Psychiatric disorder in Xhosa-speaking men following circumcision

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This study is dedicated to:

My father,

Laurence Vernon Vivian

&

My mother,

Marion Campbell Vivian

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Declaration

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Abstract

This interdisciplinary study, within the fields of anthropology and medicine, describes my qualitative research as an anthropologist into the mental illness histories of five young Xhosa-speaking men who, within a year of their circumcision, suffered psychotic breakdowns. The study took place in Valkenberg Hospital for the Mentally Unwell and the surrounding disadvantaged, largely Xhosa-speaking communities in Cape Town, South Africa. Numerous admissions were screened over a two-year period, but only these five men met the study criteria. Their case studies describe how they perceived their circumcision and the stresses that may have contributed to the onset of their psychotic illness. Qualitative depth and ethnographic detail about practices was derived through interviews and fieldwork with family members, their social networks, and Xhosa-speaking people both in Cape Town and in the Eastern Cape. In addition, healthcare professionals were interviewed to provide insight into the case studies and health system practices. A thematic analysis was used to interpret the data whose strength lies in its anthropological description.

The thesis describes the nature of stress that may have precipitated the onset of psychotic illness in these vulnerable men, following circumcision. In respect of precipitating stressors, circumcision had relevance because it was a culturally pre-scribed, significant, life stage event around which distinctive psychosocial and environmental precipitating stressors clustered. Men were placed at risk for mental illness, when the intimacy and social circumstances surrounding the circumcision as a patrilineal cultural practice, were jeopardised. When this happened, especially if the youth's father did not fulfil his traditional role or because of cultural dissonance, the stressors inherent within

circumcision then became harmful. These stressors were described in local idioms of distress.

The two psychiatric outcomes described were Schizophrenia or Bipolar Disorder in the cases of Unathi, Lindelo and Ayenda, and Cultural Bound Syndromes as transient psychoses in the cases of Mpumi and Xolile. The three men who suffered with more chronic, long-term mental illness had their worst experience of stress in the months after they left circumcision. This was exacerbated by poverty and their being unsupported by family and extended kin. In respect of Cultural Bound Syndromes, precipitating stressors appeared to be inherent in circumcision. Their psychotic illness happened immediately after circumcision and their psychotic symptoms went into remission when their cultural experience was therapeutically addressed.

The study informs cross-cultural psychiatric research and promotes culturally sensitive practices in pathways to mental health care. This is particularly important given that Xhosa-speaking circumcision practices are well-established transitional rites of passage for manhood. The study thereby contributes to this already existing discourse and whilst the Rev. Tiyo Soga's (1880) writings are cited in the literature review, his descendant's voice, Dr. Ju Ju Soga is heard in the interviews. In this respect, the literature and data persistently raise questions about values pertaining to safety, injury, psychological harm, and stress. This thesis argues that primarily, it is families and culturally-intimate elders and officials who are responsible for the psychological well-being of initiates. The ritual functions well when they perform their official roles; it is this that establishes the major protective mechanism against stress-related mental illness for initiates. It is in this family context that the health system can provide appropriate mental health care services that address mental health care need.

Glossary

abafana	circumcised men in the 6 months after circumcision
abakhwetha	the initiates in the seclusion
amadlozi	ancestors
amafufunyane	idiom for distress, spirits speaking from the abdomen
amakhankatha	teacher or guardian in seclusion
amandla	power or energy
amarkhwala	“unripened fruit”, meaning they were not fully men
amaXhosa	the Xhosa people
dook	head scarf
gula	slang for sick
hlonipha	a special and new vocabulary used in circumcision
igqirha	traditional healer
iinerves	feelings of nerves, anxiety, and stress
iingqondo ziyamshiya	“madness” as an idiom of “mind has gone away”
ijwabi	the foreskin or prepuce
ikquala or ukunqula	discipline to be observed by abafana
i-krwala	the new man
imbeleko	first ritual for boys and girls done 6 months to 6 years
incanca	youth’s penis
indoda	“man” in the way he behaves
ingcibi	traditional surgeon in circumcision
inkundla	decision-making forum of senior men/law court
intlombe	circumcised peers
intlonipho	system of language and behaviour avoidances forbidding a married woman from uttering certain syllables pertaining to her father-in-law’s name and from entering designated spaces
isiseko	spiritual practice of a ritual binding to the ancestors
isithetho	customary practice
isiwasho	sangoma’s herbal medicine

isiXhosa	the Xhosa language
isuthu	period of seclusion
iyinga	name for the initiate's penis in circumcision
khankatha	teacher or guardian in seclusion
lobola	marriage payment for the bride
malume	uncle, mother's brother
mfusa	cattle system
mlungu	slang word for a white person
mwashi ingceke	white substance put on skin to make it look good
nyama	skin, and meat you eat, and skin on the whole body
nyanga	herbalist
phambene	mad person
Red Xhosa	traditional or non-school people
sangoma	Zulu traditional healer
shebeen	an African bar
ucabamane	psychotic
ukosiswa	ritual killing of a goat in circumcision
ukugula	all sicknesses
ukusikwa	operation to remove foreskin or prepuce, ritual killing
ukusoka	presentation of gifts
ukuthwasa	initiation to become a healer
ukuyala	admonition, to advise
umfana	one newly circumcised man
umgidi	coming out ceremony when the man leaves seclusion
umkhwetha	the initiate in the bush or seclusion
umlasa	ritual impurity in women
umninisuthu	principal host in circumcision
umphumo	"coming out" ceremony
umqombothi	traditional beer
umthondo	a man's penis
uyaphambana	mental illness

CONTENTS

CHAPTER 1 – INTRODUCTION

1.1 The Study

The psychological, social, and cultural circumstance of five Xhosa-speaking men who became psychotic and were admitted to hospital within one year of their circumcision[1] is the broad subject matter of the study. There has been little investigation of this phenomenon in the fields of psychiatry, psychology or in the discipline of anthropology. This descriptive study therefore provides qualitative insight into their lives and the diverse stressors and cultural discord that they experienced in their circumcisions and prior to the onset of their psychotic illness. It is suggested that harmful anxiety in the circumstances surrounding the event, combined with an uncomfortable sense of cultural dissonance, resulted in sufficient stress to precipitate the psychotic breakdowns of these five vulnerable men.

The mental disorders suffered by these five men will be described in respect of two outcomes: Schizophrenia and Bipolar Disorder as representative of more severe long-term psychotic disorders. Brief Psychotic Disorders or altered states in the context of Cultural Bound Syndromes were possibly suffered by two of the men. These outcomes were suggested by the evidence in their case histories, their original diagnoses and follow up on each man in his Xhosa-speaking family and community. It appeared that the nature of stressors that preceded the onset of illness in each outcome differed (Allwood and Gagiano, 1997). The discussion draws on the five men's descriptions of their perception of stress in circumcision, in particular their distress at their father not taking them to circumcision. Another key stressor was that of being unsupported by extended kin in their apprenticeship as new Xhosa men. This evidence, in conjunction with that in the wider data and literature supports an argument that harmful psychological stressors and socio-cultural environmental stress have become more prevalent across Xhosa-speaking people.

[1] In the interest of style and fluidity the word *"circumcision"* incorporates the circumcision and seclusion period of the Xhosa-speaking *"initiation ritual"*. In Professor Hirst's words, the study prefers *"the use of circumcision to that of initiation because, initiation is ambiguous. Initiation refers to the induction of a healer, which, of course, does not involve circumcision per se, although it is an important preliminary to entrance into the profession of healer"* (Personal communication; Professor Manton Hirst, 15 August 2006).

Although this study has a focus on Xhosa-speaking culture, it is important to mention that, in terms of referral procedures for initiates suffering from mental illness, the health system in the Cape Province must address diversity. The circumcision practice is one cultural practice in a diversity of others, but has particular significance because it is widely practised locally. In this respect, the strength of this study lies in the anthropological methodology which has brought a breadth of analysis to elucidate the relationship between circumcision and mental illness, and the pathway to care for initiates suffering from mental illness. This is vital for planning services and in addressing their health and human rights.

1.2 Context

Exploring the links between circumcision and mental illness in these five Xhosa-speaking men requires that the historical significance and cultural value of circumcision is described. This contributes to some understanding of how their bodily disposition, psychology and social circumstance could be so deeply affected as to lead to their psychotic breakdowns. The complexity of this analysis, from an anthropological point of view, requires an understanding of Xhosa-speaking culture, circumcision and local explanations for mental illness. This involves analysing what has culturally remained the same and how practices may have changed. Through this knowledge the social exigencies that people face from day to day is revealed, and this builds a broader cultural perspective into explaining their present conditions. Clarifying the nature of the specific duress they experienced offers an opportunity to understand and better address mental health care need.

Circumcision practices are described in the thesis and South African context amongst Xhosa-speaking people. The Xhosa tribe, as described by Ngxamngxa (1971) is a group of clans within the Nguni and thereby Bantu-speaking people. Their descent is traced from Xosa and his ruling clan the Tshawe. Xhosa-speakers as one group are divided into the Mfengu, Thembu, Mpondo, Mpondomise, Bhaca and Bomvana as tribes or sub-tribes. Amongst these tribes standard Xhosa was varied by dialect and Xhosa territory was situated in the Eastern Cape, from the Umzimkulu River in the north to the Great Fish River in the south. The Xhosa are a patrilineal people, united by language, culture, ancestors, and history, neighbourhood and marriage ties.

Mandela says, *"Each Xhosa belongs to a clan that traces its descent back to a specific forefather"* (1994, p4). Forefathers as ancestors anchor descent based lineages, wives, children, kinship, cattle, and land. In so doing a system of hierarchically based chiefdoms and families held authority and social status.

Whilst traditions hold strong amongst Xhosa-speaking people current practices show their engagement with diversity, westernization, Christianity and urbanization. In the Eastern Cape, Mayer (1961,1971) describe how Xhosa identity and tribal affiliations shifted with the emergence of 'School' people who held up Christianity, literacy and western ideals, whilst 'Red' people followed a traditional way of life. More fluid notions of Xhosa identity are evident in urban communities. In Cape Town in the Apartheid Era (1948 – 1994) unlike other parts of South Africa, they were the dominant group of autochthons but a minority in respect of 'coloured' and 'white' people. In 1975 a largely Xhosa-speaking community of nearly 7,000 people claimed their right to citizenship (Cole, 1987). Despite oppression Xhosa people have held to their extended kin networks and traditional practices in the use of clan names and marriage customs. They continue to migrate to their rural homeland in the Eastern Cape (Ramphele, 1993). In an urban setting such as Cape Town, Xhosa people do experience many more diverse problems such as unemployment, competition for housing and service backlogs. Moreover traditional structures have been questioned and authority, which used to be held by men, has been challenged by the empowerment of women, education and Christianity and the increase of women and families in town.

In respect of demography in Cape Town, the South African National Census of 2001 cited the population of Cape Town as 2,893,251 people but more recent figures place this number at 3.5 million. Coloured people account for 48.13% of the population, followed by Black Africans at 31%, Whites at 18.75%, and Asians at 1.43%. 58.3% of the unemployed are black, 38.1% are Coloured, 3.1% are White and 0.5% are Asian. 41.4% of Cape Town residents speak Afrikaans at home, 28.7% speak Xhosa, 27.9% speak English, 0.7% speak Sotho, 0.3% speak Zulu, 0.1% speak Tswana and 0.7% of the population speaks a non-official language at home. 76.6% of residents are Christian, 10.7% have no religion, 9.7% are Muslim, 0.5% is Jewish, and 0.2% is Hindu. 2.3% have other or undetermined beliefs (Statistics South Africa, 2007).

This study has sought to give recognition to the pre-morbid psychological disturbance that may exist in respect of circumcision. The effect of cultural dissonance within a Xhosa-speaking population as a related contributing, environmental factor that exacerbates residual anxiety will be discussed. This study strengthens an already existing field of cross-cultural psychiatry in South Africa where Ensink and Robertson state that although traditional mental illness categories have been incorporated into medical expertise, there remains *"a paucity of information on indigenous idioms and categories of distress"* (1996, p 137). The study seeks to address an absence of qualitative information that should inform health system practices. This intends to ameliorate Ensink and Robertson's concern that misdiagnosis is inherently likely because of the multiplicity of patient beliefs.

1.3 Study rationale

I first had contact with the newly circumcised Xhosa-speaking men, who participated in the study, in Valkenberg Hospital when they were suffering with their psychotic illness. Each man at some stage clearly described a sense of being in an altered state of consciousness or awareness in the circumcision. This was contrasted with a distinct sense of sudden and total loss of conscious awareness during their psychotic illness. This critical perspective on the change in a man's sense of himself was to form an underlying theme in understanding how their circumcisions and later their mental illness deeply affected their experience of stress and their lives.

All five men were interviewed first during their hospital admission and subsequently followed up in their community. This follow-up data is arguably more reliable than that on their circumcision, or onset of psychotic illness which relied on their memory of these critical events. The accounts, from their recovery periods, provide a sense of how they regained a sense of their own agency after their mental illness and these inform the discussion on their perceptions of stress, circumcision and mental illness. In this I, as a medical anthropologist, have had to understand and comment on the men's psychiatric diagnoses, albeit as a naïve psychologist. Each man was diagnosed, and this is recorded, with a known psychiatric condition and this was reviewed with consultant psychiatrists during the course of the study.

The study shows that in some cases men did better than their diagnosis suggested they might, and others remained more significantly ill. It appeared that at least two men had psychotic events that appeared to resolve completely. These were suggestive of cultural bound syndromes in that their cultural context dominated the manner in which their psychosis was expressed. They may well have better outcomes than seem possible for the other three men.

Each found a particular pathway to care in the health system (Goldberg and Huxley, 1992). The data has provided culturally rich, descriptive material which has followed their pathway from within their community and the circumcision, to their admission and recovery. In two cases this shows their relapses back into mental illness. Insight into all the cases was gained from observations within the hospital and this has included interviews with doctors and nurses across the health system. Each case study prompted a wider investigation into the social and cultural world behind the five subjects and through this a deeper understanding arose about their referral pathways.

1.4 Valkenberg Hospital and its surrounds

Valkenberg Hospital is one of twenty-four public psychiatric hospitals that deliver acute and chronic in-patient care to approximately 14,000 patients in South Africa (Collins, 2006; Emsley, 2001). Within the Western Cape Province, Valkenberg Hospital is one of three psychiatric hospitals with, Stikland and Lentegeur hospitals also being relevant to the study; each has its own comparable catchment area. Shah describes this as essential to a larger jig-saw puzzle for mental health care services directing and co-coordinating a *"comprehensive and community-based mental health service"* (Department of Health, 1997). These strategically direct services as part of a drive towards *"an integrated model of care – where this care is integrated into the general medical services"* (Shah, 2002, p 3).

In January 2002 there were 150 acute psychiatric beds. There were 1,949 admissions in the period 2001-2002, ranging from 128 in March 2002, to 200 in May 2001. The average length of stay ranged between 21.0 days to 27.6 days. These data were similar to those for Lentegeur Hospital (to which one man was admitted before he was

transferred across). Admission is most often through the casualty system, where the tertiary Groote Schuur Hospital has a psychiatric casualty ward that will assess, treat, and refer people suffering from mental illness into Valkenberg Hospital or an appropriate alternative facility. Some patients are admitted directly into Valkenberg Hospital through the police services.

Collins argues that historically, government mental health was *"characterized by reliance on hospital-based care, racial inequities in service provision and underdeveloped community services"* (2006, p 981). Reforms since 1994 have attempted to redress existing inequities and implement a mental health care system that is more responsive to mental health need (Collins, 2006; Shah, 2002). Shah describes how past inequities place a significant burden on the transformation of existing services to meet community need, in particular deprived mental health services in rural areas. An over-emphasis on meeting in-patient need in the major city centres has continued into the present. This has meant that rural people move to the urban areas to seek better care. Shah cautions that the health system needs to consider if services for acute care are being met before the service is changed to address primary health care need. Shah (2002) demonstrates that whilst service problems in the Western Cape mirror those within the developing world, current services and transformation correspond to the same process of de-institutionalisation of services in the developed world.

