

CULTURAL CONSTRUCTION OF PSYCHIATRIC ILLNESS:  
A CASE OF AMAFUFUNYANE

by

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## ABSTRACT

The purpose of this study was to explore definitions of an illness condition amafufunyane and the subsequent help-seeking behaviour amongst Black Psychiatric patients who were attending a psychiatric community clinic in Guguletu (a residential area for Blacks in Cape Town). Psychiatrists have always been faced with the problem of having to deal with patients who present with this condition.

The concern was to do an exploratory research in this area using the Explanatory Model framework as a method of enquiry in studying the condition of amafufunyane. Within the parameters of this model, Black psychiatric patients presenting at the psychiatric clinic, were studied in order to explore the context of illness definitions regarding the condition of amafufunyane. Of importance also was to explore the patterns of help-seeking behaviour employed by these patients, and the effect that the psychiatric orientation adopted at the clinic had on such patterns.

An interview schedule was developed using the Explanatory Model framework as a guideline. The sample was identified by screening the population of Black psychiatric patients who were attending the community psychiatric clinic in Guguletu (a residential area for Blacks in Cape Town) in 1988. The patients were screened by using a preliminary questionnaire designed for this purpose. The sample included only those patients who conceived of their condition to be amafufunyane.

The data collected were analysed by reading the protocols and extracting themes that were then summarized and discussed. Explanatory models elicited from the patients revealed that

the present-day notion of amafufunyane is not easily defined, and it varies from informant to informant. This finding contradicts previous research done on the amafufunyane which always showed this condition to have a typical cluster of identifiable symptoms.

The study also demonstrated the differential use of various treatments by patients, and associated factors with future patterns of help-seeking were established. The importance of enquiring about the patients' explanatory models regarding their illness condition, has been highlighted. Case illustrations are presented to illuminate the discussion of the findings. Lastly, some suggestions for future research are offered.

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## CHAPTER-1

### CHAPTER OUTLINE

The work reported on in this study focuses on three areas:

(i) exploring the ways in which Black psychiatric patients attending a community psychiatric clinic construct explanations to account for their illness condition - amafufunyane. That is, how Black psychiatric patients define and explain their illness condition of amafufunyane. The process of defining and explaining was seen as an interpretation of an illness within a narrative reconstruction of their lives.

(ii) The second area included relating the issue of illness definition and explanation to the patterns of help-seeking behaviour (regarding a particular illness episode). That is, exploring how certain choices are made in order to decide whether to continue in care, when to switch practitioners and practices, and how to interpret treatment outcome.

(iii) The last area examined the effect of the psychiatric setting or orientation on help-seeking behaviour. Also how the patients within the setting evaluate and interpret treatment outcome.

In order to address these questions a study was undertaken including a sample of Black psychiatric patients attending a psychiatric community clinic run by Valkenberg Hospital in Cape Town. Certain questions were raised, namely; how do the patients who attend this clinic define and explain their illness conditions? what informs the patterns of help-seeking employed? how are these viewed by the clinic staff? and to

what extent do the answers to these questions influence the kind of treatment which the patient receives?

Chapter-2 provides a detailed description of conceptual issues surrounding spirit possession and current research issues on amafufunyane. Chapter-3 examines theories of help-seeking behaviour as applied in other countries and the little that has been done in South Africa. Chapter-4 introduces the reader to the psychiatric setting of the clinic.

The psychiatric clinic in Gugulethu (a residential area for Blacks) is run by Valkenberg Psychiatric Hospital. During the period under study (1988), the clinic was in its eighth year of existence. It was open to patients every week from Monday to Thursday, with a psychiatrist or a psychiatric registrar coming twice a week. Referrals were made from other institutions, clinics, private practitioners, social agencies. The orientation of this clinic was mainly chemotherapy.

In Chapter-5, the rationale for and the aims of the study are presented, and the reader is introduced to the theoretical framework on which the present study is based. In Chapter-6 Kleinman's (1980) Explanatory Model was used to demonstrate how it can aid in overcoming the limitations of descriptive psychiatric models. The Explanatory Model (EM) allows a specific way of looking at how the patients pattern, interpret and treat their illness condition amafufunyane. That is, it allows the patients to offer explanations about particular episodes and the significance these have for the patients and their families.

Since the central issue in the study was the conception of amafufunyane and the implications of help-seeking, patients who were included in the sample were only those patients who labeled their illness condition to be amafufunyane and who were attending the psychiatric clinic for the first time (in 1988) after discharge from psychiatric hospital.

This thesis considered the entire spectrum of conceptions of amafufunyane in the context of the above model. The main concern being to establish whether using such a model would help in creating skills in eliciting patients', families' and practitioners' EMs of illness. Also, whether it would help in describing culturally based problems affecting the patient and families' perceptions of symptoms and communication of distress and coping responses.

An interview schedule was developed using the EM framework as a guideline. This included in-depth interviews recording the way patients define and explain the condition; exploration of decisions taken and the social network of referrals involved in such decisions, consultations with various healers, and actual determinants of such behaviour; and lastly, the examination of the orientation used at the clinic and its effect in influencing future patterns of help-seeking behaviour, and how the patients evaluate the treatment received. This practical work is illuminated by case illustrations and diagrams.

Theoretical conclusions relate to this framework. It is, however, in combination that the parts of the study demonstrate the contribution that can be made to the understanding of illness condition of amafufunyane by using

the EM approach. For the present study, such an approach committed itself by elucidating the logic of these behaviours from the patients' perspective, in the context of their other life experiences. Also, it provided an overall framework in which to view several distinct yet overlapping areas of interest to psychiatrists and psychologists. Drawing from the interviews, the findings of the thesis argue the positions advanced on the basis of an examination of the above areas. Data presented illustrate what being mentally ill entails (to these patients) and how beliefs about illness affect individual and family decisions in the health seeking process.

The findings are divided into three sections. Chapter-7A reveals that the present-day notion of amafufunyane is not easily defined and it varies from informant to informant. For some it conveys a condition with symptoms that bring physical changes as well as changes affecting interpersonal relationships at home and at the work place. For others it signifies a condition with drastic, frightening symptoms, and for the rest it conveys the idea of a psychological disorder. On the question of explanations of cause, some informants attribute the cause of this condition to umona, that is, jealousy. Others also acknowledge the influence of other factors involved such as psychosocial stresses. They view these stresses as engendering the condition of amafufunyane.

In Chapter-7B decisions about what to do and who to consult have been shown to be based on illness beliefs regarding the particular illness condition. Also, the various patterns illustrated show that help-seeking is based on various determinants the most dominant being an illness label which

implicates etiological factors which further provided logic for the choice of a particular treatment and evaluation thereof. The chapter ends with two case illustrations of the patients involved in the human 'drama' of help-seeking.

Chapter-7C: In relating the psychiatric setting to the process of help-seeking behaviour it was found that the psychiatric services are not seen differently from any other medical services in the community. That is, the skills of the psychiatric professionals are not so well understood, other than that they are drug dispensers. It was also shown that psychiatric assessment does not appear to give as full an appreciation of the patients' definitions and explanations of their illness condition as would have been the case if a different model were used. And this had implications for future patterns of help-seeking behaviour that were based on the patients' experiences within this particular setting.

Chapter-7D concludes the report on findings by drawing together the information on the definitions and patterns of help-seeking to seek an understanding of the implications that these have on patients who attend the clinic. This is presented in the form of two case illustrations.

Chapter-8 concludes by: firstly relating the findings to the main concern of the study which was to use the EM framework in eliciting conceptions of psychiatric phenomenon amafufunyane, thereby confirming the relevance of using such a framework; secondly, the limitations of the present study are discussed; and lastly, recommendations for further research are presented.

## CHAPTER-2

### WHAT IS AMAFUFUNYANE? WHAT IS ITS PSYCHIATRIC SIGNIFICANCE

The concern of the present chapter is to examine the conceptions of mental illness amongst a group of Black psychiatric patients, who conceive of their illness as being amafufunyane rather than mental illness. Firstly, definitions and types of amafufunyane will be given, placing it within the context of evil spirits. Secondly, to start the discussion on what is understood by the condition amafufunyane, conceptual issues pertaining to the condition will be addressed. This will be done against the background of current research on spirit possession, and amafufunyane in particular.

#### 2.1. DEFINITIONS OF AMAFUFUNYANE

Until Ngubane's (1977) work on the Nyuswa speaking people there was very little serious effort done to study the condition of amafufunyane (ufufunyane - amafufunyane in Zulu, and ukuphosela in Xhosa). In the present thesis the Zulu version is retained because that is the commonly used term by both Zulu and Xhosa speaking people. The English dictionary definition of ufufunyane, illuminates the essence of amafufunyane, as "rapidly spreading disease which causes delirium and insanity; type of brain disease, mania, hysteria" (Doke and Vilakazi in Ngubane, 1977). Ufufunyane then is a form of possession by a spirit which is not deemed to be acting on its own accord, but has been sent by an ill-disposed person by means of sorcery (ukuthakatha) (Ngubane, 1977; Weiss, 1984).

Manganyi (1972) refers to this condition as a form of hysteria which is called Ufufunyane by the Zulu, and Ukuphosela by the Xhosa.

Before giving a brief description of ufufunyane, it is important to first describe the other type of evil spirit (umoya wokukhohlakala okanye omdaka), that might be confused with it, and that is indiki. This is a milder form of possession by evil spirits that developed at the turn of the century (Bryant, 1949,1970; Junod, 1927) in Ngubane (1977). This condition was mostly experienced in Zululand and in Mozambique, among the Tsonga, around 1913 - a period of industrialization in Africa.

Men from the rural areas moved into the cities and mines to look for work. When they died, sometimes there was nobody to indentify them and therefore relatives were left ignorant of these incidents. According to African custom when a person dies, a burial rite (ukubuyisa ceremony) must be done in order to allow the spirit of the dead person to be integrated with the body of other ancestral spirits. Because the relatives of these dead persons were left ignorant of such deaths, these burial rites were never done or are never done even today. Thus the spirits of these dead persons then roam around and by chance take possession of innocent victims.

Once the indiki spirit enters the person (this happens by chance), it resides in the chest. The possessed person start behaving like somebody who is mentally deranged. That is, crying in a bellowing voice, speaks in foreign tongues. Effective treatment is by a diviner who was also possessed by indiki. This means that indiki possession usually leads to

spirit cult membership. The whole initiation calls for a sacrifice of an animal, and appealing to one's ancestors to replace the alien spirit and protect one from further attacks. The process is said to promote within the possessed person powers of prophecy and healing. That is why exorcising of such a spirit is mostly done by a diviner who was also possessed by indiki.

Amafufunyane, on the other hand, differs from indiki in certain ways. In both indiki and ufufunyane, the possessing spirits are said to be males. With indiki there is only one male spirit that enters the person, whereas in ufufunyane there are many and it is only in rare cases that only one spirit enters the person. Whereas the possession with indiki is by chance, sorcery is given as the primary cause in ufufunyane though other factors are not ruled out as will be demonstrated in the next section. After the spirit has entered the body, the onset is sudden in both types of possession. The symptoms of indiki appear to be milder than those of ufufunyane which are severe. As shown in the previous section, indiki possession can lead to healing powers (if treated properly) which is not the case with ufufunyane.

Edwards (1983) distinguishes two types of amafufunyane, and she calls these, the speaking and the silent types. There are three stages through which the person having an attack goes, but the sequence can change depending on the type of amafufunyane possessing the person as will be indicated below. The salient features of each stage are outlined below.

## 2.2. TYPES OF AMAFUFUNYANE

### 2.2.1. THE SPEAKING AMAFUFUNYANE:

#### STAGE-1

-----

When amafufunyane enter the body, they are believed to lie dormant for some time with no obvious changes that can be observed in the person's behaviour. After a certain period the person complains of persistent headache, stomach cramps, walks with the body slightly thrust forward, the limbs feel heavy and this makes the person drag the body when walking (there is no obvious swelling that can be seen).

There is a strange quietness about the person which makes those who know the person better, suspect that there is something unusual about this behaviour. The person further avoids contact with other family members and keeps more to him/herself. The person displays lots of appetite and craves for certain foodstuffs especially white bread. If the environment cannot offer what the person needs, s/he becomes very irritable with those around and is believed to be entering the second stage of the attack.

#### STAGE-11

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During this stage anything can trigger off the violent outbreak (for example, direct confrontation, mere presence of bystanders, singing and clapping of hands in church, preaching etc.). Without warning the person jumps high with arms flinging around kicks out wildly and in the process hurts those standing around. There is a wild look on the face with eyes protruding from the sockets, tears and sweat running down the face. When people try to hold the person down s/he displays such strength that it requires a lot of

people to hold him/her down.

#### STAGE-111

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After struggling to get free the person throws him/herself on the ground and 'passes out'. Strange voices begin to speak from the person's mouth which remains slightly open but unmoving. The voices sound strange in the sense that they are different from the person's voice; speak a language/s that is/are different from that spoken by the person. This happens even though it can be proved that the person has never been exposed to it. (For example, most often in Xhosa speakers the voices speak in clear, fluent Zulu and/other languages.

The voices will then start by: identifying themselves by names sometimes without being asked; the names refer to persons from the North and to those who sent them; the reason why they were sent; the length of time they are going to occupy the body; start threatening anybody who tries to exorcise them in whatever manner. After some time (about ten to fifteen minutes) the voices stop and the person lies on the floor as if in a coma. There is always something that the person spits out in the form of a mixture of saliva and straight pins mixed with split ends of human hair. When the person wakes up he/she has no recollection of what happened, will complain of headache, tiredness and sleepiness.

#### 2.2.2. THE SILENT AMAFUFUNYANE

The silent amafufunyane differs from the above presentation because of the more pronounced symptoms of quietness, stomach cramps, social withdrawal and no appetite. The silence is attributed to the fact that the amafufunyane have been introduced purposely to present in this manner - aqubudile.

The person only enters the second and the third stage when provoked (for example, in the presence of a healer and when the person is being prayed for).

The above picture of the presentation of a person possessed by amafufunyane is summarized by Ngubane (1977) in the following passage:

A person with ufufunyane in its worst form usually behaves as if mentally deranged. She becomes hysterical and weeps aloud uncontrollably, throws herself on the ground, tears off her clothes, runs in a frenzy, and usually attempts to commit suicide. She reacts violently and aggressively to those who try to calm her.

p.144

From the above description it becomes apparent that amafufunyane can present in a mild form (for instance, in the case of the silent type) on the one hand, and can present in a very wild and disruptive form, on the other (as shown in the speaking type, and in the passage above).

Having drawn a picture of the manner in which a person with amafufunyane presents when having an attack, one gets the impression that anybody who conceives of his/her illness to be that of amafufunyane would necessarily present in the same manner. But that would be distorting the picture. Drawing from the experience of working in a psychiatric institution, the present author came across psychiatric patients who believed that they had this condition but had never gone through the ordeal of a typical attack. It became of interest to find out the different conceptions surrounding the notion of amafufunyane. Also, why people get amafufunyane in the first place.

Also, the language used in the above descriptions regarding the condition of amafufunyane reflects a strong emphasis on the issue of gender.

### 2.3. CONCEPTUAL ISSUES

As with other medical disciplines, psychiatry has generally sought to belittle 'mystical' interpretations of spirit possession where these were claimed by those who experience them to represent 'irrational, non-scientific thinking' (Lewis, 1971). The sanction of heresy has proved a powerful deterrent in curtailing and discrediting these 'wayward' personal mystical experiences (ibid). In circumstances discussed in Lewis (1971), possession is concerned essentially with the enhancement of status. The effect of possession by 'peripheral' spirits is to enable people who lack other means of protection and self-promotion to advance their interests and improve their lot by escaping, even if temporarily, from the confining bonds of their allotted positions in society. He further warns other disciplines that the phenomena of possession states, that are so readily assimilated to the bizarre and abnormal, must be approached cautiously if the issues involved in their assessment are not to be prejudged.

The literature reviewed has provided differing approaches to the understanding of spirit possession. The first approach adopts a personalistic systems approach. Proponents of this approach would argue that spirit possession is due to the purposeful active intervention of an agent, such as a supernatural being (a god), a non-human being (ghost, ancestral spirit), or a human being (witch or sorcerer)

(Foster & Anderson 1978, in Helman). The second approach tries to locate illness (in this case spirit possession) in a social context. Following is a review of these approaches.

### 2.3.1. APPROACHES CENTERING AROUND PERSONALISTIC SYSTEMS

- sorcery/witchcraft
- ecological approach
- African worldview - ancestors

#### (a) Approaches centering around sorcery/witchcraft

According to the proponents of this approach, amafufunyane is primarily due to sorcery - ukuthakatha (Ngubane, 1977; Edwards, 1983; Weiss, 1984) though chance is not ruled out as a secondary cause (Ngubane, 1977). In their original form, amafufunyane are believed to be ants that sorcerers take from the graves, grind and mix with other substances to make a harmful concoction (Ngubane, 1977; Edwards, 1983; Weiss, 1984; Mdleleni, 1986). Such a concoction is sold to anybody who needs it to harm others.

