.

He lights Ray's cigarette.

"Nqiyabonga Sibali". (Thank you my 'swaar', that is 'brother-in-law' - a colloquialism).

"Lungile". Aloysius walks off.

"Give me a smoke my brother", says Jabulani, putting his hand through the bars of his door.

"Cha, Suka", (Get away) Ray says to him and sits down to enjoy his smoke. Jabulani withdraws his hand and is quiet. Zondo begins to sing "Yodelayee. Yodelayee", (something he did the night before last also). He carries on for about an hour. No-one comments or tries to stop him. Vusmuzi is fast asleep, still groggy from his "overdose" (staff slang for a large injection of Largactal.)

* * * *

Nene gets up to do a round. All is quiet in Ward One. Only young Petrus and Wilson are sitting up. Petrus is sharing a cigarette with Wilson and is sitting on the latter's bed. Wards Two and Three are quiet. Nene shines his torch around the rooms, rather than switch on the light. Tension gets up and goes out to the toilet.

* * * *

In Ward Five the light is on. Aaron is reminiscing about his past life. How it was in prison. How some people escaped. It is quite fascinating - especially since no-one ever talks as a rule in our dormitory (except to themselves - Sergeant Major, Siqobolo, Marabi, John). Even Godolwendlovu is quiet and listening. The speaker is urged on with "uh huh's" Little else in the way of back-chat occurs. Occasionally Aaron is quiet, and says "Too mush".

He begins to talk about some Europeans. Caiaphas looks at me to see if I am listening, and says, very quickly, "Tu-tu-tu-tu". ('Tu' means 'Tula' or 'be quiet'). Aaron stops. I sigh, and get under the blankets, feeling dispirited that my presence is so felt to intrude. It was simply out of politeness to me. The conversation bore no trace of racial antagonism. Oh, well! What is there to say?

* * * *

Albert is sitting on the bed in his private room singing a hymn to himself.

* * * *

Nene walks into one of the double rooms, one which Daniel shares with Moses, the kitchen worker. He wakes Daniel up and makes him take off his uniform. Daniel climbs back into bed again, now naked.

* * * *

Down in Dormitory Eight, Nene finds Solomon singing a hymn to himself. Next to him, in a separate set of blankets, is Ephraim, fast asleep; next to Ephraim, Mkwena has no blanket covering him.

Nene goes over to Mangisi's bed, takes one of his blankets and scolds him, "Hey! Mangisi, don't take this boy's blanket do you hear?"

"A! ya! ya! ya!" (or some similar growl) is emitted by Mangisi, who pulls his remaining blanket over him and goes to sleep.

* * * *

9 p.m.

Aaron's monologue has turned to his own life history. How he has always been in trouble even from the age of a small boy. How he had killed the neighbours' fowls and his mother had taken him to a Zionist priest to cure him. He has been talking for over an hour - a person who had never done so before in the dormitory! Moreover, what he was saying, is, surprisingly, public conversation. Without exception everyone is listening to him.

Saki comes in to look for a light. The conversation lulls. All eyes are on the intruder. He goes out again.

* * * *

In Dormitory One, Wilson and Abraham are talking about girls. The conversation turns to the terrible acne on Wilson's face. Abraham suggests he ask the nurses for ointment to put on it. Wilson agrees he'll do it tomorrow. Only Danger is smoking.

* * * *

In Dormitory Two, Joseph-the-Dreamer and Moses are lit up and smoking together. Joseph is talking about building dams, saying that he even

has a book about it and, if the Government would let him, he would like to build a dam and start farming.

Sifundza says "Hah! ... Do you think the Government can give all the materials to you, so you can have a farm to yourself?"

Elias who had been listening (and seemed to have been taken in by Joseph's scheme up till now) begins to talk about farming and brewing beer. He complains that this is not a good hospital since it gives no-one 'utywala', not even at weekends.

Jameson laughs, saying "You know Dlamini's all like to drink utywala. When they die they even put them in a sitting position, and place a big pot of utshwala in front of them and put them in a cave."

Elias' face is stern at first. He breaks into a smile, however, when everyone else bursts out laughing at Jameson's tale and says "Jameson likes to talk nonsense." He laughs also, realising the joke is on himself, and wishing to laugh off its implications.

Makhanya goes over to ask Joseph for a match. He hands him the box of matches - a real extravagance in the hospital, since Joseph is smoking himself. Joseph arrived at the hospital with nearly R3 in his pocket, and so is able to get the nurses to buy him private matches. (Tobacco is handed out every second day to everyone. No matches are ever handed out. Apart from buying matches with private income, personal jobs for staff are sometimes paid for with a box of matches. Alternatively, Red Cross pineapples are sold to staff, instead of eaten, and the proceeds are used to buy matches.)

* * * *

All the other dormitories are quiet and their occupants asleep. Only Ruben, in Four, is talking to himself, saying "This woman is unfaithful to me. She must be punished. I must bewitch her."

* * * *

In Dormitory Eight, Mangisi gets up, goes over to Mkwena's bed and steals his blanket from him again. Mkwena does not protest. He just curls up on his remaining blanket to try to keep warm. Mangisi gets under both blankets.

* * * *

Outside, in Kulukhuthu, Ray is banging on the door of his cell.
"All right, I'll go", says Moses.

He switches on the light. Ray says to him, "I am not sleeping,
I want pills."

Moses gets him some sedatives and gives them to him with water.

* * * *

Michael S is in Albert's room, on another bed there (which has no mattress). He is asleep on the springs. Moses S and Aloysius S walk over to Albert's room to chat with him. Albert, who has been reading, now switches on his wireless, and, seating the others, begins the conversation by saying that he missed Aloysius today. (The latter often comes to chat with him on off-days, and, when on night shift, during the day-time.) Aloysius replies that he was in Manzini that day. Manzini becomes a topic of conversation - how it was there today, the market, food prices and so on.

* * * *

Nene is in the staff room, reading a 'Time' magazine - one of those left by the Red Cross women.

* * * *

10 p.m.

Uneventful. Everyone is asleep. Michael S is asleep. Aloysius, Moses and Albert are still chatting.

* * * *

11 p.m.

Maceda gets out of bed, puts on his uniform and walks along to Albert's room. He opens the door, without knocking, and addresses everyone. "I want tobacco."

"Voetsek!" Moses S shouts at him, getting up as if to clout him one. Maceda closes the door, walks outside and across the yard. He looks in the window of Dormitory Four, but finds no-one smoking there. He goes up to the windows of Dormitory Two, where Joseph P gives him a light.

* * * *

Nene gets up to do the rounds.

In Dormitory One, he is asked by Wilson to give him some pills as

he cannot sleep. He walks to the medicine room, Wilson following him. He gives Wilson two sedatives.

* * * *

Down in Dormitory Four, Nene shives his torch around the room, walks over to Stephan's bed and uncovers his head (it was covered by a blanket). James wakes up. He is still groggy from his injection of the afternoon. He begins to urinate next to his bed. Nene takes him by the arm and leads him to the lavatory. Then he leads him back to his bed again.

* * * * *

CHAPTER X : A DAY IN THE STAFF 'UNIVERSE'.

Some Preliminary Notes and Impressions:

The so-called 'Bachelor quarters', where we stayed, housed twelve out of the nineteen permanent staff members. Although four of the men were married, they had voluntarily chosen not to live permanently with their wives, for reasons apparently concerned with ownership of property elsewhere (private farms tilled by their wives) or because their wives worked in town.

Nene, a night-staff worker used to stay in Mbabane with his wife and children on his off-days. (The night staff work four days on, two off; whereas the day staff work three days on, one off.) He stayed at Matsapha during the other days, but sometimes went into town even on these days - the trip taking about one and a half to two hours by bus. His closest friendship tie was with Shadrack, the kitchen worker, the two of them being 'drinking-buddies', consuming mainly 'jabulani' - a drink made both by a local factory, and commonly known as 'Shake-Shake", and also brewed locally by many private homes and sold (legally) in backyards.

Michael was not a permanent resident, but would quite often sleep over at the bachelor quarters in Sumane's room. He lived quite close by - between Matsapha and Manzini - and also had friends in Manzini where he would stay overnight occasionally. (I have not included him among the twelve.)

* * * *

The bachelor quarters, themselves, were in a long building made of asbestos, with iron windows and wooden floors. Each room had its own basin, a built-in cupboard and a bed-plus-mattress. Nurses had to provide their own blankets, towels, curtains, soap and food, and any additional furniture such as tables and chairs which they might wish to have in their rooms. At the end of the long passage, from which twentysix doors led off into twentyfour rooms and two 'kitchens', there was a communal toilet with two wash-basins, a urinal, two laundry basins, two bath-tubs and two showers. None of the rooms were empty. Those not occupied by mental hospital staff were occupied by TB hospital staff. I myself stayed in the fifth room on the right of the passage with Sumane and 'Super-Rose' (a TB nurse) on either side of me. The two rooms

opposite me were occupied by 'Daddy' (an old man and TB nurse who did not mind being called 'Daddy', but objected strongly to any allusions to his being an 'old man'), and Mandla (a TB worker and veteran pot-smoker, sociable joker and good soccer player) whose favourite pastime in the evenings was to place his chair in his doorway and chat to passers-by, his radio blaring music, news and information-cum-propoganda from Dar-es-Salaam.

* * * *

Start of the day:

5.30 a.m.

It is five-thirty, Thursday morning. I hear a door slam closed, and 'tackies' (tennis shoes) squeaking down the passage. Thoughts are tumbling down through my mind in the hazy half-consciousness/half dream of the waking state.

"Sumane! Bongane!" Knock-knock! Knock-knock! "are you awake? Are you ready?"

"O.K. Just wait."

"I'll be with you now."

I wish I could get up, but I am so tired. I know they are going to train for soccer this morning. They are going for a run, but I just can't climb out of bed to join them. I wish Moses would knock at my door, but he probably thinks I'm not interested, since I haven't been to the last two soccer practices. I wish he'd just pop his head in and say "Come on. I thought you were going to run with us", then he'd shame me into getting up; but I'm so tired, so lazy!

"Is Bongane (Aloysius) coming?" Moses asks Sumane, as the latter runs out onto the road (to join the former there). "Yes. He says to wait for him. He's just going to get his vest off the line."

Moses and Sumane are running-on-the-spot.

"O.K! Lets go!" Aloysius runs out and the three are off together.

"Isn't Stan coming with us?"

"No. He must still be sleeping."

Wait! I jump up. I open the window to call after them. I run down

the passage to see if I can catch them before they run around the corner. Too late. They're nearly at the gate already. Damn this indecision of mine! It's all this watching, all this passivity and observation, falling short of full participation and involvement; yet I can't afford to participate fully, since that would make me too critical of many existing measures. I can't afford to try and change things while I am trying to understand 'this side' of the hospital community, whose control and judgement I have thus far been subject to as a patient. Not asserting myself in the nursing sphere, I feel I have become too passive as a person in other spheres also. It is a vicious circle. I get back into bed, thinking about the smooth texture of the sheets, after having slept so long without them as a patient; and I immediately fall asleep.

* * * *

6.15 Enoch knocks at my door. (Enoch wets the tea in the morning, Moses cooks the lunch and I prepare the evening meal for the three of us.) "Tea time".

"O.K. thanks! "

I wake up slowly. Next door 'Super-Rose' has his radio on full blast. (The Everly Brothers are singing an 'oldie' entitled "Dream, dream, dream" or "All I have to do is dream", or something, an old favourite of by-gone days and quite popular these days on Swaziland Radio.

* * * *

"These bloody people have got no consideration. Don't they think someone might like to sleep in the early hours of the morning. I can't understand it. Why must they turn their radios up full-blast?" This was a comment a friend of mine from Cape Town made when he spent a night in my room.

"You're absolutely wrong", I remember telling him. "I can't tell you how much I appreciate these radios. It shows a tremendous consideration for anyone who wants to put his radio up full blast. You know that no-one on earth is going to stop you turning up some music if you want to listen to it. You may be right if you say there's no consideration for someone else's hangover or insomnia, but in this long narrow passage I want to tell you

everyone's got room to breathe and to be his own man, and nobody treads on your feet or carries on about anyone else's 'insensitivity' or any such artificiality."

My tirade seemed to have taken him aback somewhat. He mumbled something about "lack of awareness" and "only education can teach people the true worth of other people's feelings."

* * * *

Remembering this now, I step out of the shower, smiling to myself. Suddenly the door swings open and Duma (mental staff) and Jameson (TB staff) burst in, almost simultaneously. They are both laughing. Down the passage, 'Timer' (TB staff), the barracks humorist, is saying something like "From what sort of thing did your mother manage to pop out such a 'moegoe' (square, dullard)?" (which sounds terribly funny in Siswati), followed by "Who can know such joy who has never been a mother?" - an idiomatic expression used exclusively by older women who have already given birth to children. The two of them are doubled up with laughter.

Duma says to me in English. "Oh, Stanley man, you are laughing here all by yourself." It is neither a question nor an accusation.

A little embarrassed, I answer, "Yeah. That's great, isn't it?"

"What do you mean, Stanley man? Are you happy because you are no longer a patient?"

"No. Actually I'm thinking of something else."

"There it is, yes, man. You are thinking too much and reading, and you are still happy". ('Too much' means colloquially 'a lot' or 'very much', but I take it that he probably is upbraiding me, in a way, for isolating myself from the rest, through my incessant reading.)

"O.K. See you later". I wrap the towel around my waist, put on my slops and walk down to my bedroom, soap and scrubbing-stone in my hand. "How 'sensitively' put", I think to myself. Something else is worrying me. Jameson stopped laughing too soon for my liking. He walked across to the toilet without greeting me. What's wrong with this bugger? I'm going to loosen him up with a little hard tackling in the next soccer practice. I'm going to 'pressure' him.

* * * *

Benson's (permanent) girl friend, whom he intends to marry some time in the future when he can afford it, comes out of his room. She passes me on the way to the toilets with a cloth rolled up in her hand. Her eyes are downcast as befits a Swazi lady in the presence of a strange man. Her little son follows her, crying mournfully, big liquid tears filling his eyes. I stop next to him and he stops crying.

"Sawubona mtwana'm", I say to him.

"Good morning", he says, and holds out his little hand, to shake mine.

"Hawu, Benson", I call to his father, "indodana yakhe igentleman impela!"

Benson comes to the door in his shorts and vest. "Yes we are teaching him." He looks at his son, shakes his head and says to him "How are you?"

"I'm fine thank you."

He laughs. "He's very clever," he says to me, "You only need to tell him something once and he remembers it."

"Who is this, Michael?"

Silence.

"Who is this?"

Silence.

"Igama lakhe ngu Stanley."

"Stanley".

"Nantsko ke! (There you are!)"

* * * *

I pass the kitchen and Enoch says to me, "Your tea's getting cold."

"That's Okay. I'll be with you now. As long as it still tastes like tea, I don't mind if its cold."

* * * *

I dress and comb my hair and beard. Moses walks past the door. "Now I'm going to sleep", he says to me.

"Moses! You must call me next time you go running."

"Did you want to come? I thought you were asleep?"

"Well, you know how it is. I don't know how you manage to wake up, but just come and give me a shout next time you go."

"No, fine. I'll give you a shout next time."

"How far did you get?"

"We went right to Manzini, Stanley."

"Jeez. Aren't you dead?"

"Underground!" he says, in imitation of King George, "I'm going to sleep the rest of the morning."

"Well, have some tea first. Enoch's just made it."

"Oh, good. Thanks."

* * * *

I go into the kitchen and sit down with Enoch.

"Where's your fiance?" I ask.

"No man, she went to see her relatives. An aunt of hers has died and now everyone must get together to bury her. Hayi, uhuh! Too much troubles! One thing after another. We just buried this uncle of mine and now it's her aunt."

"What do they say? If you gotta go, you gotta go", I crack weakly. To change the subject I say, "Do you think you can trust this girl of yours?"

"Oh yes. She's a good girl, and beautiful too. I'm not so young, you know. I've had lots of girls. I lived in Johannesburg for twelve years, but I'll never marry a girl from the city."

"You think they can't be trusted?"

"City girls are good for a good-time, but when you're married you want to settle down and build a home. A girl who is used to a good time will never settle down. They always want to keep moving. If you get a good girl from the country, she will settle down and you know when you go home she's there, not running around looking for excitement."

"Yes, but you're still taking a chance. Don't you think she'll start wondering what she's been missing?"

"Well ... I'll have to take care of that. You must keep them busy, then they don't start to look outside."

"Then you'll have to make some children quickly."

"I've already got one child. A son. Didn't I tell you? He's six years old."

"What? And you think she's going to settle down when she sees how you've been playing around, yourself, before marriage?"

"No. That's all finished now. I've got the right wife. What do you think I paid the mother for this child?"

"No. I couldn't even begin to guess."

"Six cattle! Don't you think it's too much?"

"For a human being? How can that be? No, I'm sorry. But actually, you know, I can't really say. I suppose it depends on the mother - how much she loves the child and so on. But this is something I'm not used to. We must discuss some more about this."

* * * *

Aloysius and Sumane walked past from the showers, to get ready for work, a moment ago. Now Moses walks in, dressed in pyjamas and slippers, and sits down on a box to have his tea. I notice a certain strained atmosphere between Enoch and Moses. I wonder what is going on between them. Mike walks past on his way to work, and Enoch excuses himself to fetch his jacket. I go to get mine too. We walk along just behind Mike. The prison training staff 'squad' has just fallen in for their early morning parade drill.

* * * *

7 a.m.

We arrive at the gate just as Nene and Bingo walk up to go out.

"Oh, Mister Stan", says Bingo, laughing boyishly.

He seems to be making a show of his continuing incredulity at what I am doing at the hospital. I decide to be taken in by his performance, since I cannot see any ulterior motive behind it. He has what appears, at first sight, to be a particularly appealing 'country-boy' approach to life and his fellows, open-hearted, frank and entirely unsophisticated. Yet he is not too popular among the male staff. He stays away from the hospital with his family most of the time, although he does have a room in the male 'barracks' and farms the plot of ground just outside the barracks. He is more apt than most to be referred to as a 'gayisa' (a term commonly applied to the type of migrant worker who has returned for the first time from working on the mines and who likes to deck himself out in certain tribal adaptations of western

dress such as, for example, a highly coloured scarf tied around the head under a stetson-like black hat, who strides along the street in the prime of his young manhood, a 'nouveau riche' celebrating his rite-de-passage through his initiation into city life.) That the term was felt by himself to be uncomfortably close to the mark, was made evident by his joking threats to those who referred to him as such. He once said to me "I'm sure Mr. Khasa doesn't like me. Yes, man. Look how long I have been working here and he doesn't give me a promotion."

* * * *

At the side of the gate is Sigedla P, looking out at us. Daniel P walks slowly up to the gate, turns around and walks slowly back again.

* * * *

Bingo walks out of the gate, talking as he goes. I hold up my hand, cupped, to indicate that he is walking off with the keys. "Oh", he says, laughing, his face showing great surprise. Sumane and Aloysius round the corner, followed by Benjamin, who has been running to catch up to them.

"You mustn't tire yourself so soon, you still have whole day to go", Bingo teases him.

Benjamin laughs. "No; I just want to get through the gate before it is locked", he explains.

"Cheerio", I call to Bingo just to end off a fumbling over-gestured meeting.

"Bye-bye", he calls back to me and walks on slowly to give Nene a change to catch up to him. The latter is talking to Enoch saying how Sigedla had annoyed them last night, by banging doors.

Enoch: "Why didn't you inject him."

Nene: "He's a strong bugger, man. I'm scared to tackle him."

Enoch: "You people are playing. If I were you I would have knocked 200 ml (Largactal) into him."

Mike strides down the path, now ready to 'get down to business', then remembers that he does not have the key with him and calls back to me. "Keys please".