Primary health care services in the public sector that exist mainly for socio-economically disadvantaged people, including indigenous Africans who form the study population group, and who rely also on the public mental health services is important to understand. In parts of Khayelitsha on average less than 5.6% of the population live in formalised dwellings although one section allows for 40.0% in formal dwellings[2]. Gugulethu has 31.1% living in formal dwellings and Langa 23.5%. Each of these areas has primary health care clinics that to a limited extent meet mental health care need in the community.

[2] Shah (2002) a formal dwelling is defined as all buildings and structures that comprise of, house of brick structure, flat in a block of flats, town/cluster/semi-detached, house, unit in retirement village, or buildings in backyard.

The extent of unmet need is best reflected in Ntshingila's description of the abject poverty of seven million South Africans who live on less than R5 per day (The Sunday Times, 16th July 2006). Many of these people live in small female headed families who are surviving off child grants of R190 per child or state pensions of R820 per month. The desperate nature of this and its relationship to mental illness is argued for by Shah (2002), who cites literature stating that unemployment and poor socio-economic factors impact on admission rates. Of further significance is that Lund (2002) states, *"the availability and critically the strength of the community would logically seem to be fundamental to preventing relapse and managing patients out of the hospital sector, thereby reducing the likelihood of admission"*. Yet, the weight of evidence suggests that the strength of local communities is compromised by their impoverished circumstances and this has exacerbated mental health care need.

1.5 Motivation

Dr. David Kibel, as the consultant psychiatrist on the closed male psychiatric ward at Valkenberg Hospital, first described in Xhosa-speaking patients a concurrence between psychosis and patients' references to circumcision, and asked me to assist him in an informal period of observation. From observations we noticed that a significant number of Xhosa-speaking males of various ages, who were acutely mentally ill made references to their male circumcision, or failure thereof during their psychotic period.

From 1995 I had permission to work on the closed male psychiatric ward as an anthropologist in a multi-disciplinary health care team. My place in the team was to facilitate a cultural and psychosocial interpretation of the patients' background that might be relevant to their mental illness. Dr. Kibel then suggested that we should look more closely at a link between circumcision rituals and psychotic episodes in some young Xhosa-speaking males. This period was fundamental to my learning as it deepened my limited experience of Xhosa-speaking people in the Western Cape Province and gave me a working insight into the South African psychiatric health system.

Over this period I worked as an anthropologist at the University of the Western Cape[3]. My students provided social activist insight into the circumcision custom. Some young male students, who were eligible for circumcision or had been, advocated against the ritual being continued. This advocacy argued against the domination of tribal custom. Arguing that the freedom of democracy was paramount, student newspapers called for the banning of circumcision saying, *"That it spread AIDS as the circumcision was done by traditional leaders who used unclean knives and were irresponsible"* (PACE Newspaper, October 1997). Those whom I tutored as social science postgraduate students researched and prepared papers on the topic. Their research argued more for the custom to be continued as tradition but adapted to be safe.

Their advocacy fell in line with ongoing newspaper reports about the physical dangers experienced by youths in the bush through failed circumcision practices. Cultural dissonance in its varying hues emerged from this time as a dominant theme. Mirroring the students' concerns, newspapers reported incidents each year on injuries and deaths suffered by *abakhwetha*[4] in different parts of South Africa. The Eastern Cape received significant coverage and one report in June 1996[5] is pertinent. Following circumcision four youths died and fifty-three youths were admitted to local hospitals. This highlighted the concerns and injuries that are prevalent. On this occasion elders and women voiced their concern about the custom being continued.

The newspaper reported that youths' penises were septic and some had to be amputated. Others had been severely assaulted for failing to perform the traditional procedures and one of these died from head wounds as a result. Traditional surgeons and teachers were blamed for using unclean knives and assegais and failing to dress wounds properly. The paper reported a complaint that the *"once secret tradition"* had now been opened to police and media attention. The local government was

[3] The University of the Western Cape under the apartheid government was categorized as a *"coloured"* university. Since 1994 it has been described as a previously disadvantaged.

[4] Van der Vliet (1937) refers to initiates as *abakhwetha*. This in Xhosa refers to youths in the period when they are secluded following their circumcisions and before they are taken from seclusion. Once they leave circumcision they are known as *abafana.* Their circumcised peer group is known as *intlombe.* The period of being *abafana* lasts for six months and during this time; they must always be seen wearing their caps and jackets, and behaving respectfully to all elders, but especially male elders. For the purpose of fluidity in style the *abakhwetha* will be referred to as the initiates and the *abafana* as the new men.

[5] The Cape Times Newspaper June 1996.

recorded as having introduced legislation on the procedure and trained traditional surgeons in more sterile procedures[6].

The Weekend Argus of 22nd July 2006 featured an article that typified the media's six month to yearly, presentation of ongoing concern over circumcision. This, as one of a number of similar articles highlighted that cultural dissonance and malpractices in circumcision are no longer social issues but, political. This is especially in respect of health and human rights. The sub-title was *"Ancient rite: a surge of deaths and mutilations has horrified government officials, health workers and traditional leaders"*. The title read, "Debate rages as young men keep dying" and the article described how nineteen young men had lost their lives in the previous month in circumcisions in the Eastern Cape. On 3rd and 6th July 2007 Cape Argus reported that in the Eastern Cape, six youths had lost their penises, eighteen had been assaulted and two died during *"botched"* circumcisions in *"illegal institutions"*. One surgeon had been arrested.[7]

The issues that arose around the deaths were important in informing this study. Fourteen deaths happened in the Pondo clan where elders claimed other clans persuaded their sons to go too early for circumcision. They were encouraged by older men to go without parental consent and they found themselves isolated and uncared for by unprepared attendants who themselves were too young. Poverty, isolation, HIV, pneumonia and infections were blamed for the resulting morbidity and deaths. These complaints and others such as, that surgeons used the same blades to cut and that admissions to hospitals were delayed for sick initiates form pervasive themes. This evidence suggests that circumcision practices remained closely culturally circumscribed as the details of the clan were recorded. Of concern in the reports is the question of who is taking responsibility for practices given that decision-making should be happening within each initiate's family and immediate clan. Moreover, the social exigencies that initiates and their families endured in terms of poverty, disease and profiteering was of equal, if not greater concern.

[6] Insert corroborated evidence from The Cape Times Newspaper, 4 January 2007.

[7] Special Assignment on SABC3 on Tuesday 14th August 2007. Local television also featured the case of a twelve year old youth who had been accused of raping a four year old girl after being instructed to do so in his Mpumalanga circumcision school. This is of special interest to this study as this information was revealed during his psychological counselling sessions which had been instituted by the court. This area has different practices to those in the Eastern and Western Cape as youths are circumcised much earlier and in larger groups.

My professional activities have informed the study and contribute to insights in the participant observations. I joined the Faculty of Health Sciences at the University of Cape Town in 2000 and at the same time began my doctoral research. During this time I have taught health science students about culture in different clinical environments and communities. This included participating in circumcision workshops for health care practitioners in the community. Another invaluable experience was taking medical students on a number of fieldtrips to the secondary hospital SS Gida in the Eastern Cape[8]. These helped me to place Xhosa-speaking circumcision into its rural and indigenous context.

Developing the methodology for my doctoral research entailed being more precise about one aspect of the circumcision. The study was therefore refined to examine only young men who had recently experienced circumcision, and this limited it to a particular age group, defining specific stressors in a delimited cultural event and period of time. The hypothesis had inherent risks and limitations because I personally had observed only one such case presentation. What had been pervasive in our patient observations was psychotic illness where the early symptoms could have been anxiety about going for circumcision; others were untreated depression around having not been or failed circumcisions.

In general there was much symbolic imagery relating to circumcision practices in hallucinations, dreams and voices and vivid descriptions of failed or remembered circumcision rituals. This psychotic imagery was confused as they were deeply disturbed. However, what was distinctive was that the men believed that in some way their social and/or psychological dysfunction was related to what had happened in the course of the ritual. This could have been delusional but anthropologically this still made it relevant as a culturally rooted delusion or symbol. Alternatively it could have been true and have been remembered.

What was evident was that there was rich evidence that suggested a deep and little understood relationship between mental illness and circumcision as a cultural rite that

[8] SS Gida Hospital has been used as a faculty health education site for a number of years and interviews and observations from health carers and local people there are included in the data.

structured identity and social roles within a Xhosa-speaking community. In the telling of these men's stories their accounts were often inappropriate or tangential. But, even though what they said was incoherent it resonated with their cultural identity and social role. These accounts are powerful and when put in the context of a comparative, anthropological method; beg the question, as to whether the same phenomenon is relevant in other indigenous African speaking people who circumcise men?

1.6 Aims and objectives

1.6.1 The study aim

The study aim was to explore the links between circumcision and mental illness in African males in South Africa.

1.6.2 Objectives

a) To explore the links between circumcision and psychosis in 5-10 Xhosa-speaking males admitted to Valkenberg Hospital.
b) To promote informed psychiatric practice with regard to the presentation of behavioural disturbance when this is related to a culturally described stress factor such as the circumcision ritual.
c) To improve referral procedures for initiates who are suffering from mental health sequelae by promoting their access to treatment.

The key study objectives were met and these are well reflected in the study results and addressed as part of a meta-narrative in the discussion. During the study period (18 months) only 5 Xhosa-speaking males were admitted to Valkenberg Hospital where each had become mentally ill within one year of their circumcision event. All were Xhosa-speaking males within the sixteen to twenty-six years age limit, who presented to Valkenberg Hospital suffering from psychosis. The data collection took place over a period of eighteen months, but follow up extended for another similar period. This group was followed up within their communities in as far as the ethics of the research and accessibility would allow.

The five case studies were examined within an anthropological methodology. This

initially placed each individual's experience of his illness and circumcision into the context of his family and cultural background. It then explored the wider community's perception around the issues that were brought up during these interviews and the themes that had emerged. The perceived value of cultural rites against the culturally perceived problems were continuously asked about and evaluated. Relevant questions that were posed to the community and informed the research process are included in the appendix. The cases histories form the substance of the study results. Aspects that are common amongst them are then discussed in the context of the central themes that arose from the case histories and other evidence. This material then contributes to a discussion or meta-narrative describing the critical perspectives and theoretical implications of the study. The central thesis from the data was that circumcision played a significant role as a precipitating event in the onset of their mental disorder.

Within the biomedical establishment in Valkenberg Hospital, the surrounding clinic facilities and at S.S. Gida Hospital in the Eastern Cape, key informant interviews with psychiatrists, psychologists, and nursing staff were carried out. These attempted to assess their understanding of the psychiatric diagnosis each had received. Questions were also asked about their understanding of the circumcision and how this might affect their patients' lives and their families. Themes from these interviews, along with participant observations carried out in the wards, and community, are extensively incorporated into the discussion.

The study looks at three parameters in this context:

- Xhosa-speaking circumcision practices.
- Stress and mental illness.
- Circumcision and stress.

In a psychiatric context the evidence from the five cases will be used to support the thesis that:

i. The circumcision may be a precipitating factor for psychotic illness in Xhosa-speaking initiates who have a predisposition for psychotic illness. Psychotic symptoms would present within the context of their circumcision.
ii. To be effective, treatment needs to be culturally sensitive.

iii. Pathways to effective care may fail when appropriate cross-cultural psychiatric and general health services are neither available nor supported. Incorporating culture into the health services means better outcomes for patients as the diagnostic procedure and follow up is better informed.

CHAPTER 2 – LITERATURE REVIEW

2.1 Introduction

The literature review describes the relationship between stress, circumcision, and mental illness. It would appear that as a stressful, transitional life event circumcision has the potential to be a precipitating factor for mental illness in some young, vulnerable Xhosa-speaking men[9]. Circumcision[10], it is argued, plays a significant role in the psycho-social and cultural aspect of an environmental contribution for their mental illness episodes.

There is very little in the literature on psychological harm for the male initiate in South Africa. Yet, Van Vuuren and de Jongh (1999) cite two centuries of records from missionary reports, ethnographies, scientific and medical reports on Xhosa male initiation. In these sources the ethnographic literature tends to describe its practice, structure and function as having a distinctive cultural or tribal ritual procedure (Mayer and Mayer, 1961, 1971; Pauw, 1975; Ngxamngxa, 1971; Hammond-Tooke, 1989). In general, considerable discussion is devoted to its psychological and social value as a rite of transition for African youths to attain manhood. Psychoanalytical perspectives on the rite of passage[11] and along with these, on gender relations, identity formation and peer interaction have been critical aspects for investigation (Laubscher, 1937; Van Gennep, 1960; Turner, 1962, 1969; Van Vuuren and de Jongh, 1999; Boyle et al, 2002; Silverman, 2004). In this context Silverman argues that anthropological accounts *"probed common symbolic themes: enhancement of masculine virility and fecundity, arboreal fertility, complementary opposition between men and women,*

[9] Male circumcision practices relevant to this study are those of autochthonous African peoples. This practice is very similar across diverse ethnic groups who share African descent, kinship, beliefs, and language. Caldwell et al (1997) suggest that a distinctive African practice of circumcising adolescent males had its origin in Egypt and North Africa where there was no differentiation made between the sexes in early practices. The distinguishing of male from female circumcision is, in Caldwell et al's discussion, a more recent anthropological *"phenomenon"* amongst autochthons.

[10] In defining circumcision Ngxamngxa states, *"by circumcision we shall understand (i) the actual operation of removing the (ukusikwa) the foreskin or prepuce (ijwabi) of the male genital organ with the accompanying rituals; (ii) the period of seclusion (isuthu)… which follows upon it, during part of which period the healing of the wound is expected to occur; (iii) the coming out ceremony (umphumo) with the attendant admonition (ukuyala) and presentation of gifts (ukusoka)"* (1971, p 185)

[11] Rite of passage will be used in the discussion to refer to the ritual event in a holistic sense. This describes the preparation for the event, the operation, the seclusion and the 6 months following when the man must demonstrate that he is a man.

preparation for marriage and adult sexuality, and the hardening of boys for warfare" (2004, p 421).

In the medical literature there is significant material on injury, malpractice, social disease and human rights in circumcision (Funani, 1990; Beinart, 1991; Meintjes, 1998; Mager, 1999; Van Vuuren and de Jongh, 1999; Sidley, 2006[12]). This includes a substantial investigation into the proposed benefit of circumcision in preventing the spread of the human immunodeficiency virus (HIV) (Siegfried et al, 2005; Zoysa et al, 2006). In the general medical literature, psychological harm is inferred but there is no evidence for psychological or psychiatric morbidity in practices amongst males[13]. Psychological harm is therefore mostly understood or suggested as a consequence of physical injury and social harm (Crowley and Kesner, 1990[14]; Meintjes, 1998; Van Vuuren and de Jongh, 1999[15]). This absence of any substantial evidence for mental illness – but more importantly psychosis – reflects Meintjes' assessment in 1998 that as far as can be ascertained, *"the psychopathology resulting has never been quantified or addressed in a coherent management strategy"* (1998, p 23).

A number of reasons present for a lack of evidence for psychological harm both in the literature and from local experts who were consulted[16]. Firstly, there are no actual cases where psychological harm or mental illness can be attributed to circumcision in the historical, anthropological or medical records (van Vuuren and de Jongh, 1999). All reports are therefore "*hearsay*". This absence could be that the secrecy, taboos

[12] Hopkins Tanne (2006) presents evidence that since 1998 in New York City there have been seven cases of herpes in Ultra-Orthodox Jewish newborn boys which was linked to the custom of *"metzitzah b'peh"* or *"suction by mouth"* done in their circumcision. There was one death and one case of brain damage. The newborns contracted herpes when the practitioner sucked the blood from the wound to clean it after he had removed the foreskin.