The notion of amafufunyane is believed to be a very complex phenomenon to explain in simple terms. One needs to be well-versed in the cultural language of healing in order to understand it (Mdleleni, 1986). Amafufunyane are evil spirits which are introduced into the body by people who are envious of others' achievements and want to harm or kill them. The rich and the more fortunate are the most liable to attacks by abathakathi sorcerers. These people are subject to such practices because their fortunate positions arouse envy and jealousy in the minds of others. To get out of this impasse, people consult a sorcerer who will collect ants from the graves and mix these with soil and herbs to make a desired

concoction. When this is ready for use it is sold in powder form.

There are various ways of introducing amafufunyane to the person. These include: direct poisoning, that is, by putting the powder in the person's food; by using the person's name, that is - in the absence of the target person - by calling out the person's name and blowing the powder into the air, amafufunyane will enter the body; there is also what is called chance affliction, that is - in cases where amafufunyane after having been taken out of the afflicted person are believed to be roaming around until they attach themselves to those innocent people who are vulnerable to any kind of environmental illnesses. It is important to note that usage of the name in the absence of the target person is significant in this context. The senders have the power to hold magical dominion over the recipient's body by mere possession of the person's name. Another common method is to obtain some of the essence of the person to be harmed, person's nails, cut-off hair, shadow, reflection as in a mirror, or footprints to have magical dominion over the other person's body (Mdleleni, 1986).

(b) Approaches centering around ecological factors

The term ecology here refers to the relationship between the person and his environment, and the equilibrium between the two (Ngubane, 1977). This balance can be disturbed if there are undesirable elements in the environment that a person can contact by stepping over dangerous concoctions placed on the pathways, especially by people who culturally are regarded as vulnerable to the environment. For example, pregnant women,

and the bereaved, are believed to have very low resistance, their state of marginality makes them particularly susceptible to the condition (Ngubane, 1977).

This explanation is linked to the phenomenon of ipleti (a malformed placenta), which is an ailment of infants connected with amafufunyane. This is believed to have been introduced during the late twenties and thirties (ibid). The pregnant women suffering from amafufunyane during these periods, often gave birth to babies with ipleti. The midwives were apparently careless when discarding such afflicted placentae in the sense that they used to bury these along the common pathways. As a result, pregnant women or any other vulnerable persons were easily affected (that is, when they stepped over such pathways - umeqo). Ecological or environmental factors may, therefore, form the basis for an explanation (Cheetham and Griffiths, 1982).

#### (c) Approaches centering around angered ancestral spirits

This is another explanation that relates illness causation to the supernatural world. Ancestral spirits, as spiritual beings who are responsible for the living, are invisible members of the society (Shembe, 1986). Although they live in the spirit world, they continue to care for those in the immediate world. All faith, hopes and fears are centred in them. Prosperity, health, misfortune and even death are attributed to the ancestors, by whom such events are arranged (ibid).

There are several ways in which ancestral spirits reveal themselves to the living. According to Lewis (1971), the ancestors can reveal their identity by the particular

symptoms they cause. The most important and dramatic way being by spirit possession, whether this leads to health (as in the divining process) or to ill health (as in amafufunyane). It is important, therefore, to maintain good relations with the ancestors. If they are angry with their descendants, for whatever reason, they are believed to have the power to withdraw their protection, which leaves the individual very vulnerable and this can lead to illness and misfortunes (Ngubane, 1977; Shembe, 1986). The person concerned can show guilt feelings and may develop the signs of a person possessed, behaving as though mentally deranged (Ngubane, 1977). In such cases invocation of the displeasure of the ancestors is frequently given as an explanation of illness that is viewed as punishment -izinyanya zimfulathele.

### 2.3.2. APPROACHES CENTERING AROUND PSYCHOSOCIAL STRESS

Previous studies on spirit possession have revealed that there is a relationship between spirit possession and stress, and this can be brought about during times of rapid social change (Ngubane, 1977; O'Connell, 1982; Edwards, 1983). During the nineteen twenties and thirties there was a high degree of industrial development and this concentrated on certain geographical areas like the cities and the mines. As a result urbanisation increased, people came from different parts of the country to work and live together.

To many Africans, it was necessary for the men to leave their homes in order to work in the mines because work was not available nearer home. The family life that is so vital to these men was disrupted because this meant long periods of

time in separation. Relationships, as in many cultures, depend on such bonds as loyalty and affection; these in turn depend upon mutual support and comfort and shared experiences (Thomas, 1974). When the migrant workers were forced to leave home all these had to be sacrificed.

In the rural areas insecurity became rife because women no longer felt confident about their own positions with husbands; marriages broke up, there was unfaithfulness; there was often less support both material and emotional, coming from the breadwinners. As a result there was poverty, malnutrition became rife, and there were outbreaks of disease and illness. It became worse in the urban areas because of stressors associated with: the migratory labour system and its related consequences; the men were faced with stressors occasioned by living in the ghettos - poor housing facilities, overcrowding, lack of privacy, no comfort from loved ones, no security of person and property; at work it was the survival of the fittest (resources were scarce and unequally distributed) as people competed for jobs. There was total individualization as people promoted and protected their own interests (Thomas, 1974).

In an individualistically oriented urbanizing and industrializing society group protection is removed (Kiev, 1972). Also, it becomes evident that this period of heightened transition gave rise to insecurity, unhappiness, distrust, lack of loyalty to friends, and increased tensions. People became suspicious of one another, envy and jealousy (umona) increased and people regarded one another as enemies. This created an opportunity for the people to practise sorcery (ibid), in order to protect themselves against the

'enemies' and to fight the 'enemies'.

In this context sudden change was in itself a source of stress. This is demonstrated in forced migration which exposed individuals to new, strange and sometimes violent environments which placed enormous demands on the coping strategies (Ngubane, 1977; Manganyi, 1981). Overwhelmed by the immediate problems of adjustment, the migrant may become frustrated, angry, insecure, isolated and helpless (Kiev, 1972).

Given the extent of the stresses and strains, the incidence of spirit possession is not only pronounced in migrants (who are usually men) but also in women (Lewis, 1971; Hammond-Tooke, 1960; Ngubane, 1977; O'Connell, 1980). There is also the question of marginality which states that people who occupy marginal social positions are strongly at risk (Lewis, 1971). This view is supported by Ngubane (1977) and O'Connell (1982) who argue that because of their inherent female vulnerability, women are at higher risk than their male counterparts.

Ngubane (1977) has argued that the fact that women are naturally marginal as compared to men, may be a consequence of women's greater vulnerability during certain critical periods (for example, during pregnancy, death, and other periods in the rites of passage). Women are also believed to use spirit possession for secondary gains (Lewis, 1971; Ngubane, 1977; Weiss, 1984). This is based on the assumed evidence that women have fewer coping alternatives than men who are portrayed as enjoying what O'Connell (1980) calls "sanctioned freedom" by having mistresses in the cities, to

'comfort' them (Ramphela, 1988).

In this context amafufunyane is seen to be an expression of disturbed social relations associated with rapid social change (Ngubane, 1977; Manganyi, 1981). The migratory labour system is shown to have played a significant role in creating many stressors experienced by those directly exposed to it (Ngubane, 1977; Edwards, 1983). Failure to cope with conflict that is generated is believed to have increased the experience of insecurity, and this resolved into a culturally sanctioned way of expressing such stresses in the form of this condition (ibid).

Drawing from the above assertions, Ngubane (1977) suggests that amafufunyane represents an extreme form of depression which may be coupled with hysteria and suicidal tendencies. The assertion therefore is that psychosocial stress leads to neuroses such as hysteria and reactive depression which then are expressed in the form of a belief in spirit possession.

Manganyi (1981) lends support to the above assertion, by pointing out that the impact of industrialization is reflected in the ways used by Blacks to cope with social stressors. Neurosis should no longer be seen as a whites only illness, it has been seen to exist not only among Blacks in the urban areas but also in the rural areas. The type of neurosis seen amongst the Blacks manifests itself in amafufunyane in Zulu, and in ukuphosela in Xhosa (Manganyi, 1973). He came to the conclusion that with increasing modernisation and industrialization the Africans will ultimately lose their cultural mechanism used in traditional societies, and in the process become more vulnerable to

social stressors.

Further, given the insecurities that were related to the disruption of family life through such laws as the influx control and the migratory labour system, new clinical patterns of neuroses would emerge. He suggests that there is a need to search for explanations of the sources of change in psychopathology, with particular regard to neuroses. This seems to suggest that the processes of modernization have led to a change in the patterns of coping with stress and this needs to be looked into.

### 2.3.3. CONCLUDING REMARKS

The high incidence of supernatural causation of illness is representative of general beliefs held by the society about illness in general (Kleinman, 1980). This does not explain to what extent the individual patient views possession with amafufunyane as constituting a certain type of mental illness. Current theories on possession states share a common assumption that the features of such conditions are determined by cultural factors (Leff, 1981) and that they represent social tensions and stressors in the community. Ngubane's (1977) study of health and disease amongst the Zulu attempts to situate the understanding of disease within an ecological context. She does this by drawing a distinction between natural causes of illness and illness related to sorcery and ancestral cults. By so doing she emphasises the mysterious and exotic out of context. At the same time she does appreciate the role of social factors - stressors and strains.

This approach places her in the tradition of South African transcultural psychiatric research (Swartz, 1986). Schweitzer (1977) has also been criticized for decontextualizing illness in his research work, that is, by treating illnesses as mere categories instead of situating such illness in everyday social and health practices (Mills, 1983). On the other hand O'Connell (1980) attempts to give social meaning and context to the study of thwasa, but fails to view it from the person's perspective. The beliefs about spirit possession are a response to psychosocial strains found in society, and the more exactly those strains can be identified the better we can understand the response (Mayer, 1954).

The present study takes as a point of departure, the idea that reality (in this instance, mental illness) is socially constructed (Berger and Luckmann, 1976), and that the person's position in the social structure will influence the explanations developed in order to account for particular experiences and decisions made (Elder, 1973). The social stress perspective taken in the literature reviewed, suggests that differences in exposure to stressful environments and in the marginal position of those exposed, can account for the differing proportions of amafufunyane among the people. Also because of their limited resources of coping, spirit possession can be a convenient way of dealing with stress.

But, regardless of which interpretation of amafufunyane is accepted, the issue of illness as a means of coping is more complex than would first appear (Swartz, 1986). Rack (1982) states that in order to understand why a person reacts in a certain way to a particular situation, one needs to understand what that situation meant to that person. That

means finding out how the patient is communicating the distress. Do the cultural symbols used during such communication provide a way of articulating mental illness for the particular patient?

Amafufunyane can only be understood as a culturally specific mode of responding to traumatic experiences, dramatic social circumstances or life events. The case of amafufunyane should be regarded as constituting a test case in the cross-cultural definition of 'normality' and 'abnormality'. In such states, the person who becomes possessed in response to difficulties is at once provided with a means of 'coping' with the situation which does not alienate him disadvantageously from other members of the community (Kiev, 1977).

For possession to occur, Yap (1960 in Lewis, 1971) holds, the following conditions are necessary. These are: the person is dependent and conforming in character; the person occupies a position in society that does not allow for reasonable self-assertion; the person is confronted with a problem which s/he sees no hope of solving. Other conditions that Mayer (1954) observes are: observable tensions and strains in the society both at interpersonal and at community levels, with resultant social disorder; there is jealousy and envy as individualization and competition amongst people increases - and action is taken against neighbours and friends; the person with amafufunyane becomes the victim of circumstances. Whether these hold for the present study, will be addressed in the later chapters.

Some psychiatric or psychoanalytic theories of hysteria which

attempt to explain possession as aggression on the part of the socially repressed (as in Freud's theory) seem to be overlooking the fact that such aggression is a voice of protest directed against other more fortunate members of the society. Lewis (1971) puts it very well when he says,

This aggressive assertion is directed at society where some of it inevitably rubs off in competition and conflict for power, and also at the total environmental conditions in which men live

p.203

Against this background, the present study adopts the retrospective method of the Explanatory Model proposed by Kleinman (1980) and attempts to explore some of these problem areas.

## CHAPTER-3

### HELP-SEEKING BEHAVIOUR

The previous section on conceptions of amafufunyane has shown that explanations of illness are embedded in the cosmology which defines what patterns of disturbed behaviour are regarded as illness. It has drawn the attention to the fact that amafufunyane should be understood to have its meaning in a social context. These explanations of illness should not be seen as mutually exclusive, but as interrelated, because they form the basis for decision making regarding which treatment to choose. As a stress-related condition it becomes interesting to see how cultural elements can be marshalled as a response to stress brought about by social change.

From experience of working in a psychiatric setting, for some patients psychiatric treatment seemed to be effective for amafufunyane. But in other situations such treatment was regarded to be effective only in relieving symptoms. This observation became evident when patients' relatives came to hospital requesting to take the patients out to a healer of their choice. This was done because the relatives believed that the hospital doctors would not cure the condition unlike the healers who were regarded as specialists in that area. When many explanatory systems and a variety of healing techniques are encountered in search for the cure of a single illness, it becomes interesting to establish how patients can experience the multiplicity of points of view.

There is very little work done in South Africa on how psychiatric patients conceive of mental illness and how they seek help. A few studies that have been conducted have shown

that concepts of physical illnesses among Blacks residing in the urban areas have altered, and this is attributed to the influence of medical services and christianity, but that psychiatric illnesses are still explained in traditional terms (Daneel et al, 1987). The study by Edwards et al. (1983c) lends support to the above findings, and that is that modern medicine and psychiatry received increasing acceptance and this is attributed to education and urbanization. He also found that traditional theories and practices to illness in general and mental illness in particular, were still found among most people. He concluded that these theories are reinforced by traditional practitioners who typically diagnose and treat the ukufa kwabantu disorders' (1983 p10).

In referring to ukufa kwabantu Ngubane (1977) says:

**The name is used mainly because the philosophy of causality is based on African culture; this means not that the diseases or rather their symptoms, are seen as associated with African peoples only, but with African ways of viewing health and disease.**

**p.24.**

In South Africa there has been a general trend in trying to explain why patients choose to go to hospital. It is often thought that when patients are brought to hospital this action is usually a last resort. The relatives and some inexperienced healers are usually blamed for delaying bringing patients to hospital, that they try and treat in vain. It is only when the patients display behaviour that is uncontrollable and unacceptable to the community that they will decide to take these patients to hospital (Edwards et al., 1982; Gillis, 1986).

The above arguments may have certain validity for some cases, but what needs to be addressed here are the factors behind

the delaying. In other words, there should be an attempt to investigate the factors that explain the choice of healer.

In a study to investigate attitudes of Black psychiatric patients to their choice of healer, Farrand (1984) found that Black patients use and approve of a variety of healing systems. She reports that such a choice depends on the etiological explanation of the illness and the belief system associated with it. That means, whether patients see the illness as treatable by western medicine or by the 'indigenous healer' will determine the type of healer chosen. Also that the availability and the proximity to the required resources will be a determining factor.

Boonzaier (1985) points out that the patients are aware of the availability of various healing options and most appear to be able to exercise a significant choice when seeking help between these. A recurring question then is: what determines the differential use of these resources? Unlike Farrand (1984), Boonzaier points out that treatment outcome seems to be the determining factor. In other words, to this writer the choice of healer is based on the success or failure of the healing system concerned; that is, one is chosen when the other has failed. At this point one would also add that modern resources are used only when the condition is very severe or critical. Another possible way of knowing whether treatment practices are successful or not can be done by observing how they are evaluated by those who use them (Janzen, 1978).

The views presented above are not unique to Blacks in South Africa but are found world wide and across cultures. Previous

research has shown that for different reasons patients delay consultation with western doctors. In most developing countries, various health systems and a diversity of health seeking behaviour patterns coexist (Nichter, 1980). This writer suggests that much could be achieved if research focused more on the ways in which the layperson thinks about medicine, and how such thought patterns can influence the utilization of alternative healing systems.

Lin et al, (1978) have observed that little attention has been given to patterns of help-seeking by psychiatric patients in the community. They also observe that the patients' family and friends do play a significant role in patterns of help-seeking. In a study conducted among Chinese severely disabled mental patients, Lin et al (1978) tried to reconstruct and analyze these patterns of help-seeking in relation to ethnicity. The findings proved in favour of the hypothesis, that is, ethnic background played an important role in help-seeking behaviour.