I throw him the bunch and he shouts to Bungane P, who is standing

nearby, watching our entry, "Go and fetch the hard brooms, soap and bucket."

Mike S walks up to Kulukhuthu and is met at the outside door by Ray P who immediately begins to complain to him that he gave his tobacco to Jabulani during the night, but the latter took all of it, and, because his cell door was locked, Ray was not able to get it back from him again and furthermore he refused to give it to him.

"All right, come", Mike says to him, opening the door and not really listening to his complaints, "fill the bucket with water. When we clean the Kulukhuthu you can look for your tobacco."

"No," says Ray, sulking, "I want my tobacco. You can't let him steal my tobacco."

"Yes. Come. Go out now. We are going to start."

Benjamin has arrived at the Kulukhuthu by this time and says to him, "How can he take your tobacco when he is locked inside and you are outside?" It is a rhetorical question and more an illustration of Ray's stupidity than an enquiry.

"These mad buggers can do anything. Man, just look at this mess."

He opens Jabulani's door. The latter is sitting on the floor.

"Nkosi, mangiphume? (May I go out)"

"Yes. Get a broom and help to clean."

But Jabulani runs, whooping, out into the campus grounds, waving his arms up and down in motions of flying. He has tied strips of blanket around his head and around his legs just below his knees.

"Hey! Heyi! Jamela lomuntu (Look at that person!)" screams Jacob in delight.

"Yassis! He's running mad today!" Enoch says, shaking his head in wonder.

It is wonder that Jabulani's behaviour evokes. As if he could not be 'taught', 'calmed down' or 'cured' by injections and being locked up in the security block. Many of the patients just stare at him in puzzlement. Sigedla runs down from the gate, laughing, and then stops to gaze at Jabulani, as if in awe. Even Jameson P does not know how to take this

behaviour. Only Sifundza P, with his eye for the paradoxical and his healthy scepticism, is able to give out a small candid laugh, nodding his head, instead of shaking it.

I feel like going down to Sifundza and making some sort of comment to him about it, but I realise that we are on different sides of the staff-patient divide now, and, under the circumstances, any comment I am likely to make to him will probably be misconstrued.

* * * *

Jabulani wheels down behind B Block, then up again and through the top grass. Jacob P runs out to be with him, but Jabulani will have nothing to do with him, wheeling around to the side, as Jacob approaches him.

"Jabulani!" Mike shouts at him. Jabulani stops in his tracks and looks at Mike. "Come on. Come and clean your bucket."

The latter walks over to the Kulukhuthu and takes his night-bucket down to the toilet to empty it. Ray has found his tobacco in Jabulani's room and is now threatening to beat him.

"Uzofaka bakethe. (He's going to get a fist-full)", he says to Benjamin.

"Cha, yekela. (No, leave him alone)", Benjamin says to him and holds his arm in front of him to restrain him.

Jabulani walks into his cell, takes his bucket and runs down to the toilets to empty it, singing. Zondo walks out singing "Yodelayee! Yodelayee! Yodelayee!" (quietly) and follows him down with his bucket also.

(The latter two slept in locked cells, Ray in an open cell. If Ray's present performance continues much longer I am sure his cell will be locked tonight. I feel sure the thought has already passed through the minds of either or both Benjamin and Mike.)

Enoch says to me, "Tell me, Stanley, what do you think we should do with such cases?" (meaning in fact Jabulani's case in particular, just now.)

"I don't know", I reply, shaking my head, "What would you normally do?"

"Well," he answers, "We must give him an injection, because he is still mentally confused."

I nod my head slowly, more in the manner of 'I see' than 'yes, I agree

with you.'

Jabulani runs up again with his bucket. He says to Mike "I have washed it."

"All right", Mike tells him, "fill it with water and wash the passage and the rooms."

Mike and Benjamin have taken the patients' blankets out into the sun and spread them open on the lawn. Bungane has come up with the brooms, soap and a bucket.

"Go and fill the bucket with hot water", Mike tells him.

Ray has been standing at the side all this time, whining and complaining. They have ignored him thus far. Now as Jabulani brings the bucket of water to throw on the floor, Mike hands Ray the broom and says to him "Get busy". He walks in, still complaining, and begins to sweep the water along.

"Yenza futhi (Do it again)" Mike tells Jabulani. The latter runs out to the tap and turns it on, placing the bucket underneath it.

* * * *

During the time he was running around on the grass, I was wondering whether Jabulani did not feel he had reached the lowest rung (below which one could not fall) so that he was already too far gone to be concerned about further punishments, which might be inflicted on him. Now I began to wonder otherwise. I recall his first question to Mike "May I go outside?" Now I witness his obliging co-operation and the way he runs backwards and forwards on the job, as if he had too much energy bottled up inside him and wanted to get rid of some of it.

* * * *

Zondo walks up from the toilets with his bucket, and, seeing Jabulani filling his bucket at the tap, proceeds to walk there to do the same. He looks so alone, in himself - not exactly lonely, but sort of tied up in himself - that I say to him "Yitsho ngam" (this greeting is more or less the slang equivalent of "Hi, buddy!" and not really appropriate to our formal counter-positions.) Zondo surprises me, by stopping and saying to me (more or less 'announcing' the name) "B. M. Anderson!" - and looking at me with a

sort of firm pleasure.

Enoch says to him "Heyi Zondo, ngubani lo B. M. Anderson? (Who is this B. M. Anderson?)"

Zondo answers him in English, looking him directly in the eyes, "I am B. M. Anderson."

Enoch laughs. Zondo walks on to the tap. I smile, watching him go.

Many of the patients are sitting out in the sun. It is difficult to identify them immediately.

* * * *

Little 'Pilato' is walking back to his Block from Block A. I nearly bump into him as I walk around the corner. "Sawubona, nkosi", he says to me, bending his knees, holding his hand up and looking at the ground smiling.

"Hello my friend", I say to him, extending my hand to shake his. He moves forward hesitantly, shakes my hand briefly and walks off across the 'yard'; his head hunched into his shoulders.

"A member of staff, that's what I am, now," I muse to myself, seeing his embarrassment.

* * * *

In Dormitory One, Abraham, Wilson, Simon, Mbulawa and Danger are sitting on Abraham and Wilson's beds, facing each other, all sharing one cigarette. Josiah walks into the room and stands at the foot of the two beds, between them. The patients notice him out of the corners of their eyes, but do not look at him. He stands there, frowning, watching the cigarette as it changes from hand to hand. Eventually he walks out. Simon, who is inhaling at the time, blows out the smoke and looks up amusedly at Mbulawa. An amused smile begins to play on the latter's face also, and he jerks his head ever so slightly in the direction of the door, to indicate that he too understands what has happened (that is, what is amusing Simon.)

* * * *

Brown S (who must have been the first staff on the campus this morning) is in the corner, shaking Victor by the shoulder to wake him up.

"Wake up. Its time to get up," he tells him, then walks over to Amos to wake him also.

22 "Heyi, wena! Mabalane! Is that the way to wake a person? Do you think I am a dog or what?"

"You must be woken like that, because you are still mad," Brown answers, and walks out.

"This is bloody shit!" He turns to address Gwevu, who is sitting on the bed next to his. "You don't shake a person like a dog. We must see what is going on here. What sort of hospital this is. If you want to wake someone up, at least have that respect that you shake him by his feet, not his shoulders. He has got no right to be disrespectful to me, just because he is a staff."

"You are right. You are right." Gwevu says to him, both because he wishes to show his agreement and because he wants to silence the complainant.

Amos, an old patient, looks at him with a dead-pan expression on his face.

"Don't you agree with me? Why don't you say something?" Victor asks him.

"I don't know", says Amos, shrugging his shoulders indifferently.

* * * *

In Dormitory Three, Solomon is lying on the same bed as (with) Naftal, the former's shoulder resting on the latter's. Saki is sitting on Enoch's bed watching them. Enoch himself is standing in the centre of the floor, smoking and watching all three of them. (Solomon is from Dormitory Eight; Saki from Dormitory Six.)

Saki says to Solomon (who is short, but very fat) "You are going to break this bed of Naftal."

"That will never happen", Solomon assures him, "I've always done like this before and no bed has broken."

* * * *

At this point I walk in with Aloysius S. "Come along, Fats. Go to your own room", he says to Solomon ('Fats' is his nickname.) "You too Saki."

"Yes. They want to come in here, but it is not their room", says Abdal, complaining.

* * * *

I stayed in Dormitory Three with Rommel, my assistant, during the last week of my experiences as a patient, when we began to co-operate more closely and openly together, trying to make it appear that we had met by chance in the hospital and were drawn together by common interests, such as card-playing (where we first began to discuss our findings together). I am struck now by the friendliness of the Dormitory in contrast to the way I had known it as a patient. The patients are definitely not as indifferent to members of staff who enter their room, as they are to patients. I remember the first time I walked in as a member of staff, both into my own old dormitories and into the others. I entered with a slightly nostalgic feeling, but still expecting to feel sunk once more within the common indifference (both toward myself and toward each other.) The air of indifference toward me was gone and it felt as if conversations between patients had just temporarily been suspended, judging by the different looks of interest on the faces of the patients as they faced myself and Aloysius S. How easy to believe that there is some real 'spirit' here; some small joie-de-vivre - interpersonal warmth. I marvel. I recollect how I had watched what I believed to be a facade being enacted by patients in their contact with staff, then experiencing the same force of encounter as the staff members addressed me also - people, bringing with them emotions and sentiments belonging to a freer, more easy-going world, and now giving just a little of that warmth to me. I recall 'my turn' !

* * * *

I walk up through the toilets, out of Block A and across the yard to Block B. I can't face going into my old dormitory (Dormitory Five) just now. I walk into the toilet and stand urinating at the urinal. Siqobolo comes in and urinates alongside.

"Sawubona. Kunjani eMbabane?" (How is it in Mbabane?) he asks me.

(I recall the time he kept me awake for two hours one night, talking incessantly. I remember how I had shouted at him to keep quiet, and how no-one else had said anything, except Cataphas, who had mumbled to me, "He'll keep on like this all night." I remember how I waited for a staff member to come around so I could register my complaint, but none came, so I went to the

staff room myself. How Bingo S had come across with me to fetch him and inject him and how his attitude from that day on had changed toward me, becoming much more sociable than before.)

"Oh, its fine there. Nothing has changed. Do you know the place well?"

"Yes. I know it. I'm going there this afternoon."

I am surprised that he can joke this freely with me. Such jokes, with implicit self-deprecations, are rare between patients and staff. I consider for a moment whether I have not made a special 'break-through' in cross-group relations with him and maybe with a few other patients as well. Then I recall what Joshua, my assistant-staff, wrote about him, when he first started work as a member of staff: "People don't last here long if I go and report them to the staff". Right now I find his whole attitude utterly charming. I remember also the other members' of staff's respect for him since he gave Moses S a hiding, when the latter once tried to inject him.

* * * *

Outside, Sumane is just getting Ephraim, Mkwena and Umfanazana to put the last of the blankets from Dormitory Eight out on the lawn.

* * * *

In the staff room, Benjamin is getting some tobacco from a tin. He pushes past James at the door and gives tobacco to Zondo, Jabulani and Ray who are outside. James P says to Enoch (who is putting the tin away), "Give me some tobacco."

"No", he replies, "You'll get some later on at the kitchen."

"Well then give me some now and you needn't give it to me down there."

"No. You must get it down in the kitchen."

"But give me some now."

"No."

"I have just been praying for you this morning, but you refuse to give me tobacco."

"Oh have you been praying for us? Keep it up. You'll get your tobacco in the kitchen."

* * * *

8 a.m.

The bell goes. I decide to remain in the staff room with Enoch and Benjamin, while the crowd surges toward the gate, feeling pleased that I am no longer a part of that hungry mass.

Solomon, Wilson and Abraham stand outside, waiting to carry the medicines down to the kitchen. Danger walks down slowly after everyone else. I recall his exchanges with Duma yesterday, when the latter was on duty. Danger had refused to go down to eat. Duma had to beg him saying, "Come along, you're going to starve if you don't eat." Down in the dining hall he had just sat with his food in front of him. "I've seen you guys. You think you are clever. Why don't you just take a gun and shoot me." "Nobody's going to shoot you. Just get on with your food", Duma had told him. Going back to the campus, Danger again refused to move. "You better take me and shoot me. I've seen you people. You think you are too clever" he repeated once again. He then began to say that he wanted to go and see the rooms around the kitchen, but Sumane had grabbed him by the arm saying "Come along. Don't waste our time. You are taking advantage of us." He walked peacefully up to the campus after that - only to be given an injection by Duma later.

* * * *

We walk down to the gate now and pass through it, going down to the dining hall. We enter through the ante-room and find Titus S and Moses P standing in the dining room, waiting and watching. (Titus S is a kitchen staff.)

The three 'medicine bearers' put the pill trays and the book on the medicine table and stand by it until the old men and the cripples come in, then they go to the tables themselves, sit down and start to eat. The first rush of able bodied patients now makes its impact at the door, a few patients bursting into the ante-room.

"Outside! Wait outside", Benjamin gestures them out.

"Everyone in line? Come on, then." The first twelve patients make a rush for spoons and for their places.

* * * *

Albert is alone in his workshop, planing a piece of wood.

* * * *

Augustine is the first finished, as usual. He hobbles up to the medicine table, gulps down his pills and is on his way to the campus, when Sumane calls him back, "Heyi, Augustine. Sinikela igwayi namhlanje". He turns around and walks over to where the queue for tobacco will form later on.

* * * *

A large queue is, meanwhile, gathering at the kitchen door for 'seconds' - Makoyana, Mpetukane, Samson, Ray, Abednego, Ruben, Abdal, Macapha, Jeremiah, Josiah, Mathumbu, Austin, Phopho, Elijah, Linford, 'Bubesi' and David. Inside the kitchen, Moses P and Titus S carry over the bin of porridge. Titus opens the door and begins to dip everyone's bowl into the bin, handing it back half-filled with porridge.

Moses P walks out and begins to collect empty plates off the tables. Caiaphas P is busy wiping tables with a wet rag.

* * * *

"Everyone must come and take their pills before they line up for tobacco", Enoch shouts from the medicine table.

* * * *

Shadrack walks out of the kitchen and begins to talk to Sumane, who is standing between the tables.

"Why don't you do some work, instead of standing with your hands in your pockets?" he asks him, "You're employed to work not to put your hands in your pockets."

Sumane is angry. "Why do you like to talk so much when you are full of Shake-Shake? (liquor)", he asks him.

"Don't say that. When I tell Dlamini you are not doing your job, you are going to blame me."

Sumane ignores this and walks off.

* * * *

James P is being entreated by Enoch to take his pills, but he refuses to do so. It is only later when he is hauled out of the tobacco queue that he relents and eventually takes them, thereupon being allowed once more to join the queue.

* * * *

Brown hands out the tobacco. Aloysius checks the names off the list. Madevu is waiting for Bungane to collect his share. Immediately he has done so, Madevu stands in front of him. Bungane looks into his face and gives him all his tobacco (he is a non-smoker), wipes his hands on the seat of his pants and gives a little skip as he strides with stocky little steps into the waiting room. Zamfumf is also waiting there for his 'Europeans' to hand over their tobacco to him for 'safe-keeping'.

Now it is Joseph-the-Dreamer's turn. He is contesting the fact that the patient before him got more tobacco than he did.

"Move on. Don't waste our time", Brown tells him, "there are other people in this queue."

"No. You are not fair", Joseph argues. "You should do like Dlamini used to do with a scale to measure out the same weight of tobacco for every patient."

"Okay", says Brown. "Give me your tobacco". Joseph hands his tobacco over, expecting a more satisfactory share.

"Next one", says Brown.

Joseph realises that he has been tricked. "All right. I see what you are doing", he says, and walks off with nothing.

* * * *

Most of the patients are in the waiting room now. The trusted patients have already gone up, and the food bearers (who received preference in the tobacco queue).

Umtwanenkosi, the Head Nurse, walks into the waiting room and says a few words to a couple of patients there. Then he calls Enoch, Sumane, Benjamin and Mike together and begins to "discuss" something with them. Each one immediately glances at the others, aware that some hospital "politics" is on the line somewhere.

"Why hurry all these patients when they have finished eating" he says. "We must not annoy especially the old patients. Just let them sit nicely, because you are not in the kitchen all the day, whereas the person who does all the work here is Shadrack. There is no need to push things in the dining room. In the morning you will complain to me again that Shadrack is annoying us with

constant requests. "

He has not really come to the point, but the staff are already agreeing with him.

"No, we don't want any trouble here" says Mike, "We are prepared to leave everything to Shadrack. "

"I think that is better," says Mtwanenkosi, "because this is his section, really. "

It is settled. But what was behind it all? It seems someone must have lodged a complaint. Whoever may have started it, Shadrack has clearly had the last word with the Head Nurse. Now everyone is prepared to let him stew in his own juice, not helping him at all in the dining room.

* * * *

Titus is helping to collect the dirty plates and to clean the tables and floors. It is time for everyone to go up to the campus. I draw Titus aside.

"How do you find working with Shadrack?" I ask him.

"Awu. Shadrack is another man", he replies, shaking his head.

"Is he a friend of your?" I push.

"No. I don't like him. He is always shouting", he replies.

"But who are his friends then?" I ask.

"I don't know. That short chap. "

"Nene?"

"Yes. Only him. "

* * * *

Along with Moses, Ninevah, Caiaphas, Sergeant Major and Petros, Joseph-the-Dreamer has also remained behind this morning to help clean the tables. This will mean that he now has to remain in the kitchen all day. He is a very affable young man. No doubt he would not have remained behind had not the friendly Titus been on duty today. I know from my own experience that he will have to cope with the unfriendliness of 'Jumping Jack' this day.

* * * *

Alfred, Dlozi, the two Jacksons, Enoch, Tension and Gwevu follow Joseph S out into the garden with hoes in their hands. Joseph is giving them instructions on their work for the morning.

* * * *

9 a.m.

Sigedla is in the corner watching for the female patients to walk up from breakfast.

"Ujongani, Sigedla? (What are you looking at?)", I ask him.

"Umfati wami (My wife/woman)", he answers and slowly returns his gaze to the path the women are to follow.

* * * *

James is talking to Mpetukane, "You must not sit on the ground you must sit over there on the grass", he tells him.

Mpetukane does not argue. He just gets up and goes to sit on the grass.

"Yes, now you are sitting properly", he tells him, and offers him a cigarette. I wonder what is in this for James. The answer escapes me.

* * * *

In the far top corner of the ground, Vusmūzi P is talking to himself with real earnestness. I approach him to listen to what he is saying.

He turns to me, instead, and says, "I am not a party but a grinding stone."

Smiling broadly he walks off down the wire away from me.

This is what King Sobhuza says of his political party, the Mbvokodvo Party, whose symbol is the grinding stone. The Mbvokodvo party is not, as far as the King is concerned, a party, it is a symbol of the unity of Swaziland, whose people are ground together into one common substance through the Mbvokodvo.

* * * *

I walk across the grass toward the staff room and Block A. Danger is relaxing on one of the blankets outside the Kulukhuthu.

* * * *

Josiah is walking around the grounds with his long strides, his head bent downwards.

* * * *

A lot of the old men are behind Block B. Qaguqagu, Mafanyana, Pencil, Mavayana, Mason (a cripple - a re-admittal, now in Ward One),

Stephen and King George. Ngisane is also sitting with them, against the wall, and with them, too, is Jacob. I look to see where Ephraim is. He is standing by himself next to the wire at the lower boundary of the campus. Elijah is at his usual corner, leaning against the wall and watching activities in the yard. His hands are behind his back, his legs stretched out in front of him. Sometimes he leans forward and looks around the corner to see if anything is happening along the front. Seeing me watching him, he does this now.