[13] There is one exception in terms of the psychiatric evidence; Behrendt et al (2005) discussed Posttraumatic Stress Disorder for Senegalese women in Dakar following genital mutilation following their circumcision.

[14] Crowley and Kesner (1990) in "Ritual Circumcision (Umkhwetha) amongst the Xhosa of the Ciskei", *British Journal of Urology*, 66:318-21 suggest that psychotic delusional behaviour can be precipitated by circumcision.

[15] Arguing that eighteen years of age for circumcision ensures psychological maturity, Van Vuuren and de Jongh (1999) cite *"alleged cases of immature boys returning who suffered serious post-traumatic and mental disorders, who hence became amafufunyane"* (van Vuuren and de Jongh, 1999, p 172).

[16] A relatively unexamined area of records that would require an extensive audit, possibly detailing physical and psychological harm exists in medical records in hospitals and clinics. In Valkenberg Hospital patients' medical notes sometimes state when circumcision has been a significant aspect in a male patient's psychiatric condition.

and seclusion[17] have prevented any open discussion on psychological morbidity and deterred future investigation. It is also likely that initiates suffering from mental illness would in the first instance be referred to the traditional healer, and subsequently might seek biomedical care if the symptoms were not alleviated (Njenga et al, 2005).

The focus in the biomedical literature is another reason for a possible absence of reports about associated mental illness. The medical literature concentrates on issues that have presented to the local hospitals at the time of circumcisions e.g. mutilations, dehydration, and sepsis (Meintjes, 1998)[18]. Often injuries appear to have arisen as a consequence of *"certain patterns of malpractice"* and impoverished environments (van Vuuren and de Jongh, 1999, p 164). Addressing these physical injuries requires confronting taboos in circumcision. In respect of psychological harm, however, most health professionals know that disclosure about the circumcision is forbidden and consequently psychological problems are put aside in the belief that the culture has its own healing and psychotherapeutic interventions (Swartz, 1998). Psychological harm may thus be inferred but not openly addressed in the health system (Meintjies, 1998; Van Vuuren and de Jongh, 1999).

Using culture in this context requires some definition. Swartz defines culture as *"the process of being and becoming a social being, about the rules of a society and the ways in which these are enacted, experienced, and transmitted. Culture"*, he says, *"is not static"* (Swartz, 1998, p 7). In his definition Firth wrote, *"If society is taken to be an aggregate of social relations, then culture is the content of those relations. Society emphasizes the human component, the aggregate of people, and the relations between the*m…" (1951, p 27). What is missing in these definitions is that people claim culture because cultural and linguistic differences are tangible. People know with whom they belong yet; have difficulty in defining who belongs within their cultural boundaries. It is this fluid and shifting nature both of human nature and culture that has left anthropologists unable to define culture. Furthermore the only scientific proof

[17] Ngxamngxa (1971) uses the term *"seclusion"* to describe the wound healing phase of circumcision, during which time the initiate learns to behave as a man. This is the period after the operation when the youth is an initiate in the initiation ground or seclusion.
[18] Meintjes (1998) data records medical injuries as a consequence of the practice and these present both in a primary and a tertiary health care context and include more medical conditions.

of culture is ethnographic description of a people's shared language, kinship, custom, and practices.

The biomedical literature is dominated by a renewed interest in HIV and male circumcision. As early as 1997, Caldwell et al describe that circumcised males were at less risk of infection from HIV/AIDS (1997, p 1181). Indeed Siegfried et al (2005) in their systematic review of the literature found a positive association for an intervention but, interestingly, cautioned about confounding the evidence (Siegfried et al, 2005). More recent evidence argues conclusively for a lower prevalence of HIV in circumcised men and advocates for mass circumcisions to stem rates of infection[19]. This initiative ignores Howe et al's (2000) concern that this is not a solution because circumcisions are motivated by and structure behaviour[20]. Van Vuuren and de Jongh illustrate that circumcision shapes men's personal and social behaviour and attitudes across a culture (1999, p 182). Behaviour, therefore, and not circumcision, may well explain why HIV is less prevalent in circumcised ethnic populations. Of further concern is that medical circumcision in Africa may well prevent future investigations into the protective psychological mechanisms and/or psychological harm that are inherent in the traditional practice.

Literature on the origin of circumcision practices in general, with a more detailed description on the Xhosa-speaking practice and current, associated problems will be described. This will be followed with discussion on the literature on stress and mental illness where there is an emphasis on a South African context. These perspectives come together in a discussion on stress and circumcision. Stress-related factors, especially those arising in the rite of passage that may play a significant role in the aetiology of mental illness will be explored.

2.2 Circumcision

[19] News *"Male circumcision cuts risk of HIV by half"*. British Medical Journal, Mar 2007; 334: 448-449.

[20] Van Vuuren and de Jongh in validating the endurance of a rite of passage that organises personal and social behaviour speak to the *"enigmatic persistence of circumcision and manhood rituals"* (1999, p 182). This has implications that are little understood about how resilience is engendered in men and paradoxically this elucidates how mental illness is shaped by and shapes culture.

2.2.1 Origin of the practice

There has been extensive deliberation on why male and female circumcision began in diverse human populations. Two broad theses have been presented around a possible origin for the practice. The first and more persuasive argument in respect of African practices is for an Egyptian origin for circumcision practices (Caldwell et al, 1997; Morris, 1999). The second thesis suggests different points of origin with different cultural motivations in diverse local contexts (Parsons, 1989; Seligman, 1965; Silverman, 2004). Both theses would appear to hold some validity given the geographical spread of the practice.

A related debate that has significance for an African practice asks what first motivated people to circumcise. Moreover, why do practices differ and how have cultural and religious groups assimilated the custom? In this debate anthropologists have proposed that circumcision practices may provide clues to early human behaviour and culture (Morris, 1999; Silverman, 2004). It has thus been suggested that circumcision began because it fulfilled an archetypal need in human consciousness. Another proposition suggests that the practice instigates and defines life stages in human physical and psychological growth e.g. puberty. In attempting to unravel why humans behave in this particular pattern, a third and relatively new area of investigation looks at the effect of circumcision on neurocognitive structure, stress, pain and memory (van Vuuren and de Jongh, 1999).

The literature that describes an Egyptian origin for circumcision, illustrates that Herodotus recorded a *"universal Egyptian circumcision practice"* more than twenty-five centuries ago (Caldwell et al, 1997, 1183)[21]. African autochthons were believed to have assimilated the practice following their migration into North Africa[22]. The spread of the practice into southern Africa came through *"diffusion or ethnic migration"* as African people migrated south. Circumcision, it is suggested then became part of a pan-African cultural enterprise (Harris and Wente, 1980 in Caldwell et al, 1997, p 1183). In support of a thesis for an Egyptian origin to the practice Morris (1999) argues that Jewish and Muslim circumcision practices also spread from

[21] Archaeological evidence from mummified bodies suggests that the practice was occurring in Egypt around 3000 BC (Caldwell et al, 1997).

[22] The historical record clearly demonstrates the significance of circumcision practices amongst African autochthons with Caldwell et al (1997) citing that a *"much higher proportion of males and females are circumcised in Africa than in any other continent"* (1997, p 1181).

there by diffusion. The strong archaeological record historically confers validity on the diffusion theory. Corroborating evidence from Jansen argues that a migrating African people established descent and belief systems that incorporated circumcision as a transitional adolescent rite of passage. Xhosa-speaking people, who trace descent through Nguni-speaking people, who are a linguistic off-shoot of African people, share this tradition (Jansen, 1994; Maggs, 1986; Parsons, 1989).

The historical record argues that African people from the sixth century BC[23] migrated from their origin in the Niger Cameroon basin down through eastern and southern Africa. This language group incorporates most of the languages spoken across Africa south of the Sahara. The rule that linguistically defines the language is the *"noun root similar to 'ntu' for person and a prefix similar to 'ba' for that noun class"* (Parsons, 1989, p 16). Maggs (1986) situates these migrations alongside a process of Iron Age development. Xhosa-speaking people formed part of this and arrived in the southern African region by the 10th to 12th centuries AD. They form part of the Nguni-speaking people, and they arise from within this African history. Maggs describes the impact of the late Iron Age period as having a determining influence on culture as new pottery styles and customs were incorporated into a people who previously cultivated and herded. Importantly, diversity between ethnic groups, languages, and culture increased over time. In respect of circumcision, variations occurred in cultural styles for ritual cutting and wound healing and in the initiation rite of passage as the custom responded to ethnic, geographical and socio-political environmental forces.

Against a thesis for an Egyptian origin is the evidence that circumcision occurs in diverse sites across the world. This brings up the question as to why practices should occur as distinctive cultural phenomenon in diverse human populations? The evidence for this thesis is complicated by the fact that these sites have strong oral histories but unlike the Egyptian experience, the archaeological record is poor[24]. In respect of an alternative thesis, Seligman argues that circumcision practices originated for different reasons in diverse cultural groups. He highlights that one-seventh of the world's population practise male circumcision as it *"occurs independently in a great number of widely separated cultures"* (Seligman, 1965, p 5). Silverman (2004)

[23] By the sixth century BC an early and later Iron Age culture was absorbed into an essentially pastoral and nomadic people who were then established across the eastern part of Africa.

[24] The Timbuktu manuscripts in Mali, which are currently under translation, may well give new and important insights into the African experience of circumcision.

concurs, presenting evidence that male and female circumcision occurs in *"sub-Saharan and North Africa, the Muslim Middle East, the Jewish diasporas, Aboriginal Australia, the Pacific Islands, Southeast Asia"* (2004, p 419). In support of this thesis Parsons (1989) argues for the possibility of a local origin for southern African customs[25]. Parsons (1989) suggests that southern African practices may have their origin in local traditions. This, however, suggests that a Xhosa-speaking practice is less rooted into an African or indigenous African-speaking enterprise and more relevant in a regional South African context.

The literature on the argument for different points of origin for practices has brought up a number of suggestions as to why people circumcise. One argument, previously mentioned is that circumcisions are motivated by our archetypal nature (Seligman, 1965; Silverman, 2004). As an archetypal need circumcision fulfils an innate instinctual desire to ritually scar the penis, transforming the person's mind and social disposition. Circumcision then alters relationships across that group, culturally marking generations and the passage of time. Cultural, symbolic, and spiritual relevance is thus accorded to the rite of passage (Turner, 1962). An alternative theory (more valid for male circumcision) is that some cultures believed and perhaps had evidence that circumcising men prevented infections; especially in geographical areas that were hot, with little water and where hygiene was poor. The control of infections brought physical, sexual, and reproductive benefit (Morris, 1999). In a parallel circumstance to that proposed for HIV and circumcision this theory suggests that epidemiologically circumcision practices became critical to the prevention and spread of infectious disease.

The strongest evidence is for an Egyptian point of origin for circumcision practices amongst autochthons who trace their descent through African people. This does not negate an argument for diverse points of origin in human population as cultures evolved and adapted. However, two valuable insights emerge in the literature: firstly, diversity has deeply influenced African practices, as is evidenced in their engagement with other cultures and religions e.g. Arab, Muslim, Christian, western and biomedical beliefs and practices. Ethnicity within Nguni-speaking peoples has also shaped a diverse experience of circumcision in South Africa. Secondly, the literature

[25] Parsons (1989) suggests that circumcision in southern Africa may not have originated in North Africa, but may be a local custom adapted from or influenced by sea traders.

suggests that male rather than female circumcision – as an integral part of adolescent rites of passage – is more prevalent in southern Africa. Caldwell et al (1997) pose that historically in Egypt and northern Africa no distinction was made between male and female circumcision practices[26]. These authors propose that female circumcision has not spread geographically south of the equator[27].

Van Vuuren and de Jongh (1999) state that in most indigenous South African community's initiation rituals coincide with physical puberty or late adolescence, but circumcision is only practised for males[28]. History, language and descent-based practices have instantiated a cultural right to practice circumcision. This history suggests that circumcision is an embedded practice, with circumcising peoples describing it as *"being inevitable: it has always been done, society expects it"* (Caldwell et al, 1997, p 1186). Cultural value is accorded to the rite of passage by virtue of its re-enactment in each generation and in each generation males who hold well defined customary roles take responsibility for the event to ensure that *"the cutting binds them (initiates) to the spiritual world"* (Knudsen in Caldwell et al, 1997, p 1186).

2.2.2 Circumcision amongst Xhosa-speaking people

Xhosa circumcision lies in a broader South African context amongst Nguni-speaking autochthons. Circumcision specifically initiates adolescent males or youth into manhood for patrilineal kinship practices and ancestrally-based rituals (van Vuuren and de Jongh, 1999). The custom used to be integral to the formation of tribal identity[29], promoting distinctions between rival peoples e.g. the Zulu, and the Swazi

[26] It is recorded that Herodotus' informants, *"discussed male and female circumcision as a single phenomenon carried out for the same reasons"* (Caldwell et al, 1997, 1181).

[27] Caldwell et al (1997) offer two explanations for female circumcision being practised predominantly in North Africa. The first is that male circumcision is more superficial but remedial in terms of disease and thus this was retained as African people migrated southwards. The second is that female circumcision is not practised in matrilineal societies and a belt of matrilineal societies extends across Africa south of the equator.

[28] Van Vuuren and de Jongh (1999) state that initiation is gender specific, describing distinct and separate rites of passage. Collective initiation for girls happens amongst the Venda, Pedi or Northern Sotho and Tsonga communities. Amongst the Zulu, Ndebele, Swazi, and Xhosa, girls are initiated individually. Clitoridectomy has not been part of initiation rites of passage except probably in the Tsonga community in Mozambique (Geisler in Van Vuuren and de Jongh).

[29] It is possible that as ethnic groups changed the practice so regional differences may have occurred. Migration, foreigners, and technological change also had an inevitable impact not just on the custom but in defining tribal identity (Maggs, 1986; Parsons, 1989).

people banned the practice[30]. Van Vuuren and de Jongh distinguish between a collective and an individual practice, suggesting that the Xhosa have turned to the latter. In this practice each initiate and their family must decide when the youth should go for circumcision rather than age grades being circumcised together[31].

The literature shows that the pattern of Xhosa-speaking circumcision has remained very similar to the account given by Ngxamngxa (1971) and other ethnographies. However, Van Vuuren and de Jongh (1999) argue that the ritual structure has become less important. The institution remains the most significant event in Xhosa men's lives, which suggests that Ngxamngxa (1971) is accurate in his description of its functionality in integrating Xhosa-speaking people[32]. In this regard an important theme that emerges in the literature is that on gender-based relations and practices in relation to circumcision. Xhosa male status is understood to be achieved through initiation into patrilineal authority structures. Thereby circumcision functions in the allocation of gender-described tasks which then define power and status within African society (Maggs, 1986; Parsons, 1989). Repeated over generations, circumcision sustains identity formation as it defines the body, gendered behaviour and psychology and in so doing structures a Xhosa cultural landscape[33].

In the past circumcision was linked to chiefdoms, and Mandela (1994) says of his own experience that it was mainly performed for the chief's son, and on this occasion commoners or other youths with status were included as his peers (Gluckman, 1956, p197; Van Vuuren and de Jongh, 1999). Mager (1999) describes circumcision as, *"it was a rite of passage that placed young men on the path to marriage, homestead*

[30] Shaka banned circumcision amongst the Zulu and Mswati banned it in the Swazi (van Vuuren and de Jongh, 1999). Shaka was said to have banned circumcision to break social cohesion amongst peer groups thus promoting solidarity in his warriors.