Nitcher (1980) suggests that much could be achieved if research focused more on the ways the layperson thinks about medicine, and how such thought patterns can influence the utilization of alternate healing systems. In support of the above, Chrisman (1977) observed that decisions about what to do when one gets ill tend to be based upon knowledge and beliefs about the illness, and what treatment options are available. He suggests that research should pay more attention to the lay consultation and referral processes. In other words, these factors should direct the researchers' attention to the critical contextual factors of health

beliefs and practices, and the social network of significant others as they impinge on the natural history of illness (ibid).

Decisions about help-seeking should not be seen as coming solely from the patient, but as often representative of the outcome of complex negotiations within the social network (Weiss et al., 1986). For example, a person may consult others for help in identifying an illness, for suggestions about treatment and for recommendations to competent help. In this context it would be inappropriate to focus cross-cultural studies on illness/disease, patients/healers without locating them in particular health care systems, because that would seriously distort social reality (Kleinman, 1980).

Kleinman (1980) states that it is important to study patients' and families' explanatory models because they tell one something about how they give meaning to illness, and how they choose and evaluate particular treatments. He puts it very succinctly when he says:

... it is also imperative to examine the context of meanings and relationships within which certain choices are made not only to decide among alternative treatment options, but also whether to remain in care, when to switch practitioners and practices, how to interpret treatment outcome...

p.

After patients receive treatment, they return to the popular sector to evaluate it and then decide what to do next (ibid). From the above passage it becomes imperative to rely not only on the decisions made by the professionals about what is good or not good for the patient, even though such evaluations are usually made on behalf of the patient and not in consultation with the patient. The popular domain should be seen as as the

chief source and most immediate determinant of health care (ibid). It is the most central part of all health care systems across cultures (Chrisman, 1977).

## CHAPTER-4

### THE PSYCHIATRIC SETTING

The psychiatric community clinics from which the present sample was obtained, are part of Valkenberg Psychiatric Hospital. During the period under study, psychiatric community facilities were still lacking. The present clinics were accommodated at the local Day Hospitals, run by one professional nurse with a daily attendance of 60-70 patients per day. There was a doctor coming once a week and a social worker from Cape Mental Health Society coming once a week to see those patients who had been referred with 'social problems'. Referrals were made from other hospitals and other agencies, and the patient capacity was increasing daily.

The orientation of the clinics was mainly chemotherapy, various factors made it difficult for the nurse to offer proper care to these patients. These were: overcrowding in the clinic; not enough staff to run the clinic; restrictions on follow-up visits (one had to go through a lot of red tape before permission to do a home visit could be obtained). All these made it difficult for the already overworked staff to give a proper community service. Many patients who were 'defaulting' and those who had absconded from hospital, could not be properly followed-up.

This meant that the 'community' nurse could not reach out into the needs of the community. The restrictions were made by the very service that claimed to be helping. This often brought a lot of job dissatisfaction and resentment because of the disparity in the application of the measures of constraints. For instance, these appeared to be relaxed when

they applied to the white community.

Given this background one would expect (and justifiably so) to find a high rate of 'defaulters' or non-compliance to treatment, followed by a high rate of relapses and re-admissions. The role of psychiatric services in the community appear not to have crystallised, it is not clear to the layperson. That is, these services are not seen differently from any other medical services present in the community. Sometimes the willingness, expressed by some of the patients, to attend these clinics was because of the drugs they got, that they thought were helping them. But the skills of the psychiatrist as well as of the psychiatric nurse were/are not so widely understood and accepted, other than that they are drug dispensers.

Also, the demand for psychiatric service for the few who have insight into its effectiveness, far exceeds its availability. In other words, the scarcity of psychiatric time (for the community) has made it difficult for the few patients who work to avail themselves of the psychiatric services offered.

With this background it becomes imperative to assess the effectiveness of aftercare services provided by community psychiatric health programs. In other words, do these help discharged psychiatric patients remain in the community? Research evidence shows that there is little work done on this area. Gillis et al. (1985); Sandler and Jakoet (1985) have raised useful suggestions to indicate that there is a need for more effective community-based services in order to minimize re-admission rates, by paying more attention to more effective patient care and after care.

The findings of another follow-up study by Gillis et al. (1986; 1989) has yielded disappointing results. Among various factors (like, inadequate after care, short hospital stay etc), non-compliance and non-attendance have been highlighted as being most problematic. An evaluation of the effectiveness of community follow-up has been done solely on pill count and one home visit basis. These findings have actually reinforced this attitude by creating an impression in the minds of the patients and their families that there is no other form of service that psychiatry can offer their patients except to reassure them that drugs are the best form of care. Also, that if they can learn to take their drugs as prescribed, their conditions will improve. One home visit per patient has been found to be sufficient to arouse their sense of responsibility towards their own health.

It is a given fact that one cannot change a patient's past psychiatric history or demographic characteristics to increase the probability of remaining in the community (Stuart, 1976). But something can be done to change the social circumstances of such a community at risk directly by: creating housing facilities, creating job opportunities, improving living conditions, equal distributions of health services (my emphasis because this is where any health service can directly involve itself in the creation of such a service).

Patient satisfaction within a health service structure has not been investigated in South Africa. Research in other countries has linked patient satisfaction to practitioners meeting patients' perceptions and expectations (Like and

Zyzanski, 1987; Linder-Pelz, 1982 in O'Neil, 1989). This has also been attributed to patients' participation in the decision-making process (Zola, 1981).

It was against this background that the third aim of the present study was advanced in order to explore the effect of such a service on help-seeking behaviour of its patient population.

## CHAPTER-5

### RATIONALE AND SCOPE OF THE STUDY

#### 5.1. PROBLEM

Previous research on mental illness has laid heavy emphasis on trying to understand psychiatric phenomena (including amafufunyane) in terms of descriptive psychiatric models (Kleinman, 1977). One way to determine how people make decisions and carry them out in their daily lives would be to observe their actions; another is to ask about what they do; seeing that direct observation has not been a typical feature in psychiatric research, there is bound to be some distortion (ibid).

For instance, in reflecting upon the results of previous psychiatric research in South Africa (Gillis et al, 1984, 1985, 1986, 1986, 1987), it can be observed that tables like those appearing on the findings of such research do not reveal the reality of everyday interaction which leads to decisions about help-seeking/ adherence to treatment/ admission/ readmission rates etc. Such tables do not show how family life or the person's daily activities produced the various phenomena those tables portray (Cicourel in Mehan and Wood). This becomes evident when looking at the Gillis et al (1987; 1989) study on non-compliance with psychotropic medication.

Psychiatrists have most often been confronted with the problem of high rates of readmissions; non-compliance to treatment; and late referrals to hospital (due to prolonged delays or detours via other treatment systems), especially

when treating Black patients.

The case of amafufunyane has proved problematic enough for the professionals treating such patients and for the patients themselves. This seems to stem from the fact that no consensus has been reached regarding the dynamics of this condition (that is, between those who treat and those who experience it).

The way people use language when they refer to disease and illness reflects their beliefs concerning such. Listening to people speak about their own illness, what they say, as well as the way they say it, may give the listener some insight into what they believe about the illness (Kleinman, 1980). Allowing people to give their own views of their illness conditions may prove to be valuable, especially when planning an appropriate treatment approach.

It seems quite reasonable then that by studying the content of people's conceptions/explanations of illness, some insight might be gained into how: a) they choose particular treatment models for their illness; b) why they remain or do not remain in care; c) or why they move from one model to the other (Kleinman, 1980).

Experience of working amongst psychiatric patients has shown that patients and patients' relatives often do not volunteer information concerning their own conceptions about illness. When they do, the information given is short, single-phrase explanations and the reason behind this is the expressed fear of being ridiculed and intimidated. Sometimes the patients would express the notion that they do not see the need to divulge such information because the doctors and staff will

not understand.

It has been observed that the encounter between the doctor and the patient is one between experts and those who are ignorant. This often limits research to 'problem frames' defined by biomedicine, that is, the solutions offered fit only from that standpoint (Kleinman, 1980). In agreement with the above assertion, Sager et al (1972), observed that therapy that results from such an encounter may bear little relationship to the problem for which help was originally sought.

Given this background, it becomes important to know how the patient population who use psychiatric services define and evaluate them since it is the layperson who first defines and initiates health care activities (ibid). Also, it seems important that patients be made to feel that they are participating in the planning of their well-being.

Experiences such as those of spirit possession demand attention for several reasons, irrespective of whether they are recognized or labelled as mental illness by the individual, circle of friends and relatives or professionals. Firstly, possession states are not only common, but are in large part the result of experiences that are strongly related to social position. Psychiatric disturbance and in particular the possession states which are the main focus of this study, are in a critical sense social phenomena, and their distribution in a population is therefore an important way of evaluating and understanding the workings of a society (Brown and Harris, 1975).

There are no systematic follow-up studies of patients treated

by 'traditional' healers, or those currently receiving 'modern' treatment, with careful evaluation of their health status before and after treatment. The present study has tried to enter this untouched area, though retrospectively. The data include case illustrations and reports from psychiatric patients treated by 'traditional' healers who are also currently receiving psychiatric treatment. Also, what has been done in the present study was to try and establish the proportion of amafufunyane among patients receiving psychiatric treatment.

## 5.2. THEORETICAL FRAMEWORK

The argument put forward in the thesis is that the meaning of illness episodes should in itself be treated as a phenomenon worth investigating; that is, outside of descriptive methods of enquiry adopted in psychiatry. Because without such an undertaking no full understanding of patients' 'own' conceptions of illness will ever be reached. With this background, a theoretical framework is introduced that is going to look specifically at ways of alleviating some of the problems highlighted in the previous sections.

Kleinman (1980) has proposed a useful way of looking at the process by which illness is patterned, interpreted and treated, which he calls the Explanatory Model. Within the parameters of this model, the present study adopts the Explanatory Model (EM) and seeks to explore the context of meanings and relationships within which certain choices are made, to decide among alternative treatment options, whether to continue in care, when to switch practitioners and practices, and how to interpret treatment outcomes.

EMs offer explanations about particular illness episodes and the significance of such episodes for the patient and his family, along with their treatment goals. EMs need to be distinguished from general beliefs about sickness and health care. Even though they draw upon these general beliefs, they are marshalled in response to particular illness episodes. In other words, EMs 'are formed and employed to cope with a specific health problem, and consequently they need to be analyzed in that concrete setting' (p.106). Equally, unlike the widely shared beliefs that form a public ideology, idiosyncratic sets of beliefs are also held by individuals and families. Berger and Luckman, (1973) describe these as 'individual packages of ideas, no two of which are exactly alike...' (p.95-96).

Kleinman (1980) distinguishes between EMs held by patients and those held by practitioners, stating that the study of practitioners' EMs explains how practitioners understand and treat sickness on the one hand. On the other, the study of patients' and families' EMs tells readers how patients and families give meaning to particular episodes of illness, and how they choose and evaluate particular treatments (ibid). It is the latter that the present study will be concerned with (AIM-3).

### 5.3. AIMS

With these problems in mind, several questions were raised which related the problem of illness definition and explanation to the patterns of help-seeking. It was therefore decided that a study would be undertaken to try and examine the issues raised in the literature reviewed, and those stemming from the author's experiences. In order to do this,

the decision was made to study a sample of Black psychiatric patients who were attending a psychiatric community clinic run by Valkenberg Hospital in Cape Town.

1. The primary aim was to present a cultural perspective on the study of amafufunyane through an exploration of patients' explanatory models. That is, the definitions and explanations offered by Black psychiatric patients who regard their illness to be amafufunyane were explored. The focus on a particular phenomenon of African illness is not meant to overgeneralise what seems to be the obvious. But to try and highlight details of explanations about the conceptions of illness etiologies that might be revealing of the dynamics of amafufunyane as perceived from the patients' point of view;

2. The second aim was to try and establish the existing patterns of help-seeking behaviour. That is, by exploring the context of meanings and relationships within which certain choices are made (regarding a particular illness episode), in order to decide among alternative treatment options: that is, whether to continue in care, when to switch practitioners and practices.

3. The third aim was to explore the effect of the psychiatric setting or orientation on help-seeking behaviour of patients who are using the psychiatric service. This includes the patients' evaluation of the psychiatric service.

## CHAPTER-6

### METHODOLOGY

#### 6.1. INTRODUCTION TO KLEINMAN'S FRAMEWORK

Kleinman (1980) has introduced a conceptual model for studying general criteria that guide (1) the health care seeking process and how people evaluate the treatment approaches; (2) the management of particular illness episodes. His approach to the proposed model is by citing field notes of clinical ethnographies, in order to illustrate the phenomena that need to be understood.

Explanatory models (EMs) are the notions about an episode of sickness and its treatment that are employed by all those involved in the clinical process (Kleinman, 1980, p. 105). He emphasises that the interaction between the EMs of patients and practitioners is a central component of health care. The study of practitioners tells the reader something about how practitioners understand and treat illness. The study of patient and family EMs tell the reader how patients make sense of given episodes of illness, and how they choose and evaluate particular treatments.

In sum, both patients' and practitioners' EMs offer explanations of illness and treatment to guide choices among available therapies and therapists. They also reflect personal and social meaning on the experience of sickness (Kleinman, 1980). Of particular importance, they provide explanations for five aspects of illness: (1) etiology of the condition; (2) time and mode of onset of symptoms; (3) the pathophysiological processes involved; (4) course of illness (including both the degree of severity and type of

illness role - acute, chronic, impaired, etc.); (5) the appropriate treatments for the condition.

These models are marshalled in response to a particular episode of illness. They are used by individuals to explain, organize, and manage particular episodes of impaired well-being (Helman, 1984). These EMs can only be understood by examining the specific circumstances in which they are employed (ibid).

Helman (1984) proposes another way of looking at the same process and that is, to examine the sorts of questions that people ask themselves, when they perceive themselves as being ill. These are: (1) What has happened? (which includes organizing the symptoms and signs into a recognizable pattern, and giving it a name or identity); (2) Why has it happened? (explaining etiology of the condition); (3) why has it happened to me? (trying to relate the illness to aspects of the patient, such as behaviour, personality, heredity etc.); (4) Why now? (the timing of the illness and its mode of onset, sudden or slow); (5) What would happen if nothing were done about it? (its likely course, outcome, prognosis and dangers); and (6) What should I do about it? (strategies for treating the condition, including self-medication, consultation with friends or family, or going to see a doctor).

## 6.2. RATIONALE FOR USING EXPLANATORY MODEL FRAMEWORK

The model itself is presented to demonstrate how it can aid overcoming the limitations of the biomedical model because it studies medicine as an inherently semantic subject that is inseparable from the conceptualizations of it held by

patients, communities and practitioners. Kleinman's design is found useful in the present study, because it allows a specific way of looking at how patients explain illness.

### 6.3. THE DESIGN OF THE STUDY

The explanatory model framework is found to be useful in the present study, because it allows a specific way of looking at how patients explain illness. It is possible to explore the three basic areas which form the aims of the present study. But firstly, the sample had to be identified and that involved screening the population of patients who attended the clinic in 1988. This was done by using a preliminary questionnaire designed for this purpose.

Data was collected by using depth interviews which are regarded as relevant in obtaining qualitative material. Open-ended questions were asked under each category mentioned above. A pilot study was conducted initially to test the efficacy of the instrument. Patients and their next-of-kin were asked to describe their illness condition (amafufunyane); describe decisions that had been made and give reasons for those decisions; list all treatments that had been given and the different healers who had been consulted in the sequence they were chosen; assess the outcome of each treatment.

The interview schedule was administered in the following format (see Appendix for details):

#### (1) THE PATIENTS' DEFINITION AND EXPLANATION OF ILLNESS

This was measured by the responses to the following questions dealing with illness episode history. These included:

- onset and course of illness

- what made you aware that something was amiss?
- what do you think has caused your condition?
- why do you think it started when it did?
- what does your condition do to you?
- how severe is it? will it have a short or long course?
- what do you fear most about your condition?
- what are the chief problems/difficulties your condition has caused for you?

## (2) THE PATIENTS' HELP-SEEKING BEHAVIOUR

Data were obtained about help-seeking behaviour for this specific condition and about attitudes towards utilization of 'traditional' healers and of professional care, and the evaluations thereof. This area included the following questions:

- past consultations prior to psychiatric treatment
- what made you seek help in the present treatment?  
(here the concern is on perceived failure or success of past treatments)
- what kind of treatment do you think you should receive for your condition?

## (3) THE INFLUENCE OF THE PSYCHIATRIC SETTING OR ORIENTATION HELP-SEEKING BEHAVIOUR

- what did the doctors call your illness?
- what do they think of amafufunyane?
- what are the important results you hope to receive from the treatment? (expectations)
- have your expectations been met by any of the treatments you have received in the past and present?
- have you come across anything in this service that you

are not happy about and would like to raise?

- what are your plans regarding future consultation (are you intending to remain in care, continue changing practitioners?)