* * * *

Against the sunny wall of Kulukhuthu, Mandundulwane, a young boy with one hand virtually crippled, is using a stone to knock into place some nails, in a piece of wood, which he constantly carries with him. He is a feeble-minded patient. Mbutyulwa is standing next to him, his eyes seemingly fixed on some imaginary distant point. Next to him is Robert, the deaf patient, also looking into space.

* * * *

Below the Kulukhuthu Mike S is getting Austin, Jameson and Simon to clear away the grass and weeds. Jameson is saying, "I can work. I'm not bloody lazy. I'm not sick. I want to go home."

* * * *

Gwayi is sitting just below them, watching them work. The section between Kulukhuthu and Block A is his usual 'territory'. Here he worries no-one and no-one worries him.

* * * *

On the side of Block A, sitting on sitting blocks, or on the ground, are Linford, Mshiyeni, Samson, John, Owen, Rub-adub and Abednego. Ray walks down the middle of the yard, smiling.

* * * *

I walk into Block A and enter Dormitory Two to see if anything interesting is happening there. Brown P, who is sitting on his bed, calls me over to talk to him. He starts off by telling me how he had advised Leonard to take his turn in sweeping the dormitory like everyone else, and explains to me that he has always known how to get on in life and that it is just his misfortune to be landed here in the mental hospital. He tells me

how he explained to Leonard that one gets promotion in the hospital in the same way as one would get it in a factory. Therefore one should demonstrate one's willingness to do the jobs to hand. (Leonard had yesterday been severely reprimanded by Jameson, Madevu, Sifundza and others for not taking his turn in the sweeping, but he had stuck to his guns and refused to sweep. He also leaves his bed unmade in the morning. The general consensus is that he should be moved to another ward.)

Now Brown begins to complain to me about Mr. Khasa (Superintendent). He had tried to ask him when he would be discharged. The latter, however, had just brushed him off without giving him a definite answer. He had refused to say anything about Brown's illness, or discuss his length of stay with him. He added that he himself would not try to escape, but said that up till now he had had respect for the staff here, but this respect was not returned to him.

* * * *

(On the next afternoon the doctor was to arrive and a number of patients were called to see him. Brown was excluded from the list. He had waited inside the gate, hoping to be able to attract the doctor's attention, somehow, and when Duma had come out from Mr. Khasa's office, he had been asked by Brown if he would not, please, do him a favour, and go and ask the doctor if he could not see him today.

Duma had asked me what he should tell Brown. I said to him, "Why don't you go and ask the doctor?"

Duma said, "No we can't go and ask him. He tells us what patients he wants to see. We can't tell him."

I said, "Tell Brown you are not in a position to ask the doctor."

He said, "No. I don't like to disappoint Brown, because he especially asked me to speak to the doctor for him."

He returned to Brown and told him that the doctor was very busy but would see him next time he came. Brown was satisfied and pleased with Duma. Duma felt gratified and was pleased he had not left Brown disappointed. He only hoped, he said, that Brown would not remember what he had told him, next time the doctor came - (A cycle of deception was under way.))

Petros and Solomon, the only other patients in the dormitory, are playing a game of draughts on Petros' bed.

* * * *

In Dormitory One, Wilson is lying on his bed. Victor, too, is sitting on his bed, smoking.

* * * *

Daniel, Zondo, David, Macapha and Lucky come in with Aloysius S who supervises their scrubbing of the floor. No-one takes on the job of overseer. All of them just work methodically before moving on to Dormitory Two. Maceda comes in and stands around passing comments and laughing. Aloysius orders him out.

* * * *

In Dormitory Three, 'Red Indian' lies on his bed, as usual, facing the wall. 'Rub-a-dub' walks in, sits down on his bed and begins to rub his legs with his hands. Abdal walks out of the room, fetches a broom and begins to sweep the floor.

* * * *

In Dormitory Four, Owen and Simon are lying on their beds. Kanyezi, who is sitting on James' bed, says to me, "I get tobacco but I prefer snuff. Why don't they do what they used to do and give those who want it, snuff, instead of tobacco?"

"If they've got snuff they'll give it to you", I tell him, and then I realise that I have succeeded in passing the buck. What am I to do? He seems such a hopeless 'case'. If he is not lying down somewhere, he is outside sitting on his haunches in the shade of a tree. He does nothing and no-one ever asks him to do anything. He is so 'helpless' that he sometimes has to be led down to the dining hall, because he has not realised that the bell has gone. He is incontinent, sleeps in Dormitory Eight and has no responsibilities whatsoever. What can I give him to do? There are always more competent people around to do any job and I know if I ask him to help in a work-gang the staff will berate me with, "Leave him alone. Get some-one who can do the job. He's just an old fool." Staff opinion is no small sanction! Only those who are competent are given work to do. I am in a quandary. What is my relation

to this patient? What is expected of me? There is no blueprint, no programme for patients, either individually or collectively. I look at this poor miserable dejected patient and think to myself, "If you had your snuff, what good would it do you?"

How shall I treat this man in such a way as to respect our common humanity?

* * * *

"I want to go home", Simon P says to me. How can I tell him of his predicament? What use to tell him of mine? If you say that too many times, Simon, they'll say you are "mentally confused". If you don't say it at all they'll ignore you. You're an old patient here, Simon. Nobody expects great things from you. Why have you been here so long? Who is going to tell the doctor you're ready to go home? No pathways are clear to either of us. We inhabit different worlds. How can I give you hope, when I see no hope for you? How can I tell you your position is as hopeless as it appears to be? I feel so sorry for you.

"You must speak to the doctor, Simon," I tell him. I hate myself. I hate the excuses I make for myself. I hate the way I look for excuses. I decide to go and buy Simon some matches at tea-break. I want to make it all up to him, somehow, give him some self-respect. How low I have sunk! Simon, with things as they are, I can't help you. Be brave. Be strong. One day things will be different. I fall back on my role as researcher. I find compensation here (Oh, the great researcher! Oh, the great humanitarian with his hands so clean, his eyes so bright and his heart so pure!) I walk out of Dormitory Eight, feeling my soul as empty as the world it inhabits. I am guilty because of your plight, Simon, my brother. We can only be redeemed together.

* * * *

I walk up to the staff room. Enoch is giving Jabulani an injection.

"I don't want an injection."

"You must have an injection."

"Why must I?"

"Because that is why you are here. It is to make you well that the

doctor says we must give you an injection."

"Oh, you are going to hurt me with this injection now."

"No. We are not going to hurt you. This will make you better.

Come - turn around."

Jabulani offers no resistance. He turns around and docilely takes the shot of Largactal which Enoch pushes into him, then he ties up his trousers and walks out of the door, the torn strips of blanket still tied around his legs and his head.

Brown S is busy cutting into the tops of some phials and flicking the glass tips into a wastepaper basket. Two new patients are also waiting to receive injections - part of a course of Vitamin B injections, to build up their strength. The job is soon over, two more crosses are made in the book and the injection needle and syringes are put into the sterilizer.

* * * *

I reflect on the ease of mobility which I have as a staff member. I have free access to any dormitory I choose to go into. Not even Abdal has the right to stare at me with unfriendly eyes. Yet I see, at the same time, that I do not have any dormitory's open consent to stay there for any length of time, without a good reason. Patients are always watching me to see what I am going to do. I am expected to be on the move, to be doing something. Patients live here. Staff work here. How strange that I never noticed this about staff when I was a patient! I always wondered why they spent so much time in the staff room when they were not busy organising patients. This is their 'territory' - It is not disinterest that keeps them there, but an absence of events to organise - or a retreat from requests that they are unable to meet.

* * * *

"Do you want to go for tea now, or later?" Enoch asks me.

"No. I think I'll go now." (I notice how I have answered 'No' first, in the colloquial idiom.)

I look out of the window. Aloysius and Sumane are at the gate.

"Wait for me!" I call after them.

* * * *

10 a.m.

"I'm feeling a bit stiff in my calves. How about you?"

"No. I'm used to running, really."

We walk along the road.

"We had a great run this morning, Stan, man. Why didn't you come with us?"

"I was still asleep. I'll come next time."

We walk along in silence. I want to ask them something, but I don't know how to put it. (Let me just 'sommer' ask, as we're getting close to the barracks now.)

"What's up between Moses and Enoch?"

"How do you mean?" Aloysius asks.

I knew that was wrong. I'm asking questions again. Both of them are on the defensive.

"Well. You know, things are a bit strained between them and I thought you might know what is happening."

Sumane says nothings.

"No. You see, Stan. That is another thing. Enoch likes to be with young people, but his own ways are not young. That's why, as you might have noticed, we are not all so friendly together any more. It's just one of those things. So now its getting to be the same way with himself and Moses. That's all it is."

"Oh, I see. He likes to play young, but at the same time if everyone starts to shake the place up and make a noise, he'll go and make a report to Ndabazewa."

Sumane roars with laughter. "So you know about him, but you still ask us?"

"Hey. Come on. How do you know all this?"

"Oh, I keep my ear to the ground." I see they don't know the expression. "No, I just ... Well, for example ... a few days ago in the kitchen, I heard Sumane tell Enoch to 'keep off his back', so I got to trying to find out what Enoch was up to."

"i Dangerous le ou", Sumane says to Aloysius.

"What do you mean?" I protest. "I'm not turning any wheels around here. You can't expect me not to be interested in what's going on around me. Where does 'danger' come in?"

"Ho! Now you are talking politics," says Sumane, and they try to laugh it off. I feel a wedge has been driven between us. Rumour has it that I am working for the Swaziland Government and that I am going to report on the way they are running the hospital. Aloysius and Sumane are worried about their jobs.

"Hell, man. Why don't you guys believe me? I told you I'm just doing private research here. I've got nothing to do with the Government. I'm only studying these patients and I'm not making any report to the Government on the staff here."

"You know, Stan. We do believe what you tell us, but still we don't know what you are doing and what you are going to do with this information."

There is no more to be said. He is right, of course. This basic mystery is, inevitably, creating suspicion.

"Do you want some tea with us?" Sumane asks, as we enter the building.

"No thanks. I want to get something from the grocery store. Do you guys want anything?"

"Just get me some matches", Sumane says.

"Make that two boxes - and some milk too, if you can." Aloysius adds.

"O.K. Sure - can you give me the money now? I'm a bit short."

"Sure Here you are. Thanks."

* * * *

I am a bit short, in fact. I limited my income to the same as that which the other staff are getting. Last week, when I was off duty and Benjamin was on, the latter asked me to get him a filament for his 'fridge'. It cost me fifty-five cents and I haven't been paid back yet.

Benjamin is just leaving the barracks now with his 'boys' - Abraham, Amos, Bungane and Mbulawa.

Abraham P says to me "Don't you want me to clean your room for you?"

I tell him. "That would be great Abraham, I'll just give you the keys. You know which one it is."

"Yes. I know it."

I give him the keys and indicate to Benjamin.

"That's all right", he says to me, "Just don't forget to bring him back." We both laugh.

"Listen, Ben, I want to ask you something. Do you remember the filament I bought you? You said you didn't have the money on you, because you were at work, but you still haven't paid me."

"Ya. You see this is a difficult thing. Moses said he didn't have money for food, so I lent him my last rand, and now I've got nothing myself."

"Well look, old boy, how much food have you got till the end of the month?"

"No. I've just got a sack of mealie-meal and I get some vegetables from the garden."

Well, cook for two. I'll be joining you tonight. If I can't buy my own food, then I must get it from you. Not so?"

"Yes. O.K. We'll see. I'll try to make a plan."

I don't altogether believe him. I recall an extract from notes made by my assistant-staff:

"Moses' girl-friend said to me, "You must watch out for Benjamin. He likes to borrow money in a cool way. He says something like 'Give me a rand; my money is all big and I must give some to someone I owe. I will try to change mine later on and pay you back. There's somebody worrying me just now.' He says his money is fast, and yet he doesn't have a cent in his pocket. Later on he'll tell you another story that he doesn't have any money." She said, "Benjamin eats his money with his girl friends." "

Another extract from my assistant's notes (26th November) read:

"Today Benjamin tried to borrow some money. He wanted to borrow R1 saying that he forgot he had lent Enoch some money on the 24th. But in fact he had borrowed money from Enoch and I was with Enoch on that day. He forgot I was there."

I knock on Moses' door. "Come in", he calls out. He is lying in bed. "Hullo, Stan", he says, sitting up.

"Tell me, Moses", I say to him, "Benjamin owes me some money, but he tells me he lent his money to you. Is it true?"

"Xh!" Moses clicks his tongue in anger and annoyance. "He's a liar! I'm not going to lend him another cent. I actually lent him a rand. He likes to involve other people in his business."

"Well, that's O.K., Moses. I just wanted to see where my money is. Benjamin must just cough up, that's all. Do you want anything from the store?"

"No thanks, Stan."

* * * *

It's a long haul down to the store. I start running.

"Keep it up 'Red', m'lad. We'll enter you for the cross-country."

"Hullo Colonel", I shout to the Colonel, who is on his way to tea with Mr. Khasa, the hospital superintendent. Patronising old fossil, I think to myself. 'Red, m'lad' indeed!

* * * *

I'm in a real sweat now. The sun is beating down. I stop, to walk. The dispensary truck pulls up alongside me. "Are you going to town?"

"No, thanks, I'm just going to the store. You can lift me till the path going down."

I hop on board.

"Thanks a lot. Boy, is it hot today?"

"You said it. Too hot!"

He drops me off and I walk down through the long grass to the store. I buy a pint of milk and drink it on the spot. I buy two more pints, a loaf of brown bread, two tins of fish in chilli sauce, and two scones (2 cents each). "Oh yes, give me a 6c packet of Boxer tobacco and three boxes of matches."

The storeman puts everything into a paper packet. I give him another five cents and bargain with him for three oranges.

"All right. Take them", he says, eventually.

* * * *

It seems so far to walk in the heat.

"Let me give myself a work-out", I say to myself.

I start to jog back. It seems like one of those dreams where you keep

running, but get nowhere.

Suddenly I am surprised to see someone in a hospital uniform jogging up the road in my direction. An escape? It is the first thought that crosses my mind. I pretend to see nothing, and wait for him to get even with me. I see it is Moses P, the kitchen worker.

"Hullo, there!" I say to him.

"Yebo", he answers me.

"Where are you going?"

"No. Shadrack sent me to buy him something at the store."

"Are you sure? You're not escaping?"

"No. He often sends me."

"That's very nice. What do the people say when they see your uniform?"

"Oh, they just look at me. I don't care. Some of them know me already. They can see I'm not mad. They'll never cheat me with money."

I look at my watch. "I've got to run, Moses. See you lunch time."

"Hamba kahle. (Go well)" He says to me.

I wonder why he has not been discharged. He seems to like his work in the kitchen and, even with the openings I gave him, he did not try to complain about his being a patient.

* * * *

My half-hour is nearly up already. I'm about fifty yards from the gate when Duma and Mike come running out.

"Thayima says one of the patients has escaped. Did you see anyone?" Duma asks me.

Duma had obviously gone to report it to the staff on duty and Mike has joined him to look for the escapee.

"I don't think it's an escape", I tell them. "Moses has just gone down to the shop to buy something for Shadrack."

"Oh, he must just have seen Moses", says Mike to Duma.

"Yah, man. That's what it is", says Duma to Mike. To me he says, "We thought it was someone escaping."

* * * *

We walk back to the barracks together. The conversation turns around old escapes. I begin to worry about having left Abraham P unsupervised in my room, but my fears turn out to be groundless. I recall a time when an old patient, Cornelius (now discharged) rebuked Enoch, who had said to me "You must not leave these patients alone, they might try to escape." Cornelius had said to him "Awu, Enoch, how can you insult us? We are old patients here."

Abraham, I find, has polished my floor, made my bed and dusted my table and books, carefully putting them all back as he had found them. He has even started to clean my shoes now.

"Look", he says to me. "I have cleaned and tidied your whole room. Haven't you got just a pair of old socks for me?"

"No, I haven't. I only wear old socks myself. But I tell you what I'll do. If you wash two shirts for me I'll give you a packet of Boxer tobacco."

"Hawu. Enkosi. I will come and clean your room every day. You must not ask another boy. Only me."

So easy it is to set up a private exchange system! The 'labour market' is potentially huge; the costs, negligible.

"I can't do that, Abraham. It's not fair on you or on the other patients. You are not working for me here. You are here to get better and go home."

"Oh please! Just let me do it for you once a week then."

"No. Just today. Because you ask me now when you are working here. Another day my room will just be a part of the whole job this side. I only lock the door because I'm afraid someone will steal my books."

"Oh, I see."

"Thanks."

* * * *

I realise that while Abraham is doing some work for me, I am, technically, his supervisor, so I decide to take off a few moments to have some tea with Enoch, who is now off duty for his tea-break.

* * * *

"Tomorrow I'm going to get some mealies from my sibali (brother-in-law)" says Enoch, as I bring the 'loaves and the fishes' into our kitchen.

"That's good!" I say. "Then we can eat well again."

I give him a scone and he pours me a cup of tea, sweetend with condensed milk.

"Are you fed up with Moses about something?" I enquire.

"Yes, man. He used to help with the washing up, but now he leaves everything to me. He is doing it purposely."

* * * *

I try to work out the pattern. It seems Moses is trying to break up his kitchen partnership with Enoch, and, so long as I am supplying food, Moses is prepared to eat alone, while Enoch leans on my supply. From discussion with Joshua (my assistant-staff) I gauge that Enoch himself is trying to save money, because he wants to get married, and so he is not prepared to buy any more food than he has to. This has resulted in an unequal set of food and cooking exchanges and Enoch has become labelled as 'mean'. Sumane and Aloysius, who also used to be in the food-group have already split off and are eating separately, together. Moses, whose room is right next door to the kitchen, has probably found the split less easy to make. Enoch, who is somewhat senior-staff has laid claim to the kitchen, and Moses, who is extremely neat and tidy, does not like to cook food in his room.

* * * *

Duma crosses the grass outside Moses' window. Moses leans out and shouts to him, "Duma! Where are you going?"

Duma shouts back, "I'm going into Manzini."

"Ya, you're going to that girl who is eating your R3, because your girl friends usually earn R3 or R4 a month", Moses teases him.

"Ah! Suka! Why are you so jealous of what you haven't even tasted?"

"What do you mean tasted? I am eating steak, but you are digging into porridge."

Duma walks on. They both laugh at the friendly insult.

* * * *

"Now you will see the girls coming here", Enoch says to me. "End of the month! That's when these youngsters find out how popular they are."

Hayi! Uh-Uh. These girls are no good. They just come to eat money."

"You mean these country girls?"

"Even here in Swaziland things are not the same as five years ago. Things are becoming worse. Everyone is losing respect. You'll see them coming right in here and even ask 'where is so-and-so's room?' "

* * * *

I look at my watch. It's eleven o'clock already.

I say, "See you later. I've got to move."

Abraham is sitting on my bed. I give him the tobacco and tell him to share it with the people in his dormitory, because it is just a present; I don't have to pay him for cleaning the barracks - he is getting paid tobacco for that anyway. I see the shirts on the line outside. "Ngiyabonga khakulu" I tell him and shake his hand with solemnity.

"Masigijime", I say to him (Let's run)

We trot along to the campus and I shake the lock on the gate.

* * * *

11 a.m.

"You must give us a hand with this patient", Sumane says to me, as he comes to let me in.

"What's happening?", I ask.

"We are giving Moshweshwe a haircut, but he is being difficult."

I follow him down to where Moshweshwe is arguing with Aloysius about having his head shaved. Aloysius is holding him down on the ground. Sumane has the clippers in his hand. A number of patients are gathered around them, watching.

"Anyone who cuts my hair will be cursed", says the old man. He has long ironed-out hair which is kept straight and flat with a kind of paste.

"All right, we will see", says Aloysius. "Here, help me hold him still while I cut his hair", he says to Sumane and I.

"Did you tell him why you are cutting his hair?" I ask.