[31] Van Vuuren and de Jongh (1999) record that collective circumcision still happens amongst the Ndebele, certain Northern Sotho-speaking communities, peoples in Lesotho, the Free State Province and the Southern Sotho.

[32] In this respect, Parsons (1989) argues that three customs retained their importance in southern African Nguni traditions. Circumcision in the form of male adolescent circumcision schools was one; *"mafisa"* or cattle system was the second, and the *"lobola"* or marriage payment the last. Parsons argues that these instilled a gender-based allocation of tasks and power. In this patrilineal culture, male status was achieved through circumcision into hierarchical, male, authority structures.

[33] *"In the field of transpersonal anthropology… our increased knowledge of human neurological processes will enhance our understanding of ritual engagement. Within the neurocognitive structure our understanding of neuro relations such as intentionality, dialogue between hierarchical levels of the cortical system of the brain, could explain how ritual as technique, for example, dancing, drumming, fasting, ingestion and painful or stressful ordeals works, both within and among participants"* (van Vuuren and de Jongh, 1999, p 182).

headship, and fatherhood; it allowed access to the inkundla (decision-making forum of senior men). Despite increasing diversity… initiation enabled a shared sense of a common Xhosa nation" (Mager, 1999, p 133). The practice enabled men to serve as warriors and the stick fighting amongst youth and in the ritual was seen as training for defence purposes in intertribal conflicts. Mager describes sticks as being *"symbols of culture; they were also cultural weapons"* in that men after circumcision turned from fighting to understanding Xhosa law and society (Mager, 1995, p 4).

Ngxamngxa (1971) describes that the youth himself decided when he wanted to go to circumcision, but the father had a say in his decision[34]. Mager (1995) explains that Xhosa people needed to feel that the youth had *"lived out his boyhood"* to be circumcised, otherwise it was postponed. He had to be *"stable and even-tempered"* (Mager, 1995, p 2). In adverse circumstances, circumcision was delayed for many years. This suggests that consent required a broad-based familial and community decision-making process. Set against this was the youth's fear that, if he remained uncircumcised he would stay a youth, with no status, *"security or a place in adult society"* (Mager, 1995, p 4). Pauw (1973) argues that an uncircumcised man remained an object of ridicule, unclean, a dog or *"half-witted"* and no one had any expectations of him. Furthermore, if any young men side-stepped some of the process their community would suspect that they were mentally unstable.

Circumcision as a rite of passage happens in three stages: the operation, the seclusion and the coming out. Prior to the event ritual preparations take place, but these are not overly emphasised as preparation for a youth's circumcision begins at his birth. The three stages will be described with reference to Ngxmngxa's (1971) account.

2.2.3 The operation

The pre-ritual preparations involve families and the community in the construction of initiation huts in the seclusion area. These preparations set the stage for all those designated to participate in the rite of passage. Immediately before the operation or circumcision, youths were brought together in a ceremony with feasting, singing, and dancing. Key officials, trained in apprenticeship for their inherited office oversee the

[34] This statement was confirmed by Professor Manton Hirst. He states, *"Xhosa tradition is clear on the point that it is the young man himself who determines when it is time for him to attend circumcision, rather than a parent or authority figure"* (Personal communication, Professor Manton Hirst, 8/3/2005).

event. These were the *ingcibi* or surgeon and his assistant; the *amakhankatha,* teacher or guardian and the *umninisuthu* or principal host. It was incumbent upon the fathers of the initiates to select the surgeon and his assistant.

Although elements of the practice differ within Xhosa clans, a distinctive procedure underpins the operation. This happens after a ritual shaving of all body hair and the initiates eating meat from a first ritual slaughtering. The youths, with only a blanket, were then led by the surgeon and teacher to the river for purification and then to the place chosen for the circumcision (Mandela, 1994). Accounts illustrate that men and elders will forcibly ensure that youths do not turn back. Initiates had to succumb and silently endure the pain and they were restrained if necessary. Ngxmngxa describes (and this differs in how it was done) the youths as being placed on their backs, their arms and legs held in an extended position and a strong man lying across their chest (Ngxmngxa, 1971, p 187). The foreskin was taken in one hand and severed from the penis with a sharp knife. Once this was done the surgeon shouted, *"You are a man"* and the initiate replies *"I am a man"* (Ngxmngxa, 1971; Mandela, 1994).

Symbolically, circumcision and pain must be experienced by the initiate and witnessed by other men in gesture, language, and behaviour. At this stage a new name was given. Symbolic references such as the blankets and the initiates being naked except for their penis sheath have stood as distinct markers for the initiate's transitional process in seclusion. Once circumcised, and before going to the smoke-filled seclusion hut, the wounds were bandaged and dressed with leaves. To stop the initiate being a coward the surgeon gave him a mouthful of a mixture of ant heap and water and this was smeared on the face and chest of the initiate. The foreskin, depending on custom, might be swallowed by either the youth or the father. Mandela described burying it later that night and this being symbolic of burying his boyhood.

Ngxamngxa's analysis of the function of the operation suggests that this symbolically alters the initiate's ties to boyhood, initiating him to his *"status"* in manhood. At this time the youth changed his relationship to his mother. Ties to wives and daughters then took precedence over the ties of boyhood to mothers and sisters. This culturally described change in the man's psychological attitude and bodily posture was essential to him, demonstrating that he had assumed responsibility for his mother and family.

Ntantala says that a man at circumcision was reminded of this obligation, *"see to it that your mother's ointment jar is never dry"* (Ntantala, 1993, p 236). Of further note is that the blood that passed between initiates during the cutting becomes symbolic of friendship and new legal ties. This turns the initiate to embrace a *"wider tribal authority"* rather than his family of birth (Ngxamngxa, 1971, p 201). Lastly, the operation requires many traditional resources that were once vital for its performance both symbolically and realistically.

2.2.4 The seclusion

The seclusion has two phases. During the first wound healing phase, initiates remained more in their huts, all of which lay within the seclusion area. In the past there were two initiates in each smoke-filled hut[35]. In a second phase the old taboos and prohibitions were disregarded and new ones put in place; the initiates must not see women whose faces were uncovered; they cannot approach the young girls who bring food to the ground; they wear only a penis sheath, a blanket and their white clay or ochre, which in Mandela's (1994) account symbolises their purity. This was a more active phase, with the teacher and elders training the initiates in *hlonipha* – a special and new vocabulary; they were disciplined to behave[36] in a particular manner and to care for themselves and their wound. They also learnt dancing, and stick fighting.

The seclusion and their socialisation by peers, teachers, and elders prepare them for the new world they are to embrace[37]. The principal reason the youths were secluded in the bush was for wound healing and so as to avoid all ritual impurity as this had a negative effect on the process. The dietary restrictions, such as dry *mealie meal* or

[35]All initiates were engaged in dressing and airing their circumcision wounds. In the early stage when the wound was healing, they ate hard food such as dry maize, and abstained from drinking anything, other than wetting their lips with moist clay. A ritual killing, the *ukosiswa* marked the end of the first phase for healing of the wounds. This ended these dietary restrictions and some taboos were lifted, as was the close supervision from the teacher. They then enter a different phase when they eat soft food such as milk, pumpkin and green mealies. This new phase makes the assumption that wounds have healed as new taboos were put in place and more freedom and activity undertaken by initiates.

[36] Changed forms of unspoken respect, duties, roles and obligations were impressed upon them in order for them to turn from childish ways. They must begin to demonstrate respect for the property that they will inherit from their father and the authority of older men and the chief. Of importance was that their way of engaging with women changed as the seclusion intends that the initiates' allegiance was placed in respect of men and in defence of their tribe.

[37] Ngxamngxa (1971) describes a labyrinth of tests and hurdles that should have been surmounted in the seclusion period and before manhood was attained. Entertainment in the seclusion included stick fighting, dancing and singing which, although enjoyable, have status and social hierarchy implications as initiates challenge each other in mock battle.

corn and no water were said to promote healing and these appear from the evidence to have changed very little[38]. Early literature suggests that seclusion was safe and the methods used promoted healing. Seclusion generally lasts for three to four weeks but Ngxamngxa (1971) described seclusion as formerly being between three to six months and in East London, at his time of writing, as seven weeks.

2.2.5 The coming out

The coming out party ends the period of circumcision and seclusion and begins the initiate's transition into manhood. In terms of their being socialised into manhood, Ngxamngxa (1971) explains that when the circumcised men were reincorporated into the social group at the *umgidi* ceremony, they were given new sticks or weapons, and admonished and adjured by their elders to respect and care for their parents and to maintain tradition[39]. The significance of these requirements goes beyond the utilitarian, marking respect for the ancestors as the initiate's change of status to being a man, brings him into an intimate association with men and his ancestral patrilineal descent line[40]. His status has legal implications and is symbolised by the black staff of peace given to him to denote his authority[41]. This was described by Nonganza (2005),

"The long, freshly-cut white and brown stick held steadfastly in your right hand like a shepherd;

[38] Ritual taboos and sanctions – many of which are implicit or unsaid in various actions, activities, and instructions – abound in the seclusion. Ordinary activities become changed or reversed as in Van Gennep's (1960) argument that ritual allows for an inversion of the ordinary. In ritual, what is sacred or high status is denigrated and the profane is elevated. This ritual inversion facilitates a later acceptance of status, authority, and hierarchy in ordinary times. Illustrations of these inversions in circumcision are the avoidance of women, being naked and the derogatory terms that are used.

[39] Before the party began the older men admonished the initiates, instructing them to behave as men. Ngxamngxa states, *"The initiates' new status as men was stressed, with the duties which they have to assume and behaviour expected of them towards wives, in-laws, and the tribal authorities"* (Ngxamngxa, 1971, p 191). Coming together with women, feasting on a third ritual slaughtering, gifts, dancing and singing all happen at this time.

[40] *On these occasions abafana on return from the bush used to gather in the cattle-fold on ritual occasions and were consistently chased out, sometimes with a stick if necessary, by the adult married men. This is because adult 'malehood' was not just a social status bestowed on one by or through ritual (even if the ritual charts in esoteric terms the trajectory of a man's life). Young males have to go well beyond the ritual context to establish their adult status, through marriage and children. Marriage was a social, political, and economic institution. These were long established forms of conduct or behaviour. To be a man means to have employment and the means to get married and have a family. Only then is one truly a man and eligible to sit in the cattle-fold at beer drinks and sacrifices. Thus they were adjured in the cattle-fold by their fathers and paternal and maternal uncles to look after their parents, to be the centre-pole of the homestead. This indicates the central significance of abafana's future economic role in support of the homestead* (Personal communication, Professor Manton Hirst, 18 August 2006).

[41] 'Initiation: Coming of Age and the Mother's Pride' Nonganza (2005).

the new black hat, that stamped your authority placed firmly on your clean-shaven head;
the new khaki shirt, trousers, jacket, shoes and name."

In these terms circumcision for Ngxamngxa is a structural process that marks a man's relatedness and relationships in the context of his wider Xhosa community[42]. Thereby a circumcised man's father would traditionally assist in the negotiation for his son's wife. He would do so knowing that traditionally no father would allow his daughter to marry an uncircumcised man, and indeed no woman would agree to marry a man who had not been circumcised (Ngxamngxa, 1971, p 195). Such relationships and their consequences were portrayed in the posture of the new man, his sense of identity, display of desire and sexuality and social responsibility. These attributes were in fact inculcated into a man through language and re-education over the course of his life time.

2.2.6 Functional[43] changes in Xhosa-speaking circumcision practices

What may be stressful in the rite of passage is important in considering the supposition that circumcision may be a precipitating factor for mental illness. The literature suggests that stress may arise in two different contexts. The first relates to stress that is inherent in the customary practice e.g. induced trauma that may provoke anxiety. These stresses will be discussed in relation to the psychiatric literature. The second context is the stress that arises out of changes in the practice that make it functionally more stressful. This forms a significant theme in the more recent literature.

The ethnographic and medical literature describes circumcision as changing in response to historical moment. This is congruent with the theory that the custom

[42] In the past young men could spend time at the Great Place of the local chief and then return to pastoral and agricultural activities in their homestead. With marriage in mind, fathers and their brothers (all of whom are fathers) assisted their sons to build up a small herd of livestock. Nowadays, in the absence of a cattle-keeping economy even in the rural areas, young men have to migrate to urban areas for work e.g. a contract on a mine. Here they become unemployed as even mine work is no longer possible. Once these young men reach the city they need to rely on kinship connections, which is not always possible and they are poor and under nourished. This is because rural areas are poverty stricken and conditions are precarious. (Personal communication, Professor Manton Hirst, 18 August 2006).

[43] The word functional is used following Ngxamngxa (1971). As a Xhosa-speaking man he was insistent that function, structure and organisation of the event were paramount to its successful outcome.

spread by diffusion, establishing a powerful and pervasive core African identity which incorporated diversity and change. More recent literature presents evidence that change, rather than being integrated into traditional practices, has become disruptive and problematic (Mayer, 1971; Van Vuuren and de Jongh, 1999). These changes are described as consequences of urbanisation and increasingly impoverished cultural environments. Of concern is evidence that the operation is less safe than it was in the past[44]. Ngxamngxa (1971) also described that it was increasingly difficult to obtain traditional resources that were needed e.g. white clay, materials for the penis sheath, cattle for ritual slaughter, cleared areas, staffs, blankets. These were once vital for the actual and symbolic performance of circumcision. These requirements are either impossible to obtain or too expensive to get in Cape Town where calamine lotion has replaced white clay to paint the body after the operation. Van Vuuren and de Jongh therefore suggest that this has brought substantial shifts in people's way of life, devaluing the ritual and symbolic experience.

A tension exists in the literature as Mager, for instance, argues that despite migration, cultural practices such as the circumcision show people to be *"managing contradictions and challenges… and creating order in turbulent times"* (Mager, 1995, p 2). It is interesting, however, to note that Mager's (1995) evidence for increasing violence and marital instability in Xhosa society in the Eastern Transkei was based on court records. Mager attributes this violence to the effects of poverty and political hardship. She does not feel that it is related to a Xhosa-speaking crisis in identity or morality. In support of Mager's thesis, a survey on circumcision practices described it as critical in retaining a sense of Xhosa-speaking moral integrity and identity. People commented that circumcision remained a*" compulsory requirement for marriage, it accesses manhood and it promotes tradition"* (The Steyn report in Van Vuuren and de Jongh, 1999, p 166). This suggests that some changes continue to be accommodated and these are illustrated in the new man wearing a working man's cap and jacket or in the pre-screening for sexual infections (Meintjies, 1998).

The most persuasive evidence in the literature is for a broad-based disruption of practices (Meintjes, 1998; Van Vuuren and de Jongh, 1999). Legal documents,

[44] Meintjes (1999) refers to Turner (1915) and Barker (1962) who record that previously the outcome of circumcision was good and practices were hygienic, with no early records of sepsis. However, Turner had heard of 200 cases of sepsis and syphilis and surmised that it was possible that *"weaklings"* would die of exposure and the hardships of the ritual.

medical records and media reports predominate in a description of malpractices in circumcision bringing injury and having harmful psychological and social consequences. Although the majority of initiates remain unharmed these reports indicate increasing numbers of injuries and deaths[45]. Meintjes thus refers to a Circumcision Task Team making an anecdotal observation that complications were higher in urban than rural communities and problems appeared to occur in geographic clusters. This suggests that malpractice may be associated with certain communities that fail to watch over what is happening and may allow rogue, unqualified surgeons and teachers.