#### 6.4. SAMPLING AND CASE FINDING

Since the central issue in the present study was in the conceptions of amafufunyane and the implication of help-seeking, many of the central issues that came out of the study can only be viewed by looking at patients who conceive of their illness to be amafufunyane but are presently receiving psychiatric treatment. However, ideally there would be a control group of patients with comparable conceptions but who have not sought psychiatric help, in order to see the range of coping responses in the population. Lacking such a group, the present study would be limited in the inferences made from the data. Of particular importance would be those inferences related to gender issues. Only those men and women whose conditions resulted in psychiatric intervention could be compared.

The following criteria were used for inclusion in the sample: Any Black person receiving psychiatric care between the 2nd of January 1988 and 28th December 1988, who was a resident of Gugulethu when s/he entered treatment is defined as a 'patient'; Satellite clinics are psychiatric clinics developed in these areas for the purpose of providing community psychiatric services to the local community; The requirement of residence in this community excluded patients whose homes were elsewhere, but were under psychiatric treatment in the same community: For example it excluded psychiatric patients who came to Gugulethu satellite clinic

from other communities like New Crossroads, KTC squatter camp. Patients who were included in the present study were those who were attending the psychiatric community clinic for the first time after discharge from hospital. It was, therefore, assumed unlikely that the passage of time or their experiences in hospital would distort their reports.

The sole avenue of access to data regarding personal details (names and addresses) was through the Out-Patients records from Valkenberg Psychiatric hospital. Permission from the head of the Psychiatric Department, as well as the cooperation of the psychiatrist in charge and the community nurses of the clinics concerned were obtained. These were thought to be essential to the realization of the objectives of the present study.

Firstly, the list of all the patients who have been attending the Gugulethu psychiatric clinic in 1988 (January to December) was obtained. This came to a total of 117. Subsequent to this, all one hundred and seventeen patients were screened at the clinic during attendance, this was done in order to get to the target population. The screening was done by using the preliminary questionnaire which was designed for this purpose. The patients were asked two questions: (i) what do you call your condition? (which also refers to illness when translated into Xhosa); (ii) why have you given it this name? (this was supposed to confirm the first question). Only those who self-labelled themselves as having amafufunyane were included in the sample.

Problems were encountered during this stage of the research. The attendance rate at the clinics was very low. For the

first three weeks in the Guguletu clinic (which operates on a daily basis from Monday to Thursday), only four out of twenty patients from the sample attended whilst others defaulted. The only possible solution was to do the screening at the patients' homes instead of at the clinic as was planned initially.

Out of the total population of 117, only 98 were actually screened. 19 were untraceable either because some had moved to other areas; one had died (cause of death unknown); other's whereabouts were unknown; and others had returned to the homelands. Out of the 98 that were screened, only 14 called their condition amafufunyane. All 14 patients were interviewed together with their next of kin. The depth interview schedule was semi-structured with open-ended questions to allow the respondents an opportunity to answer questions according to their own choice and formulation.

#### 6.5. ANALYSIS OF DATA

This study made use of qualitative method for comparing patients' EMs of the condition of amafufunyane. Analysis of data collected involved reading of protocols and extraction of different themes. These were then summarised and the discussions take the form of case illustrations as will be shown in the next chapter on findings.

## DISCUSSION OF FINDINGS

### SECTION-1

#### CHAPTER-7A

#### DEFINITIONS OF AMAFUFUNYANE

##### 7.1. INTRODUCTION

The present chapter is divided into three sections. The first section deals with the incidence rate of amafufunyane among the psychiatric patients. The second section focuses on the first aim of the present study: that is, to explore the ways in which Black psychiatric patients define, and explain their condition.

##### 7.2. INCIDENCE RATE OF AMAFUFUNYANE

It was in the interest in the present study to first establish the proportion of Black psychiatric patients who conceive of their illness to be amafufunyane. The rates of amafufunyane were calculated by relating the number of psychiatric patients admitted to the Guguletu psychiatric community clinic for the first time in 1988 (between January and December) and who labelled their illness to be amafufunyane, to the total number of patients who attended during this period.

Table 1. Incidence rate of amafufunyane for the period 1988:

Area:	Total no. of patients attending the clinic in 1988	Total number of patients with ASP
Guguletu:	98	14

Table-1 shows the total number of psychiatric patients who were attending the clinic for the first time in 1988; and the

number of patients who conceived their illness to be amafufunyane. Data revealed that only 13,72% of patients receiving psychiatric care retain the belief that they are suffering from amafufunyane.

### 7.3. EXPLORATION OF DEFINITIONS OF AMAFUFUNYANE

The patients were asked to describe the kind of symptoms they had experienced when they first got ill. Since qualitative material pertaining to individual patients will be presented, each patient is assigned a pseudo name to protect the identities of the patients.

Table-2 (see Appendix-1A) shows the frequency distribution of symptoms associated with amafufunyane as they were presented by the patients in the sample (when they first got ill). Some of the patients presented with none of the distinct symptoms usually associated with amafufunyane, although they still believed they were possessed by the same condition. Three patients had one 'classical' symptom each: two were asocial and one had stomach cramps. Three patients had two features each: one showed persistent headache and asocial tendencies; the other wild behaviour and asocial tendencies; the last one showed running aimlessly and jumping around. One patient exhibited three classical symptoms: irritability, wild behaviour and enormous strength to those who tried to restrain him.

When the patients were asked to describe their symptoms, the expectation was that they would mention at least a cluster of the distinct symptoms usually associated with this condition (Refer Chapter 1). The picture which has emerged, however, contradicts this initial explanation. The patients were then

asked about their current ideas regarding the symptoms associated with amafufunyane. Table-3 (see Appendix-1B) shows a list of symptoms given by patients regarding their current ideas about amafufunyane

The impression one got when patients were describing their current views of symptoms usually associated with amafufunyane, was that the patients looked pleased by the fact that they did not present with those symptoms. This might have been due to their frightening nature.

The data in this section allows for certain inferences of attitudes displayed by the patients. Patients' attitudes are inferred in this section from the observations made on the symptoms given in tables-2 and 3 rather than from direct questions presented to these patients during the interviews. For example, when a discrepancy was observed between their presenting symptoms and the typical picture of amafufunyane, the patients were not asked a direct question in order to unveil this: "what do you think is the reason for the discrepancy in your conception of amafufunyane?" Instead inferences were drawn from the open comments they made when the author showed a surprised gesture. They were asked to comment on the other symptoms that appeared in the picture when they were describing this condition. Emphasis was placed on establishing whether in their comments they were relating the symptoms of this condition to mental illness or not.

Two said they did not know, they thought what they told the author were all the symptoms associated with the condition; Tally said her symptoms could not resemble the typical picture because her amafufunyane were put in the brain. She

believed that if she had had the ordinary type of amafufunyane that reside in the stomach she might have presented differently. Thus, the absence of classical symptoms was made explicit and such presentations contained statements to justify such an absence. The following statements were exemplary: as they refute a notion of 'classic symptoms':

... well in my case the amafufunyane were put in the brain, that is why I did not do all those things that other people with amafufunyane do...

Tally

... may be it's because I am also different from other patients with this, I am a strong person and will not allow myself to be like them...

Amelia

The presenting symptoms of the four patients were possibly like those of people who are mentally ill. They did not think that their condition was different from people who are mentally ill, because their symptoms were no different from those of mentally ill patients. They further explained that in both conditions there is a disturbance in brain functioning, and this usually happens when a person worried too much. The following comments shed some light into the matter:

a person with amafufunyane talks about things that other people cannot understand, talks alone, wanders in streets away from home...acts like somebody who is mad...the brain does not function properly, it is disturbed...

Eric

...whatever the cause, somebody with amafufunyane acts like a person who is mentally ill, becomes wild, undresses in public, wants to have sex all the time, has an enormous appetite. The person's brain does not functioning well, it is disturbed...

Amelia

The symptoms in the above two quotes depict a picture of

people who are very disturbed but who define their disturbance in terms of the culturally accepted idiom. The presentation appears to be linked to the explanations of cause (that is, personality traits), and to the type of amafufunyane that differs from the known conventional type. To these patients, this became a justification for the different symptoms that do not reflect those of a classical nature.

In conclusion, the presentation of symptoms does not reflect adherence to the conventional ideas held in general about the symptoms of this condition; also, the current views regarding the symptoms associated with amafufunyane reflect a certain amount of knowledge about conventional ideas regarding this condition. Some of the patients expressed the view that people get amafufunyane prior to becoming mentally ill. In other words, amafufunyane had predisposed these patients to mental illness. For instance, when a person has been bewitched with amafufunyane, he/she never functions normally again. The following comment from a patient's mother is an example:

...my son is mad now, but he had amafufunyane  
before he became mad...these can be introduced  
through witchcraft, I say witchcraft because I  
don't know how to explain amafufunyane...  
Onele

In their original explanations of cause, all the patients in the sample attributed the cause of amafufunyane to sorcery/witchcraft; except for Amelia thought that it was sorcery/witchcraft on the one hand, and the works of God on the other. From the examination of explanations of cause, it was found that witchcraft beliefs still existed linking



amafufunyane to sorcery/witchcraft; one patient thought that it was sorcery/witchcraft on the one hand, and the works of God on the other hand. From the examination of conceptions of cause, different themes emerged. It was found that witchcraft beliefs still existed linking to the evil of others who harbor malice toward a patient. They seek out a sorcerer to cause their enemy harm.

In addition to sorcery/witchcraft and supernatural causation, patients gave other explanations. Such magical explanations about cause coexisted with 'rational' explanations that are similar to those used in psychiatry. For instance, a patient's belief that she had been bewitched was accompanied by her awareness that she could have become ill because she had been working under stress, also that she had been worrying too much with nobody to share her worries. As some of the respondents gave more than one causal explanations, their responses were divided into four different categories. Their conceptions were then considered under each category.

#### (1) SORCERY/WITCHCRAFT

For 83% of the patients in the sample, witchcraft/sorcery was still the major explanatory model for the occurrence of amafufunyane even after hospitalisation. This became evident in the last section when the conceptions of symptoms were explored that, even if the patients' presenting symptoms differed from conventional ideas about amafufunyane, two of the patients retained the conception of the cause of their illness which was in agreement with conventional ideas about the etiology of amafufunyane. But Eric and Faith no longer

associated their illness with amafufunyane, through discussions with their doctors they came to realise that the nature of their personalities were responsible for their illness [Refer (2) below].

### (2) PERSONALITY TRAITS

It was also evident from the responses of two of the patients (as mentioned above), that certain personality traits were perceived as having predisposed them to illness. These patients had changed their original conceptions about the cause and the very label of their illness. They now thought their illness was due to a disturbance in the functioning of the brain and this in turn is caused by worrying too much. They also thought that the doctors in hospital made them see things differently. The following comments were exemplary:

... I have always been a nervous person. I get worried easily over small matters, that would not worry other people...

Eric.

...I had a lot of worries before I became ill, and we used to quarrel a lot with my husband... he did not want to listen to me and I decided to keep quiet... doctors said that is what made me sick and I agree with them...

Faith.

... I am a very serious person, I take things seriously and this makes me worry a lot... things were bad at work but there were also my in-laws...

Amelia.

These patients viewed themselves as having been made more vulnerable to illness by the very nature of their personalities. Amelia, unlike the other two, had not ruled out sorcery/witchcraft. She saw her personality disposition as additional factor that contributed to her illness.

### (3) PSYCHOSOCIAL STRESS

As can be seen from Table-4, this category was used to group

only two types of psychosocial stress, that is, external stress related to one's job; and internal stress related to intrafamilial problems.

(i) JOB RELATED STRESS:

Only one patient related directly to job-related stress as playing a role in bringing about her condition (that is, Amelia). She had proved herself well in the company as a result she was recommended for a higher position which was particularly demanding, and was expected to perform extremely well. She could not perform well because of various reasons: she did not have the necessary Maths skills for the work she was supposed to do; she also hated the subject at school; her supervisor was very unsympathetic. She, therefore, considered this job to be a significant cause of her illness.

ii) INTRAFAMILIAL STRESS:

The same patient discussed in the previous category was convinced that her long-standing problems with her in-laws who hated her coupled with an unhappy marriage were responsible for her illness. She felt that there was nobody with a right frame of mind who could survive such pressures. The fact that she was exposed to such stressors made her ill, she could not function 'normally' under such circumstances.

Another patient also thought that his unhappy relationship with his wife made him ill, there was always friction in the house and he did not know how to handle the situation. He then became ill.

(4) SUPERNATURAL CAUSATION:

Here illness is attributed to the direct actions of supernatural forces, such as God, demonic or ancestral

spirits. In the present sample this explanation was used by Amelia only, when she described her illness as a Test of her Faith. She used demonic possession interchangeably with evil spirit to mean amafufunyane on the one hand, and as a predisposing factor for amafufunyane on the other hand. Drawing from her religious orientation, one patient said that people could get sick if God so wishes. In her case it was God who made her ill, because He was testing her Faith. If she had been loyal to God, prayed everyday she would not have got the evil spirits/amafufunyane/demons because God would have protected her from such attacks. She used these concept interchangeably to mean the same thing, that is, amafufunyane.

In sum, most of the patients still believed that the sole cause of their illness condition was that they had been bewitched; one thought it was the combination of sorcery/witchcraft and intrafamilial stress that was responsible for his illness; one thought it was the interplay of all four categories: sorcery/witchcraft; her personality traits which predisposed her to illness; job related stress and intrafamilial stress also made her ill; and lastly it was the direct action of God); the last two patients totally rejected their initial conceptions which placed emphasis on sorcery/witchcraft, and instead adhered to the explanations emphasising personality traits.

Sorcery/witchcraft was the major explanation of cause for all the patients, that is, when the symptoms first appeared. The different conceptions given by patients showed an interplay between the magical and social/natural

explanations. This interplay was probably characteristic of their psychiatric orientation. Thus, along with the ideas about sorcery or witchcraft, some of the patients pointed to further determining influences such as social stressors. During the interviews it became evident that the majority of these patients had never discussed amafufunyane with the western-trained doctors who treated them. Their psychiatric orientation was based on their personal interactions with other patients in the wards and during their visits to the clinic.

#### 7.5. ASSESSMENT OF LONG-TERM PROGNOSIS OF CONDITION

A question had been posed to the patients as to how the condition had affected them. The responses were divided into two: that is, those who thought the condition had affected them and the kind of changes reported; and those who thought it had not affected them.

The patients who thought the condition had affected them, gave clear judgements about impairment of functioning produced by symptoms of this condition. These judgements were partly explained in terms of interference with normal functioning (that is, social and interpersonal relations). For some impairment was severe and permanent, and for others it was temporary. Several of the patients volunteered the information that they were unable to perform their work tasks, that they had poor concentration or were fearful of the future. The following statements are illustrative:

**This has really affected me, I always feel tired, cannot pay attention or concentrate in class...**  
Millie

**... it is no longer easy to do simple tasks at home, like cooking, cleaning the house... I do not**

have the energy to go anywhere...

Bill

... I lose interest when I am working, I often fear that I will never be able to work again.

Connie

To judge the impairment as permanent or temporary was associated with the length of time the person had had the condition, and the failure of the different treatments that had been tried. The patients who had had amafufunyane for more than two years, said they had less chances of recovering from the impairment incurred from the condition. The following remarks were typical:

I can no longer do household chores like washing, cleaning the house...

Connie

... all the healers we have contacted have not been able to cure me, I am still sick...

Isabella

... there seems to be no cure for this, I have had it for many years... I do not think I will be normal again ... I can no longer do the things I used to do...

Bill

Some of the patients said that they stopped working because of amafufunyane. They never had energy to go out and look for work; if they were lucky to get a job, they could not keep it for long because they often got sick at work. This condition made them susceptible to harsh treatment that they got from unsympathetic employers who expected a lot from them.

The other two patients felt differently on the issue of impairment. They did not think that the condition had affected them that much. The changes that were experienced when the illness started were perceived as temporary. Some made reference to their previous functioning (before they had amafufunyane), comparing that with present functioning. They

could not see how the condition might have affected them because they could not perceive any difference in the way they thought and behaved, and in their relationships with others. This was clearly reflected in the statement made by one patient who did not think that he had been affected by the condition:

... I cannot see any change in me, I can still feel and think like before. At work I am still holding my old job, nothing has changed...

Eric

When asked about their future plans, there was a lot of uncertainty amongst those who felt that the condition had affected them. They did not know what would happen to them if they could not get a cure. The following comments were exemplary:

I do not know what will happen to me if I cannot get a cure...

Millie

... everything will depend on whether the treatment from Pinelands will cure this amafufunyane...

Bill

... I feel well now and the doctor told me I am not sick anymore. But I am not sure whether I will not get amafufunyane again...

Tally

The above comments had a bearing on the future patterns of help-seeking as it will be shown in the next chapter on Help-seeking behaviour.