"You can't cut my hair. This is my respect", he pleads.

"Tell him why you want to cut his hair", I tell Aloysius.

"You see, Moshweshwe, we must keep all the patients clean in this

hospital. If your hair is long it is difficult to keep it clean."

"No. This is my property. You can cut your hair, but not mine."

"Come. Cut it. We won't get anywhere by just talking to him", says Aloysius to Sumane S.

"Let me cut it for you", suggests Samane P, who is standing nearby.

"O.K. Go ahead."

The old man's head is shaved and he says "Just don't let it blow away, I want to bury it."

"Why does he want to bury it?" I ask Samane.

"No. You see. Sometimes he might not want the birds to make a nest with his hair. Maybe he doesn't want them to mess on his hair."

"When are you going to wash?" he is asked.

"If something doesn't happen to you, I'll wash tomorrow."

"I think we just leave him now", I suggest to the others. "I think his pride's been hurt enough for one day. Tomorrow we'll make him stick to his words about washing." (I am speaking in English, he does not understand me.) We agree to let him be, for the time being.

He collects all his hair together and puts it in his pocket. It seems he wants to bury it secretly.

Later, seeing him still sitting by himself and looking at the ground, I go up and ask him what happened to his hand - (in this way hoping to demonstrate 'medical' concern for him, since his hand appears to be somewhat crippled.)

"I was digging on the mountain for some herbs when something bit me and my arm swelled up. So I went to a witchdoctor who cured my hand, but it has never worked again."

"Is it going to stay like that now?"

"Yes. It is all finished now. It won't work again."

"I see. All right. You mustn't worry yourself here. This is a good hospital. It is just the law that everyone's hair must be cut. We will look after you here."

"All right, my brother", he says to me.

I leave him.

* * * *

I hear the screams of Makhubukhubu in Dormitory Five. Aloysius and Mike rush to the rescue. A few people stand around the window of the dormitory, looking inside.

"Makhubukhubu kwakhona" says Amos to me. (He is one of the patients with whom I shared Dormitory Five when I was a patient.) I look through the window also.

The incident has occurred as a result of Jabulani's lying on Makhubukhubu's bed. Being a sleeping member of Kulukhuthu, he has no bed of his own. Having been injected earlier in the day, he must just have wandered into Dormitory Five and decided to lie down on an empty bed, which just happened to be Makhubukhubu's. He has obviously just been discovered there by the latter, who wanted to attack him for "starting". This is what he is shouting now, over and over in a high-pitched scream, "Uyaqala! Uyaqala! Uyaqala!" Frank P seems to have intervened to prevent a bodily attack and has come in for some of the abuse himself.

"All right. We understand. We can see what is happening." Mike tries to console Makhubukhubu, while Jabulani is being helped out of the room by Aloysius. A lot of people are now laughing at the irony of the incident. Benjamin S, who is standing next to me, is laughing also. Aloysius walks out with Jabulani and says to us, "Awu! Makhubukhubu again. What a hell of a noise."

"Ya. I think we must ask Ndabazezwa if we can't move him to a single room somewhere. He is getting too much of a problem."

"Where are we going to put Jabulani now? That's the first problem."

"Oh, just take him up to Kulukhuthu, I'll fix some blankets for him, and he can sleep it off there."

* * * *

I walk around the campus. Behind Block B, I see that Ngisane has got hold of Ephraim and is hitting him over the back of his head, with a flat hand.

"I won't do it again", says Ephraim.

"Are you sure?" (Hit)

"I won't do it again."

"Are you sure?" (Hit)

"I won't do it again. "

Ngisani lets him go. Ephraim picks up a stone, throws it at Ngisane and runs away. Ngisane shakes his finger at him.

"I'm still going to teach you", he says.

* * * *

I walk around, inspecting a few patients' nails, cleaning and cutting those needing cutting. Mavayana, an old man, who has a habit of habitually talking to himself in a whisper, has very long nails. As I cut them for him, he looks at me impishly and giggles to himself. I try to talk to him, but I can't hear what he is saying. He continues his monologue, although it seems partly addressed to me now. I hear him say something about horses, something about being tied up, something about escaping. When I have finished, I leave him. He continues talking in the same vein, as if my presence made no difference at all to his conversation with 'unknown others', or simply with himself. (My assistant-patient one day pointed out to me that he thought that Mavayana must be possessed by two spirits, or demons, since he would suddenly speak in a loud voice and then change back again to a low whisper. I also recall Bingo saying to me that Mavayana talked more on cloudy days than on sunny days. I told him I didn't think he spoke more, it was just that the sound carried better on cloudy days. I asked him why he thought Mavayana always picked up stones, turned them around, and placed them a few feet away from where he found them. "He thinks he is making a boundary line", Bingo told me.)

* * * *

I approach Sigidla and ask to see his nails.

"Why do you want to cut my ancestors (emadloti) off?" he asks me.

"These are not your ancestors. They are just ordinary nails. If they are long and dirty they will poison you when you eat your food. Do you understand?"

"Yebo, baba. (Yes, my father)"

"Will you let me cut them then?"

"Kulungile. (All right)"

* * * *

I walk back to the staff room to find Enoch blowing off some steam about Zamfumf to Benjamin.

"What's the matter?" I ask.

"No. You see this Zamfumf is going too far. He keeps demanding more than everyone else, because, he says, he must look after his Europeans. Now he has just refused the soap I gave him and has taken nearly a whole bar of blue soap."

"He wants to take the lion's share", says Benjamin, trying to make light of it.

"But I mean he does look after his two patients", says I.

"Yes. You see, he's got his point. But then he mustn't demand. He sets a bad example for other patients", Enoch argues.

"Maybe you should tell him to get his Europeans to come and collect the soap themselves. That will be teaching them something also."

"You are right", Benjamin agrees. "Then it won't look as if we are favouring Zamfumf."

* * * *

12 p.m.

The bell goes for lunch. The crowd forms in its usual fashion around the gate. Jabulani wanders down from Kulukhuthu, looking like a person who is intoxicated. When the gate is opened for the old men, Jabulani goes up to Jakobus who is sitting on the ground and takes hold of his hands to pull him up into a standing position.

"What are you doing?", Zamfumf rages at him.

Jabulani looks at Zamfumf in blank amazement. Zamfumf in turn looks back at him and, seeing he doesn't understand, he explains to him, "This is a European. You are not allowed to touch a European."

Jabulani walks into the crowd and stands there. I go up to Zamfumf and say to him, "Why can Jabulani not touch this European and you can? You are both Swazis. Why do you say you are different?"

"I am God. This is my European."

It is hard to refute such illogic with logical argument.

"Zamfumf", I say to him, looking him straight in the eyes, "You

know you are not God, why do you say you are? Nobody believes you, you know?"

Zamfumf returns my gaze, heaves a big sigh and then says to me "If you know God, you know in your heart that I am God."

We have passed beyond logic now. It is the heart's knowledge that is called into dispute, and the heart has a logic of its own. I watch the old men go down. Mavayana picks up a stone, turns it around and places it further down the path.

* * * *

In the dining hall I stand still for a few minutes, looking at Zamfumf and wondering how to break his delusions. Kulukhuthu? Largactal? He catches me looking at him.

"Yah?" he laughs. "I told you. Your job is not to work in the fields. You must show the Swazis what to do." Oh God no! Even I justify his arguments.

* * * *

I remember how, when I was a patient, Zamfumf used to tell me, "You must not dig in the fields. Look how dirty you are. This is not a European's job. Your job is to teach the Swazis how to work."

I replied to him, then "We are all the same. Do you think God sees any difference in us because we have a different skin? That is why I know you are not God. You and me and the next person are all the same."

"No. We are not the same. It is only because you are mad that you say that."

* * * *

(This makes me think back on the time I first took on the job of staff member. I told my assistant-patient, Rommel, who returned, himself, a week before I started work, to keep his eyes and ears open, to see what any patients might say about my returning as a staff-member.)

He reported:

"I overheard Sigobolo saying to another patient that he knew Stan would get a job here. That's why he used to work so hard in the fields."

But on the whole he did not manage to record many reactions.

He wrote:

"Most of the patients seem to have accepted your coming to work here as a staff without so much as batting an eyelid. Elias, however, says he thinks Mr. Khasa gave you the job because you are a European."

On a later occasion he wrote:

"I walked into my old dormitory (Dormitory Two) and found Clement in a hot discussion with a few other patients. He seems to suspect we are working together, because he stopped talking when I came in. He was saying that "these American volunteers come to search our minds, but they don't want to tell us about their own back-grounds." I think he was talking about you, and thinks you are an American."

(Note: This is the same patient who refuses to take the pills, because he believes the staff are mixing African medicines into the European medicines.)

* * * *

I notice Joseph-the-Dreamer sitting and eating among the patients. I go over to him and ask "Why aren't you working in the kitchen any more?"

"That bastard says I am not allowed to work there. He just wants to fight with me."

"Which bastard?"

"The one that works in the kitchen"

"Do you mean Jumping Jack?"

"Yes, I think that's his name."

"Well, didn't you report him to Shadrack? It's not his bloody kitchen."

"Yes. I did. Shadrack said that I should leave also. He didn't chuck me out, but he says he doesn't want fighting in his kitchen."

* * * *

I go to the kitchen and say to Titus, "Why was Joseph put out of the kitchen?"

"It's that one", he replies, pointing to Jumping Jack.

"Well then, we must chuck him out. It's not his kitchen. Why don't you send him up to the campus?"

"No. You see, Shadrack is used to these workers. He wouldn't like me to change them."

"I am still here", interrupts Moses P. He is standing next to me, a 'what-did-I-tell you' smile on his face.

"So you are! You didn't let them give you the wrong change?" I poke him in the stomach.

He walks back, laughing. "How can I do that? I am not stupid."

"Then why are you still staying in the hospital?" I realise my phrasing could have been more diplomatic, but he has not taken offence.

"I will never leave here. Some people are trying to run away, but not me. As long as there is food, I won't try to escape."

* * * *

I walk out to the medicine table and pick up the plastic cup. As each patient passes I fill it with water and hand it to him to wash down his pills. Then I wash the cup in a bowl of water-diluted Dettol and refill it with water for the next patient. Enoch and Benjamin pass the patients their pills.

"Ray. Five millegrammes Stellazine."

"Amos. Hundred millegrammes Largactal."

"Mathumbu. 200 mg. Largactal. $\frac{1}{2}$ gram phenobarb. Two Vitamin B complex."

"Makhubukhubu. Mysoline two-fifty millegrams. Half-gram phenobarb."

"Simon. Hundred millegrammes Largactal. Phenobarb, half a gram,"

"Pilato. Fifty millegrammes Largactal."

Each patient swallows his pills and passes on into the waiting room. Mike is at the door to let the trusted, older patients walk back to the campus.

"Why don't they let Moses P go home?"

"Moses? He's only just come right. You should have seen him when he first came here. He was so thin and just used to sit the whole day by himself, not talking to anyone. But his trouble really is just epilepsy. It is hard to let such cases go, because when they get home they usually don't come back for their pills and the trouble starts all over again."

* * * *

I notice that Sumane S, Aloysius S and Brown S are off for lunch now. Twelve-twentyfive - just another half hour and it will be my lunch break. The smell of the food is making me hungry. Chicken today. I give the plastic

cup to Samane P, who does the washing out with Dettol and refilling, and walk over to the kitchen. A few patients are being dished out second helpings of samp by Shadrack.

* * * *

"Hey. Titus. Have you got some chicken for me?"

"Yes. You can have some, Help yourself."

The privilege of extra food is reserved only for kitchen staff and patient workers. Jumping Jack immediately starts to complain, and goes to tell Shadrack.

"Are you eating patients' food?" he (Shadrack) asks me. "That is not allowed, you know."

"Yes, I know, but my stomach doesn't agree."

"Well, don't do it. In any case this kitchen is out of bounds for all except kitchen workers."

"Cool down, man. Don't get excited. I'm just taking a little piece of meat for my poor stomach."

"All right. But don't complain about Shadrack."

A little later he asks me, "Please Mister Stan, can you lend me fifty cents. I will pay you back at the end of the month."

I tell him, "No. I'm sorry. I don't have it. I just bought some bread this morning with the only money I had left."

He says to me, "Listen, if you want bread I can try to give you some. Not that it's for selling - the patients must be satisfied first. They are all Swazi people. We must look after them. We mustn't start to neglect them just because they are sick. They are our people and they need help."

"You see, Mr. Stan," he carries on. "These people don't do their work properly. They just put their hands in their pockets when they come in the dining hall and start talking too much instead of working. They talk with their loud mouths."

"Sure, Shad. Thanks, hey. See you around."

"Ta. Don't forget you can come to Shadrack."

"Thanks Shad. See you."

* * * *

We all file up to the campus.

"Are we having soccer practice today, Mike?" I ask,

"No, I don't think so."

"Oh, I see."

I don't see, actually. We haven't played the whole week.

"Why not?"

"What? Oh, yes; well, you see, the ball has a small puncture, I am trying to get some bicycle glue, then I'll be able to mend it."

* * * *

Up on the campus Magomora has just hit Saki on the ankle with a stone, saying at the same time, "I told you I would get you."

I chase after him (as he walks toward Block B) saying, "Magomora! You'll get an injection for that!"

"You'll never give me that injection of yours," he calls back to me, "You'll have to have it first."

Just then Saki runs up behind him with a number of stones in his hand and throws one at him, which hits him a glancing blow on the head.

"Are you coming to me?" he shouts, rushing at Saki. "I'm going to stab you."

Mike and Enoch grab hold of Saki, while I catch hold of Magomora. We march them off to the staff room, Benjamin having grabbed hold of Saki's other arm.

Once in the staff room, Benjamin, who had only seen the second stone attack, asked Saki why he had done this.

"It's him. He started first," says Saki pointing at Magomora. Mike grabs him by the arm and gives him a jolt. "It's you. I saw you hit Magomora in the back in the dining room already. We have never had any trouble with Magomora from Mbabane till here. (The hospital used to be located in the prison at Mbabane.) At least this time he didn't start. I saw you hit him and he said 'I'll get you'."

"It's not true. He started."

"You are lying. You should be given a good hiding. If I were your equal I would wait till the other staff were at lunch and take you to a lonely

spot and beat the daylights out of you. That's enough now. You are too insolent."

"We are going to inject you, Saki," says Enoch, preparing the injection.

"No. I'm not going to have an injection. Magomora must get one also."

"Don't worry. We are still going to get each other," Magomora tells him.

"Sulu kanyoko. I'm going to kick you, you bloody shit."

Enoch turns Saki around, while Mike pulls down his trousers. The needle is plunged in.

Zamfumf, who is watching through the window says, "You must watch carefully now. The needle will make him dizzy. Utawuyatsa. Ha, ha, ha!"

Even while he is getting the injection, he continues to shout at Magomora, "I'm going to kill you. I'm going to pick you up and throw you on the ground."

Enoch pulls the needle out and hits Saki on the side of the head. "Why do you hit me?"

"We can't always listen to you. Go to sleep." He pushes him out of the door.

He walks off, still shouting abuse at Magomora. Magomora is warned, "Leave him alone. It's finished now."

He walks out, without answering, going to the bottom dormitories.

* * * *

I am in a bit of a sweat at that stage. So is everyone else. "Come on, get away from here." Enoch shouts at the patients gathered at the door and window. They disperse. A few of them simulate Enoch's blow at Saki's head.

* * * *

It is nearly one o'clock. We wait for the other staff to return from lunch. Mike and Benjamin go outside and sit on sitting blocks.

* * * *

1 p.m.

Ndabazewa S (the Head Nurse) unlocks the gate and walks through the campus on his way to lunch.

Joseph-the-Dreamer walks up to him. "Why do you keep me here without a reason? I have been asking you to see the doctor, but I see nothing!"

"You will see the doctor when you are ready to go home, Joseph. You just need to have a little rest here now. Only for a short while. Just to settle you."

"You lie! You are a Satan! I can rest at home. I have done nothing, but you keep me locked up here. What for? One day we will meet in Heaven and I will ask you then why you have kept me here, without a reason."

Mike interrupts him, "You are here for treatment. That is all."

Ngabazewa says, "All right Joseph. I'll see you later." He walks down the campus and out of the gate. Most of the patients greet him with great respect and he greets them also. Benjamin S stands up when he walks past (after the European manner of showing respect). As he goes out the bottom gate Brown S walks along the road, returning from lunch. He waits. They have a brief conversation together before Brown walks onto the campus.

Mike says to Ndabazewa, "I think we must give him an injection for his cheekiness."

Ndabazewa says to him, "No. Just leave him. I will see to him later myself."

"Come, lets go," says Enoch and the four of us go out at the top gate. As we walk along the road, we pass Aloysius and Samane, who are running.

"Sorry. Sorry we are late."

"Yes, you people are not serious," says Mike, laughing good-humouredly.

* * * *

Benjamin goes around the side of the barracks. I suspect he has a cooking arrangement with someone in the large staff kitchen, in the married

quarters.

"What are we going to eat today?" Enoch asks me.

"I've got some fish and bread. I'm going to hollow out my loaf of bread and put the chilli fish inside. That's the way we Xhosas like to eat."

Enoch laughs. "Are you a real Xhosa now?"

"Awu! Tyini! Am I not from Cape Town? You can have the other tin of fish if you like."

"Thanks, yes. I am going to fetch the mealies tonight, then we can eat in style tomorrow. Just put the water on for tea. I'll get us a pineapple which I saved from Tuesday." (The Red Cross gave patients and staff pineapples on Tuesday. We are most grateful.)

* * * *

I open the first tin of fish. Enoch peels his pineapple.

"I think there'll be enough if we just share this out. I need the second tin for tonight."

"Yes. It's enough."

We settle down to the serious business of eating. I've had practically nothing to eat all day. Moses does not come to join us.

Enoch begins to reminisce about his old job as a nurse in Johannesburg, but I cut him short.

"Sorry, man. Quite a bit has happened this morning. I want to go and make some notes. Will you excuse me?"

"Sure. Sure. I'll bring your tea."

"Thanks."

* * * *

I write furiously for three quarters of an hour. It is not enough. Enoch collects the cup and saucer to wash it. "Oh thanks." It is already time to go back to the campus. "Jeez, I'm tired."

"Why don't you rest a while."

"Spoil my good reputation. Let's go."

He laughs.

We set out, walking to the campus.

* * * *

2 p.m.

As we walk along the road we see Joseph S coming up the side from the fields.

"Hallo", he shouts.

We wait for him.

"How are things with you?" he asks me.

"Fine. Fine. And yourself?"

"Oh. Not so bad, thanks. We've been having some meetings with our Bishop the last few evenings, discussing applications of certain Church rules to the present-day Swazi society." (He is a lay preacher in the Anglican Church.)

"That's interesting. Anything fruitful emerge?"

"Well. I should say so. Yes. Its nothing new, really. We are just revising certain issues with regard to Swazi custom, seeing where perhaps the Church is being a little too restricted in its rulings - where certain measures are, maybe, unnecessary."

"Do you mean theologically irrelevant?"

"Yes. I suppose you could say that. Things like dress and receiving of Holy Communion. In the old days I suppose these missionaries thought certain ways of dressing were not suitable, but we are doing away with such restrictions, for instance, like coming to Church in tribal dress."

"Do you mean walking around barefoot, like Jesus used to?"

"That's one way of putting it." He laughs. "But He is usually depicted wearing sandals, isn't He?" There is a pause. "It's more a question of what dress can be said to lend the proper respect and dignity to the occasion."

Our conversation is above Enoch's head. Moreover Joseph S has a good command of English and speaks too rapidly for Enoch to follow. He is walking slightly ahead of us now, not paying attention to our conversation. We are getting near the gate.

"Are you collecting the garden workers?"

"No. It's too hot, really, for them to work today. I'm just going to tell them that we are not going to work this afternoon, so they don't

think I've just forgotten about them. In any case there are some letters I must write. Maybe after supper, when it's a bit cool, we can transplant some seedlings."