Mayer (1971) and Pauw (1973) addressed the impact that an urban landscape had on the organisation of the event. They suggest that environmental changes may have eroded the integrity of circumcision as a traditional socialisation for manhood. Both authors cited changes affecting tribal affiliations and identity formation. Mayer's work illustrates that in urban areas in particular, during the twentieth century, Xhosa identity and practices changed. In circumcision the seclusion period was shortened and traditional barriers between young and old disappeared – with the result that the ritual became *"watered down"* (van Vuuren and de Jongh, 1999, p 166). Van Vuuren and de Jongh concur with Mayer, arguing that socio-political and environmental changes became evident in the loss of such things as available land for seclusion, building materials for the lodges and clean water supplies.

These authors clearly show that an increasingly impoverished environment had a negative and determining affect across a Xhosa cultural landscape. This in turn had a negative impact on social practices and psychological disposition. A corollary to this argument is expressed by Comaroff and Comaroff (2002) who argue that all *"human beings create community and locality and"* at an individual level *"identity"*, in so doing they pull together the social and cultural fabric of their lives. As *"bricoleurs"*[46], Comaroff and Comaroff would argue, Xhosa-speaking people used what was available to them in a modern and diverse landscape to continue an ever-changing circumcision practice. A concept that defines individuals as "bricoleurs"

[45] See Bibliography for recent newspaper reports.

[46] Bricolage – from the French-language verb *bricoleur*, meaning *"to tinker"* or *"to fiddle"*. A person who engages in bricolage is a *bricoleur*. A bricoleur is a person who creates things from existing materials, is creative and resourceful: a person who collects information and things and then puts them together in a way that they were not originally designed to do. Wikipedia, the free encyclopedia.

fails, however, to acknowledge the history and cultural sense of belonging that Xhosa people seek in circumcising their men twice a year. Furthermore, this description can be interpreted so that those who suffer from mental illness are denied their right to identity and culture. The notion undervalues the psychological impact that environments that are strange and unstable (this includes cultural and familial ones) may have on those who are vulnerable. In the event of a psychotic breakdown what are most familiar to a person are the language, family and culture into which they were born.

Stressors that arise from changes in the political and cultural landscape therefore form another significant theme in the literature. These describe a distinctive shift in the nature of Xhosa social relations in the practice. Paradoxically this debate may have impacted negatively on the custom, which requires that secrecy protect initiates and the seclusion area. This demonstrates that the current debate often has political intent. Issues are therefore posed outside of an internal Xhosa-speaking decision-making process and in the public domain[47]. Injuries thus quickly become a health and human rights issue not only at a provincial, but a national level[48]. In comparison, other cultural and religious circumcision practices, e.g. Jewish or Muslim, are regulated by the constitution, but are more debated within that cultural and religious domain; with medical evidence about injury being held within the biomedical domain. The debate on the Xhosa practice, particularly in the media, is of *"grave moral concern"* to this society who considers that this challenges their cultural boundaries (Mager, 1995, 1999).

[47] In his book A Long Walk to Freedom (1994) Mandela reports on an African National Congress discussion on the importance of circumcision in maintaining Xhosa-speaking integrity.

[48] **South African Constitution: Bill of Rights Chap 11.**

Language and culture

30. Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights.

Cultural, religious and linguistic communities

31. (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community

a. to enjoy their culture, practise their religion and use their language; and
b. to form, join and maintain cultural, religious and linguistic associations and other organs of civil society.

(2) The rights in subsection (1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights.

In respect of socio-political changes, Van Vuuren and de Jongh (1999) clearly illustrate that social relations around circumcision have become more stressful. Paramount in this is the breakdown of key roles and functions, in particular those of the surgeon, the teacher, and importantly the youth's father. Meintjes (1998) and Van Vuuren and de Jongh (1999) have reported that surgeons and teachers tend to be opportunists whose inexperience jeopardises the operation and wound healing procedures. Both authors tend to attribute injuries to their poor practices. Importantly, Van Vuuren and de Jongh report that those surgeons who held hereditary office or were known and had a good reputation were more of an ideal – and unusual in current practices.

The father being absent usually denoted wider social exigencies such as his having migrated for work, or women having remained as single parents (Mager, 1995, 1999; Van Vuuren and de Jongh, 1999). In the past, tradition required that the father take his son to be circumcised to his patrilineal descent line and custom allowed for variation on the rule. This in fact anchors a society where stability is not reliant upon the nuclear family but fosters relations across extended kin (Russell, 1994). Thereby, designated men from extended kin stood in for his office or a youth was circumcised to his mother's father's descent line. This fulfilled a commitment to the patrilineal principle but inherent in this is the potential to compromise the intimate and symbolic significance of the father-son bond[49]. Further, increasingly, community participation became problematic because these extended kin were unavailable or unaware of their obligation. These absences have impacted on the rite of passage as a safe learning ground for communal, traditional decision-making and justice systems (Mager, 1995; Van Vuuren and de Jongh, 1999).

Conflicting reports emerge in the literature about the atmosphere and manner in which training and socialisation happened in seclusion. Mandela asserts, *"It was a period of quietude, a kind of spiritual preparation for the trials of manhood that lay ahead"* (Mandela, 1994, p 27). Ntantala's (1993) memories describe a slightly different picture of her as a young woman witnessing the initiates' daring escapades into their cattle-fold. Mager's (1995, 1999) evidence, however, clearly points to ritualised stick

[49] Van Vuuren and de Jongh (1999) discuss the importance of male bonding amongst peers and men in establishing male identity. They hold that male identity has precedence over an ethnic or tribal identity status.

fighting as an essential part of the peer interaction in the seclusion. She describes that *"masculinity implied unflinching toughness; it meant fighting to the finish"* and that *"to be masculine was to assert male control over females"* (Mager, 1995, p 2). Further evidence from court records in the Eastern Cape demonstrated that in the decade after the Second World War, there were unacceptable levels of male aggression in stick fighting with serious injuries because axes were used instead of sticks. Mager's (1995, 1999) evidence suggests a critical watershed in the mid-twentieth century with practices becoming disruptive and this is shown in aggression turning to inadmissible violence and gang-related conflicts. It was salient that control over aggression and decisions about justice shifted from Xhosa males and elders to the court.

Changes in social relationships have affected gender relations and the construction of gender-described roles. Formerly, taboos in circumcision regulated the initiates' interaction with females as an essential part of a rite of passage that has long socialised gender relations within the culture[50]. The taboos were supposedly employed because of ritual impurity in women (*umlasa*) – as menstruation made them ritually impure. Mager in discussing *intlonipho*[51], states that gender and power in Xhosa-speaking society has been defined through hierarchical relationships in *"designated spaces"* such as marriage – and here circumcision (1995, p3). Women were, however, active participants in this process (Strathern, 1972).

It would seem, in terms of Mager's thesis, that gendered hierarchical relations have been upset because customary practices cannot be maintained. Marriage payments, for instance do not happen and with the father being absent, mothers struggle to control their children (Mager, 1995, 1999). Van Vuuren and de Jongh (1999) and Mager (1995, 1999) suggest that an increasing number of women are single parents, marital instability has become an issue and women fear for their sons given

[50] An insightful account of the impact of this gender-based socialisation comes from Ntantala's (1993) autobiography. She witnesses the initiates' powerful dancing to gain status that will remain a testimony to their strength and courage throughout their lives. Her father took them into the cattle-fold where he talked with them. Her account is, however, from the perspective of a young female who is participating as an observer. Thus, she evokes a clear sense of the force of the seclusion taboos on her as a young girl and her memories give a Xhosa woman's cultural perspective on these gendered boundaries.

[51] Mager (1995) states of *intlonipho* that it is *"the system of language and behaviour avoidances forbidding a married woman from uttering certain syllables pertaining to her father-in law's name and from entering designated spaces"* (Mager, 1995, p3).

malpractices. Mager argues that violence and instability, which includes violence against women, is the consequence of the disruption of gendered hierarchies that are worn down by changes in traditional, economic and political structures. Thereby, it could be argued that although the status of a married Xhosa woman was understood to be equivalent to that of an uncircumcised youth, in the context of traditional structures these offered her protection and brought stability to the wider community, regulating negotiations for marriage and property[52]. The corollary to this is that women have been subordinated and asserting their right to participate in circumcision is critical to their engagement in a diverse and democratic society.

2.3 Stress and mental illness

It is known that the nature of precipitating factors such as stressors around life events may trigger mental illness[53] and psychosis (Goldberg and Huxley, 1992; Gilbert, 1992). *"Mental illness"* is defined when *"there is an identifiable onset of illness preceded by normal functioning"* (Katona and Robertson, 1995, p 10). As circumcision is the critical life event for Xhosa men it is reasonable to assume that selective stresses during the rite of passage may contribute to the onset of mental illness in those who have a genetic predisposition. Evidence presented suggests that as a critical event, the rite of passage contains inherent stressors with recent changes making it more stressful. Initiates, it appears, face more psychosocial and environmental stressors than they did in the past, with cultural dissonance often being a problem for them. Stressors described for stress-related disorders in a southern African context include, *"unemployment, poverty, poor housing conditions, noisy and crowded living conditions, marital and family conflict and difficulties relating to work"* (Szabo et al, 2005, p 119).

This section of the literature review describes the relationship between stress and anxiety in circumcision practices and how this potentially contributes to the onset of

[52] During seclusion, especially in the first phase, a young unfertile girl cousin prepared the dried mealie porridge for the initiate, leaving it in a pre-arranged spot, for him to fetch. It is also of note that when a woman attended the chief's court (i.e. law court or *inkundla*), she had to do so in the company of her father or one of her circumcised brothers (Personal communication Professor Manton Hirst, 22nd August 2006).

[53] Katona and Robertson (1995) note *"that in general medicine a distinction is made between disease (objective physical pathology and known aetiology) and illness (subjective distress)"* (Katona and Robertson, 1995, p 10).

mental illness in predisposed Xhosa men. Definitions for and the role of stress and anxiety in the aetiology of mental illness will be discussed. Central themes that emerged relate to a cross-cultural perspective on mental illness and patterns of psychopathology that are relevant in southern Africa. This section concludes in a description of psycho-social and environmental stresses prevalent in South Africa. A focus on literature that is relevant in a South African context intends to meet the DSM-IV's (American Psychiatric Association, 4th Edition, 1994) recommendation for local and cultural sensitivity[54]. Because this is essentially an anthropological study, particular attention has been given to *"locally shaped cultural psychologies and cultural constructions of the body and personhood"* to understand how *"problems of mental health and illness acquired meaning and form"* (Mkize, 2003, p 3).

2.3.1 Stress and anxiety

The DSM-IV on Axis IV of the assessment criteria allows for the reporting of psychosocial and environmental stressors that have played a role *"in the initiation or exacerbation of a mental disorder"*. Only relevant stressors that occurred within the year previous to the current admission are noted, unless problems have clearly contributed to the mental disorder. The classification of stressors includes, *"a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources or other problem, relating to the context in which a person's difficulties have developed"* (DSM-IV, 4th Edition, 1994, p 29). In respect of this study it is important also to note that when a stressor is the primary focus of clinical attention it should be included on Axis I as part of the clinical disorder[55].

In respect of this review, stressors will be placed into three categories. The first is stressors that are inherent in circumcision as a cultural life-stage event. In the DSM-

[54] *"The wide international acceptance of DSM suggests that this classification is useful in describing mental disorders as they are experienced by individuals throughout the world. Nonetheless, evidence also suggests that the symptoms and course of a number of DSM-IV Disorders are influenced by cultural and ethnic factors"* (DSM-IV, 4th Edition, 1994, p xxiv).

[55] Axis I Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention
Axis II Personality Disorders
Mental Retardation
Axis III General Medical Conditions
Axis IV Psychosocial and Environmental Problems
Axis V Global Assessment of Functioning (DSM-IV, 4th Edition, 1994).

IV this would be classified within problems in the social environment and an adjustment problem to a life-cycle transition. Psychosocial stressors form the second category which includes psychological factors (e.g. trauma, poor early attachment, inadequate coping skills, and illiteracy) and social stressors (e.g. problems in primary support group, deaths, abuse, cultural dissonance and violence). The third category includes stressors in the environment e.g. poverty, education, migration, unemployment, homelessness, crime and acculturation. An important category in this respect describes problems with access to pathways to care.

A number of theories[56] have been put forward to explain the mechanism by which stressors may contribute to the development of anxiety and mental illness (Alexander et al, 2005, p 129). Some elements from these have been selected to define the key relevant concepts. It is important, for instance to consider that *"major psychological stress (must) involve threat and loss"* for stressors to contribute to abnormal reactions or maladaptive responses (Katona and Robertson, 1995). Three alternatives are possible. Firstly, the nature of stress is so great that it overwhelms the person's ego strength and coping mechanisms. Alternatively the person's ego strength or coping skills may have been incapacitated through psychological harm in childhood or social problems. Thirdly, individual predisposition means that at critical points in their life stage development, significant stressors could trigger the onset of their mental illness.

Underscoring psychosocial responses to stress thereby is individual neurobiology and genetic predisposition (Alexander et al, 2005). In relation to these, familial coping mechanisms may either exacerbate or diminish learned responses to stress. In addition, the environment may contain underlying stresses that influence how a person is able to respond to stress. Environmental stressors such as socio-political and economic factors bring a pervasive and insidious detrimental effect to individual and also communal or cultural responses to stresses. In positive circumstances the environment could offer supportive mechanisms e.g. appropriate health care services.

Stress it would thereby seem is ambivalent by nature. Furthermore, it has been shown that an enormous variance in responses to stressors exists between individuals. One definition for stress is, "*the reaction of the mind/brain and body to change… the key*

[56] Alexander et al (2005) discuss anxiety in respect of Freudian theory, Pavlovian or classical conditioning, neurobiology and psychodynamic theory.

difference between healthy and harmful stress is that healthy stress involves rapid compensation for change, whereas harmful stress results in little or no adjustment" (Allwood and Gagiano, 1997, p 12). Allwood and Gagiano state that stress is defined by a person's response to a stressor and not by what caused the stress. Conditions may therefore be stressful, but not everyone will respond in a stress-related manner as some may demonstrate resilience. Stress is not so much a nervous reaction but has a physiological component and is better described as a response involving the mind, the psyche,[57] and the body.

Despite variance between individuals, some stresses may be common amongst people of the same age set or culture and language, which is why local idioms of distress are important to understand. Some criteria and issues thereby require explication. The period of adolescence is described in the literature as a stressful period for youth because this is a critical stage in their identity formation when they have significant neuro-cognitive changes. They are also more likely to engage in risk-taking behaviour[58]. However, the evidence on stress in adolescence may be more relevant for western Europeans. There is a possibility that transitions from youth to adulthood are not stressful in all cultures (Clarke-Stewart, 1988). This may be because coping strategies exist as protective mechanisms. Thus, youth who have cultural and family support may well develop resilience through engaging in stressful circumstances in ritual transitions (van Vuuren and de Jongh, 1999).

Anxiety, like stress, is a very common emotion or feeling but in a biomedical discourse exists as a separate concept to stress. This is important because in lay terms and in a cross-cultural context stress and anxiety may be conflated and interpreted as feelings of distress. Severe anxiety has been described as an emotive, neuro-physiological response to either internal stress and/or external stressors where a person is overwhelmed by his or her feelings of anxiety. McReynolds describes anxiety as *"an emotion characterized by intense feelings of inner distress and, anguish, and by associated behavioural and physiological features"* (McReynolds, 1990, p 5). Anxiety that is harmful impairs a person's ability to function in ordinary

[57] **Psyche –** soul, spirit, mind (The Oxford Illustrated Dictionary, 2nd Edition, 1981).
[58] In conjunction with dramatic cognitive changes, Erikson (1968) described adolescence (11 – 21 years old) as a very stressful period for youth who must engage in their own identity crisis to establish themselves in respect of their career, moral and religious values, political ideology, social roles and sexual orientation. (Erikson in Clarke-Stewart et al, 1988).

life, as these feelings are closely associated with intense fear and physiological symptoms of pain and distress e.g. rapid breathing and increased heart rate.