## SECTION-2

### CHAPTER-7B

#### HELP-SEEKING BEHAVIOUR

##### 7.1. INTRODUCTION

From the literature reviewed it was shown that amafufunyane is perceived by patients in general, as a witchcraft-related condition. Also that, it is believed to be amenable only to the therapeutic intervention of 'traditional' healers and not western trained professionals. It was shown in the previous section on etiology that all the patients in the sample still explain illness by recourse to sorcery/witchcraft as major explanations. That being the case, these patients would be expected to seek help from 'traditional' healers. From the examination of the present data, it was found that patients have been to and are still consulting various healers (prior and after hospitalisation). It is this passage from treatment to treatment that is the focus of the present section.

The different themes that emerged from the data will be discussed under the following categories: (1) patterns of help-seeking prior to the first referral to hospital; frequency of visits to healers and average time spent on such visits prior to hospitalisation; determinants of help-seeking behaviour.

##### 7.2. PATTERNS OF HELP-SEEKING PRIOR TO HOSPITALIZATION

In this section different healers that the patients have consulted prior to hospitalisation are described and illustrated by means of tables; the frequency of visits to these healers and the average time spent on such visits; and the crucial features leading to hospitalisation.

TABLE-5:

=====

Types of healers consulted prior to hospitalization

	N of patients visiting visiting each healer
Faith healer	8
Herbalist	5
Diviner	2
Practitioner in private practice	1

Table-5 shows the different types of healers that the patients had consulted prior to hospitalisation, that is, between the onset of symptoms and the first referral to hospital; the number of patients visiting each healer. Faith healers were visited by a high proportion of patients in this sample (8). The frequency of visits to these healers was also high, with five patients visiting twice; herbalists were visited by five out of fourteen patients and this made them the second type with a high proportion of patients; the diviners and the general practitioner were the least visited, with the lowest proportion of patients (2:1, respectively).

The average time spent between the onset of symptoms and the first referral to hospital ranged from a period of two months to as long as nine years. During these periods patients had been moving from one healer to the other in an attempt to get treatment. On examination of the reasons for this pattern, it appeared that some patients wanted an explanation and treatment for their condition; some wanted a confirmation for the label they had given to their condition, and also treatment. When they did not get better, decisions were arrived at through consultation with various sources, as

will be shown in the following section.

### 7.3. DETERMINANTS OF HELP-SEEKING BEHAVIOUR

TABLE-6:

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#### Determinants of help-seeking behaviour

- Specific illness label
- The aetiologies the label implicates
- Network of referral
- Severity of symptoms
- Evaluation of healers' therapeutic interventions
- Proximity to a particular treatment resource
- ignorance on the part of the patient and the social network  
about available psychiatric community resources

Table-6 lists the various determinants of help-seeking behaviour. The specific illness label appears to dominate in determining the decision/s or action/s that will be taken. When patients were asked what motivated them to seek help from healers, they all used the label amafufunyane to describe their state. The label implies a specific etiological explanation. That is, they related a series of misfortunes that had pursued them either recently or as long as a year or more before and had persisted to the present time. The network of referrals also proved to be an important determinant of help-seeking.

One was advised by a social worker who was both a friend and a neighbour because her symptoms were getting worse; four were advised to go to hospital by concerned neighbours because their symptoms were getting worse and the treatment was not helping; two patients were advised by a private practitioner and South African Police (respectively) because

they displayed wild and aggressive behaviour that could not be controlled by relatives; it also appeared that the patient who was referred by a private practitioner to hospital, friends had taken her there because they did not know what to do or where to go; the rest of the patients were referred by relatives.

The patients had gone to the healers because the healers had diagnosed the amafufunyane and, therefore, the expectation was that they would be able to cure the condition. Also, the fact that these healers had been recommended by friends and relatives to be specialists in this field, raised patients' hopes. Six of these patients consulted more than one healer, until they could see that they were not getting better, and at the same time the condition was getting worse. In other words, it was failure of the healers to treat these patients, and the severity of the symptoms that made it possible for them to be referred to hospital.

It was also the ignorance on the part of the patients and their network of referrals about the available psychiatric services in the community that accounted for the delays in seeking psychiatric help. The healers were within reach and easily accessible and also the fact that they had the reputation for treating condition of this nature made them the only plausible resource available to them.

Figure-1 (see Appendix-2) is an illustration of the various determinants of help-seeking behaviour and the actual steps involved in the process are shown in the sequence they followed.

### SECTION-3

#### CHAPTER-7C

#### THE EFFECT OF PSYCHIATRIC SETTING ON HELP-SEEKING BEHAVIOUR

##### 7.1. INTRODUCTION

The third aim of the present study was to explore the effect of the psychiatric setting on help-seeking. As a point of departure, it is important to remember that data presented in the previous sections demonstrate that when these patients came to hospital and were admitted, they still conceived of their illness in terms of sorcery/witchcraft and supernatural causal explanations as the primary determinants of help-seeking behaviour; amafufunyane was not viewed to be related to mental illness; they had come to hospital because treatment from the healers had failed to cure them; and their symptoms had persisted and worsened. It is the purpose of the present chapter to establish what happens to these patients in the psychiatric service by exploring various issues. These include: (i) the psychiatric diagnosis and treatment and place given to patients' conceptions of illness; (ii) patients' evaluation of psychiatric treatment.

##### 7.2. PSYCHIATRIC ORIENTATION and PLACE GIVEN TO PATIENTS' CONCEPTIONS

It was not the aim of this study to investigate the assessment processes and approaches used in hospital, to do that would require a different approach to that applied in the present sample. The main purpose of this section was to establish whether psychiatric doctors do consider patients' EMs in the assessment of psychiatric conditions. The

expectation was that: if psychiatric doctors do consider patients' EMS in their assessments, that would be indicated in the different phases of assessment, diagnostic formulation and in the planning of treatment. The aim of this endeavour was to look through the out-patients records of these patients to examine in retrospect the criteria employed by the psychiatric doctors in attributing diagnoses and in planning treatment. Such a criterion would have implications for the patients' future patterns of help-seeking.

TABLE-7:

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Psychiatric diagnoses of patients with amafufunyane

DIAGNOSIS	N
Schizophrenia	5
Schizophreniform disorder	4
Depression	3
Organic Brain Syndrome	1
Culture-Bound Syndrome	1

Table-7, shows that nine of the patients in the present sample were diagnosed as either Schizophrenia or Schizophreniform disorder; three as Depressed; one with Organic Brain Syndrome; and one with Culture-Bound Syndrome. Looking at Table-2 (see Appendix-1) and comparing this with patients' presenting symptoms in the hospital records (Table not available), it became interesting to find that none of the history in the records reflected culture specificity of the condition as was seen in Table-2 except for the last patient on the above table. What can be inferred from this observation is that, when in hospital, patients appeared to select only those symptoms that they thought would be

appreciated by the doctors. The diagnoses assigned to their condition were based only on what they presented with which excluded their original conceptions prior to hospitalisation.

Psychiatric diagnoses assigned to patients, reflected important impressions and evaluations. These were: nothing reflects an enquiry into or knowledge of the patients' conceptions of illness and patterns of help-seeking prior to hospitalisation; the prevailing inadequate assessments mitigate the accuracy of the diagnoses and this can lead to the questioning of the processes involved.

The patients' records contained such scanty information, that it would be an injustice to come to any sorts of conclusions about these issues. After examining the records, it was found that throughout the entire assessments there was no mention of amafufunyane or any related term and enquiry thereof to give an indication that such material had been explored before. The patients' presenting symptoms were classified into diagnostic categories that did not reflect (a) how those had been arrived at; (b) a full understanding or appreciation of the patients' conceptions about the illness.

Of significance, though, is whether a fuller appreciation of the patients' original problems would have lead to any change in the perceived diagnosis. Also, it is not known whether a fuller appreciation of patients' EMs would have led to judging the presenting problem as representing more, less, or equal amounts of disturbance. Treatment which consisted mainly of drugs, was provided on the basis of the diagnostic categories without enquiring into the patients' models.

The second issue here is to determine what inferences can be

drawn from the information available on patients who attend a psychiatric clinic. Do patients find themselves in the middle of two contrasting world views and conceptions about illness? Are doctors' diagnoses, prognoses and treatments readily accepted and in good faith by the patients? Though the patients were not asked such questions, it is permissible to draw inferences from the comments that patients made when they were asked questions to ascertain their evaluations of psychiatric treatment.

### 7.3. PATIENTS' EVALUATION OF HOSPITAL TREATMENT

From the examination of the patients' responses on whether they thought psychiatric treatment was beneficial or not for their illness, it became evident that they evaluated that on the basis of whether it had cured amafufunyane or not.

TABLE-8:

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#### Patients' evaluations of psychiatric treatment and their diagnoses

Patient's evaluation	N	Diagnosis
Treatment very helpful in curing amafufunyane	pE	Culture-Bound Syndrome
	pF	Depression
	pT	Organic Brain Syndrome
Treatment helpful in the short run but uncertain of its help in the long run	pB	Schizophrenia
	pC	Chronic Schizophrenia
	pS	Schizophreniform illness
	pM	Paranoid schizophrenia
	pD	Schizophreniform

		illness
	pT	?Schizophrenia
Treatment helpful but needs to be complemented with treatment from the healers	pA	Major depression
	pM	Depression
	pB	?Alcohol hallucinosiis ?Schizophreniform illness
	pB	Schizophreniform illness
	pI	Schizophrenia

Table-8, shows patients' evaluations of psychiatric treatment, the list of patients using their initials, and the diagnoses of such patients. Three of the patients believed that psychiatric treatment had cured amafufunyane; six of the total sample said that the hospital treatment was helpful in the short run but were uncertain whether it would be helpful in the long run. It had managed to alleviate the severe symptoms like aggression. That is, patients were no longer aggressive or too nervous after using the treatment (Similo and Mongezi respectively); Although there was some relief, other symptoms were still present. For example, Onele's mother felt it was difficult to say, because Onele was still sick, amafufunyane were still in his body. The injection that he received from the hospital and the clinic only helps in making him less active but it also makes him feel weak all the time.

Five patients felt that hospital treatment was helpful but needs to be complemented with treatment from the healers. Amelia said the treatment received in hospital made her very

sick, that is, it made her feel more depressed than before she was admitted and nobody paid attention when she complained, and she thinks that was the reason she spent so much longer in the psychiatric hospital than she bargained for. Also the fact that doctors did not address the problems that she thought were uppermost in the cause of her illness.

Would the uncertainty expressed by these patients be heightened when they discover that even in the long run the cure is still doubtful? What would happen to them when they find out? Would they find it convenient and comforting to still appreciate a visit to the healer?

#### 7.4. FUTURE PATTERNS OF HELP-SEEKING BEHAVIOUR

In the previous section it was found that the patients' main concern was that the cause of the illness was still present, it has not been attended to. This made them uncertain as to whether they should continue with the same treatment after discharge. In Chapter-7A the patients' responses were examined to assess their conceptions regarding the prognosis of this condition. In the same chapter [Refer Chapter-7A] patients' conceptions regarding the cause of amafufunyane were assessed to see whether these had changed; and the implications of such a change regarding patterns of help-seeking.

The present section looks at the patterns of help-seeking being or to be utilized by these patients. The findings show a hierarchical resort, mixed type (in Kleinman, 1980). The various patterns of help-seeking behaviour are illustrated in Figure-1 (Refer, Appendix-2A) and the patterns show an exclusive type. That is, patients' movements involved only

'traditional' healers. The mixed type of pattern illustrates the movements of patients amongst a variety of healers including the western trained professionals.

Figure-2 (see Appendix-2B) illustrates movements of patients as they seek treatment for amafufunyane among different healers. The above pattern was evident in the patients' responses when they were asked about their plan of action for the future. Their responses took the form of recommendations to others:

- when the symptoms appear the person should seek psychiatric treatment without delay. This response came from patients who, themselves, believed that psychiatric treatment was helpful in treating the condition;

- to seek psychiatric help only when there is no relief after a person has used 'traditional' treatment;

- to go to hospital only when symptoms become severe, that is, when the person gets wild and uncontrollable. These two responses were uttered by patients who believe that psychiatric treatment is helpful for short term but its success in the long run is uncertain. This means patients continue to align themselves with the treatment that brings relief even if it does not bring a cure.

The last group expressed uncertainty and ambivalence about what their future patterns will be because they were not sure of a better cure themselves. They had reservations about the treatments they had used so far. They viewed psychiatric and traditional interventions as both appropriate and can be used interchangeably in their situation. In sum they ended up recommending psychiatric treatment anyway, that is, if

symptoms get out of hand. To this last group, the treatment that they got bore little relationship to the problem for which help was originally sought.

From the patients' comments it became obvious that most of the patients had never discussed amafufunyane with the psychiatric professionals who treated them. Various reasons were given for this. Firstly, professionals were not told about the condition because they never asked about it. Secondly, patients never volunteered information because they feared being ridiculed, and that doctors would not understand. Thirdly, patients said that doctors do not have time for them, they also do not expect patients to be capable of engaging in a 'normal' conversation with them. Fourthly, doctors think that only tablets and injections are good for this condition, but these can make a person sick too.

That patients had ideas about the attitudes of doctors and about the use of treatment, meant that they had a basis for evaluating the doctors' actions. The patients have their own expectations when they go to see a doctor, and any evaluation each makes is compared to these expectations. Furthermore, that these patients had ideas about the causes of their illness, meant that they had notions of the appropriateness of their contributions in the treatment process. It was unfortunate that these were never met.

## SECTION-4

### CHAPTER-7D

#### CASE ILLUSTRATIONS

##### 7.1. INTRODUCTION

The purpose of this section is to illustrate the trends and arguments of the previous chapters and to illuminate them with the presentation and discussion of case studies. The issues that emerge from the first two cases (those of Amelia and Tally) are mainly concerned with the definitions and explanations, and help-seeking behaviour accordingly (aims 1&2). Most importantly, these cases are presented in order to illustrate issues surrounding the effects of the psychiatric orientation adopted at the clinic, on the patient (aim 3). Both have had one admission to a psychiatric institution, diagnosed Depression and Organic Brain Syndrome respectively.

##### 7.2. CASE-1

###### THE CASE OF AMELIA

Amelia is a 35yr old female born and bred in Cape Town. She has been living in a township near East London from 1978 till 1988 while employed at a local factory. During this period she got married (1981) and has a 7yr old daughter. At present she is separated from her husband and is back in Cape Town staying with her sister in a 4-room house in Langa. She belongs to the Roman Catholic Church, and attends church very often. When she was at school she had always cherished the idea of becoming a nurse. Her dreams were frustrated when she passed std-10 and could not get a vacancy to train as a nurse in any of the hospitals to which she had applied. Then she

started looking for any kind of job she could get. When she was visiting in East London she met some influential people who organised a job for her at a local factory. She passed the aptitude tests with ease.

This was 1978 when she got her first job as a packer, the position she held until 1980. Mabel describes her relationship with colleagues as 'not so good'. Everybody, including the supervisor, was rude and jealous. Between 1980 and 1987 she got seven promotions. It was very important to her to prove herself by excelling in every position that she occupied, as she put it in her own words: "... I was really happy, proving myself, found everything challenging."

#### Events Preceding the Onset of Illness

Towards the end of 1987, just prior to the onset of her illness, she was promoted yet again to work at ACCOUNTS PAYABLE DEPARTMENT when things started to change. Unlike in the previous departments where her work brought her into close contact with people, the present department differed in the sense that she was dealing with figures and accounts all day. This frustrated her because she never liked figures even at school- "... I didn't like the job... it was not my line, it was frustrating me. I also didn't like the way the supervisor was teaching me. She was not favourable to me, she was a VERKRAMPTE..." At this stage she really felt very frustrated.

At home, the situation was no better. She was living with her husband at the time and she describes her relationship with him as 'disastrous'. She says she married him out of pity because he was a nice man when they first met, the only

problem was that he was not working. He pressurised her into marrying him, and because she was 'hopelessly' in love with him she agreed on condition that he finds himself a job. Amelia thinks her husband married her because of her money and the house. He did not care for her, was unconcerned about her unhappiness at work, at the same time he wanted her to change the house into his name and she refused. She thinks he was jealous of her, she could sense that he felt undermined and threatened though he never voiced that out.

#### ONSET OF ILLNESS

The more she thought about it the more she did not feel like going to work and the very idea of work brought miserable feelings. What was strange was that the husband looked happy as if he was enjoying seeing her like that, and he never bothered to ask what was going on. She was very nervous and frightened, had a persistent headache and could not sleep at night. She became forgetful, and her mind was working very fast, thinking of too many things at the same time. She could not concentrate, had a poor eyesight and lost interest in her work and in her friends. Others at work also noticed these changes and were passing remarks like: 'why is Amelia so stupid?'