Mike S is catching up behind us now. We go in through the gate which Brown S has opened for us.

Sumane S and Aloysius S are dozing in the shade alongside the Kulukhuthu. Most of the patients are resting in their beds. Makhubukhubu and Leonard are playing ruba-ruba together. Elijah is standing alone singing to himself.

Kanyezi is crouching in the shade of a tree. He is only wearing the uniform shirt. Ruben walks past him and stops alongside, beginning to question him about his sex organs - do they trouble him? does he have any desire for women? what does he do about the situation? Kanyezi answers 'yes' to the second last question and to the last he answers "There is nothing I can do about it." Ruben laughs hilariously at these answers. Kanyezi just continues to squat without even moving - as if he were completely disinterested in everyone and everything around him. Ruben walks over and sits in the shade, opening a magazine and looking at the pictures. (Magazines are given to the patients who want them by the Red Cross ladies.)

* * * *

Benjamin rattles the gate chain. I tell Brown, who is watching the ruba-ruba, to throw me the keys, and go to open the gate. Benjamin is late. It is two-fifteen already.

"Hell, man, I fell asleep, I only just woke up now."

"It must be the heat. I feel drowsy myself."

* * * *

I walk into the staff room to find that Mike and Enoch are discussing Moses S. Mike is saying something about a court case involving his sister. Apparently he wants Enoch to be a witness (The conflict, as I later found out, revolves around the fact that Moses took Mike's sister to cook at his home. In Swazi custom this indicates that they are engaged. However, Moses has not followed up the event by instituting proceedings leading toward marriage and, moreover, there has been a fight between Mike's sister and Moses' new

girl friend.) They stop talking as I enter the room. I feel slightly uncomfortable. Mike suggests that it is time to wash the patients, and we all go out to get on with that job.

* * * *

3 p.m.

Ndabazezwa S opens the gate with his own key. He is approached by Jameson and Joseph Dreamer.

"Yes, I do understand your position, Jameson. We have been discussing you, but the decision is up to the doctor, so you will have to wait for him to tell you when you can go home," Jameson is told by Ndabazezwa.

"Yes, I see. Thank you, nkosi."

"What about me, Mr. Dlamini. You said you would see me later today."

"That's right, Joseph. Could you come inside with me, there is something I want to talk to you about."

Ndabazezwa leads Joseph into the staff room and starts preparing a Largactal injection, talking to him the while.

"Joseph, we have known each other before in this hospital, and we have always been good friends. I don't deny that you have complaints. What I object to is the way these complaints have been put forward, especially the way you insulted me this morning in front of the other staff and patients. I was extremely embarrassed by your behaviour."

"It was not an insult. I just want to have my rights, because I am not sick."

"Joseph, we are going to see to your rights. But sometimes these things take time."

"For whom are you making that injection?"

"Its for you, Joseph. You really deserve a rest now. You have been on your feet all morning."

"All right," he says, shrugging his humble shoulders and opening his palms, "Jesus can see what you are doing. Its your right to inject me. I can only accept it."

Ndabazezwa: "Why do you always bring Jesus into it?"

Joseph" "Because I am the child of Jesus."

Ndabazewa: "We are all his children. Don't think you are the only one."

Joseph does not answer, but simply prepares to receive the injection, after which he goes to lie on his bed.

"Have a nice rest. You will feel much better when you wake up," Ndabazewa tells him.

* * * *

The Head Nurse goes next door, into what is generally recognised as his own private consulting room and calls Mbutyulwa to an interview with him. He asks him his personal history, where he lives, how his sickness began and so on. This afternoon he will also interview Zelele, another new patient.

"That's the job you should do", Mike says to me, "you are always writing."

He is waiting to see my reaction. He is also making an oblique enquiry into my activities, wanting me to state what I am doing, in terms which relate to what the Head Nurse is doing.

I decline to meet the terms of his question, but answer instead, "Yes, it seems like an interesting job, finding out all about these patients' backgrounds. Do you know what he does with this information?"

"No. We never see it. I think he just keeps it as a sort of record in his office."

"Oh, I see. Its a pity we don't have staff meetings where we can all discuss patients together, including Mr. Khasa."

"Yes, that would be something", agrees Sumane S, who, addressing Mike, adds, "It would also be better if patients were brought in when their sickness begins, rather than waiting for it to get worse. The chiefs and indunas of the rural areas should be told about such people, so that they can act promptly should anyone be suspected."

* * * *

Outside, Grace, Mr. Khasa's secretary, has come to the gate, and is asking the patients there to call Mr. Dlamini to the window. Zondo and Sigedla just stare at her without moving.

Pikeleli says "Grace, I have been wanting to see you. I want to give you a letter which I have written to you."

She ignores him.

Ruben comes running up to the gate. "Grace. Do you know what?"

"I know nothing," says Grace, teasingly, looking up at the sky.

Ruben tells her how he had an erection last night and had to pinch himself to make it go down. "I want that," he says, pointing.

Grace pretends fright and shock and covers the area with her hands.

By this time, Mr. Dlamini has been made aware of her presence. "Did you want to speak with me, Grace?"

"No. You can carry on with your interviewing. Mr. Khasa just said he wants to see you before he goes home this evening."

"All right. I'll see him when the patients go to eat. Thank you."

"Thank you," answers Grace.

"You know my wives ? You know my wives ?" Ruben tries to attract her attention to speak to her.

"You must stop speaking about your wives to me. You know I get jealous."

"Okay. Okay." says Ruben, "So tonight is your night. You must prepare your room properly. I'll ask Duma to let me come and see you."

"All right," she answers and runs, laughing, back to the offices.

Pikeleli walks away, his head hung in disappointment. Ruben looks after Grace, smiling and pleased.

* * * *

In the staff room, I continue to chat with Mike and Sumane. Benjamin walks in, leading Daniel P by the hand. We call Daniel 'Zaqotha', since, whenever he becomes anxious, he starts to call this, his brother's name, stuttering over the first syllable so that it sounds like "D - d - d - d - zaqotha!" He has a deep frown on his face. His eyes are deepset and blankly staring.

Benjamin opens a cupboard to get some pills out for him. "He is starting his 'D - d - d - d - d -' business again," he explains.

I take hold of Daniel's hand. It is wet and clammy. "Kunjani

Daniel?" I ask him.

His whole expression suddenly changes and he smiles broadly. "Kulungile Baba (I am fine, my father)", he answers. Then his expression changes again. "Ngifuna ubuti wami (I want my brother). D - d - d - d - d - d - zaqotha! D - d - d - d - zaqotha!"

"Zaqotha is coming", Benjamin says to him.

"Zaqotha is coming," Daniel repeats after him, looking first at me and then back at Benjamin.

"That's right," Benjamin says to him. "Now just swallow these pills and go to lie on your bed. You will see. He will soon be here." Benjamin winks at me and laughs.

I beam back at him without comment. My conscience pricks me, but I tell myself that I am engaged in participant observation 'first' and therapy 'second'. I am not entirely convinced and so decide to take Daniel back to his room.

"You know, Dan", I tell him. "Your brother can't hear you when you call him and its difficult for him to come and see you during the week. So when you become anxious you must just go and relax on your bed or go and talk to one of your friends or one of the staff. There is no need to be frightened here. You have lots of friends. You must just go and talk to them, instead of calling your brother."

"Mm," he answers, and gives me that anxious look.

"No, you mustn't worry. Do you see those people playing rúba-ruba? Yes. We must have a game one day. How about tomorrow? Do you like to play it?"

"Yes, I like it."

My words feel empty. I wish I could give Daniel something more hopeful to cling to. However, I don't want to break entirely with Benjamin's advice to Daniel, so I leave him at the door and he goes and sits on his bed.

"Put your feet up and have a rest now," I tell him.

He does.

(Note: On subsequent occasions, I noticed him actually approach Benjamin and ask him for sedatives. These were readily given at first, but

later Benjamin began to worry about the frequency of his requests and tried to calm him down without Neurolictil - but without much success.)

* * * *

I look into Dormitory Seven and see Samson on his bed.

"Sawubona, Samson," I say.

"Yebo. Sawubona," he answers, raising his hand in greeting to return my hand-gestured greeting.

* * * *

I walk across to Dormitory Eight and stop outside the door. I hear Johannes P talking to himself inside. He is speaking in a whisper. I cannot hear what he is saying.

I walk inside. He is sitting on the floor, on a folded-out page of newspaper, facing the corner. He stops talking and looks sideways along the ground (to identify the stranger from his feet). He picks up a rolled cigarette, which he has made, and says to me, "Ngibhemise. (Give me a light)", without looking into my face.

I tell him that I am sorry, I do not smoke. He must go outside and ask one of the other patients, who is smoking. He does not move. Instead, he takes the cigarette and puts it under his legs, which are bent at the knees, because of the way he is sitting. He mumbles something to himself and then he is quiet, watching my feet out of the corner of his eye.

"Okay, Johannes. You must only go if you want to smoke," I tell him. "There are lots of people who will give you a light."

* * * *

I walk out of the room. I stop on the inside of the door which leads out into the wire-covered corridor, leading to the lavatories. Augustin P, the cripple, sitting on the steps, is talking to himself through his teeth. His voice is very tense and he is growling through his teeth.

I walk outside.

"Hullo, Augustine", I say to him.

He sits tightlipped, staring ahead of him.

"How are you?" I ask, leaning down to get my face level with his. He still does not answer me.

"You must be hungry," I tell him. "Oh well, its nearly supper-time. You can go and eat just now."

He still does not indicate that he is aware of my presence. I leave him, walking up through the toilets.

There I see Makhubukhubu, washing his hands. I remember that we were going to ask Mr. Dlamini to put him into a single room, probably one of the lower washing rooms (converted) in Block A. "How would you like to go into a small room by yourself?" I ask him.

He smiles, looking up into my face. "I told the mabalane. I told the mabalane", he says to me. "They start with me. They come and lie on my bed. They make trouble. I have told them. I have told the mabalane. Do you see? They are starting with me. They are making trouble. They are making trouble..."

"Okay Makhubukhubu, we'll see each other again."

"Yes. We will see each other again."

I walk outside.

* * * *

I walk out of the toilets and up into Dormitory Six. Maceda is sitting on Qaguqagu's bed, smoking. The latter is not in the room. Majombolo is also not in the room, and Alfred too. Otherwise everyone is lying on his bed. Saki is sound asleep, still sedated under the influence of the Largactal injection. I walk over and sit on the end of his bed, to survey the scene.

Alfred walks into the room and asks me for a cigarette.

"Are you missing your smoke in the garden?" I ask him.

"Yes", he answers simply, looking at the floor.

"I'm sorry. I don't smoke. I don't have any cigarettes."

Alfred nods and goes to lie on his bed. I get up and wander out of the dormitory and out of Block B. Yes, it is difficult to talk to patients, difficult to make friendships. There is so little we can do together. They think we control them, but we are really at each other's mercy.

* * * *

Back in Block A, I feel like going back to the staff room and chatting to other members of staff. I fight this urge. Instead I wander down to Dormitory Three to see if I can strike up a conversation with any of my old room-mates.

The only ones I could conceivably talk to, Tension and Enoch (the two garden-workers), are already talking to one another, and to Solomon, who is sitting alone on Naftal's bed between them. The three of them are discussing traditional Zulu music and dancing.

'Red Indian', facing the wall, rolls over to see who has come in. He smiles at me, and then turns over again. Abdal, who is sitting on his cupboard looking at him, turns his deadpan expression on me.

Solomon stops his conversation, puts his pudgy little head on one side, smiles, cups his hands, and says to me, "Have you got a smoke?"

"Bullshit!" I shout at him and walk out, furious that he has turned his begging routine - which he usually reserves for the Red Cross ladies and other visitors to the campus - onto me.

I am relieved to hear the bell go, as I walk up through the lavatories. I stop to relieve myself at the urinal. The surging crush is on again. Patients jostle to get through the doorway out of Block A.

* * * *

4 p. m.

I walk across to Block B to see if Daniel is coming for supper. I find him asleep now.

"Food is ready", I tell him, shaking his foot.

"Uh", he says and rolls his legs off the bed. He is unsteady on his feet. I lead him up through the toilets and out of the side door into the yard. I meet Ngisane at the top stairs.

"Four", he says to me.

I hesitate a moment.

"Five", I answer.

We are talking about the number of patients to whom food must be brought from the kitchen this afternoon.

"Who?" he says.

"Joseph Dreamer. Ujoviwe. He is sleeping in Dormitory Two."

"Five", he says.

It is decided. We walk down together. I lead Daniel into the crowd and leave him there.

* * * *

I stand on the side of the crowd. The gates are just being opened and the old men are going down.

32 { Simon, from Dormitory Four, is talking to Enoch S and shaking his head. He walks over to me and says, "Please. I want to go home."

"Why do you come to me Simon? Mr. Dlamini was here today. Did you ask him?"

"Enoch says you can let me go home", he tells me.

"Hey wena, Enoch!" I call him, "Come here!"

He walks over.

"Don't make a bloody fool of me, man, especially since I'm a European and now he thinks I'm something special around here. This is a dangerous business. You know very well I've got nothing to do with the running of this hospital."

"No man. You see. This chap keeps asking me 'I want to go home'. 'I want to go home'. What can I say to him? He is very confused."

"He is confused? Is that why you tell him something sensible?"

Enoch shrugs his shoulders. "I know what you mean" I say. "I feel the same way. But we must try not to make matters worse by building up false hopes in these patients."

"Yes. Yes." says Simon, not understanding what we are saying. He nods his head, looking intently at me.

"I'm sorry, my brother", I say, putting my arm over his shoulders. "We must speak to the other staff to see what we can do about you."

He looks into my eyes for a long time and finally says "Thank you", shaking with laughter after he has said it.

* * * *

As I walk down to the dining room, I think back on the various occasions on which the "confused" label has been attached to various activities. I readily recall three, because they seemed so bizarre at the time:- To Sipho when he had stood for a long time at the gate in order to try to call Mr. Khasa over, to discuss his position with him; to Philemon who had been crying tears and calling out "Oh Mayibaba!" when he had an acute pain in one of his eyes; to Petros, because he had said Robert, the deaf patient, was

going to die because he had not been eating.

* * * *

The usual evening meal is on the tables - a bowl of soup and half a loaf of bread.

* * * *

'King George' leaves most of his food in his bowl this evening. It is quickly snatched up and shared out at the next table. The old man goes to stand in the middle of the floor and begins saying "Gi!" and then "King George, one; Nkulunkulu, two."

Aloysius S, who is standing near the medicine table begins to tease him. "King George, one. God, two. King Sobhuza, three. Government, four."

Suddenly he rushes toward the medicine table. Aloysius, thinking he is going to attack him, ducks, to avoid a blow. But King George instead runs up to a large portrait of King Sobhuza, which is pasted on the wall. He stands directly beneath it, his chin resting on the lower border of the picture and looks up at it. "King Sobhuza, Lion", he says. Then he stands back a few paces and begins to throw some stones, which he has in his pocket, onto the floor.

"Oh 'Mavana', what are you doing?", Aloysius asks him. ('Mavana', is another of Marabi's nick-names - it means, in English, a 'lamb'. Marabi is so called because his hair has turned white in old age, like that of a lamb.)

"I am throwing these itimhlola (throwing bones) to see what King Sobhuza is saying," he answers. There is general laughter at the antics of this 'would-be' diviner.

* * * *

Enoch and Benjamin begin to hand out the prescriptions to a queue of patients.

"Mangisi. Largactal, fifty millegrams. "

"Philip. Largactal, one hundred millegrams. "

"Makhubukhubu. Mysoline, two-fifty millegrammes;
phenobarb half a gramme. "

"Simon. Largactal, one hundred millegrammes,
phenobarb half a gramme. "

33 { As Pikeleti approaches, Enoch whispers to Benjamin, "Give him three hundred (millegrammes) neurolictal this evening."

When he has passed I say to Enoch, "What do you mean this evening? Doesn't he always get that dose?"

"No. You see he is being very troublesome. He keeps demanding that he wants to go home."

"I see", I answer. I stand next to the table for a short while and then walk outside to try to figure out how such occurrences could have escaped my notice, until now. Of course! There is no reason why the doses should not be increased. But think of the ethical implications! These patients are under the impression that all the pills they are receiving are prescribed by the doctor. Does this not almost justify Clement's conclusion that the nurses are mixing European and African medicines?

* * * *

Mike is standing at the door, seeing that only 'responsible' patients are allowed to go up to the campus.

I stand next to him and ask, "In your work as a Zionist priest do you think you would be able to cure some of the patients who are here in the hospital?"

"We do work with such cases", he answers.

"What is the main way in which you bring about cures?" I ask him.

"Well", he answers, "how we work, mainly, is with the laying on of hands, use of holy water and guidance by the Holy Spirit."

"You know", I tell him. "I used to attend some Zionist open-air meetings in Johannesburg, in nineteen sixty four, where they did a lot of work with drums and dancing in a circle." (I remember at the time having compared the function of the circular dances of the Johannesburg Zionists to those of the Dervishes, whose whirling movements are intended to empty the mind of all irrelevant circumstantial thoughts and so prepare for divine communication. The Johannesburg Zionists would suddenly stop their dancing and speak 'in tongues' to the one on whom their attentions were being focussed.)

"No", Mike answers, "We don't use drums. I know they do in the

Transvaal, and when some Zionists visited us from there, we used them, but we decided not to carry on with it, because we found them a distraction. They are all right for people who are used to them, but they are of no real consequence to what is being done."

(I recall the writing of Ibn Hamdan on 'The problem of music' where he says, "Be sure that you do not train yourself to music in case this holds you back from even higher perceptions.")

"That's very interesting to me. You see, I had the idea that this dancing was one of the main parts of the ceremony, but you say it's not important."

"No. It's not important. They are just used to keep the people lively when the meetings are very long. If you like I'll take you to one of our meetings. There is a prophet who will be coming here in about a month's time."

"Yes. Thanks very much. I would like to come."

"Tell me. Do you use any of your Zionist practices here in the hospital?"

"No. Of course I don't. I am just a nurse in the hospital. It's not my place to work here as a priest. We do use similar means as we did here with people like Majombolo who was not able to eat, when he was first admitted. We rub them with hot and cold water, but the main effects come from praying and laying of hands on the person concerned."

"So you don't use medicines at all?"

"We don't use medicines as such, but the Holy Spirit can sometimes direct which injection or drug should be given in the case of a particular complaint. It happened once with us when a certain European man came to us for a cure. We gave him the name of an injection he should ask from the doctor and we told him he must just have two of these injections. Then we gave him some water which he was to use for purposes of drinking, gargling, vomiting, rubbing on his body, and enemas. The man was cured and we had a big celebration at his house."

"Could you find a witchdoctor who was also a Zionist?" I asked him.

"No. Not at all. The Zionists are prophets. We are not witchdoctors."

We don't accept money for cures. If they did that, they would be witch-doctors."

"But then it means the Zionists must always make a living in some other job."

"Well, that is so. You know the Bible says it. It is easier for a rich man to enter the Kingdom of Heaven, than for a camel to pass through the eye of a needle." He laughs. "Such a thing is difficult for many people to accept, because we would all like to be rich."

(I try hard to think back to something I have recently read by Ari Kiev and wonder if it applies here. The exact passage, which I was trying to recollect, I looked up a few days later. It reads: ...

"The churches provide acceptance and a method of emotional release. The gifts of the Spirit compensate for the lack of material gifts, while the gift of "tongues" allows the inarticulate to speak to an applauding audience." (Kiev, 1969))

* * * *

"Come on! Open the doors. We are finished here."

Enoch reminds us where we are and the crowd surges up to the campus. Aloysius is helping Daniel who is swaying about on his feet, as if he is about to fall. The garden workers walk around to the back, presumably to collect their tobacco as usual.