As a mind and body phenomenon, anxiety is behavioural, cognitive, and dispositional. Anxiety, like stress, also has an ambivalent nature as *"normal anxiety is an ubiquitous and adaptive phenomenon. Although often unpleasant, normal anxiety actually enhances performance"* (Stein and Calitz, 2004, p 135). In discussing the interaction between a genetic and neurobiological predisposition for anxiety and a person's psychosocial environment, Alexander et al (2005) suggest that a person's ability to cope with anxiety is dependent on their having learnt coping mechanisms and developed ego-strength in childhood. They argue that in facing challenge, children develop ego-strength because their neuronal network is constantly being remodelled to form an adult ego. In this process, children who are emotively and physically loved and supported form *"stronger more resistant stress systems"* and become better able to cope with anxiety in adult years (Alexander et al, 2005, p 138).

Recent changes to the current edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th Edition, 1994) included a re-evaluation of anxiety and stress-related disorders; with anxiety classified as a mental disorder[59]. Previously these disorders were not included because stress-related illness has been difficult to define clinically. Research into the origins of anxiety – particularly in relation to socio-cultural and psychological factors – has provided better insight into human cognition and behaviour. This has improved the reliability for the clinical diagnosis and treatment of anxiety and depression. Public health interventions also potentially reduce social stress and anxiety e.g. safe driving.

Stress-related disorders continue to be difficult to define clinically and treat, as the signs and symptoms are often not recognised as mental illness either in a consultation with a doctor or by family members (Szabo et al, 2005). It is suggested that stress-related conditions in particular, but also anxiety disorders, are thus wrongly diagnosed

[59] Anxiety and stress-related conditions used to be defined as 'neurotic' disorders (now a politically unacceptable definition). Previously these disorders were accorded more value in terms of their social and therapeutic relevance and some epidemiological significance. They had less worth as clinical diagnostic categories. Yet, as the change to the DSM IV indicates, the socio-cultural implications and diagnostic relevance of anxiety disorders and other stress-related mental conditions are considerable.

and remain untreated leading to a greater risk for more severe mental illness[60]. In a local context, treatment is further complicated by the fact that many African families consult traditional healers about stress and anxiety[61]. On presenting at the clinic, their language and cultural difference means their symptoms are interpreted as a somatisation disorder and untreated (Swartz, 2002)[62]. An exacerbating factor for males in the treatment of anxiety is that in general men do not talk about being anxious or depressed, but complain of emotional problems or generalised aches and pains (de la Rey, 2001; Swartz, 2002). Hale (1998) furthermore argues that anxiety needs to be differentiated from stress, because *"anxiety may be a prominent feature"* in acute stress and adjustment reactions. These are generally self-limiting and can be therapeutically managed. This is particularly relevant for adolescents who are inclined to experience anxiety in identity crises as a result of separation issues, conflict with societal norms and peer pressure[63]. Adolescents are described as more likely to be overwhelmed by non-specific worries and social phobias.

2.3.2 Stress and Psychotic Disorders

In discussing stress and psychotic disorder, it is important to first define what is meant by the term psychotic in the psychiatric literature. How stress and stress-related disorders may contribute to mental illness and psychiatric disorders can then be explored against this background.

The defining feature described in the DSM-IV for people suffering with Schizophrenia and other psychotic disorders is *"psychotic symptoms"*. Historically, a universal acceptance of the term "*psychotic"* has been difficult to achieve, but an

[60] Swartz (1998) expresses an interesting caution about doctors using the label 'somatisation' in diagnosing a patient's condition. He argues that doctors trying to be culturally sensitive to their patient may wrongly diagnose somatisation disorder rather than treat the symptoms of an illness.

[61] In Crossroads Community Clinic doctors stated that stress and anxiety were significant concerns for their patients. This became worse at circumcision because they had to save for the event and then take leave. They also feared their son would have a relapse if he had been ill (Field notes, 29th March 2007).

[62] *"The essential feature of Somatization Disorder is a pattern of recurring, multiple, clinically significant somatic complaints. A somatic complaint is considered to be clinically significant if it results in medical treatment or causes significant impairment in social, occupational, or other important areas of functioning"*. These disorders may differ across cultures and it is important to understand symptoms in the own cultural context (DSM IV, 4th Edition, 1994, p 446).

[63] Katona and Robertson also recommend a psychotherapeutic approach for adolescents who experience anxiety that is a response to stress. They describe adolescence from the onset of puberty to the attainment of full physical maturity, which is characterised by sudden physical growth, surging sexual and aggression drives and the transition to autonomy. Although this is a turbulent time *"true psychiatric disturbance is relatively rare"* (1995, p 23).

accepted, albeit narrow, definition is, *"restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature"* (DSM-IV, 4th Edition, 1994, p 273). In a primary care context Allwood et al describe a person suffering from psychosis as being *"out of touch with reality. Their behaviour is often very bizarre and their thoughts disturbed. They may suffer from delusions (false beliefs) and they may hallucinate (usually hearing or seeing things that aren't there)"* (2001, p 215). Psychosis means that the onset of more severe mental illness symptoms, e.g. hallucinations and voices results in a person struggling to meet the demands of ordinary life. Furthermore, although the degree of insight into symptoms will vary, most people suffering from psychosis are unable to comprehend the nature of their illness. This is because their reality is increasingly defined by a self-oriented, delusional perception of the world and less by the world as it exists[64].

Current definitions in the classification of specific disorders (DSM IV, 4th Edition, 1994) have shifted away from describing psychotic disorders in terms of the severity of functional impairment to broader *"multifactorial"* descriptions that encompass age, gender, and cultural perspectives. Most psychiatric disorders are therefore not described as disease, rather the aetiology and pathology of the illness or distress is understood as *"multifactorial"* in nature. This has meant that the cultural and psychosocial aspects of mental disorder have been elaborated upon. So too have patterns of familial and genetic relatedness in respect of vulnerability for Schizophrenia in particular, but psychotic episodes and mental disorders in general (DSM IV, 4th Edition, 1994). The literature increasingly places more emphasis on the neuro-physiological aspect of mental disorders and the likelihood of a genetic contribution for a biological and dispositional vulnerability for psychosis (Holzman, 1996; Alexander et al, 2005; Kaliski, 2005)[65].

[64] In respect of Schizophrenia and Bipolar disorder the DSM IV (American Psychiatric Association, 4th Edition, 1994) cites that in general males have an earlier onset, less prominent mood symptoms and a poorer prognosis. Age of onset tends to be the late teens and the mid-thirties. There is some uncertainty which gender may be more affected in terms of the sex ratio with Schizophrenia. Katona and Robertson (1995) present evidence that Schizophrenia occurs in 15-20/10 000 individuals per year, with a life time morbidity risk of 0.85% (M=F) and a peak incidence in late teens or early childhood. The lifetime prevalence of Bipolar Disorder is about 1%, with a ratio of Bipolar I/cyclothymia/Bipolar II of about 2:2:1. The female/male ratio is about 1.5:1, the female excess being in the Bipolar II group. Peak age of first onset is in the early 20s.

[65] Holzman (1996) further describes that genetic mapping, although still in its scientific infancy, will contribute to describing some of the underlying factors for patterns of mental illness.

As psychiatric disorders are understood to be multifactorial in nature, the classification of symptoms and disorders in the DSM-IV now fulfils the purpose of providing a reliable system by which biomedicine is able to assess and treat the illness on the basis of known characteristics for that disorder. This takes into consideration that mental illness is an often subjective phenomenon with the experience of distress being of greater severity and/or duration than normal. Symptoms that are associated with a particular mental disorder are described against how it is classified e.g. anxious or depressed feelings or panic in stress-related or anxiety disorders. Concern has also been given to a more careful description of the psychiatric disorders and this has meant that *"different aspects of the various definitions of psychotic"* is included e.g. positive and negative symptoms of disorganised speech or catatonic behaviour (DSM IV, 4th Edition, 1994, p 273)[66].

The following factors need consideration in respect of the contribution of stress and anxiety in the development of more severe psychiatric disorders. It is known that stress reactions may function as acute (rapid onset responses) and adjustment (abnormal psychological responses to life changes) (Katona and Robertson, 1998). Most stress-related disorders do however respond to therapy, but it would appear that when stress is untreated it may contribute to the onset of mental disorders such as anxiety disorders and in some cases Schizophrenia. Severe stressors may precipitate psychotic episodes in individuals who are predisposed for Bipolar Affective Disorder. Intense stress may also trigger the onset of transient psychoses or altered states and this is demonstrated in culturally bound syndromes such as *"Latah"* [67](Katona and Robertson, 1998).

In terms of understanding the relationship between stress, anxiety and psychotic illness, anxiety is classified in the DSM-IV as a mental disorder when symptoms are so severe that an individual's function is impaired. Anxiety disorders have a distinctive aetiology and treatment regime, are classified as a discrete entity within the DSM-IV and have a close association with depression. Stress may contribute to the

[66] The conditions that are relevant to this study are Schizophrenia and Brief Psychotic Disorder. Schizophrenia is described in the DSM IV as a psychotic disturbance that lasts for at least six months with one month active-phase symptoms. A Brief Psychotic Disorder is a psychotic disturbance that lasts more than one day and remits in one month (4th Edition, 1994, p 275).

[67] **Latah –** occurs mainly in Asia and North Africa and is a response to intense stress characterized by altered consciousness, hypersuggestibility, and mimicry.

aetiology of anxiety disorders. Furthermore, a close relationship exists between stress and feelings of anxiety in the development of psychotic illness. Extreme anxiety may also be a symptom or characteristic of some psychotic disorders such as Schizophrenia. *"Koro"*, another cultural bound syndrome, involves intense anxiety[68].

2.3.3 Cross-cultural considerations

The history of cross-cultural psychiatry in Africa requires that an interdisciplinary thesis - based in anthropology - question the discipline and practice. In respect of this, the problematic way in which concepts such as cultural bound syndromes and cultural dissonance were used in biomedical practices, particularly with indigenous African peoples mean that these categories cannot be taken for granted but their meaning has to be explicated. Issues relate to the manner in which the culture of African patients' was interpreted and then associated with these conditions. Complications and prejudice arose from the fact that the diagnosis and resolution of psychotic symptoms in cultural bound syndromes are dependent upon the patient's and indeed doctor's engagement with that socio-cultural environment. Furthermore understanding the nature of this syndrome or the stress of feelings of cultural dissonance requires a cross-cultural psychiatric perspective which then affords a comparative and non-prejudicial viewpoint (Mkize, 2003; Swartz, 1998; Guinness, 1992; Kleinman, 1995). Paradoxically - inherent in a comparative perspective - is an assumption that mental illness is dealt with and felt differently in 'other' cultures.

Challenges such as this have meant that since the 1970s medical anthropologists have successively challenged psychiatry's or a biomedical authority over psychotic phenomenon. The literature presents extensive discussion on whether biomedicine appreciates the complex nature of psychosis and if it should be considered a medical phenomenon (Kleinman, 1978; Vaughan, 1991; Csordas, 1994; McCulloch, 1995; Scheper-Hughes, 1979; Whitaker, 2006; Mahone and Vaughan, 2007). Authors such as Kleinman argue that the boundaries that define or classify mental disorders are themselves often blurred and indistinct. Brink et al (2005, p 86) state of Schizophrenia, as one psychotic disorder, that *"it remains one of the most enigmatic of all mental illnesses, subject to widespread misunderstanding and controversy"*.

[68] **Koro –** is found mainly in Asia and involves intense anxiety centred on the belief that one's genitalia are retracting and that their disappearance will result in death (Katona and Robertson, 1994).

Other critical perspectives include that of Littlewood and Dein (2000) who emphasize the social criteria rather than the clinical used to judge a person to be psychotic. Transpersonal psychologists like Rowan argue for the metaphysical nature of psychosis stating, *"if we ask some very simple questions we can distinguish very readily between pure psychotic experiences, pure mystical experiences, and three or four different mixtures of the two"* (Rowan, 1993, p 206). Rowan thereby points out that in many cultures it is traditional healers, shamans and communities that help a person to cope with the disturbances brought by psychosis. Taking this critique a step further, Scheper-Hughes (1974) and Csordas (1994) argue that a Cartesian 'mind-body divide' is inherent in the diagnostic criteria that psychiatrists use to frame mental illness and notions such as summarization. They argue that this denies the embodied nature of all human states and experience.

A vigorous critique about the history and practice of psychiatry in Southern African underpins these perspectives and it is argued that an unreflective cross-cultural psychiatry went hand-in-hand with colonisation to foster racism and inequality (Vaughan, 1991; McCulloch, 1995; Mahone and Vaughan, 2007). McCulloch states that, *"in scientific discourse the history of colonial racism has been played out between visions of the body and visions of the mind"* (1995, p 5). He poses that colonial or ethno-psychiatrists such as Shelley and Watson (1936) and Carothers (1954) over the period 1900-1960 described mental illness in African people based on a notion of their imperfectability. Mental illness was also attributed to their cultural dissonance which reflected their inability to respond to the challenges of modernity. Consequent categories for cultural bound syndromes locked African people into an ethno-psychiatry that could not envision change or a real therapeutic engagement with indigenous cultures. Of concern was that the evidence for this psychiatric practice did not come from research or anthropological studies but their personal experience of their patients.

McCulloch cogently argues that psychiatry itself was unable to reflect critically on colonial society and change and consequently, their comments more represented their own insecurities - as privileged white minorities - about African nationalism. Swartz (1998) has described that these conditions were perpetuated for African people under apartheid which juxta-posed and categorised people in terms of traditional and

modern values. This problematic perspective sharply contrasts with the work of Gasa who so succinctly describes the adaptability of Xhosa-speaking people. Gasa states, *"If you trace the context of practices you find that because of culture things are changing and different models of expression happen. There are different rationalities now for different families for different customs."*

Parnas' recommendation that research in the field of psychiatry should *"not rely only on mere symptom descriptions but should encompass phenomenological–anthropological aspects",* is pertinent and understandable when this historical context is considered (1996, p 532). It is the often ambiguous nature of psychotic features that has resulted in a more phenomenological approach being incorporated into the current DSM IV (4th Edition, 1994). In advising that the meaning of symptoms and course of the illness be negotiated, cognizance is also given to the often incommensurable socio-cultural difference between a patient who is psychotic and the doctor. The phenomenology surrounding the person's mental illness in their socio-cultural environment should thus be explicated. Edwards argues that *"phenomenological validity, therefore, concerns whether there is a fit between verbal formulation and implicational meaning"* (Edwards, 2005, p 7). This suggests that in clinical psychiatry it is important to go beyond describing the content of a patient's speech and thought and interrogate the meaning of the symbols and cultural inference.

Whilst a phenomenological understanding is important, the priority in psychiatry is to make a clinical diagnosis that will effect treatment and therapy. Furthermore, searching for meaning in a clinical diagnosis can obfuscate knowledge about the real nature of a condition because what is learnt may be vague and insubstantial. Edwards (2005) argues about implicational meaning that even in ordinary circumstances most people cannot express their *"unformulated experience"*. Cultural communication can therefore be difficult to comprehend particularly when a person is psychotic. Cultural information also often exists in implied meaning and 'said' in gesture, inference, and in symbolic relationships to such elements as land, clan totems, and ancestors. Implicational meaning is most noticeable in shamanistic behaviour and ritual. Thus, what is implied in symbolic acts or culturally described in psychotic imagery may be difficult to evaluate especially as doctors may be uninformed about the relevant traditional culture.

Edwards therefore argues that some altered states and psychotic experience may in the early stages be managed by priests, shamans, or traditional healers. However, when altered states become unstable and unpredictable and manifest as disturbed psychotic experience or illness, then biomedical care is often sought[69]. This suggests that liminal experiences or psychotic imagery fit into different cultural understandings of illness or wellbeing. Further, those who share the same sense of language and intuitive knowing may be better able to judge who is psychotic and ill against who is in an altered state.