She felt very lonely at work. The job situation had turned into a nightmare for her. The last straw was when another supervisor from the same dept. used abusive language to her. This was very degrading, she felt empty inside. The personnel manager noticed the change in her and remarked about it. He told her that she had lost the spark she used to have, and that she was less communicative with those around her, sitting alone sometimes, something she never did before. He

called her and made this remark "... Amelia you have been a progressing, strong woman, why all of a sudden you are a stupid woman who can't cope, whereas you have been coping all these years... There's something strange in you, you're quiet and accepting everything that is done to you... I'm nursing fears your attitude has changed, you're not yourself..."

#### The First and Second Consultation

On the following day she did not go to work, instead approached her neighbour who was both a friend and a social worker by profession. She told the social worker that she was not feeling well and asked for her advice on what to do. The social worker advised her to go to the local psychiatric community service where she was where she could be helped. At the service she was assessed by a psychiatrist who told her that her condition was due to the fact that she was undergoing a lot of stress at work, and was given treatment in the form of tablets to take home. She knew at the time that the stress at work was not the real reason why she was ill. She had been bewitched by her husband, her in-laws and her ex-boyfriend with amafufunyane; to her, stress created by the working conditions was secondary to sorcery. The tablets which she was given by the psychiatrist were not going to be helpful because she was staying with a jealous husband under one roof, who would use everything in his power to see to it that those tablets did not help her.

While she continued with this treatment, she visited the local church and asked to see the priest. She asked the priest to pray for her and ask God to forgive her for failing to worship His word, explaining that she has not been feeling

well in the past few days. She knew God has been testing her Faith in Him, and now the demons are possessing her. She hoped that by praying and asking for forgiveness, God would protect her from further attacks of sorcery.

After a few days she stopped taking the treatment and her condition became worse and she did not go to work for a week. When she did return to work she was not looking any better and she was subsequently taken to the psychiatrist who told her that she was having a nervous breakdown because of work-related stress. When she tried to convince them that it was her husband who was after her, nobody listened. She was then referred to a psychiatric hospital for admission.

Upon admission to the hospital, she was diagnosed as Major Depression? Adjustment Disorder with Mixed Emotions. She was described in the hospital record as follows: very depressed in the face of stressful working and a non-supportive environment; perception normal (previously had auditory hallucinations); affect mood congruent; cognition fully orientated. Her conceptions about her husband's, in-laws and ex-boyfriend's motives for bewitching her were dismissed. After three weeks of treatment with antidepressants, she was described in the record as controlled and was discharged to the care of the husband.

When she returned home she found her own mother waiting for her, and demanding an explanation for her daughter's illness from the husband who avoided eye contact. Her mother concluded, without being told, that the whole family had bewitched her daughter and that she was taking her home. The following day, Amelia submitted her resignation letter which

was received with shock by her employers who still expected her to return to work. She explained to them that she needed to be away from her husband because he was the cause of her illness. She immediately made arrangements to sell her house and move her belongings to her mother's place where she is presently staying.

At the time of the present interview (that is, three months after discharge from hospital) she has been staying with her sister for a year, finally separated from her husband, appears settled and has found a 'fulfilling' job in one of the leading local companies.

### 7.3. DISCUSSION OF CASE-1

An outline of Amelia's view of the etiology of her condition as it emerges from her case history shows that the causes of her amafufunyane include sorcery/witchcraft; demonic possession; situational stresses such as the over demanding job she held and the intrafamilial problems with her husband and in-laws. The antecedents of the illness are related to one another. For example, the symptoms displayed by Amelia indicate those of someone who is undergoing a lot of stress and without enough coping methods; her feelings about being possessed in turn are fostered by the kind of unhealthy relationship she has with her husband and in-laws which leads her to believe that they are bewitching her. Events in her inner and interpersonal life such as: worrying too much, spending sleepless nights, her guilt feelings over the fact that she has not been worshipping her God, make her vulnerable and produce susceptibility to amafufunyane.

The above description depicts all the causes and their

relationship as they were described by Amelia and her mother. But when they talked about the onset and the progression of the illness, they do not try to relate any of the causes they give into a logical whole as it is done above. Each causal explanation can stand alone as a self-sufficient explanation for amafufunyane. To her it was true that people who doubt the word of God and do not pray, will always fall prey to evil spirits. Even those who really believe in Him, can still get ill because God tests their faith - God allows them to get ill. During the interview she recounted that she had not been praying as before, has failed to go for follow-up treatment from the faith healer, all these made her vulnerable to sorcery/witchcraft. Also, possession can be attributed to sorcery. This shows that one patient can hold almost all the above simultaneously and without apparent discomfort.

Whilst giving this account, she acknowledged the stress factors that she was experiencing at the time - unloving and unsupporting husband, unsympathetic supervisor, inability to cope with her work etc. She also offers a psychological explanation for her illness, that is, 'I became depressed, felt isolated, could not think straight...' What has been interesting was that she used the magical theories of explanation without denying the 'truth' in the psychiatric explanation stress.

I believe that she gave as accurate data as possible. She proved to be a culturally dynamic and well oriented person considering the fact that she made such clear remarks regarding the difference between what is cultural belief on the one hand and psychiatric facts on the other. She sensed

and made open remarks that I valued her discriminations about the criteria for her explanations. At the end of the interview it was possible to divide the information into categories of: how she believed sorcery/witchcraft had caused her illness; supernatural causation as a result of God's wish; and what she considered to have been psychologically caused illness - psychosocial stress.

This patient appeared to be highly motivated , but I do not think that she therefore gave me false impressions based on a preconceived notion of what kind of information would please me. She even remarked at the end of the interview that she felt like somebody who has been relieved of some burden she had been carrying for a long time. The following statement clarifies this:

**Talking to you was very helpful, you know it's the first time that I have talked about these things. Even my sister does not know about some of the things I have discussed with you. You made me feel like saying more, like, you didn't judge me or anything...**

I then asked her whether she had ever discussed what she had just been telling me with the doctors in hospital or at the clinic, she dismissed me by saying:

**Why should I? doctors are not interested in that stuff, they don't have time for a mad person. They don't expect any normal conversation with them...**

In addition to assessing her own standards of accuracy it was possible to measure the reliability of her data by comparing what she said with the psychiatric record. In her file only one explanatory model appeared and which correctly designated the course of illness that she described earlier to me, and that was the psychosocial stress paradigm which fitted well

with the doctors' model. The other explanations she described to me did not appear in the file. There was no indication that there had been any enquiry before.

It becomes very important, therefore, to enquire about the patient's EM in order to get a global picture of the illness at hand. When Mercy was in hospital, she was never asked about her conceptions regarding her illness. She was merely told that the stress at work was responsible for her condition, and it was too much for her to handle that is why she broke down into a depressive state. She believed it important to understand what was wrong with her and to play a part in planning her treatment. She placed considerable value on communicating with her doctors, but this was not happening because doctors were "always in a hurry to see the next patient". She came to the conclusion that doctors do not have time for their patients, they should try and give themselves enough time to talk to their patients - to get to know them better. She felt that they do not have time for a mad person, they do not expect any normal conversation with them.

In terms of the broad divisions between magical and scientific theories, the patient used the magical theory in her explanation of causation of illness without denying the 'truth' in the psychiatric explanation. The failure of the doctor to enquire about the patient's EM may lead the patient to seek treatment from another source in order to meet this need.

#### 7.4. THE CASE OF TALLY

Black patients have a variety of healers to choose from in seeking treatment for illness. These include: amaggira (singular iqgira), translated as diviner/s; amaxhwele (singular ixhwele), translated as herbalist/s, abathandazeli (singular umthandazeli), translated as faith healer/s, the private practitioner, the hospitals. The present case study traces the movement of one patient seeking treatment for amafufunyane from a number of healers. These healers are grounded in different and sometimes contradictory assumptions about the cause of illness. In this context, the case of Tally is of interest because it clearly illustrates how a patient can manage to move from one diagnostic and treatment system to another without ever experiencing conflict with her own conceptions about the cause of illness and help-seeking thereof.

Tally is a 39-year old single lady with 3 children who are staying with their grandparents in the Transkei. She first came to Cape Town in 1974 to look for work. She did domestic work for different families until 1976 when she decided to sell second-hand clothes. She continued in this business until 1980 when she got sick. She had been staying with the father of her three children in the men's hostel which they shared with three other families.

The present illness started in 1980 when she woke up one morning, feeling home sick. This was strange to her because she had just returned from home. This went on for a week then she decided to tell her boyfriend who did not take her seriously (dismissed that as a joke). Then one morning she

started packing her suitcases and put them outside the hostel. Other people remarked about this and asked her if something had happened at home (for example, death in the family), but she ignored them. When people from the neighbouring hostels came around (to console her lest something had really happened at home), she started swearing at them. The boyfriend says she had been talking to herself the whole night and that they could not sleep. She had told them that she was hearing a voice talking to her. When started running and jumping around, people said she had amafufunyane and would have to be taken to a healer. When this behaviour subsided for a while, she could not explain what has got into her, she did not know what was happening to her.

#### The first Consultation

The boyfriend took her to see a diviner who diagnosed amafufunyane and gave her treatment to take home. After taking this treatment for a week there was slight improvement, she stopped being wild but she still felt ill. She did not sleep well at night, was frightened and felt like running all the time. The boyfriend became worried and suggested that they go to the Transkei to visit a faith healer who was very famous at the time for her healing powers.

#### The second Consultation

The faith healer also diagnosed amafufunyane and gave her treatment in the form of Holy water to drink, Holy ropes to tie around the waist and she also laid hands on her. She remained at this faith healer's residence for a period of about three months using the same treatment. Although she was still using this treatment, she thought it was not curing

amafufunyane and decided to go back to Cape Town to try other healers.

#### The third Consultation

This time the boyfriend took her to a herbalist who after listening to their description of her symptoms, also told them that she had amafufunyane and gave her medicine to drink every morning and evening, and another to wash her body every night before she goes to sleep. She used this treatment for about a week and she could not feel any better.

#### Fourth Consultation

By this time they did not know what to do when a neighbour recommended yet another faith healer who they went to see the following day. The diagnosis was still the same, she was given Holy Ropes to tie around her waist all the time, these were supposed to protect her from further attacks by amafufunyane; Holy water to drink; laid hands on her and then she returned home. In the following two days her behaviour became uncontrollable: she was screaming and singing aloud; jumping around and running aimlessly; undressing in public. Everybody was astounded by her behaviour and they did not know what to do, but ultimately the boyfriend with the help of a few friends, decided to take her to a private doctor. According to the boyfriend, the private doctor did not even examine her but told them to take her to hospital immediately.

Upon admission to hospital, Tally was told that there was something in her brain that needed to be removed. According to her hospital record, she was treated for a subarachnoid haemorrhage and a middle cerebral aneurysm which was subsequently clipped when she was operated on. Her behaviour

after the operation was described as problematic. Her problems were listed as follows: difficult; restless; with impaired judgement and aggressiveness. She was assessed as a frontal lobe syndrome and was then referred to the psychiatric hospital.

#### Hospitalisation

On admission to the psychiatric hospital she was described in the record as mildly disinhibited and was diagnosed: Organic Brain Syndrome with Frontal Lobe Features - Post Neurosurgery. After three weeks on medication, (phenytoin and haloperidol) Tally was described in her record as settled and giving no problems on the ward. She had been put on phenytoin following a grand mal seizure post-operatively. Upon discharge, she was told that she had something in her brain which was then removed. The doctors had stressed that the drugs would put everything right and that her life would be normal again if the medication were taken regularly. There was no mention of her prior consultations, nor the condition of amafufunyane.

She has been an out-patient for eight months after discharge, during which time she was seen twice by the doctor at the local clinic. During the first interview, the doctor described her as 'better', no fits since discharge, appropriate, giving a reasonable account of herself, reduce haloperidol. The second and last time the doctor had described her as quite appropriate, no more fits, to attend day hospital for raised blood pressure, stop all medication and discharge.

### 7.5. DISCUSSION OF CASE

The interview of the present study was done a week prior to her discharge from the clinic. She and her boyfriend felt that she was 'cured' of amafufunyane. When she was asked what she thought about the causes of the illness, she said that she had amafufunyane that could not be cured by the healers she had consulted prior to being hospitalised. That the doctors in hospital removed them when she was operated on.

She thought that the prognosis of her illness was somehow good because the amafufunyane had been removed and has been assured by the doctors that she will be 'fine', and if she should get sick again she must just go back to the clinic.

This positive evaluation of her condition contradicted that of the doctors (both in hospital and at the clinic) who have recorded it as poor. To confirm that, on discharge from the clinic, they had put her on a disability grant renewable every year. The implication here is that her impairment has been judged to be permanent and not of a temporary nature as she thought.

She thought that the healers failed to cure her because her amafufunyane were in the brain, if she had had the ordinary type which is put in the stomach they would have cured her. In short she still adhered to her original conception of amafufunyane, that is, the main cause of the illness was sorcery/witchcraft. The doctors in hospital were not aware of the cultural context of the patients' understanding. But from the patient's point of view, what happened in hospital, although somewhat mysterious, was assimilated to her explanation of sorcery.

The overall impression which emerges from this case is that it shows that the patient is involved in a number of healing systems linked together through causal relationships rooted in African beliefs about illness. All these healers have helped Tally and her boyfriend to translate the illness into an acceptable cultural idiom.

The hospital is an exception to this general situation of shared belief. The hospital operates within a system of medicine that is hidden from the patient's understanding, in which her diagnosis is Organic Brain Syndrome and her treatment; an operation and then haloperidol and phenytoin. But though not using language that is accessible to the patient, the hospital refers to the idea of amafufunyane when it presents the illness to the patient as a result of something put in the brain.

The language which the doctors use to describe the illness to the patient (for example, 'something in the brain that needs to be removed'), simply because it uses the most meaningful explanation available, inevitably calls to the mind of this patient the explanations and images of amafufunyane located in her brain. In that context the patient translates psychiatric etiology into her own category and this allows the patient to explain her illness in collusion with the doctors' definition of her illness.

In spite of their divergent theoretical frameworks, in practice the various healing systems provided this patient with etiologies susceptible to interpretation in terms of a common idiom, and with consistent repetition of a diagnostic process which help maintain the etiological explanation of

externalized forces. These characteristics of the healing systems are created, not by any connections among the systems themselves but, by the passage or movement of the patient among them.

CHAPTER-8  
CONCLUSIONS

8.1. INTRODUCTION

The present chapter concludes this study by: firstly giving a brief overview regarding the relevance of using the EM framework; secondly, summarising the findings and relating these to the aims of the study; thirdly discussing the limitations of the present study; and lastly proposing recommendations for future research.

The purpose of the present study was to raise issues in an area where at present the identification of meaningful questions appears necessary. Where tentative questions were raised, these will have to await confirmation by further research. It is believed that the method of enquiry applied for studying some aspects of psychiatric phenomena was useful, since it must of necessity define the help finally given to a patient. The method has indicated a way for finding answers or indicators to theoretical and practical issues concerning psychiatric phenomena, that is, when used on a large scale. It may also complement intensive studies on similar problems.

8.2. SUMMARY OF FINDINGS

a) AIM-1: DEFINITIONS OF AMAFUFUNYANE

The primary focus of the study was to gain an understanding of the EMs offered by patients in terms of their definitions and explanations of illness episode amafufunyane from their point of view. 14 patients (and their next of kin) made up the sample for the study. The depth interviews centred around issues concerning the three basic aims of the study.

The findings revealed that the present-day notion of amafufunyane is not easily defined and it varies from informant to informant. For some it conveys a condition with symptoms that bring about physical changes that can lead to impairment in functioning, as well as changes affecting interpersonal relationships with others. For some it signifies a condition with drastic and frightening symptoms. For the rest it conveys the idea of a psychological disorder.

Patients with amafufunyane may complain of symptoms other than those specified in the literature. For example, a person may complain of hearing voices. Patients believe that these noises are due to the amafufunyane inside the person. The person is continually looking wild as if to run and is liable at times to jump, seemingly without cause.

The symptoms experienced when the patients first got ill differ from the current views held about amafufunyane. That is, the patients showed awareness and knowledge about the symptoms that a person with amafufunyane experiences, but they did not associate these symptoms with their own experiences of the condition. They recognize that the condition of amafufunyane may manifest itself in different forms depending on the type of amafufunyane possessing the person.

The patients attribute the cause of amafufunyane to umona, that is, jealousy. For example, the more fortunate are most liable to attack by sorcerers/witches. It is believed that they are subject to these conditions because their fortunate positions arouse envy in the minds of others.

A few others also acknowledged the role of other factors, such as psychosocial stresses. But these they view as engendering amafufunyane, that is, stress is experienced when a person is bewitched. These findings lend support to the works reported in Kleinman (1980); that is, the explanations given by the patients were consistent with their views regarding a particular illness condition and its significance for the patient and the family. It was a general feeling amongst the patients that the condition is incapacitating in nature.