"Leave the lower gate open for me, I'm going to fetch something from my room," I tell Mike.

"Righto", he answers.

* * * *

I walk past Albert's workshop and notice that he has made himself some sliced bread instead of eating the whole half-loaf, as it is given to the other patients.

"Hello there," I say to him. "I see you're eating in style."

"Hello, Stan. Long time I haven't seen you. Oh, you mean my sandwich? Yes, I don't like to eat like a 'gayisa'."

We laugh together.

"So how do you keep busy these days?"

"Oh, I get a few odd jobs. Haircuts . . . Some things to repair. I'm just trying to fix this radio which Thayima (the TB staff. 'Thayima' or

'Timer' - I am not sure of the spelling) brought to me."

"How do you know about radio repairing?"

"No. I just teach myself by looking inside and seeing how it works. I can fix your watch also if it is broken."

"Is that so? But your talents are wasted here. Why don't you try to set up a barber shop and take in regular customers with repair work on the side?"

"That is what I do. But I can't charge people the real prices, because I am still a patient."

"Ya. It must be very difficult for you."

"Very difficult," he agrees.

"I'll see you around", I say, walking off. "You can give me a hair-cut next week sometime."

"Yes. I will do it for you. Why don't you come and visit me any more?"

"Well, you know, its not like before. Now I'm working on the staff and when I'm not on duty I'm mostly writing things up." (I have let him know what I am doing here also, with the proviso that it is strictly a secret between us.)

"But come when you have some spare time."

"Thanks, I will. Bye-now."

"Good-bye, Stanley."

* * * *

I walk up to the barracks and collect the box of matches I had bought this morning for Simon. (The other box I had left in the kitchen.)

On my return I notice Alfred with a watering can, watering seedlings. The two Jacksons are also in the garden with Tension, Enoch, Mpaseka and Joseph S. Moses, the kitchen worker, is forcefeeding a grey goose which Mr. Khasa has placed in a wooden box, in order to fatten it.

* * * *

I enter the campus via the lower gate just as four prisoners are being escorted there by a prison warder.

"It's not locked", I say to them, and unravel the chain securing

the lower gates together. We all walk in and I bind up the gates again, this time locking them with the padlock.

* * * *

5 p.m.

Brown, Mike, Aloysius and Sumane are all sitting outside on sitting blocks, talking 'soccer'. Pilato is also there. So is Majombolo, Ngisane, Maceda, Moses from Dormitory Two, Vusmuzi, Jameson, James and Victor. Enoch is inside attending to the prisoners, and Benjamin is handing out tobacco to workers.

Mike is saying, "I trust my left foot. I want to show Titus something. He can put me with any team and I'll just play. Even in school no-one was able to pass me when I had the ball. When I was playing in Mbabane, one of the prisoners had to come and kick me on the leg. I didn't even have the ball at the time. They took me to the doctor and he said it is a fracture."

While he is talking, Brown S picks a packet of tobacco out of Sumane's pocket and begins to steal up to the Kulukhuthu with it. A few of the patients nudge each other and point out the fun with their eyes. Brown has not gone far when Sumane notices his tobacco is missing. He feels all his pockets and then starts to look around him. He catches a backward glance from Brown and leaps in pursuit of him. They run up behind Kulukhuthu, and Aloysius is at the other end to receive a 'pass' from Brown, but Sumane catches him too soon. There is a brief tussle and Brown throws it to Aloysius, but the throw lands short, and Sumane is able to retrieve it.

"You bugger! Next time I'll inject you," he threatens jestingly. Brown S laughs and they walk down together.

* * * *

Wilson comes up to me and says, "May we hold a prayer meeting, because Abraham's scar is hurting him and we wish to pray over it?"

I don't take his request altogether seriously. Abraham is his 'buddy' and it sounds like a pretext for a few of them to have a jolly time.

"Sure. Go ahead." I tell him. "Why do you ask me?"

"No, its just because some of the other staff might think we are making a noise and want to give us injections, so we just want a permission."

"Oh, I see. Well, it's not time for sleeping yet, so I think you can make as much noise as you like."

"Thank you, sir", he says, and runs to his dormitory.

* * * *

Aloysius goes down into Dormitory Eight. I follow him. A great pile of blankets, brought in by the patients, is lying in the centre of the floor. Mangisi, deaf Robert, Augustine and Umfanazana are lying on some other blankets which they have, themselves, placed around the room. Mandundulwane is standing against the wall on the far side. Johannes (from Dormitory Three) is standing on the right of the door as we walk in.

"Vuka! Vuka! Vuka! Opstaan!" shouts Aloysius. "Get all these blankets out for tonight. "

Johannes, his right hand cupped over his left hand (resting on his chest), slips nervously out of the door.

All the patients, except Mandundulwane, help to carry the blankets into their places. Sumane and I also do some carrying.

* * * *

We walk up through the toilets. At the top steps, James is talking to himself. He is smoking a cigarette. As I pass him I hear him saying to himself, "You must not smoke in front of this European, James" and he cups the cigarette in his closed hand, so that it is no longer visible to me.

* * * *

In the double room next to Albert's (these two correspond to the staff room and Mr. Dlamini's interview room in Block A) Durban is talking to Jack. Durban is agreeing with Jack that it is better to have an education these days.

"I am behind with tax," he says. "The Government gives you any kind of job when you are not educated. This is a modern government. "

I enter the room. Durban says to me, laughingly, "I am happy while I am here at the hospital, because when I go out I drink a lot and smoke dagga. Now I am resting nicely. It's this dagga and alcohol that kills us.

But I must go out and work, because I must support a girl, whom I have made pregnant."

* * * *

I walk into Dormitory Six. Pilato and Phillip are smoking together on Phillip's bed. Lusiba, a very old man, is lying on his bed, facing the wall. Zacharia and Macapha, two quiet patients, are sitting together on Macapha's bed. Blind Robert is on his bed as usual, under the blankets. Mafanyana is sitting alone on his bed also. Zamfumf walks in, turns around, and walks out again.

* * * *

"Heyi, Samane, soshumane ke kangako (No, Samane, don't be such a shumane - that is, a young man who is shy of girls)" I hear Aloysius saying in Dormitory Five.

I walk across and find Samane lying on top of a young patient, Roy, who is struggling to free himself. Samane gets up, laughing.

"No, I'm just playing", he says, "Uphi na lomfana obomvu ungumfati wami? Ngoba ngizile ngifuna ngengithi ebusuku (Where is that country boy? I have been giving him things to get him. I am going to intercourse with him tonight.)"

"Oh, Samane! Are you so sex-starved?" asks Aloysius. Samane laughs and walks out of the room.

"What can you do?" Aloysius asks me.

"It's a problem", I answer.

"It's a problem all right," he says, "I wouldn't like to be locked up here for six months. It's enough to drive anyone mad - just for a woman."

* * * *

We walk outside. Jameson is standing on the top grass with a few other patients.

"How are you, Jameson?" I ask him.

"I am fine, my European," he answers, "But I want to go home now. I am thinking about a wife. I am thinking about my penis. Even when I am going out I will kill a person and I will kill myself too by drinking medicines, then I will hide myself in order that they don't find me. That's me, Jameson."

"Hawu Jameson", I tell him, "How can you say such things to me, knowing I am a staff here now?"

"No, my brother. It is a joke, is it not?"

"Yes. It is just for us to be happy."

* * * *

Just then a patient they call 'Mandoviane' falls to the ground with epileptic seizures.

"What is it?" says Jameson, looking at him in awe. Jacob runs up to him and says "Sukuma! Heyi nina, uyagula, uyafa lomuntu. (Hey you people, he is sick, this person is dying)."

Makhanya and Magisane tell Jacob just to leave him alone.

"It is because this month is just ending and it's time for fits," says Makhanya.

Brown S walks over and says, "Its all right, just leave him. He'll be all right. He just needs to rest here a while. He'll recover in a minute." He goes down to open the gate for the kitchen workers and Albert.

* * * *

6 p.m.

Mike S is walking over to Block A when Simon comes out and approaches him. He drops his hands to his sides and says "Please. When can I go home?"

"Okay. Okay" Mike tells him, leading him back inside, "I'll go and tell Mtwanenkosi. He'll give you some pills before you leave."

Simon walks back down to his dormitory.

* * * *

I walk into Dormitory One.

Wilson, Abraham, Petros and Jabulani are sitting on Wilson and Abraham's beds. They are singing rhythmic hymns and clapping their hands. Jabulani still looks slightly drugged and they are teasing him every now and then, swinging his arm or helping him to clap or inflicting painful rhythmic slaps on his body. Emotionally charged singing is interspersed with laughter and even hints that Jabulani may be possessed by a devil. The meeting changes into a divining ceremony in which Jabulani's illness is divined. Suggestions are greeted with "Siyavuma! (We agree!)" A tribal song follows.

I am surprised that the other patients are as disinterested as they appear to be. Victor and Daniel are watching the show, but others, like Samson, Mathumbu and Linford are not showing the least concern that anything at all is happening. I try to put myself in their places and find myself asking the question "What is the use of this frivolity that comes out of nowhere and is going nowhere? I am also here in this same world as they are, but I see no point in pretending that this is part of a pantomime."

* * * *

I walk into Dormitory Two and sit down on Brown P's bed. He moves his legs to make room for me. I don't feel like talking. We are good friends. There is no need for us to talk.

Caiaphas, from Dormitory Five, walks into the dormitory. Being a kitchen-worker it is not difficult for him to make friends and to have a little mobility.

"Did you see Samson's wife yesterday?" Sifundza asks him. "Such a doll to be owned by a maniac."

"You've got a sharp eye for other people's wives," Caiaphas assures him. Sifundza laughs at this clever retort. Elias and Petros are also laughing.

* * * *

A little later Sumane walks in and gives Elias a matchbox half-full of matches, telling him he must share it with Magomora, who is following behind him (Sumane S). The two start quarrelling. I do nothing. Just then Benjamin S walks in with another box of matches and gives it to Magomora. The two of them are soon talking amicably again, Elias commenting to Magomora that the staff here are "prophets" and that it is better to die in this hospital, which is a Swazi hospital, than to die in a European hospital.

* * * *

I remember that I too have matches on me now and go down to Dormitory Four to give them to Simon. I walk up to his bed and he tells me that Mike has said he will soon be leaving the hospital.

I sit down on his bed and look around, to see if anyone is watching me. Ruben, Jackson, Josiah and James all have their eyes on me. I turn my back toward them and say to Simon, "Listen. I'm going to give you a

box of matches and I want you to light the other people's cigarettes when they want to light up. O. K. ?"

There is a pause.

"Yes", he assures me.

I slip him the box of matches along the blanket. He takes it, laughing, and puts it under the blanket.

"Don't forget now," I tell him.

I walk out, wondering if I have done the right thing. (On the following day, Simon came to me and told me that his box of matches was missing.)

* * * *

Benjamin S comes down and asks if I will do a "patient count". I agree to do it and walk up to Dormitory One. As I reach the door, Aloysius walks out with pen and paper in his hands.

"Are you counting?"

"Yes."

"Right. I'll count with you."

We walk into Dormitory Two. "Sixteen", we count.

Dormitory Three, "Fifteen".

Dormitory Four, "Fifteen".

We walk out of Block A, locking the entrance gate in the side passage.

Dormitory Five, thirteen.

Four in the rooms around the entrance.

Dormitory Six, seventeen.

Dormitory Seven, one.

Rooms around lower passage, three.

Dormitory Eight, twelve.

Kulukhuthu, seven.

* * * *

Benjamin: "How many did you count?"

Myself: "A hundred and six."

Benjamin: "Yes, that checks with my count."

* * * *

34 { I look in the day report to see if the epileptic fit is recorded. It is.
 There is a knock at the door.
 "Yes?"
 "I want something for my stomach."
 "You must get it from the night staff. We are just finishing up now."
 "All right."

* * * *

7 p.m.

We all wander outside, locking the corridor gate behind us. Nene, Mbingo and Mike arrive at the gate. Greetings are exchanged. We hand over the keys and are on our way. Brown cuts down the side road on his way to the married quarters.

* * * *

"Just put on some tea, please" Enoch says to me, "I am going to get ready to go to my sibali's house."

"Okay."

* * * *

I wonder what implication's my friendship with Enoch has, with respect to my relations with other staff members. Across the passage, Mandla has just opened his door and is sitting halfway in the passage now, a strong smell of intsango (dagga) coming from his room.

"Hello sibali", he greet me.

"Hello Dla, uyabhema kahle (you are smoking well)"

"Bhema kahle" he repeats, laughing.

"Tell me, Dla", I say to him, "You know I've noticed all the TB workers smoke intsango. Does it help you protect yourselves from tuberculosis?" (The smoking of dagga is Boereraad (Farmer's advice) for treating asthmatic and other chest ailments). I also remember having read:

"Recently there has been some interest in Eastern Europe in cannabis as an antibiotic. It is reported to be active against gram-positive organisms at one part per 100,000. But since it is ineffective in the bloodstream, it seems that its use is confined to ear, nose and throat conditions." (Laurie, 1967)

"No. I've never heard of that", he answers. "But I do know that the inyanga's use it as an antibiotic against all kinds of poisons. Even if

your dog has been poisoned, you must just crush it finely and add it to some hot milk. Then give it to your dog. It will soon take care of his poison. Do you smoke intsango?"

"When I can get my hands on it", I answer.

"You should ask Michael next time he goes to Mahlanya. He can easily buy you a whole packet for twenty cents."

"What's the main reason for smoking it?" I ask.

"You know, Stanley," he tells me, "If you and I were working each on a piece of ground the same size - let's say we are weeding - and you smoke an ordinary cigarette and I smoke intsango, you will never finish before me. It gives you strength."

* * * *

Enoch walks into the kitchen.

"I'll see you later," I tell Mandla and follow Enoch inside.

He pours the boiling water into the tea-pot and I get the cups ready.

"Tell me, Stanley," he says to me, "How do you get your money from America?"

"What?!" The question is completely unexpected. "What makes you think I get money from America?"

"No, we saw you got a letter from the U.S.A. the other day."

(I received a Christmas card from my cousin, who is studying in Boston.)

"Look, that was a Christmas card from a cousin of mine. Do you want to see the card? What exactly do you think I am doing here?"

He laughs.

"No. The other people are saying that you are from America and that you are working for the Swaziland Government and that when you are finished working in the hospital you are going to investigate in the prisons. But we can't see how you are working."

"Is that what the other people think? But, you know, before I came in as a staff member, we all had a meeting and I told everyone what I was doing here and I said if anyone ever wanted to ask me more, I would be pleased to tell them. But even so people are suspicious of me and want to make private investigations. I told you I've got the Government's

permission, but I am not working for them. I am working for the University."

"I know what you said, but still the people are wondering why you had to get the Government's permission."

"Which people? Okay, forget it. That doesn't matter. I only want to say I got the Government's permission, because I am not a spy or a secret agent, so if I'm working on Government property they must know what I am up to."

"Yes. Well, that is your affair. If they say that, that is how it must be done."

"Okay. Let's call it a day. You can tell the staff I'm having them all up in court for trying to cure mental patients."

"Hayi! Uh-uh. Stanley, man. Uhlakaniphila."

We drink our tea in silence. We say 'cheerio' to each other and Enoch begins his walk.

* * * *

I return to my room and try to catch a quick nap. I am tired, but I cannot sleep. I get up and go to see if Duma is back from Manzini.

* * * *

I knock at his door.

"Come in."

"Hello here!"

"O, hello Stan." He gets off his bed and offers me a chair.

"Oh, thanks. So how is the 'women-situation' in Manzini."

He laughs. "Oh very bad. Ya, man. I got this chick to take a bus with me as far as the gates, but she wouldn't come in. She asked me how she would get back and I told her I have a European friend with a car who would take her back later on, but she said I must show her his car and no-body's car was here. Even Mr. Khasa had left already, so there was no car for me to show her."

He is laughing at his own unsuccessful 'shaping'.

"Then I told her 'wait', she must come in for a while. I have got a plan. But she decided to take a bus. I didn't even have money to pay for her bus fare."

We analyse his mistakes and work out a more fool-proof formula for possible, future, similar occasions.

"Would you like some supper with me?" he asks.

"Well, thanks a lot. Sorry to ask, but what are you eating?"

"No. I just bought some rice and beans."

"That's great, because I have some chilli fish. We can mix them all together."

"That's terrific, Stanley, man."

* * * *

I walk down to my room and am met in the corridor by Benjamin.

"Oh, there you are," he says to me. (I had forgotten I had threatened to share his food this evening) "I have got some money for you" he says. "Here it is."

He gives me thirty cents and then says, "Now there is only one other person to whom I owe money."

"That's good", I tell him, "It's no good to have a lot of debts. Okay, thanks a lot."

"Thank you for lending it to me," he says.

"Skebengu! (rogue)", I think to myself. "He only gives me thirty and pretends he has paid me back in full. Well, good luck to him. He's a lively old fellow, anyway, and doesn't moan about his lot."

* * * *

I return to Duma's room with the fish. He has already put two plates, knives and forks on fresh newspapers, laid on his table.

"We eat like bachelors here", he says to excuse his table-ware.

"With your luck and my looks how else can we eat?"

He laughs. We settle down to eat.

"Tell me Duma," I say to him, "If someone asked you what your job here was, what would you tell them? I mean, if they asked you 'what do you do from the time you start till the time you finish?'"

"You mean for the whole day?"

"Yes."

He stops eating, thinks for a while, and takes told of the first

finger of his left hand, with his right. "First of all we come in at seven, then we count the patients. We unlock the gate of the office side ...!"

"Hang on a sec. If you don't mind I'd like to get some paper and write this down. Okay?"

"Fine. Go ahead."

* * * *

I walk down the passage, cursing myself.

"This is the last time I write anything today," I promise myself. I walk back into the room, gulp down a few mouthfuls of food, and say "Okay, let's go."

This is what he told me:

7 a.m. "At seven o'clock we come in. There is no patient count, because the patients are counted at five-thirty by the night staff.

"We unlock the office side ward (Block A). We wash the toilets. We wash the Kulukhuthu and we take out the blankets on the other side (Dormitory Eight).

8 a.m. "At eight o'clock, we collect the medicines and go to breakfast. After breakfast has been eaten, we hand out the medicines and return to the ward. Sometimes we give out tobacco to the patients - about every second or third day. Then we boil the instruments and give vitamin B injections to those for whom they are prescribed, and Largactal to the rough patients.

"Then there is a washing of floors and picking up of papers around the yard.

"Immediately after breakfast, the boys are taken to clean emalaweni (in the barracks).

10 a.m. "This takes till ten o'clock. Then the first group goes off for tea till half past ten and the second group goes from ten thirty to eleven o'clock. There is nothing to do in the ward, at this time.

11 a.m. "Washing of patients takes place at eleven o'clock. At this time we wash Majombolo and other patients who have not washed due to their state.

12 a.m. "At twelve o'clock the medicines are collected. The patients

line up at the gate. Then they receive their food and medicines. They return to the ward and disabled patients are given food ... I forgot to say, this also takes place at breakfast time. The first group are off for lunch between twelve and one.

1 p.m. "We wait until one o'clock. Then the second group goes off for lunch from one till two p.m.

2 p.m. "At two o'clock there is a general washing of patients who are lazy to wash or just don't care to look after themselves. Then there is a relaxation until four p.m.

4 p.m. "At four o'clock there is the same routine with the supper (as at the other meals.)

"At four-thirty until it is finished there is treatment for patients and prisoners with cuts in their skin, or stomach or headache complaints.

"Then there is the writing of reports, counting of patients, preparation of bedding and handing over of the day report to the night staff.

7 p.m. "At seven o'clock we are off and the night staff clock in and count the patients."