Cross-cultural diagnosis of mental illness is therefore far more difficult because the meaning of the language, mannerisms, affect, and symptoms may differ widely. Psychotic features or idioms of distress that are expressed may vary cross culturally and in respect of gender. Patel et al cite that the amaXhosa emphasise the *"behavioural and, to a lesser extent, the emotional components"* of mental life and not the cognitive – as in European culture (2005, p 45)[70]. An example of this difference in an amaXhosa context is *ukuthwasa.* This appears to manifest as psychotic behaviour. However, these symptoms within Xhosa culture are understood more as psychic phenomena for initiation to becoming a healer. This condition has been described as a cultural bound syndrome in the DSM-IV, as the psychotic episode is known to go into remission if the affected person takes up their calling. It is of interest in terms of familial relationships and genetic relatedness that this calling is culturally described as being passed down the descent line in either men or women. An African experience of ameliorating known stresses and social exigencies through initiations, ritual and healing processes is also well described in the literature (Feierman and Janzen, 1992).

Whilst it is known that some psychotic disorders are universal, it is also relevant that the nature of symptoms and behaviour during psychosis differ significantly between affected individuals and across cultures, and this may present challenges to acceptable definitions and diagnostic categories (American Psychiatric Association, 1994;

[69] Rowan suggests including a discourse on traditional healing into psychiatry to *"bridge the gap between psychiatry and the transpersonal"* (Rowan, 1993, p 206).
[70]Patel et al (2005) describes that the amaXhosa believe the soul is the seat of feelings and resides in the blood and heart whereas the mind is located in the brain.

Njenga et al, 2005)[71]. For these reasons biomedical practices today encourage that socio-cultural awareness be part of multi-disciplinary, professional participation in an informed clinical decision-making process (Kleinman and Benson, 2006). Moreover, psychiatry in Africa, as argued by Njenga et al (2005), does not sit outside of or objectively decide upon the nature of illness. As culture is inherent in biomedical discourse, so biomedicine is in Xhosa-speaking culture. In this respect locality, as in Cape Town or South Africa, and cultural homogeneity amongst indigenous African people is important because this determines the phenomenology and context of mental illness presentations.

2.3.4 Patterns of psychopathology

In terms of an African experience for patterns of mental disorder, Guinness' (1992) findings for psychotic presentations amongst youths in Swaziland provide a comparative perspective. Her research and that cited in Njenga et al (2005) suggest that patterns of psychotic illness in African people need to be understood in their local and cultural context[72]. Guinness' research amongst Swazi youth interrogates how cultural dissonance affected their mental illness presentations. Of concern in her research was evidence that relapse and the development of more severe psychiatric disorders such as Schizophrenia may be attributed to the impact of environmental and social stresses and inadequate pathways to mental health care. Guinness reported that relapse was of particular concern for those youth who suffered from depressive symptoms, as they had a higher risk of developing Schizophrenia. In respect of stress, those in education or in paid employment were at increased risk for brief reactive psychoses. Of note is that Guinness presents an argument for "*undoubted Schizophrenia"* which may present in the early stages with features of a transient psychosis (Guinness, 1992, p34).

[71] In the light of this discussion it is important to consider an anthropological concern in respect of defining psychotic disorder. Cross-cultural studies have raised the significance of the complex nature of psychosis. In respect of this debate, Littlewood and Dein comment about psychiatric definitions for psychosis that, *"whilst cancer… is everywhere the same… in its objective symptoms…. A neurosis or a psychosis most probably has also an organic basis or components, but those are not known to us and we can diagnose mental disease exclusively by observation of changes in behaviour and mental content, incompatible with successful social activity; such changes are not biological but socio-cultural phenomena"* (2000, p 133).

[72] Professor Hirst (Personal communication, 18 August 2006) noted that a British psychiatrist working in private practice in London told him that acute, transient psychosis was fairly common among his black patients living in the greater London area. He saw it as a condition that occurred relatively suddenly and readily responded to conventional psychiatric treatment and drugs.

Guinness' (1992) thesis postulates a link between stress, anxiety, and psychosis. Anxiety for Swazi youth arose out of stressors that originated in the disruptive effect brought by urbanisation. This was described as forming an underlying 'neurotic' predisposition for them to later develop more severe psychotic illness. In discussing the relationship between stress-related illness and brief, reactive psychosis, Guinness examines the major psychoses, arguing that transient psychosis could possibly be a central feature for those who present with psychopathology in Swazi people. In support of her thesis, she describes the prevalence of the brain fag syndrome as a stress and anxiety-related condition arising from the pressures and stresses of western acculturation on Swazi traditional culture. She argues that – as with this and other stress and anxiety-related conditions – when these are unresolved they may present as more extreme psychopathology and frequently as transient psychosis.

Two patterns described by Guinness (1992) have relevance. With regard to the nature of psychopathology in transient psychosis, Guinness argues that, "*suggested possible mechanisms for transient psychosis: intense over arousal with protective dissociation of consciousness, an acute circumscribed disruption of the ego; also intensification of the 'spiritual' symptoms producing psychotic phenomena such as dissociative hallucinations and sub-cultural delusions*". Of significance was that delusions had a specific cultural orientation and these were a significant aspect of the reactive psychosis and "*closely related in content, timing, and meaning to the precipitant stress*" (Guinness, 1992, p65). This psychopathology would be suggestive of an acute brief psychotic episode, with a sudden onset and the psychosis could resolve within days. It is possible that this psychopathology could present as a cultural syndrome (Allwood et al, 2001[73]).

The second pattern was where the onset of the psychotic episode was more suggestive of severe chronic mental illness with features of psychosis arising from depression

[73] Allwood et al. (2001) Handbook of Psychiatric Nursing for Primary Care. "Culture bound syndromes are not homogenous in terms of either their symptomatology or their aetiology. Some relevant features are;
Patients are generally normal before the onset of the syndrome.
The trigger for their behaviour may be difficult to isolate but is usually some psychosocial stressor.
The illnesses do not generally involve any deterioration in personality or functioning.
There is no evidence of an underlying psychosis.
Illnesses may improve spontaneously or require treatment with anti-psychotics.
Therapy should be multi-disciplinary and take account of the patient's culture. (Allwood et al, 2001, p33)

and anxiety. This was described by Guinness (1992) of one group of Swazi adolescents who presented with a *"brief reactive psychosis… as a form of illness behaviour for depression, it more closely resembles a dissociative state, relapses in the same form or with uncomplicated depression, and resembles affective psychosis in demographic features"* (Guinness, 1992, p65). Another group of Swazi youth demonstrated a variation on this pattern and showed no preceding depression, but had greater anxiety where *"a major threatening life event precipitated a form of 'reactive mania' or malignant anxiety'"*.

2.3.5 Idioms of distress

Mental health, as Njenga, Szabo and Mbugua posit, requires understanding *"that mental health is not simply the absence of mental illness. In fact mental health is a dynamic process, the pursuit of which has implications for vulnerability to developing or recovering from mental illness"* (Njenga, Szabo and Mbugua, 2005, p 209). Szabo et al (2005) thus emphasise the importance of a clinical diagnosis, but state that it is essential to understand stress-related conditions and mental illness in the cultures and peoples of sub-Saharan Africa. Supporting an argument for better pathways to care they argue that *"neuroses are the commonest psychiatric conditions in the community and in primary care populations"* (Szabo et al, 2005, p 117)[74].

It has been argued that understanding what is stressful in a culture requires looking at how idioms of distress are expressed. Idioms of distress are local or cultural expressions about stressful feelings and offer a *"talking point"* to share common worries and problems. Stresses could therefore be described as clustering around significant life events and daily survival. In a phenomenological sense these are embedded in a cultural or linguistic frame of reference or worldview and it is this that imparts meaning to the idiom. In an African context, Robertson et al (2004) define idioms of distress as local categories or labels for illness that exist within a traditional worldview. These traditional categories are more fluid and shifting than biomedical categories. In respect of the amaXhosa as Nguni-speaking people, an example of an idiom or metaphor for distress is *"amafufunyane"*. MacGregor (2000) describes this

[74] Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) places phobias, obsessive-compulsive disorder as well as certain stress-related disorders within the anxiety disorders, with adjustment disorders as a separate entity (Szabo et al, 2005, p 117).

as a metaphor about mind which speaks to local idioms for mental illness, defining *amafufunyane* as *"spirits speaking from the abdomen"*. In the community these were used not as categories, but flexibly and with a variety of meanings.

Idioms of distress, from a biomedical perspective offer modes for the interpretation and elucidation of stresses and mental illness symptoms (Swartz, 2002; Stein and Calitz, 2004; Szabo et al, 2005; Patel, 2005). A number of concerns arise as to the reliability of idioms of distress that need to be mentioned. For instance, the impact of diversity may question the relevance of an idiom of distress that may have had currency in the past, but has become out-dated. This is especially true when social relations and cultural patterns change significantly and gender relations are an example. It is problematic, therefore, to assume that an idiom of distress has relevance across a culture as locality, diversity and urban living may influence the nature of distress and what expressions are used. Xhosa-speaking peoples' shared experience of language and culture suggests that many idioms of distress have relevance across different communities, where even their re-interpretation may offer a better understanding of what causes stressful circumstances.

Local idioms of distress amongst the amaXhosa illustrate that diversity has been incorporated into their cultural discourse (Patel et al, 2005). The literature argues that many African people live with diversity, selectively incorporating varied features from urbanisation and biomedical discourse into their daily lives (Mdleleni, 1990; Comaroff and Comaroff, 1987; Hirst et al, 1996). The amaXhosa are cited as recognising most mental illness conditions, but tend to attribute illness to external causes such as witchcraft or failure to propitiate the ancestors (Patel et al, 2005). This evidence posits that the amaXhosa have three major comparative categories for acute psychoses, major depression, and a third stress-related condition or calling to become a healer.

Swartz (1998) and MacGregor (2000) argue that amongst Xhosa-speaking people it is important to understand how stress is understood and used as an idiom in its own local, social context. In Khayelitsha in Cape Town, idioms such as *"iinerves"* were described by MacGregor as representative of feelings of nerves, anxiety, and stress. These were local cultural expressions but did not necessarily explain how stress and

stressors that have been deeply embedded in custom, such as circumcision, might be personally and socially employed and what coping mechanisms existed. MacGregor argues that an idiom of *iinerves* more often reflects other social exigencies brought about through urbanisation and related to the effects of *"hunger, violence, and extreme poverty"* (2000, p 251). Explication of these idioms was said to promote a more informed perspective of individual presentations and offered some interpretation on the aetiology of different mental illness conditions.

MacGregor also demonstrated that psycho-social stresses were often not dealt with and consequently stress-related factors became pervasive across the community. Her research illustrated that the idiom most used for *"madness"* was *"mind had gone away" (iingqondo ziyamshiya*[75]*).* This notion, MacGregor (2000, p101) argues, was *"used in Khayelitsha as a way of describing both behaviour and encounters with beings (such as ancestors and witches' familiars) that are beyond every-day human experience"*. Symptoms of anxiety were often inferred to be closely associated with fears of envy and bewitchment[76]. In her explanation 'mind' is understandably seen in a holistic but functional sense to be missing. Of interest is that Patel et al describe the "mind" as an amaXhosa concept as located in the brain and *"the initiator of action and required for health"* (2005, p 45). On these occasions the person was called *"mentally ill", "mad",* or sometimes *"bewitched"*. This did not appear to be a cause for great concern as liminal feelings can be part of ordinary and ritual experience. The course of action taken to remedy the problem depended on the cultural interpretation of that person's illness symptoms. Most often help was sought from the family and/or traditional healers, and occasionally from the health system.

Another good illustration of a local idiom of distress that was embedded in cultural ritual was Swartz's (1998) discussion on the case of Mr. Jaxa. He showed how an idiom that expressed Mr. Jaxa's fear of being uncircumcised was expressed somatically in his illness and anxiety[77]. His complaint had currency because it was

[75] Xhosa-speaking people, MacGregor records, have a *"reported and observed experience of those who are judged by others to be 'mad'* (*phambene)"* (2000, p 14).

[76] In Xhosa-speaking culture a discourse on bewitchment has been shown to be intrinsic to their ancestral belief system and worldview (Janzen, 1994; MacGregor, 1992).

[77] If meaning is somatised then cultural sensitivity that shows caution not to stereotype is relevant (Swartz, 2002). This is difficult for doctors who, knowing little about customs such as circumcision must prioritise and provide a diagnosis and the treatment of symptoms rather than the meaning of any illness.

central to an accepted idiom of distress and alerted his cultural familiars of his need for circumcision (Kleinman in Swartz, 1998)[78]. This highlights the fact that an idiom encapsulates social information that has previously been culturally encoded into a person's psychological and bodily disposition. Authenticity or the reliability of an idiom would, however, appear to be dependent or perhaps more reliable in a culturally homogeneous society where a person has a prescribed identity. Thereby the idiom stands as a metaphor that reflects the manner in which a particular cultural milieu describes psychological and social wellbeing, and contains culturally relevant assignations for gender and age.

These examples illustrate that psycho-social stress manifests in particular behavioural patterns in Xhosa culture. This behaviour is represented or talked about in idioms of distress which encourage the sick person to either seek help in their traditional domain or in the health system. Thus, at a point in time people in a Xhosa-speaking family or community reach a consensus that a person is sick rather than stressed or bewitched, and medical help rather than a healer is sought. MacGregor's (2000) explanation of help-seeking behaviour is that mental health services are most often used when people are acutely ill or psychotic. Clinics, doctors, and hospitals therefore tend to deal with more severe psychopathology, disability grants and less severe mental illness; whilst much anxiety and depression is either accommodated into family life or brought to the traditional healer's attention. Therapy therefore tends to lie with traditional healers and kin and this ameliorates psycho-social stress.

Idioms of distress demonstrate that a person's problems have stressful psychological consequences for others. Furthermore, idioms of distress are instilled in each person in an internalised mechanism or rationale to judge their own and others' illness and help-seeking behaviour. Culturally-based idioms of distress may also pose competing metaphors, ideologies, or discourses to biomedical ones and this could provoke anxiety and stress. This is of particular relevance when a concept such as *iinerves* may be similar to – or entirely different from – biomedical concepts about stress. It is

[78] The evidence from doctors working there suggests that idioms of distress around circumcision frequently present in Crossroads Community Clinic. One 24-year old man presented asking for a routine check up and letter from the doctor (which is now required by law) prior to his circumcision. He said that he was so anxious because he wanted to feel a part of something, and did not want to go for circumcision but needed to do so to fit in. He was tired of being excluded. This is because whatever he did in the community, even eating with people, was a reminder that he was uncircumcised.

stressful to have to move psychologically between local metaphors and explanations of distress and biomedical senses of illness or *"dis-ease"*. Thus a world of multiple modernities may be neither safe nor helpful in building psychological reassurance for those who are distressed, severely mentally ill, or afraid.

2.3.6 Psychosocial and environmental stressors

The literature suggests that although cultural practices, language, and kinship embed the personal and social orientation of most Xhosa-speaking people, their most familiar experience is of heterogeneity in respect of culture, diversity and politics in this urban environment. Psycho-social and environmental stressors that are germane in South African urban contexts must therefore influence the nature of precipitating stressors for mental illness and psychosis in this cultural group. Critical amongst these stressors are those relating to cultural dissonance and changes in gender relations; poverty, migration and resulting patterns for poor psychological attachment and coping mechanisms, and trauma and violence.