When analyzed closely, the concept of amafufunyane or what is regarded as madness by the patients, can be regarded as constituting a continuum between 'traditional' beliefs and western orientations to medicine.

#### b) AIM-2: PATTERNS OF HELP-SEEKING BEHAVIOUR

The second aim of the study included an exploration of the patterns of help-seeking behaviour employed by these patients. It was found that a patient who eventually gets admitted into a psychiatric institution passes along various routes. (i) The first route consists of relatives who attempt to label the condition

(ii) Where relatives were either unresponsive (in the case of Amelia) or when they were at a loss about what to do, help was obtained from neighbours and friends. This implied a poor understanding of mental illness because a community that knows the causes of psychiatric conditions and the resources available will respond by taking advantage of these resources. (Hollingshead and Redlich, 1958).

(ifi) The third route was by way of traditional healers.

Reference to hospital was only made after treatment had failed to improve the condition.

In trying to understand the patients' definitions of the condition, it should be realised that the patients' EMs take the essence of mental illness to be witchcraft/sorcery and not necessarily social stress, which is what the concept denotes in psychiatric usage. The lay interpretation of amafufunyane as an illness is an African EM that helps explain the high rate of non-compliance with chemotherapy that characterize the condition.

Non-compliance is held by professionals to be a major obstacle to the effective management of mental illness. When patients feel/experience the symptoms, they believe they are suffering from amafufunyane (which to them denotes something different from mental illness). The persistence of this model in the patients' minds is a measure of the staying power of cultural meanings (Kleinman p.23).

It is not just traditional labels of disorders that are value-laden; symptoms, too, carry cultural significance (ibid). When an individual has a serious disorder - when the normal functioning is radically impaired and the person does not get relief from symptoms quickly from one resource - it is reasonable to assume that he might try nearly everything available to him. This is in fact what the patients in the present sample have done; they are patients who have tried nearly everything to which they had access.

The present study has tried to assess the differential use of various treatments by patients in the sample - to establish

the associated factors with future patterns of help-seeking. It was found that features of the condition were helpful in accounting for the way they used different resources. Of particular importance, the perceived etiology of the condition and the degree of functioning/impairment caused by the condition were found to be associated with the selection of a therapeutic alternative. And from this, compliance and future patterns of help-seeking could be predicted.

c) AIM-3: PSYCHIATRIC SETTING AND ITS IMPLICATION ON  
HELP-SEEKING BEHAVIOUR

The third aim of this study was to explore the effect of the psychiatric setting on the help-seeking behaviour of the patients. The findings showed a lack of appreciation of the patients' conceptions of illness and patterns of help-seeking behaviour prior to being hospitalized. Secondly, the psychiatric treatment was evaluated as good in bringing relief to the dreadful symptoms, but this was only in the short term. The patients expressed uncertainty regarding whether they should continue in care or not, and this stemmed from their dissatisfaction with the way their personal illness experiences were ignored or overlooked. These had implications for the future patterns of help-seeking.

In view of the long-standing call for professionals in the field of psychiatry to improve their understanding of the mental disturbances of Black people by considering their language and culture, too little has been published, though authors like Burhman (1977); Edwards et al (1981) have called for attention to issues concerning this.

#### d) CASE ILLUSTRATIONS

The two case illustrations were presented in order to show:

- how a patient's EM and view of clinical reality can be discordant with professional psychiatric model, thereby producing misunderstanding and problems in management;
- how cultural beliefs shape the patient's EM, which then strongly influences the perception of clinical reality...
- the importance of negotiating between discrepant patient and psychiatrist EMs;
- how 'practitioner's EMs in case-2 are translated by patients in terms of their views of clinical reality. Such translation most frequently occurs outside the doctor's awareness and can result in marked distortion of the doctor's explanatory model and the treatment prescribed.
- clinical reality is viewed differently by doctor and patient. Discrepancies between these views strongly affect clinical management and lead to inadequate or poor care (Kleinman, 1978).

#### 8.3. LIMITATIONS OF STUDY

It was anticipated that there could be some difficulty in keeping a track of patients who would be moving in and out of the area under study. That is, when one has to determine whether people with amafufunyane are originally from the area in which they were counted or came from rural or other areas. The literature reviewed has indicated that the rate of amafufunyane is higher in the urban than in the rural areas. Some of the patients may have developed amafufunyane before moving into an urban area under study, others may have developed this condition when they got into the area. There has been no attempt to try and control this possible source

of error.

Also, the focus on the incidence in those patients only who were attending a community clinic for follow-up rather than on the incidence of the condition in the whole community can render the present study to be less representative of the population under study, and therefore methodologically inadequate. Problems were encountered during the screening stage because of the low clinic attendance rate. This was resolved by doing the screening at the patients' homes instead of the clinic as was planned initially.

Ideally there would be a need for a control group of people with comparable conceptions but who have not sought psychiatric help, in order to see the range of coping responses in the population. Lacking such a group, the present study would be limited in the inferences made from the data. Of particular importance would be those inferences related to gender issues.

#### 8.4. RECOMMENDATIONS FOR FUTURE RESEARCH

Although the present study dealt with only a small sample of 14 patients, they represent 12 months turnover at the clinic and can therefore be considered as reasonably representative for the clinic. The study was exploratory in nature but the findings have raised important issues pertaining to psychiatric care given to Black psychiatric patients. These include lack of appreciation of patients' EMs by doctors who treat them. Typical comments were that doctors do not give enough time to their patients and fall short in enquiring about what they (patients) think about their illness condition. This is an area that will need to be looked at

seriously in the future if confidence and trust is to be maintained.

The second issue concerns the services provided for these patients. These are inadequate and besides their value is not clear to the patients and their families. The psychiatric service is seen as a drug dispenser when people are distressed and not in any other light. It is therefore suggested that these facilities be improved by making the role of the psychiatrist and the psychiatric nurse clearer to the residents.

Also, there is a dire need to study a wide range of EMs in the clinic population to determine how significant amafufunyane EM is.

- Can something be made of patients' EMs?
- Does it make any difference to success or failure of treatment?
- If two groups are compared in which EMs of patients and psychiatrists converge with those in which they diverge from one another, will there be a difference in the degree of success of treatment?

These are some of the questions to be studied in future research.

Psychiatric community research should address the issues that affect the patients' lives and everyday experiences as well as the impact these have on the patients.

## REFERENCES

- American Cultural Association.  
(1980) Diagnostic and Statistical Manual of Mental Disorders (3rd. ed.)  
Washington, D.C.: APA.
- Apple, D.  
(1960). How laymen define illness.  
Journal of Health & Human Behaviour, 1, 219-225.
- Balint, M.  
(1964). The Doctor, His patient and The Illness  
London: Pitman.
- Berelson, B.  
(1952). Content Analysis in communication research  
New York: Hafner.
- Biesheuvel, S.  
(1987). Psychology : Science and politics. Theoretical Development and application in a plural society.  
The South African Journal of Psychology, 17, 1-8.
- Blackwell, B.  
(1976). Treatment Adherence.  
British Journal of Psychiatry, 129, 513-531.
- Boonzaier, E.  
(1985). Choice of healer: An important area of interest for general practitioners.  
South African Family Practice, 6, 235-240.
- Boonzaier, E., Sharp, J.  
(1988). South African Keywords: The uses and abuses of political concepts  
David Philip: Cape Town.
- Brown, G.W., Bhrolchain, M.N., and Harris, T.  
(1975). "Social class of psychiatric disturbance among women in an urban population"  
The Journal of British Sociological Association, May: 225-253.
- Buhrmann, M.V.  
(1977). Western Psychiatry and the Xhosa Patient.  
South African Medical Journal, 51, 464-466.
- Bulhan, H.A.  
(1985). Frantz Fanon and the Psychology of Oppression.  
New York: Plenum Press.
- Cassel, W. & Lin, T.Y. (Eds.).  
(1976). Disease as an "it": Concepts of disease revealed by patients' presentation of symptoms.  
Social Science and Medicine, 10, 143-146.
- Cassidy, C. M.  
(1982). Protein-Energy Malnutrition as a Culture-Bound Syndrome.

- Cassirer, E.  
(1946). Language and Myth  
Dover Publications Inc: New York.
- Chan, K.B.  
(1977). "Individual differences in reaction to stress and their personality and situational determinants: some implications for community mental health."  
Social Science and Medicine, 11 89-103.
- Cheetham, R.W.S.  
(1975). Conflicts in a rural African patient treated in an urban setting. Medicine, 30, 1563-1566.
- Cheetham, R.W.S., Griffiths, J.A.  
(1982). Sickness and medicine - an African paradigm. South African Medical Journal, 62, 954-956.
- Cheung, F.M.  
(1987). Conceptualization of Psychiatric Illness and help-seeking behaviour among Chinese.  
Culture, Medicine and Psychiatry, 11, 1, 97-105.
- Chrisman, N.  
(1977). The health seeking process.  
Culture Medicine and Psychiatry, 1, 351-378.
- Colson, A.C.  
(1971). The differential use of medical resources in developing countries.  
Journal of Health and Social Behaviour, 12, 226-237.
- Cormaroff, J.  
(1981). Healing and Cultural Transformation: The Tswana of Southern Africa [1].  
Social Science and Medicine, 158, 367-378.
- Csordas, T.J.  
(1987). Health and The Holy in African and Afro-American Spirit Possession.  
Social Science and Medicine, 24, 1, 1-11.
- Dawes, A.  
(1985). Politics and Mental Health. The position of clinical psychology in South Africa.  
The South African Journal of Psychology, 15, 55-61.
- Daynes, G. and Msengi, N.P.  
(1979). "Why am I ill? Who made me ill?" - The relevance of Western psychiatry in Transkei.  
South African Medical Journal, 56, 307-310.
- Edwards et al.  
(1982). Zulu culture-bound psychiatric syndromes.  
South African Journal of Hospital Medicine  
April, 82-86.

- Edwards et al.  
(1982). Conversion disorders in Zulu patients.  
South African Medical Journal, 62, 97-99.
- Edwards, F.S.  
(1983a). Amafufunyane Spirit Possession: A Report on some current developments. Paper delivered at the Fifth Annual Congress for the Study of Religion, University of Durban Westville, 30 June- 01 July.
- Edwards, F.S.  
(1983b). Healing and transculturation in Xhosa Zionist practice.  
Culture, Medicine and Psychiatry, 7, 177-198.
- Fabrega, H.  
(1972). The study of disease in relation to culture.  
Behavioural Science, 17, 183-203.
- Farrand, D.  
(1984). Is a combined Western and Traditional Health Service for Black patients desirable?  
South African Medical Journal, 66, 779-780.
- Finkler, K.  
1985). Spiritualist Healers in Mexico. Successes and Failures of Alternative Therapeutics  
New York: Bergin and Garvey Publishers, Inc.
- Frankenberg, R., Leeson, J.  
(1976). Disease, Illness and Sickness: social aspects of the choice of healer in a Lusaka suburb. In Loudon, J. (ed) Social Anthropology and Medicine. London: Academic Press.
- Gelfand, M.  
(1964). Psychiatric disorders as organised by the Shona. In (ed. A. Kiev) Magic, Faith, and Healing. London: Collier-Masmillan.
- Gillis, L.S., Elk, O., & Teggin, A.  
(1982). The Present State Examination. Experiences with Xhosa-speaking Psychiatric patients.  
British Journal of Psychiatry, 141, 143-147.
- Gillis, L.S., Sandler, R., Jakoet, A., Dickman, B.  
(1985). The rise in readmissions to psychiatric hospitals.  
South African Medical Journal, 68, 466-470.
- Gillis, S.  
(1986). Psychiatric Illness in Africa. In L.S. Gillis, Guidelines in Psychiatry  
Cape Town: Juta. 157-166.
- Gillis, L.S., Sandler, R., Jakoet, A., Elk, R.  
(1986). Readmissions into a psychiatric hospital: outcome on follow-up.  
South African Medical Journal, 70, 735-739.

- Gillis, L.S., Jakoet, A., Trollip, D., Sandler, R., Elk, R.  
 (1987). The outcome of psychiatric illness: A 2-year follow-up study.  
South African Medical Journal, 72, 598-602.
- Gillis, L.S., Koch, A., Joyi, M.  
 (1989). Improving compliance in Xhosa psychiatric patients.  
South African Medical Journal, 76, 205-208.
- Hammond-Tooke, W.D.  
 (1975). "African world view and its relevance for psychiatry."  
Psychologia Africana, 16, 25-32.
- Heap, M.  
 (1983). Natural-Supernatural Causation in The Disease Experience of Two Communities in South-Eastern Lesotho.  
 Paper for submission to the ASSA Conference - Sociology of Health - Durban, July 1986.
- Helman, C.  
 (1984). Culture, Health and Illness: an introduction for Health Professionals.  
 WRIHT: Bristol.
- Janzen, J.  
 (1978). The Quest for therapy: Medical pluralism in Lower Zaire.  
 Berkeley: University of California Press.
- Kapur, L. R.  
 (1987). Commentary on Culture - Bound Syndromes and International Disease Classification.  
Culture, Medicine and Psychiatry, 11, 43-48.
- Kerlinger, F.N.  
 (1973). Foundations of behavioural research (2nd ed.).  
 London: HOH, Rinehart & Winston.
- Kiev, A.  
 (1972). Transcultural Psychiatry.  
 The Free Press: New York.
- Kleinman, A.  
 (1977). Depression, somatization and the 'new cross-cultural psychiatry'.  
Social Science and Medicine, 11, 3
- .....  
 (1980). Patients and Healers in the Context of Culture  
 Berkeley: University of California Press.
- .....  
 (1985). Culture and Depression: Studies in the Anthropology and cross-cultural psychiatry of affect and disorder.  
 University of California Press: Berkeley.

- .....  
 (1988). Rethinking Psychiatry: From Cultural Category to Personal Experience  
 The Free Press: New York.
- .....  
 (1988). The Illness Narratives: Suffering, healing, and the human condition  
 Basic Books: New York.
- Leff, J.  
 (1981). Psychiatry Around the Globe.  
 Marcel Dekker: New York.
- Lewis, I.M.  
 (1971). Ecstatic religion: An Anthropological study of spirit possession and shamanism.  
 Middlesex: Penguin.
- Lin et al.  
 (1978). Ethnicity and patterns of help-seeking.  
Culture, Medicine and Psychiatry, 2, 3-13.
- Lin, K.M.  
 (1983). Hwa-Byung: A Korean Culture-Bound Syndrome?  
American Journal of Psychiatry, 140, 105-107.
- Littlewood, & Lipsedge, M.  
 (1982). Aliens and Alienists, ethnic minorities and psychiatry.  
 Harmandsworth: Penguin.
- Manganyi, N. C.  
 (1972). Being Black in the World  
 Johannesburg: Ravan Press.
- .....  
 (1974). Health and Disease. Some Topical problems of sociocultural transition.  
South African Medical Journal, 48, 922-924.
- .....  
 (1981). Looking Through the Keyhole: dissenting essays on the Black experience.  
 Ravan Press: Johannesburg.
- Mayor, P.  
 (1961). Townsmen or Tribesmen.  
 Oxford University Press: Cape Town.
- Mdleleni, T.N.  
 (1986). Amafufunyane Spirit Possession and Faith Healing Practices. An Exploratory Study.  
 Unpublished Honours Paper.  
 University of Cape Town.
- Mechanic, D.  
 (1962). The concept of illness behaviour.  
Journal of Chronic Diseases, 15, 189-194.

- Mills, J.J.  
 (1985). The possession state intwasa. An Anthropological reappraisal.  
South African Journal of Sociology, 16, 9-13.
- Mosala, I.J.  
 (1983). African Traditional Beliefs and Christianity.  
Journal of Theology for Southern Africa, 43,  
 15-24.
- Moses, R., and Shanan, J.  
 (1961). "Psychiatric outpatient clinic. An analysis of a population sample."  
Archives of General Psychiatry, 4, 60-73.
- Murphy, J.M., and Leighton, A.H.  
 (1965). Approaches to cross-cultural psychiatry  
 Cornell University Press: New York.
- Ngubane, H.  
 (1977). Body and Mind in Zulu Medicine  
 London: Academic Press.
- Nichter, M.  
 (1980). The layperson's perception of medicine as perspective into utilization of multiple therapy systems in the Indian context.  
Social Science and Medicine, 14B, 225-233.
- O'Connell, M.C.  
 (1980). The aetiology of thwasa.  
Psychotherapeia, 6, (4): 18-23.
- O'Connell, M. C.  
 (1982). Spirit possession and role of stress among the Xesibe of Eastern Transkei.  
Ethnology, 21, 21-37.
- Orley, J. & Wing, J.  
 (1979). Psychiatric disorders in the African Villages  
Archives of General Psychiatry, 36, 513-520.
- Prince, R.  
 (1985). The concept of culture-bound syndromes: Anorexia Nervosa and Brain-Fag.  
Social Science and Medicine, 21,2, 197-203.
- Prince, R. and Tchong-Laroche, F.  
 (1987). Culture-Bound Syndromes and International Disease Classifications.  
Culture, Medicine and Psychiatry, 11,1,3-19.
- Rack, P.  
 (1982). Race, Culture, and Mental Disorders  
 Tavistock Publication: London.
- Ritenbaugh, C.  
 (1982). Obesity as a Culture-Bound Syndrome.  
Culture, Medicine and Psychiatry, 6,347-361.