* * * *

At last the list is over. I had for a long time been wanting to ask a staff member to describe his duties, as he saw them, but now I wonder what I have accomplished. What have I written down? It is a sort of formal account which staff might give to an outsider wishing to know what the job of a staff member was. An account of the 'external system' (Homans, 1959). We carry on eating.

Aloysius and Sumane walk past the window. Sumane is carrying an aluminium pot. They have obviously just done their cooking in the married staff kitchen on the 'big stove' and are returning to eat it.

"Heyi, bakits," I call out of the window. "We are all going to S.U.T. tonight. 'Esuthini'. Do you want to come? Drinks on the house."

"Fixed up", they both say, "just let us finish supper first."

"Is that O.K. with you, Duma? I hadn't got round to asking you yet, but I thought I would catch these two while I could."

"No, that is wonderful. Just my line." He laughs. "What was I going to do this evening? Oh yah. We had this Ballroom Dancing Club evening, but I'll just forget about that."

"There has been some sort of disagreement?" I ask.

"You know what women are like. They always want something for nothing." He laughs. "Victoria and this other female nurse said they weren't going to pay their subscriptions, because they had no more money. So Gideon, who is running the club, asked them why they have no money, when everyone else has money to pay their fifty cents (50c per month). So they told him they need it to buy make-up and things, to look beautiful, and Gideon has threatened to sell the record player, which he bought for the club and eat that money himself."

* * * *

There is a knock at the door.

"Come in."

"Wouldn't you guys like to have something to eat with us?"

It is Aloysius.

We have finished our own food now and follow him down the passage. Aloysius and Sumane have already dished out their own food into two plates - rice and chops. Chops!?

"Hell, where do you get such a banquet from?" I ask.

They laugh. "It's from my brother," Sumane answers. "He had some visitors who gave him a whole sheep, so he has given me some also." (His brother is Ndabazezwa, the Head Nurse.)

"Well I wouldn't like to steal your supplies, I'll just have one chop."

"Ya, me too, man", says Duma, "But maybe I'll just take two or three."

"No, go ahead, Stan, take as much as you like", says Sumane, pushing Duma, who is laughing at his own joke. "Nobody needs to ask you twice", he tells Duma.

"What do you mean?" says Duma, pretending to be affronted.

"You know I eat like a bird."

"Yes you eat like one of those birds with the big beak. What are they called?"

"A pelican?", I suggest.

"Ya. That's right. A pelican". The joke falls a bit flat because its spontaneity has been somewhat staggered, but Aloysius still laughs heartily.

"What's that?" says Sumane.

"You know those birds with the big beak that you sometimes see on vleis, more in the Republic," Aloysius tells him in siswati.

"Oh, yah. I know what you mean."

* * * *

We set out walking down to the S. U. T. "I've never been here before, you know. Is it a sort of shebeen?"

"No. I wouldn't say 'Shebeen', although that might be the right word. Its just some houses that sell home-made jubalani and also shake-shake."

"Oh. They sell shake-shake too?"

"Yes. It's a little bit stronger than the home-made stuff, but you don't get so much for your money." (Shake-Shake is the slang term for a local factory brew.)

"It's in here", says Aloysius. We walk onto a path which leads around the side of a house. At the back there is a gramophone, turned up full blast, and playing some local pop number. Thayima is sitting with one of the drinking groups and we exchange waved greetings.

The drinkers are sitting mainly on benches placed around the garden. Three young men are dancing to the music. They are not dancing 'together', but more in the traditional manner of dancing by themselves, although the music is a sort of rock-twist-kwela variety. There are only two women among the drinkers and they look rather out of place.

"They are not excluded," Duma tells me, "but only cheap girls, or wild girls, will come here, and then they usually come alone as well, because you don't find many men who will come here with their girl friends."

"Where do I buy the drinks?" I ask him.

"Give me the money. I'll go and choose. I know all the different brews. Some are nicer than others."

* * * *

Aloysius and Sumane are already inside. Duma walks in and I find myself standing alone, outside.

"Hello", someone says to me in a tone which might indicate that we have met somewhere before. "How are you?"

"Oh, hello", I say. We shake hands. "Have we met someplace before?"

"Yes, wasn't it in Manzini?"

"I don't know, was it?"

"Must be. Take a seat."

I sit down.

"Its very nice for you to come and drink with us", he says. (This is all I need! I definitely have not met him before.)

"What do you mean us? I haven't come to drink with any 'us'."

"I mean with the black people."

"That's what I thought you meant. But you're wrong. I'm just here with my friends."

"Oh. Are you an American volunteer?"

"No."

"Where are you from?"

"Are you a detective or something?"

"No. I'm a policeman."

"It sounds like it; but you're not on duty are you?"

He laughs. "Let me buy you some Shake-Shake," he suggests.

"No. Thanks all the same. My friends are just buying some jabulani."

"I see", he says, and begins singing the tune 'The Blues are in Town', changing the words to 'The Pro's are in Town' (that is, the prostitutes.)

The others are just collecting a small bench and placing it opposite another small bench so that we can drink in a circle. They turn to look for me and beckon. I tell the policeman, "Cheerio," and he says to me "Bye-bye, see you later. By the way what is your name?"

"Dlamini", I tell him. "Wellington Dlamini."

* * * *

I join the others and ask them, "Do you know that chap over there?"

"Yes, we know him," Duma says.

"I mean are you a friend of his?"

"No. He is a policeman," says Aloysius.

"So? What's wrong with policemen?" I ask.

"They are all right if you know them from before, but it doesn't pay to become friendly with them." The others nod their agreement. "You can think they are your friends, but as soon as you have an argument with them they want to try to arrest you."

* * * *

Duma gives me fifteen cents. "Here is your change," he says to me.

"But surely that whole big tin is more than five cents?"

"No, that's the price."

"Economy size", says Aloysius.

* * * *

Thayima's group is leaving now. He comes over to us, and squats down on his heels. "Have a drink." I offer him the tin.

"Thanks", he says, and takes off his hat before accepting the cup. He drinks a draft and then puts the tin down."

He has still not joined us. He waits to be invited.

"You can take a seat", Sumane says to him.

He sits down on the bench. He is now part of the group.

The same procedure is repeated by another old man who comes over to greet us and is invited to join us. The evening's drinking continues. One more tin down the hatch.

"Come on", says Thayima, "inkazathi. (Chip in). Stanley is paying for everything."

I protest. "No, its on me."

"He is quite right", Aloysius corrects me. "That is our custom. We must all put in for the round."

Thayima puts in one cent, Duma puts in one cent, Aloysius puts in two cents. "One more cent, who is going to put it in?" The old man gets up to leave. I put my hand on his arm. "That's all right. You can stay," I tell him.

I fumble through my pockets and find an extra cent.

Thayima says, "I'll go and get it."

I give him an extra five cents and say to him, "Buy some for Shadrack. He's sitting over there."

He does.

Shadrack comes over to thank me, before he starts drinking himself. He offers the beer to our group. Aloysius takes first sip, but Shadrack stops him. "Uh-uh! Bonga, kuqala! (Praise first)" Aloysius spills some out on either side of the tin and then drinks and passes the tin around. He leaves us with the tin and pours the contents into the clay bowl of his own drinking group.

* * * *

A young girl comes over to our group and starts to converse with Duma.

"Hayi. Duma speaks to funny people," Thayima says out loud. The others laugh. The girl ignores this remark. They talk for quite a while. Thayima scratches his head, shuffles his feet and clears his throat, to the amusement of the rest of us.

When she leaves us, Duma leans over and says to me, "How do you like her, Stanley?"

"Are you joking?" I ask. The others are laughing also.

She says she likes you and she has just gone inside to get her coat."

"No man, Duma. You are lowering us", says Thayima.

"Let's go", I suggest and we leave the tin to the old man who joined us, slipping quickly out of the gate.

* * * *

Along the road we bump into "Daddy", who is swaying his way home.

"Oh, Daddy. Are you on the spree again?"

"On the spree again." Daddy repeats.

"Or were you never off it?" Aloysius suggests.

"No. I'm never off it", says the old man. "Where are you from now?"

"S. U. T."

"I didn't see you there."

"You must have been at another place."

"Do you want to come to the police pub with us?"

"No. I'm going to bed now."

* * * *

We all walk to the junction of the S.U.T. and main roads together. Then Daddy goes his own way. Thayima also excuses himself and walks along with Daddy. (They are both TB staff).

The four of us walk in the opposite direction to the Police Training College. The police pub is where Ndabazewa usually drinks. It has a posh bar, and tables and chairs in a hall. The barman himself is an Englishman, with a real 'Limey' accent, full of wisecracks and good humour.

Ndabazewa is not there this evening. We arrive there at ten o'clock and find they are just closing. (This is fortunate, because we only have about five cents between us.)

It is a long walk back. We finally arrive at the barracks, and bid each other good night, before we go inside.

"Listen", Aloysius says.

We can hear Ruben shouting in the distance. "Now I am in this hospital and you have chased me away from home. Are you satisfied? When I come out I will get you!"

Everyone laughs and shakes his head. "Heyi; Ruben! He has always been like that, since he first came in", says Aloysius.

"He is my best friend in between all of the patients", says Duma.

We go inside and I get wearily into bed. It has been a long day. I wonder if we have made any progress with the patients today. How shall we ever know?

* * * * *

SECTION C.

"Just as a melody is not made up of notes nor a verse of words nor a statue of lines, but they must be tugged and dragged until their unity has been scattered into these many pieces, so with the man to whom I say 'Thou'."

(Martin Buber)

CHAPTER XI:: SITUATED USE OF THE MODEL ; THEORETICAL AND PRACTICAL LIMITATIONS.

Presentation of preceding sketches discussed - rationale - formal limitations - the subject-object split - determinism and freedom - usefulness of the model - practical limitations - the need for concrete goals in 'correcting' and 'steering' operations.

* * * * *

In the presentation of the preceding two sketches of life in Hospital A, close attention was paid to the suitable superimposition of recorded events onto social maps recorded on two particular days. None of the campus material was 'made up' as a story might be 'made up', using some past experiences as a background against which to compose possible sets of circumstances and events. In fact, all events were recorded within at least six hours of their actual occurrence and most were recorded within an hour of their having taken place.

In these sketches, only those situations which could conceivably have occurred on the same day were included in the two days described. Considerations regarding inclusion or exclusion of material included constraints imposed by the society of the mental hospital, the personalities of its members and circumstantial contingencies imposed by preceding sequences in the sketches. Each sketch was thus forged by the desire to present as accurately illustrative a picture of hospital life as possible.

In presenting the material in this way, cultural elements which go beyond the framework assumed by the situational model were revealed. For example, the relative self-containment of certain features of staff and patient sub-cultures, considered separately, is not taken into account by the

existing model. The material presented is in this way illustrative both of the possible field of practical application of the model and of the theoretical and practical limitations of the model in encompassing the reality of the total field under scrutiny. The sketches were not presented merely to illustrate the application of the model. They represent attempts to give a true picture of the actual context in which the application of the model is envisaged.

Formal limitations of the model.

Individual persons are not psychologically explicated. Their construct systems remain private, except when they are made evident in the framework of concrete situations - and, then, only within the expressive order prevailing in such situations. The field opened up by the model is thus limited to an analysis of classes of staff conduct in relation to patients, classes of staff-patient conduct exchanges and classes of significance of such conduct exchanges for the institutional order as a whole - an order which both governs and is governed by relations embodied in situational interchanges themselves.

The model presented can not be reduced to purely behavioural dimensions, since it transcends the context to which behavioural analysis can properly be applied. By setting up 'consciousness' as something more than a reflection of ongoing processes - by crediting it with power to transform the situation in which it is embedded - the subject-object split is overcome at the level of self-awareness rather than in terms of an objectification of the subject in an historical perspective.

In terms of Kelly's (1955) construct theory, two types of determinism

can be discerned in human psychology:

(1) The determinism of superordinate constructs over subordinate constructs and elements, and

(2) Cause effect chains,

Thus 'determinism' may be characterized as the control which a construct exercises over its subordinate elements, while 'freedom' may be characterized as the construct's relative independence of these elements. Once such 'freedom' is theoretically allowed for, the analytical potential of the model itself is partially discredited. However, if this position is consistently taken, most other models applied to human conduct will also be seen to fall short of comprehensive analytical treatment.

At best, then, the situational model serves as a pointer. But it is a pointer that can be embodied in the situation itself to stabilize and modulate demands in such a way as to give them situationally meaningful therapeutic dimensions. In this way the model, if so used, will serve the function of mediating between therapeutic goals - which can be realistically envisaged for particular patients - and the therapeutic requirements of current situations, viewed as stepping stones to the attainment of these goals. This is where its primary utility value lies.

Practical limitations of the model.

The 'cause' of any particular sequence of tactical exchanges can only be sought by referring back to a description of the total system. Therapeutic strategies must be seen as exerting pressures in specific situations to change both some peoples' behaviours and other peoples' responses. Unless behavioural sequences spiral with respect to therapeutic biases purposely

written into the rationale underlying hospital practices, only homeostatic adjustments to a stable and therefore essentially 'non-therapeutic' environment can be expected from patients. Only a progressive, systematically ordered change in the setting of demands made on patients progressing in the therapeutic system will change the entire range of their individual construct systems and consequent situated conduct patterns. Hence the controlling staff need to be engaged, ideally, in both 'correcting' and 'steering' operations. If this is not so, sequences such as those exemplified by Situation 12 (page 210) will be predictable. A systemically ordered bias needs to be entrenched in the therapeutic system so that appropriate changes in patient conduct and construing can be both recognized and reinforced.

In the absence of clearly established therapeutic goals, a classificatory schema which relies on the existence of such established goals is clearly limited in its practical application, since therapeutic end-points clearly underwrite all therapeutically ordered situations.

Conduct-regulating constructs, invoked to structure and encompass the nature of particular demand situations facing patients, can be viewed either from the point of view of what they actually stand for, in terms of current hospital practices, or in terms of what they could stand for, were therapeutic practices established on the basis of the ideal of therapeutic integrity envisaged. The difficulty which arises in applying this abstract set of derived imperatives to the concrete situations described in Section B, lies in the resistance to classification which these situations present, in terms of established practices historically embedded in institutional patterns, structured according to an alternative model.

Problems of hospital reorganisation are not the central subject matter

of this thesis, although they have been touched upon with reference to Colarelli and Siegel's Ward H experiment, which showed how the effects of structural changes need constantly to be assessed with reference to the effects these changes have on existing patterns of relationship. Of interest here, is Argyle's (1964) conclusion that it may be impossible to change a prison or mental hospital in a liberal direction, without also selecting staff of a less authoritarian character at all levels. Such selection he deems necessary in order to facilitate freer communication, which, in turn, allows freer access to a mutually shared understanding of the nature and the practical effects of various therapeutic practices.

Speaking from his own experiences of working with 'therapeutic communities', Jones (1968) asserts that an essential feature of the therapeutically viable community is 'the daily community meeting'. He makes it clear that this meeting involves "the entire staff and patient population of a particular section." This, he suggests, should be followed by a 'review' immediately after the meeting, which affords "a useful on-the-spot training opportunity." During this second meeting, attended only by staff members, responses to the same interactional scene in the community meeting (on the part of various types of personnel with different skills, expectations and prejudices) are examined. Perceptions and feelings of staff are, in this way, discussed retrospectively, and a measure of feedback about the nature of their own participation is given. Here too, alternative possibilities are not confined to consideration of contingencies operant at the time the interaction took place. Rather, an overview is sought in terms of which more profitable constructs might be invoked to guide and regulate therapeutic conduct on future occasions. It is for use in such a context as this, that

the classificatory schema and the situational model on which it is based have been developed here.

Just as 'personality structure' has been construed in this thesis in terms of 'character', which implies the existence of a set of judgemental criteria for making inferences about one's own conduct and about the conduct of others, so too the 'character' of a mental hospital becomes clear only through observation of judgemental criteria used by community members (that is, staff and patients) with respect to the role conduct appropriate to each, at different stages of the mental patient's therapeutic career. In the process of trying to resolve conduct problems arising in therapeutically circumscribed situations, the approach has been to focus on the position of signs in the overall context, on the meaning which these assume, and on what has been left out in order for these signs to be there at all. In viewing therapy as a co-operative enterprise, the ideal envisaged is eventual mutuality of standards, shared by staff and patients alike. The function of the therapist is viewed as therapeutic intervention aimed at step-wise integration of patients on to the subjective side of knowledge and power, through a common sharing of the normative principles embodied by the logic of the therapeutic system.

Selected Situations marked and numbered in Section B.

Under the limitations imposed by the inadequacies of current institutional practices, the situations ear-marked in Section B have been classified as follows:

C L A S S I F I C A T I O N S

Situation	1.	Comprehensive	(p. 183)
"	2.	Comprehensive	(pp. 183, 184)
"	3.	Disjunctive	(p. 185)

Situation	4.	Comprehensive	(p. 186)
"	5.	Unaligned	(p. 191)
"	6.	Comprehensive	(p. 195)
"	7.	Comprehensive	(p. 195)
"	8.	Disjunctive	(p. 200)
"	9.	Disjunctive	(p. 201)
"	10.	Subversive	(p. 208)
"	11.	Disjunctive	(p. 209)
"	12.	Subversive	(p. 210)
"	13.	Comprehensive	(p. 214)
"	14.	Subversive	(p. 216)
"	15.	Disjunctive	(p. 217)
"	16.	Comprehensive	(p. 221)
"	17.	Unaligned	(p. 221)
"	18.	Disjunctive	(p. 231)
"	19.	Subversive	(p. 243)
"	20.	Comprehensive	(p. 260)
"	21.	Unaligned	(p. 261)
"	22.	Unaligned	(pp. 263, 264)
"	23.	Subversive	(p. 269)
"	24.	Subversive	(p. 273)
"	25.	Unaligned	(pp. 275, 276)
"	26.	Subversive	(p. 282)
"	27.	Disjunctive	(p. 282)
"	28.	Comprehensive	(p. 287)
"	29.	Disjunctive	(p. 290)
"	30.	Comprehensive	(pp. 299-300)
"	31.	Subversive	(pp. 301, 302)

Situation	32.	Disjunctive	(p. 306)
"	33.	Subversive	(p. 308)
"	34.	Comprehensive	(p. 318)

KEY TO CLASSIFICATION INDEX.

	(1) Authentic	(2) Inauthentic
(3) Epistemologically Strong	1, 3	2, 3
(4) Epistemologically Weak	1, 4	2, 4

1, 3 : Comprehensive

2, 3 : Subversive

1, 4 : Unaligned

2, 4 : Disjunctive

* * * * *

CHAPTER XII : THE FUTURE - SUGGESTIONS FOR IMPROVEMENTS IN HOSPITAL A.

Part-obligation as a researcher - suggestions for further research
 'read into' improvement suggestions - research perspective : a framework for
 asking basic therapeutic questions - the 'logic' of the therapeutic ideal
 assumed - implications for hospital organisation - suggestions - a patient
 grading system - recreational pastimes - replacement of tobacco incentive
 with exchangeable 'token' chips - work groups organised on dormitory basis -
 hospital conduct related to extra-hospital circumstances - daily community
 meetings - an industrial therapy unit - a hospital chip-exchange 'shop' -
 a fixed 'rate' of incentive payment - incentive gradings - religious parti-
 cipation - employment of psychiatric social workers - the rationale behind
 suggestions.

* * * * *

Part of the agreement under which I was permitted to carry out research
 in Hospital A, lay in my obligation to the relevant authorities to inform them
 on issues which I considered to be hampering the therapeutic functions of the
 hospital, and to suggest possible improvements which might increase the
 therapeutic viability of its organisation. During the time I was engaged in
 research in Hospital A, methodological exigencies required that I alter as
 little as possible the conditions under scrutiny - at least until such time as
 sufficient data had been collected to make accurate description and analysis
 of situated practices possible. It was only after I felt that my study was
 more or less complete that I was able to advise those concerned about the
 nature of my findings and to suggest improvements to existing structural
 patterns and their functionally ordered processes.

Suggestions for Improvement.

The nature of everyday situations in Hospital A have perhaps been sufficiently dealt with, thus far, to make a detailed description of them, here, superfluous. Furthermore, since this thesis was not written for the purpose of establishing any specific or general programme of reorganisation, but rather of seeking to establish a framework within which certain basic therapeutic questions could be asked, it would be pretentious for me to try to suggest a step-wise reorganisation programme at this stage. Nevertheless, since the logic of therapeutic enterprises was considered in terms of practices currently in use, to assume that the logic evolved did not presuppose an ideal organisational character would be to miss the point. It was, in fact, from the practical problems faced by both patients and staff in therapeutic situations that the thesis itself derived a great deal of its dialectical thrust. In each individual situation, I was more or less obliged to consider how the limitations of present practices might be overcome, through an extension of the therapeutic imperatives dictated by the logic evolved. At no stage were therapeutically circumscribed situations considered 'in vacuo'. Rather the solution to each problem was faced in terms of the dialectical epistemology evolved. Each theoretical advance was considered with respect to concrete situations actually observed and described. It is from the loving centre of this constant

interpenetration of theory and practice, that the following suggestions for improvement in Hospital A are made:

Suggestion 1: That a system of patient grading be instituted.

A system of patient grading, made evident through assignment of patients to positions of authority over other patients (whom they would be obliged to help), would serve to provide patients with a means of assessing their own progress. Hospital privileges - freedom of movement, lowering of drug dosages, freedom to indulge in recreational and other pastimes, token payments to exchange for certain available goods (to be discussed later) - would similarly indicate progress in the therapeutic system.

Suggestion 2: That sporting and other recreational pastimes be introduced for all patients.

Patients should be divided into groups which include patients who fill the entire range of patient status grades, requiring them to organise themselves into teams for engagement in such events as soccer matches, leggy, tug-of-war, ring throwing or any other sort of competitive game in which team participation is required. Staff members should be included in such teams, so that they would be competing against one another, along with the patients. Floating trophies and other prizes could be given to winning teams. Dancing and debating teams should similarly be organised to compete against one another, with selected judges from patients and staff deciding the winners. Such teams could also compete internally so that each team produce its own champion to compete in interteam competition, in singles events, such as tenniquoits. Again the winning team representative could be either a patient or a staff member.

Such teams would enable patients to develop patterns of group solidarity and interpersonal loyalty such that status differences among patients, and between patients and staff, would be played down in the service of goals which only the group as a whole could attain. Patients would also be able to practice new modes of interpersonal conduct in such situations, where therapeutic circumspection is reduced and the self-defining implications of alternatively

occupied role positions in the therapeutic system played down. Such role distantiating conduct would naturally be carried over into the more formally regulated aspects of the therapeutic system, so increasing interpersonal flexibility in role commitments in other areas.

New patients would only be assigned to teams after one week, although, if they were capable, they could play in different teams before this time. The teams themselves should be identifiable through arm-bands of different colours to be worn by patients whenever they wished. As a punishment for undesirable conduct team members could be excluded from certain sporting events or even dropped from a team for a period. Patients who are sufficiently recovered and whose standard of play merits their inclusion, should be included in the Matsapha Football Team to play outside clubs, at least in such games as are played in the St. George Barracks grounds; games which are at present watched by responsible patients.

Suggestion 3: That a system of token chips replace tobacco payments.

The handing-out of non-incentive tobacco should be abolished, all tobacco being replaced by chips, which could later be exchanged for tobacco at pre-arranged times. Such chips would be given to patients on the evidence that they were capable of certain 'normal' duties - washing themselves, making their beds, bringing uniforms and blankets to be exchanged when these uniforms and blankets have been in use for a certain period, and so on. Non-performance of these duties would incur chip 'fines'. Payment of chips should be officially noted, to obviate stealing.

Boxes of matches should be similarly earned, but they would be in the safe-keeping of a 'dormitory leader', as a fire-prevention measure. This leader would himself have to earn this role-position and his match-box - carrying right and privilege would oblige him to be responsible for lighting patients' cigarettes. This leadership position would be revolved among responsible patients on a weekly basis, to avoid possible abuse of power. Any complaints would be dealt with by staff intervention, after all sides of the story had been presented and sorted out within the group itself in the presence of a staff member, who would be required to summarise the pros and cons of the issues at stake before executing judgement.

Suggestion 4: That work groups be organised on a dormitory basis.

The practice of selecting only patients currently capable of fulfilling certain cleaning tasks should cease. Cleaning duties should be assigned on a dormitory basis so that improved patients be put in charge of certain cleaning duties to be undertaken daily. Cleaning duties should be undertaken in turn by all the dormitories. All willing patients would be assigned particular cleaning duties for a week, on a pre-arranged chip-payment basis. Those made responsible for organising the other patients would be paid extra chips in accordance with their duties and the way in which they put these duties into practice. As patients improve so they should be assigned to more responsible role positions. Lavatory cleaning, floor scrubbing and polishing, weed clearing, uniform washing, blanket-washing, hanging out and collecting, are among the duties considered appropriate here. Patients' abilities to cooperate with one another on a working basis, and their sense of personal and group responsibility, would be improved hereby.

Suggestion 5: That patient conduct be consistently related to extra-hospital circumstances.

Conduct problems arising in the hospital context should be consistently resolved with reference to extra-hospital conduct. For example, refusing to shower could be met by the question: "How are you going to look after yourself when you are discharged from the hospital?" Resistance to hospital work duties should be met by questions relating to ability to earn a living, to support a family and so on. In this way, the patient is continually validated in roles he will be obliged to assume on discharge. No problem situation should be left unrelated to extra-hospital situations. In this way, the patient is constantly led to prepare himself for the time of his discharge and is not led to view the hospital as a self-contained world, without relevance to his previous life outside of its boundaries, or his future life in the wider society. Questions such as "How did you manage to do this or that (the activity in question) when you lived at home?", or "when you worked in Mbabane or Manzini or Johannesburg?" (as the case may be) would relate present activities to past problem areas. Each status improvement earned by the patient should

be evaluated along similar lines. Each privilege earned, each fine or punishment imposed should be related in this manner, in preparation for after-discharge life.

Suggestion 6: That the Superintendent and Head Nurse attend daily community meetings on the campus.

The therapeutic staff of all levels should not only work as a team behind the scenes, but should function together as a team, together with patients, on occasions where the latter's progress can be discussed. Due to the large number of patients in the hospital, it might prove more effective for the patients of each particular dormitory to meet fortnightly for full-scale discussions. At such meetings, which should last for at least an hour, the floor should be open for any questions, comments or complaints which patients might wish to raise about any aspect of hospital life. The staff should also be open to criticism at these meetings, should patients wish to criticise them. Clarifications of the meaning of therapeutic practices and their relation to patient progress could be discussed at these times and individual patients' problems dealt with either on a personal or a group level, as the therapeutic staff see fit. A 'review' would follow the meeting, attended only by staff, where therapeutic strategies would be discussed.

Suggestion 7: That an industrial therapy unit be established.

An industrial therapy unit, whose work-products would be handicrafts, such as sisal and grass mats, wood carvings, beadwork, modelled and carved cattle horns, baskets, and so on, should be established, and the products sold from a stall erected on the Mbabane - Manzini road (preferably near Chick's Garage) and manned by recovering patients.

The profits from the sale of these articles could be used to buy personal effects such as combs, toothbrushes, toothpaste, towels, jerseys, and so on, for internal patient use. These would themselves become symbols of status advancement inside the hospital and would be available in exchange for chips earned in industrial therapy occupations. Second-hand clothes, at present being supplied to patients on discharge (and supplied to the mental institute

by the Red Cross Society), should similarly be 'sold' to patients, with chips earned from the sale of handicrafts. These clothes would be kept for patients to wear on the day of their discharge. Chips should also be exchangeable for bus-fares to the patients' home areas, as well as for 'pocket-money' which the patient could take home with him. Should patients desire it, they should be allowed to buy their own work-products at a reduced price, so that these themselves would be chip-exchange goods. Garden- and kitchen-workers should share the same privileges as industrial therapy workers in this respect. Patients should be allowed to send certain things to their relatives at home. This would serve to maintain contact with families and improve relations within the household, in preparation for the time of patient discharge.

At present the empty dormitory of Section B could be used to start off the industrial therapy unit. (Dormitory Seven).

Suggestion 8: That a shop, to be run by patients, be established in the hospital.

A shop, possibly in the present kitchen complex should be established, where different colour chips could be exchanged for different grades of goods. Fruit and sweets, at present handed out weekly by members of the Red Cross Society, could be incorporated into the shop and exchanged for chips, earned through fulfilment of normal duties. Brown paper, much in demand for rolling cigarettes, and tobacco could also be sold here.

The shop should be run by responsible patients who would be obliged to take stock of exchanges. They would be paid accordingly. This would serve to incorporate recovering patients right into the centre of the incentive system, as therapeutic agents.

Second-hand clothes to be worn on the day of discharge could also be sold here. Toothbrushes, toothpaste, mirrors, towels, personal soap and combs would likewise be on sale. Money derived from the sale of handicrafts could be used to sponsor the buying of these articles. Tobacco, supplied by the Government, and at present handed out by nursing staff, would be available from the shop instead. Nursing staff would pay patients in

exchangeable chips, instead of with tobacco, as at present.

Suggestion 9: That a fixed 'rate' of incentive payment be established.

In order to circumvent the possibility of informal systems of exchange developing (with exchange of goods on grounds which are not therapeutically based), the organisation of work groups on a dormitory basis was suggested. Now, to establish and further entrench the impersonal therapeutically ordered basis of hospital work programmes, a fixed rate of incentive payment for each task is suggested. 'Payments' and 'fines' should be entered in books (one book per dormitory), so that these might serve as bases for discussion in fortnightly dormitory meetings. Patient improvement would in this way become 'measurable'. Injections, pill dosage, confinement in the security block, and so on, would similarly be entered. Separate daily reports would then become superfluous. Books would be divided out among staff for the day although entries could also be made by other staff members.

In this way therapeutic progress would be functionally integrated into a predefined pattern of structural arrangements. At present there are not sufficient staff to allocate one staff per dormitory during the day. This would be ideal.

The various recreational 'teams' might be organised on a dormitory basis also, with staff members being transferable across teams, in keeping with patterns of on-and-off-days. Periodic reshuffling would avoid favouritism developing for any particular patients or groups, at the expense of other patients or groups.

Suggestion 10: That incentive tokens be graded in relation to level of task 'difficulty' viewed as a measure of patient improvement.

Not all chips should have the same value. Fruit, sweets and tobacco should be available to patients performing normal self-care duties, such as making one's own bed, sweeping the dormitory in one's turn, taking a daily shower, and so on; whereas personal effects such as combs, toothpaste, soap, jerseys and so on, should only be available to patients who join dormitory work groups, who perform such co-operative tasks as scrubbing the

dormitory floors, cleaning the toilets, weeding the garden, working in the fields, helping in the kitchen and so on. Chips would be graded according to the level of co-operation required and available goods for exchange at the shop should be similarly ranked. Prizes for competitions would, in their turn, constitute another grade of chips. These could be won by staff members, so increasing their own incentive to play an active part in the teams of which they are members. Teams, not individuals, would be awarded these chips. They would be handed out by the Head Nurse or Superintendent, so that informal 'lifting' and spending of incentive chips by staff members in the chip shop, would be circumvented.

Suggestion 11: That religious services be organised on Sundays and Holy days.

Since there are three lay preachers of different denominations in the hospital (working as male nurses), these persons should be encouraged to preach and to hold services in the hospital itself. Those patients who are involved in religious organisations outside the hospital, should be encouraged to participate in devotional practices in the hospital. Outside guest speakers, especially from areas where a large number of patients are resident, should be invited, so that links between patients and religious of these areas be maintained, during and after treatment. Similarities of religious custom and practice would cut across team, work-group and industrial therapy in-groupings, established in other areas. Such similarities would also serve as bases of common interest for staff and patients, so helping to minimise staff-patient differences in certain areas of activity. Patients should be encouraged to speak at religious meetings and so to relate their own conduct to religiously-centred principles, and the meaning of these principles with regard to interpersonal relations in hospital and everyday settings.

Suggestion 12: That social workers be employed to investigate the extra-hospital social situations of the patient.

Social workers, employed to investigate the social situations of

patients, both before and after discharge from the hospital, should be required to work with patient households, so as to facilitate integrated patterns of social re-engagement. Problems should be mutually discussed with the patient's family and with the patient himself, as well as with mental hospital staff. Such intra-hospital discussions would take place either privately with patients, and separately with staff, or with a combination of both. Another possibility could be that such discussions take place in communal dormitory meetings, attended by all the patients of a dormitory, plus nurses, the Head Nurse and the Superintendent. This would enable the patients to take account of other patients' personal problems, to look at the way in which they, themselves, are going to cope with their extra-hospital situations on discharge, and to discuss their own problems in similar situations. This would also give the social worker a good opportunity to learn about other patients' extra-hospital problems, before discussing these with their families. Following up patients after discharge would enable the social worker to report back to dormitory meetings on ex-patients' progress and extra-hospital problems faced by them, so allowing patients awaiting discharge to consider and discuss how they might cope with similar situations. The social worker would be able to discuss these with the patients' families before discharge. The social worker could also help to establish and/or cement relationships with the patients' regional chiefs and/or ministers of religion.

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The 'suggestions for improvement' presented above, derive from an attempt to meet a complex deficiency in the running of Hospital A - namely, the absence of clearly definable therapeutic goals whose recognizable presence could stabilise and guide therapeutic practice. Such therapeutic goals, if consistently worked towards, would make therapeutically ordered situations immediately permeable to situational analysis. The suggestions are thus essentially an attempt to map out guidelines for therapeutic practice. They do not strictly 'derive' from the situational model, since the model merely

serves to illustrate logical relations and meta-relations in a particular social system. Nevertheless, each suggestion reflects the logic of the model in that it takes into account the functional relation of conduct demands, constructs and sanctions relative to the institutionally ordered workings of a functionally viable therapeutic system, 'ideally' construed.

The 'therapeutic system' can be understood as the way in which the mental hospital structures social relations, regulating and stabilising conduct through the use of sanctions which reinforce certain conduct patterns in accordance with therapeutic principles embodied by the professional super-structure (and therapeutic staff). These 'therapeutic practices' are dictated by and large, by therapeutic goals and the institutionally ordered means laid down for attaining them. Thus 'therapeutic principles' are realized in terms of the institutional ordering of therapeutic purposes into institutional functions. These institutional functions, in turn, integrate individual needs within the structurally ordered requirements of the therapeutic system as a whole. Through the constructive use of sanctioning procedures individual needs become legitimised in terms of a limited vocabulary of positively sanctioned motives (public constructs) which link individual conduct to therapeutic goals and institutionally ordered means to attain these goals.

Areas in which certain predefined conduct expectations and demands will generate the maximum therapeutic potential are explicitly set out in the suggestions, so as to facilitate constructive practical underlinement of them with reinforcing sanctions. The form which these sanctions may take is also set out in detail. A viable therapeutically ordered public construction of joint staff-patient enterprises may thus be realized.

As patients begin to learn to fit into this therapeutically ordered scheme of things they will move from the object to the subject side of power and control, finally attaining role positions in the hospital culture where their readiness for discharge will be clearly evident to all.

Due recognition is paid to the need for structured marginality to be built into flexible areas of role commitment so that status transitions may take place unencumbered by rigid role boundaries. Thus the evolution of situations which will permit upward mobility of patients in the hospital culture, in a therapeutically biased manner, is made possible.

Thus, Suggestion 1 makes provision for a system of patient grading; Suggestion 2, for areas of built-in marginality, where commitments could be tested in therapeutically less consequential situations; Suggestion 3, for a clear-cut system of sanctioning which could be constructively related to conduct demands made on patients; Suggestion 4, for extending control and increased status to improved patients in therapeutically circumscribed areas; Suggestion 5, for ensuring the relevance of controlling staff constructs to wider social expectations; Suggestion 6, for ensuring a close functional integration of the staff hierarchy in terms of practical day-to-day institutional functions and the social purposes they are designed to subserve; Suggestion 7, for broadening the base of the material infrastructure of the hospital's therapeutic systems so as to enable institutional functions to partially integrate with wider community practices, actively involving the patients themselves; Suggestion 8, for integrating patients meaningfully into the operation of the therapeutic incentive system; Suggestion 9, for ensuring that all exchanges take place on the basis of the therapeutic system alone, thus obviating the possibility of private, exploitative exchange systems taking root in the hospital; Suggestion 10, for providing both staff and patients with a means of assessing therapeutic progress in terms of patient involvements in day-to-day institutional processes and practices; Suggestion 11, for integrating the ideological and situational demands of wider social practices within the framework provided

by the therapeutic system and for enlisting the aid of community leaders in the process of social reintegration of patients; Suggestion 12, for preparing both patients and their families for the process of the former's reintegration into wider community settings.

In exploring theoretically the significance of 'situations' to mental hospital practices, the point of view that conduct, constructs and consequences are therapeutically interdependent has been argued for. Mental hospitals, it is stressed, can best be looked upon as subserving a resocializing function on behalf of particular communities. Their effectiveness would seem to depend in part, at least, therefore, on taking into account demand situations central to the patients' own cultures. The suggestions for improvement put forward here are a logical extension of this argument in that they point the way to its practical embodiment in one particular hospital setting.

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EPILOGUE

"While we live with others, no judgement of ours on them is possible which exempts us and separates us from them"

(Maurice Merleau-Ponty)

The hospital's therapeutic strategy may be judged to be existentially relevant if it can be shown to lead to a renunciation of personal life styles which are self-defeating because they do not sustain the social and material conditions which embed the individual adopting them, or, conversely, if they do not enable him to alter his material and social conditions in such a way that they provide a conducive: social and material context for him. What would seem to be necessary, therefore, is a preparation of the individual for commitment to a logic which incorporates suitable pay-offs for him, while, at the same time, embedding him within a system which benefits from his action through secondary consequences, contingent upon his conduct within it. This essentially represents, then, a programme of reconciliation of individual and social systems, by virtue of a higher synthesis and logic which sustains both embeddedness and pay-off matrices within a common framework of predefined goals. (This being the case, it is difficult to see how therapists can escape from prior political and/or religious commitments.)

'Being' always means 'being-in-relation-to-something'. 'Authentic being' would seem to involve commitment to action within a social context which the individual must finally be left to infer for himself. He will therefore need to have committed himself to a system - not usually explicit - within which he is prepared to act and outside of which he is not prepared to act. If this system is inconsistent or self-contradictory, then the individual's identity will necessarily be unstable, or, at worst, self-destructive.

Each one of us centres upon certain goals and in so doing places himself in the centre of a system defined by the nature of the possibilities open for the realisation of these goals, and the concurrent realisation of oneself in the process of trying to attain them. The style of action adopted in trying to attain these goals sets the limits on one's being, expands or constricts one's imagination, one's courage and one's ability to believe and to commit oneself.

Those of us who are concerned with therapy of mentally disordered persons are ourselves necessarily committed to such a system. It would seem a reasonable demand, therefore, for us to love those whom we wish to realign with a certain definition of reality in such a way that we become model participants in their dilemmas.

Let us assume, at this stage, dear reader, that you are more interested in your Fellow Man than in a system of ideas. Then the truth we shall be fighting for will be the truth of our own human existence. Not merely the pros and cons of this or that distortion of reality 'out - there', but our own lives, are at stake. It is that which holds us which we are trying to grasp, and we are a part of It. Let us not conclude, then, that "It thinks, - therefore I am not." (Heller, 1952). Rather, let us join hands across the boundaries of sanity in the common universe we share.

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