- Sager, C.J., Brayboy, T.L. & Waxenberg, B.R.  
 (1972). Black Patient - White Therapist.  
American Journal of Orthopsychiatry, 42, (3),  
 415-423.
- Schweitzer, R. D.  
 (1977). Categories of experience among the Xhosa  
 Unpublished M.A. Thesis.  
 Rhodes University.
- Saunders, L.  
 (1975). Healing Ways. In Bernard, H.R. (ed.). The Human Way.  
 New York: Macmillan.
- Solomon, A.  
 (1979). Traditional and western medicine in the rural areas. In N.J. van der Merwe & M.E. West (Eds.). Perspectives on South Africa's Future. (Occasional Papers No.3).  
 University of Cape Town: Centre for African Studies.
- Stimson, G.  
 (1974). Obeying doctor's orders.  
Social Science and Medicine, 8, 97-104.
- Suchman, E.  
 (1965). Social patterns of illness and medical care.  
Journal of Health and Social Behaviour, 6, 2-16.
- Swartz, L.  
 (1985). Issues for cross-cultural psychiatric research in South Africa.  
Culture, Medicine and Psychiatry, 9, 59-74.
- .....  
 (1985). Anorexia Nervosa as a Culture-Bound Syndrome.  
Social Science and Medicine, 20, 7, 725-730.
- .....  
 (1986). Overview. Transcultural Psychiatry in South Africa. Part I and II.  
Transcultural Psychiatry Research Review, 23, 273-303.
- Swartz, L. & Foster, D.  
 (1984). Images of culture and mental illness: South African psychiatric approaches.  
Social Dynamics, 10, (1), 17-25.
- Thorpe, M.R.  
 (1982). Psycho-diagnostics in a Xhosa Zionist Church.  
 Unpublished M.A. thesis, Rhodes University.
- Vilakazi, A., Mthethwa, B., Mpanza, M.  
 (1986). SHEMBE: The Revitalization of African Society  
 Skotaville Publishers: Johannesburg.

- Weiss, E.  
(1984). Amafufunyane.  
University of Cape Town: Unpublished Paper.
- Weiss et al.  
(1986). Traditional concepts of mental disorder among  
Indian psychiatric patients: Preliminary report  
of work in progress.  
Social Science and Medicine, 23, 4, 379-386.
- Young, A.  
(1982). The Anthropologies of Illness and Sickness.  
Annual Review of Anthropology, 11, 257-285.
- Zola, I.K.  
(1972). The concept of trouble and sources of medical  
assistance.  
Social Science and Medicine, 6, 673-679.
- .....  
(1972). Studying the decision to see a doctor.  
Advances in Psychosomatic Medicine, 8, 216-236.

APPENDIX-1

TABLE-2

List of symptoms experienced by patients when they first got ill

- Amelia
- Social withdrawal
  - lost interest and initiative in her job
  - headaches, forgetfulness, poor eyesight
  - mind working very fast, thinking of many things at once
  - acting stupid
  - disturbed brain functioning
- Babini
- loss of appetite
  - loss of weight
  - asocial
- Bill
- laughing and talking to self
  - talking nonsense & mumbling
  - grandiosity (wealth)
  - social withdrawal
- Busi
- very quite
  - afraid of people, keeping to herself most of the time
  - not sleeping well at night
  - bad dreams
- Connie
- phambana
  - preaches
  - aggressive behaviour
  - strangled my soul
- Eric
- hearing funny/strange voices inside his head
  - seeing funny things
  - have nightmares
  - disturbed brain/mental functioning
- Faith
- palpitations
  - crying aloud
  - social withdrawal
  - does not want to talk

TABLE-3

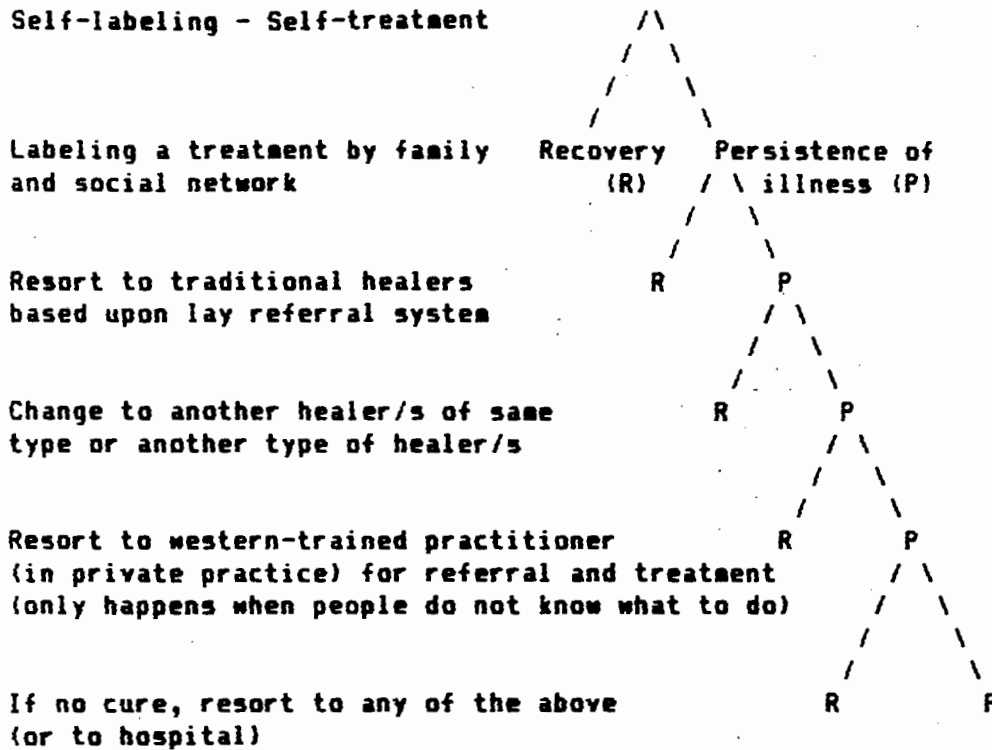
List of symptoms given by patients regarding their current ideas about amafufunyane

- Behave like a mentally ill person
- Wild
- undressing in public
- libidinal drive high
- disturbance in functioning of brain
- wanders away from home
- does not know
- running wildly (towards graves)
- wanders away from home
- talks & laughs to self
- appetite ++, (eats a lot)
- strength ++
- 2 types of amafufunyane
- a) silent - dangerous / killer
- b) speaking
- enormous strength
- looks wild
- mind is disturbed
- talking nonsense
- talks alone
- running wildly
- acting like a mentally ill person i.e. disturbed brain functioning
- palpitations
- crying a lot
- irritability
- social withdrawal
- undresses in public
- frightened look
- running wildly

Isabella	- not sleeping well at night (bad dreams, people chasing) - always frightened of the - no trust for other people	: - wild, runs wild : : - insults other people : - strength ++ : - wandering around : - undressing in public : - carries sharp instruments
Millie	- loss of appetite - social withdrawal - wild and screams - frightened of being alone - wandering in streets	: - laughs/cries without provocation : - craves for food : - appetite ++ : - sleeping a lot : - social withdrawal : - easily frightened
Mongezi	- stomach cramps - tires easily - bad dreams - seeing funny and scarring things (hallucinations) - social withdrawal (afraid to seen by people, avoids friends)	: - destructive behaviour : - wandering around in streets : - hoarding rubbish : : : : :
Onele	- very talkative - hearing voices (God) - wearing girl's clothes - destructive behaviour	: - talks with strange voice : - runs about wildly : - violent : - amafufunayne in stomach, waist : - barrenness : - discolouration of skin, especially : of skin
Similo	- frightened look, scared - wild - chasing people - eating and drinking dirty stuff - wanders away from home - enormous strength	: - cramps in stomach : - headaches : - discolouration of skin : - short tempered : : - wild : - threatens to hit people : - losing one's mind : - very talkative
Tally	- running wildly, jumping around - talking to self - hearing strange voices  - singing loudly - undressing in public	: - talks to self : : - laughs without provocation : - in church : fall to ground, : strange voices heard talking : through them : - runs wildly : - threatens to hit people
Thami	- sitting alone away from other people - loss of appetite - loss of weight - irritable	: - has a funny cry : - likes to fight with other people : - running away from home : :

APPENDIX-2A

FIGURE-1: Diagram of Hierarchical resort: Exclusive type



B

FIGURE-2: Diagram of hierarchical resort: mixed type

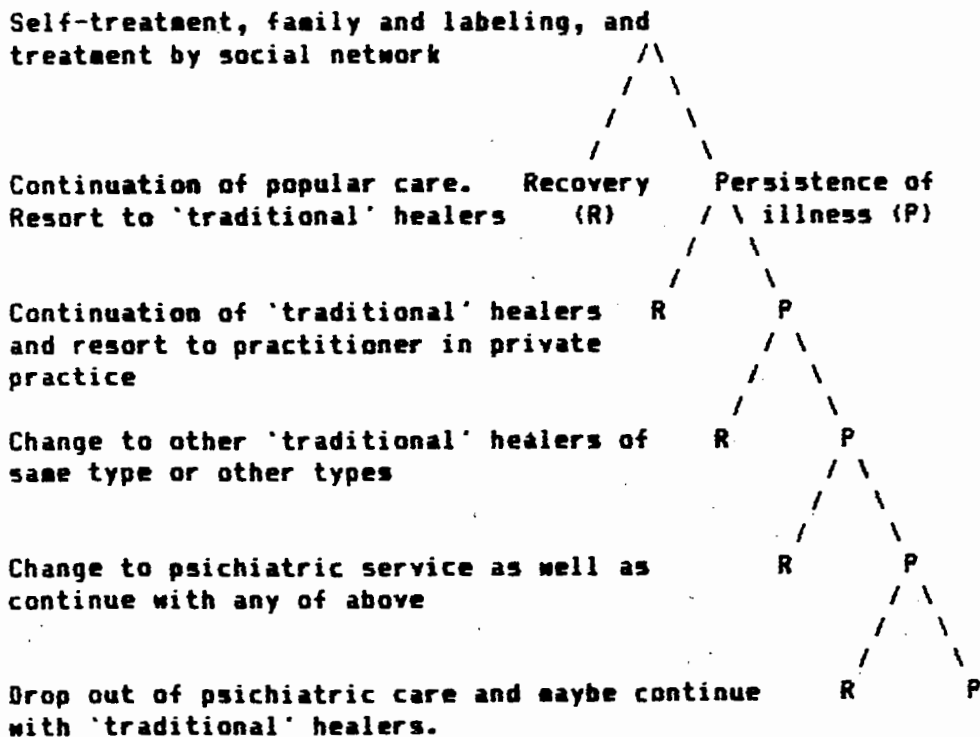


Figure-3 Diagram of help-seeking behaviour of two patients with amafufunyane;

Health problem: 35-year-old-mother of one child, from city of Cape Town.

Diagnosis: Self - Amafufunyane;  
Hospital - Major Depression.

<u>Labeler</u>	<u>Label</u>	<u>Etiologies implicated</u>	<u>Choice of treatment</u>	<u>Evaluation of treatment outcome</u>
Patient & family	: Amafufunyane	: bewitched	: sleeping, off-sick, praying, getting advice from neighbours (S/W),	: unsuccessful, no change in symptoms gettin worse
Psychiatrist:	Depression	: work-related stress	: antidepressants	: unsuccessful threw away all treatment, went back to work, condition worse, employer took back to same psychiatrist
Same Psychiatrist:	Major Depression	: job-related stress	: antidepressants	: Sedation succesful in calming patient patient en route to hospital. Still believe in witchcraft - refuse in-laws, but settles down after 2/52, discharged to clinic for follow-up.
Clinic	: Major Depression	: job-related stress	: antidepressants	: Successful in giving relief from syptom, but still worried about amafufunyane that have not been treated; is going to consult a faithhealer to treat the condition.

APPENDIX-4

Figure 4 Diagram of help-seeking of above two patients with  
amafufunyane

Health problems: 39-year-old mother of three children, from the rural area of Transkei with amaafufunyane, and Organic Brain Syndrome.

<u>Labeler</u>	<u>Label</u>	<u>Etiologies implicated</u>	<u>Choice of treatment</u>	<u>Evaluation of outcome</u>
Family & Friends	Amafufunyane	bewitched	diviner diagnosed Amafufunyane and medicines to drink	unsuccessful, no improvement after a 1/52 before family took her to Faithhealer
Faithhealer	Amafufunyane	no explanation offered by Faithhealer	Holy water to drink, Holy ropes to wound waist, laying-on of hands	stayed at healer's residence for 3/12 whilst using treatment, slight improvement but treatment rated as unsuccessful in treatment of amaafufunyane - to try another healer of a different type back Cape Town
Herbalist in Cape Town	Amafufunyane	no explanation offered, healer just listened to patient, offered explanation & treatment accordingly	medicine to drink and another medicine to wash body	unsuccessful, after 1/52 using treatment, did not know what to do, neighbour recommended another Faithhealer
Faithhealer	Amafufunyane	bewitched	Holy Rope to tie around the waist - supposed to protect her from attacks by Amafufunyane. Holy water to drink, laid-on of hands.	unsuccessful, condition worsened, friends suggested that boyfriend take her to western-trained doctor in private practice
Western-trained doctor in private practice	No examination carried	refer them to hospital	_____	_____

Hospital doctors	OBS	something in operation to her brain clip aneurysm that needs and drain to be removed haemorrhage (subarachnoid haemorrhage & a middle cerebral aneurysm)	unsuccessful, develop other symptoms, behaviour problematic, diagnose again as frontal lobe syndrome and refer to psychiatric hospital	
Psychiatric Hospital	OBS	Not clear	phenytoin haloperidol	Feeling better and refer to psychiatric community clinic for follow-up.
Community Psychiatric Clinic	OBS	something in brain has been removed treatment to prevent further attacks	Phenytoin & Haloperidol on subsequent visits	Successful in alleviating symptoms and treatment some of illness 3 <sup>rd</sup> visit stop all medicines - discharge home - for follow-up at local Day Hospital for monitoring of BP.

INTERVIEW SCHEDULE

(1) THE PATIENTS' DEFINITIONS AND EXPLANATIONS OF ILLNESS

(With regard to present illness):

a) When did you realise that something was amiss?

- onset

b) What made you aware that something was amiss?

- physical changes

- mental changes

- social changes

- observations by others

c) What do you think has caused your condition?

- why do you think it started when it did?

- who are parties or entities involved in the cause?

- do you think of them/these as of natural,  
supernatural or social?

d) Assessment of long-term prognosis of condition:

- what does the condition do to you?

- how severe is it? will it have a long course?

- what do you fear most about your condition?

- what do you think will happen to this condition?

- how has condition affected your life?

- how will it affect your life in the future?

e) Where did you learn of the above?

- how did you come to know about amafufunyane?

- what does the term convey or/and mean to you?

(2) THE PATIENTS' HELP-SEEKING BEHAVIOUR

a) What did you do when you recognised that something was

amiss?

- the role of all significant parties including healers who were consulted.

- who influenced choice of healer decision?)

b) Was any of the above treatment beneficial/noxious?

c) What made you seek help in the present treatment?

- why did you take so long before seeking help in the present treatment?

(3) THE PSYCHIATRIC ORIENTATION AND ITS INFLUENCE ON HELP-SEEKING BEHAVIOUR

a) When you first came into this service what did the doctors call your illness (diagnosis).

- what do they think about amafufunyane?

b) What are the important results you hope to get from the present treatment? (expectations)

- have your expectations been met?

- do you think you are benefitting from this service?

c) Have you come across anything in this service that you are not happy about and would like to bring up?

d) What are your plans regarding future consultation?

- do you intend to remain in care, continue changing practitioners?

(4) BASIC PERSONAL INFORMATION

Name:

Sex :

Age :

Marital Status:

Children:

Place of birth:

No. of years in an urban area:

Present occupation:

Employment history:

Number of years schooling:

Other qualifications:

Present residence: (address, area)

a) size of household

b) relationship to household head

c) total number of wage-earners

Do you belong to any church?

- how often do you attend church gatherings?