A critical environmental stressor cited by Guinness (1992) in her work on mental illness amongst Swazi-speaking youth is cultural dissonance. She suggested that increasing rates of severe mental illness were a consequence of the disruptive forces of western acculturation, more specifically urbanisation and industrialisation impacting upon traditional practices and custom. She wrote, *"The cultural destruction which accompanies urbanisation can be seen in the loss of protective social customs – such as child-rearing practices"* (Guinness, 1992, p64). The literature has indicated that many commonalities to those described by Guinness exist for Xhosa-speaking youth. Traditional practices have changed and youth face many challenges in education and employment. Cultural dissonance in this local environment does, however, impose different challenges as socio-economic development is not the same as in Swaziland, and diversity amongst African peoples is historically and culturally more germane[79].

[79] Guinness (1992) describes a common social aetiology in the presentation of psychopathology amongst Swazi adolescents. Guinness infers that her evidence from a Swazi cultural context has relevance to most indigenous African people who have been affected by urbanisation. History has inscribed diversity in cultural and national difference across African people and although there is some degree of shared language, there has been a disparate history of colonisation and urbanisation.

Cultural dissonance inevitably affects the nature of gender-described relationships and this becomes evident in the literature on stress, gender and mental illness. Thereby, the literature on stress-related conditions suggests a close relationship between gender and patterns of mental illness in South Africa. For instance in relation to gender[80], psycho-social stress is shown to affect men and women differently, but recently an emphasis is on women, stress, and mental health. This intends to redress previous historical imbalances in South Africa, as women are vulnerable and described as disempowered by their cultural traditions (Njenga et al, 2005). In terms of gender and cultural rights, Strathern (1972) argues that it is important to interrogate gender inequality in traditional African culture. She posits that gendered-relations need to be understood in terms of a negotiation of rights within descent-based practices. This would suggest that a phenomenological approach should be used to interrogate stressors and mental illness in their own context and in relevant idioms of distress.

In terms of stress, gender and mental illness it would appear that women bear the burden of most stress-related disorders, depression and mood disorders[81]. This is attributed to their biological and hormonal disposition, life events and stressors related to life tasks such as child bearing, family, status, economic adversity, and discrimination. Many of these adversities are described as being culturally based and arise from traditions that discriminate against women e.g. inheritance laws (Njenga et al, 2005). This gender bias has been questioned, as in general women are recorded as having better health-seeking behaviour for mental health care. It has also been argued that women communicate their feelings more effectively (Njenga et al, 2005). In the light of this evidence Njenga, Szabo and Mbugua's acknowledge that increasingly *"not only understanding gender differences but also addressing gender specific needs is being recognized in the mental health field"* (2005, p 209). De la Rey also usefully argues that if gender differences in mental illness presentations are significant then higher rates for gender-based illness need to be shown and gender differences in types of mental illness and symptomology defined (2001, p 310).

[80] In respect of psychiatry gender identity disorder in the DSM IV (American Psychiatric Association, 4th Edition, 1994) classifies the severe symptoms of gender identity confusion such as persistent cross gender identification, inter-sex conditions, or persistent preoccupation with castration.

[81] Njenga et al (2005) describe that in general men and women show a 1:1 ratio in the presentation of generalised anxiety disorders; men show gender-specific contexts for war and trauma in the presentation of post traumatic stress disorder and men are more likely to be diagnosed with personality disorders that tend to show a societal stereotyping.

Acknowledging gender differences in mental illness presentations is important but gender constructs themselves pose problems in the way that data is researched. Potential stress and anxiety in any cultural arena arises from gender constructs, as these are implicit in language and behaviour and as the evidence indicates may create barriers for health-seeking behaviour[82]. Gender constructs often ignore that people's sexual and gender preferences may be different and those who do not choose to fall within traditional categories of *"women"* and *"men"* suffer stigma. This is especially true for homosexuality, about which little is written. Njenga, Szabo and Mbugua (2005) briefly describe that same sex relationships present no substantial mental health distress, but are subject to the stigma and homophobia that is prevalent amongst African people. Homosexuality[83], however, is said to be an increasingly prevalent aspect of modernisation and brought about through shifts in *"societal values and norms"* (2005, p 213). Njenga et al's definition begs the question of how sexual and gender differences have been incorporated into or excluded from traditional African societies. However, very little other evidence exists on how homosexuality is dealt with amongst African, and in particular Xhosa-speaking.

The evidence on stress, gender, and mental illness suggests that women's roles in the home and family support structures across many communities have been negatively affected by politics, cultural change, poverty, and migration (de la Rey, 2001; Njenga et al, 2005). If women bear the burden of stress-related illness then their children must surely suffer some psychological and developmental harm. Therefore, despite evidence that extended kinship may have once ameliorated some of the negative effects of migration in African families, increasing rates of violence amongst men suggests that this may no longer hold true (Preston-Whyte, 1993; Russell, 1994). Added to this is the fact that men have the stress of finding work, and when unemployed the harsh reality of the social exigencies their families endure. Work offers men a meaningful role in urban and rural societies yet many do not have adequate education or skills to find gainful employment (Swartz, 2002) [84].

[82] Gender definitions are critical in understanding what may be stressful in circumcision, yet do not explain why stress is felt variably amongst individuals, or why stress varies and is given different explanations within and between cultural or indeed circumcision groups (Swartz, 1998).

[83] *"Psychiatry has moved beyond the view of homosexuality as a disorder, and that sexual orientation is in itself a variant rather than an aberration of human sexuality"* (Njenga et al, 2005, p 213).

[84] In respect of Schizophrenia, Warner (1985, 1994) *"attributes better recovery… in the Third World in part to greater participation in the economy by disabled people… (Who then) play a meaningful role in*

Violence and trauma has already been cited as being problematic in South Africa, but especially in respect of men, stress, and mental illness. As other cultures have inevitably impinged on traditional ones, competing ideologies have also resulted in social change and conflict. Cock describes the powerful historical impact that patterns of gun-related violence had on male identity across South African society. In her discussion on the culture of gun violence, Cock positions identity (and this is true for culture) as *"neither fixed and essentialist nor completely fluid and shifting, but rather historically and socially constructed in changing processes of social interaction"* (2001, p 295). Cock cites Beinart (1992) suggesting that men are the primary agents of violence in most ethnic communities and their aggression is bound up with their status, identity and a dominant masculine code as a defender or protector[85].

Cock (2001) suggests that mental illness data may be deflected into statistics for the high incidence of trauma and violence in males. This concurs with evidence for increasing violence in circumcision (Beinart, 1991; Mager, 1995, 1999). Stressors, it would seem, operate in a circular process instigating or being the result of aggression that impacts on mental health and this in turn on male imprisonment, and early deaths. Cock contends that underlying this pattern of violence and trauma is that male identity has been historically formed through *"ethnic nationalism, a language of blood and belonging"*. Men thereby seek to legitimate their status and ethnicity through contest and violent behaviour. This means that violence and related stress has become instantiated within many socio-cultural environments (Ignatieff in Cock, 2001, p 303).

Literature reviewed thus far posits that mental health outcomes are improved when the socio-cultural environment informs the diagnosis, treatment, and aetiology of stress-related illness. Thus, poor or uninformed pathways to care add to environmental stress for those who are mentally ill. Addressing men's mental health care needs de la Rey (2001) quotes evidence from Kisekka (1990) that more males have been admitted to psychiatric institutions in Africa than women. This contradicts the evidence for Western countries (de la Rey, 2001). African male presentations to

society, which would lead to better reintegration? (this means) the damaging effects of unemployment are avoided" (Swartz, 2002, p 207).

[85] Of further significance is that in 1996; 17,600 guns were reported lost or stolen in South Africa, where in 40% of murders and 79% of all robberies in 1995 guns were used.

psychiatric institutions are, however, likely to be for psychotic events. One rationale for this evidence is that African men worked in the formal economic sector and had better access to psychiatric institutions. Women remained part of the traditional domain and sought help from healers (de la Rey, 2001, p 310).

Political and legal sanctions from colonial and apartheid policy have had a disturbing impact on African identity, freedom of choice and mental health, especially on men in urban areas (Swartz, 2002). Swartz's evidence suggests that African men did not so much seek access, but in fact entered psychiatric institutions through political and social misdemeanour and violence (Boonzaier and Sharp, 1988; Cock, 2001). *"These social reactions reflect how our transition from authoritarian rule has produced a deep well of social anxiety as the familiar social identities and traditional practise have been disrupted and breached"* (Cock, 2001, p 297). It is also important to note that the exigencies of poverty and deprivation formed critical environmental stressors that made a major contribution to mental illness.

2.4 Circumcision and stress

2.4.1 Stressors for the development of mental illness in circumcision

The evidence on stress-related illness begs the question of what traditional coping mechanisms existed and continue to do so in circumcision practices. A rite of passage must be stressful for it to have a successful outcome (Van Gennep, 1960; Bloch, 1986). Confirming this, the literature, Ngxamngxa (1971) in particular, discusses the psychological aspect and anticipatory anxiety of the rite of passage, but in the traditional practice harmful stress is not inferred. Mandela (1994), illustrating this, describes an experience of intense but short lived anxiety in the circumcision. Ngxamngxa's description also suggests that there is a healthy integration of stress through schooling and wound-healing procedures during the seclusion. A man's new identity thereby meant that through language and re-education *"initiates are hardened to a new (adult) discipline"* (1971, p195).

This evidence suggests that, in general, coping mechanisms in circumcision inculcate a more resilient state of mind for circumcised men, with the proviso that those few who are predisposed for altered states could experience a brief psychotic episode.

However, evidence exists that traditions have not always been safe for all initiates. Custom dictated that if a youth died or disappeared in the seclusion, an elder would come to his home and when the parents opened the door he would drop a pot signifying that the youth would not return. Some oral records for fatalities in circumcision thus contradict the evidence that past practices were safe. For instance, some youths must have had a greater fear of injury, making them susceptible to increased anxiety[86]. It would also appear that the liminal state in seclusion has the potential of becoming an altered state in some vulnerable initiates. It is possible that these few cases describe what may have happened to youths who became mentally ill or psychotic in seclusion. They may have wandered off and remained missing or have died from unnecessary aggression or violence or not been claimed from the seclusion.

The complex nature of this debate is elaborated upon in more recent literature which presents evidence that circumcision practices are no longer safe and may present increased risks for those who are vulnerable[87]. Meintjes (1998), for example, expresses concern that external stressors from urbanisation may have negatively challenged Xhosa-speaking custom. Some evidence therefore exists for stress-related mental illness and psychosis in initiated men who have a predisposition for mental disorder. This would be their response to the impact of a stressful inter-relationship between circumcision and an environment that has become less predictable, less supported, and more violent. Youth at greater risk would be those who had *"an underlying psychological malfunction"* (Totman, 1979, p 182). These men would be susceptible to acute and chronic stressors that over time could act as causal agents in the development of their mental illness. By way of comparison, most male initiates who were not predisposed for mental illness would have a healthy response through successfully accommodating changes in their bodily, psychological, and social status. Their coping mechanisms would enable them to withstand external stressors such as inadequate traditional resources or undue fears and anxiety.

[86] Doctors working in Crossroads Community Clinic recalled that prior to circumcision some parents of youth who suffer from retardation, diabetes, or mental illness express a desperate sense of *"is he ever going to be a man" (*Field notes, 29th March 2007).

[87] Doctors working at Crossroads Community Clinic recalled that one youth hanged himself, when he heard that his pre-circumcision blood test showed that he was HIV positive. This clearly shows the level of anxiety that youth have, the need for them to perform and the fear of being different or of not being able to embrace manhood because they have a marginal status.

Another cause for increased stress and anxiety in this critical life stage event is that environmental stressors and cultural dissonance may have increasingly harmful consequences. Factors such as poverty or poor support from family and kin contribute to *"increased external demands (stressors)"* and undermine an initiate's coping mechanisms (Allwood and Gagiano, 1997, p 12). A key stressor in this respect was the 'absent father' in a circumcision process that brings together patrilineal descendents. In contradistinction, a youth who was financially and emotionally supported by his father, family and community is at less risk and more likely to successfully endure the rite of passage. The stress of the six months following circumcision presents chronic stress that may be exacerbated by poverty and unemployment. This six month period is not interrogated in the literature, which tends to focus on the transformative nature of circumcision. However, this period can be stressful as a man's personal disposition, psychology and behaviour has to be shown to change in these months. Poverty and poor support from kin may aggravate his circumstances, leaving him unable to reference key male figures that would support his psychological growth. Allwood and Gagiano's explanation that the *"combination of environmental and individual factors determines the severity of reactions to stress"* has particular relevance (1997, p 12).

It would appear that Xhosa youth increasingly face hardship during circumcision and this potentially has mental health consequences for some who are vulnerable. In a cross-cultural context, Guinness[88] (1992) argues that Swazi youth used to be protected from anxiety by cultural defence mechanisms that had been embedded in their own traditional practices. She suggests that western acculturation has posed the primary stress factor for Swazi adolescents, as this socially disrupted the nature of extended families, kinship, and belief systems. This is corroborated in the literature on Xhosa-speaking practices, which describes the disruption that circumcision brings in terms of migration and work for youth (Mayer, 1971; Mager, 1995, 1999; Meintjes, 1998; Van

[88] Guinness' observations and research were drawn from her work as a clinical psychiatrist in Swaziland from 1982 to 1987. She cites 3 ways that urbanisation may influence and change patterns of mental illness.

1. *"Selective factors may alter the distribution of morbidity e.g. rural depopulation, family, and psychosocial adversity.*
2. *The process of social change itself may be pathogenic e.g. examples of this were the breakdown of the extended family, changes in child-rearing practices and inadequate resources for rituals.*
3. *Certain syndromes may arise and become more frequent during this social transition, in particular transient psychosis"* (1992, p 65).

Vuuren and de Jongh, 1999). Faced with the competing demands from urbanisation, such as education and work, youth feel thwarted and more anxious, posing an increased risk for those who are vulnerable. In Guinness' thesis traditional coping strategies that were once useful, and this includes a concept of becoming a man, actually become absent or valueless in an environment that requires western education and work skills.

Discussion on the nature of stress-related factors around circumcision and how these may have precipitated mental disorder will focus on a number of perspectives. The first theme examines harmonious transitions for those men who remained well, suggesting that stress that inherent in the rite of passage has the potential to engender resilient behaviour and attitudes. The second theme looks at harmful stress in the rite of passage arguing that psychosocial stressors and environmental stress which is often latent may precipitate stressful feelings and anxiety for some psychotic illness. This has a focus on one crucial stressor – the absent father. The stress of having an absent father and what this represents in a patrilineal society is shown to be psychologically and socially harmful for initiates. Themes include a broader analysis of selective stressors; the influence of historical change on practices and perceived stress. In relation to this a theme on the impact of cultural dissonance emerges. Finally, literature that examines pathways to care for injured or mentally ill initiates will be discussed. Guinness' argument is pertinent as she argues that there has never been a former harmonious state for African people or a lower rate of mental disorder. Mental disorder was rather addressed through traditional practices (1992, p 50).

2.4.2 Harmonious transitions

A good illustration of a circumcision that brought a sense of wellbeing is described in Nonganza's (2005) poem, 'Initiation: Coming of Age and the Mother's Pride', which is about her own son's 'initiation'. Nonganza celebrates his circumcision, but describes her son walking away from his period of seclusion and alludes to the past – expressing her dispossession from her traditional inheritance. She says; *"As you walked in that parched vastness, I could not help but conjure scenes of yore, when African men rightfully possessed vast tracts of lands and stock"*. Woven in to her description are the conflicting values that urbanised, traditional Xhosa-speakers face (Nonganza, 2005). Her poem resounds with a sense of her son's wellness of mind, body, and spirit and their family's wellbeing. The rite of passage was successful and she marvels at his resilience[89], but describes a sense of cultural dissonance[90].

"Were the smiles to steel yourselves against the new world you were entering
a world that contained no formula for your existence?
Or were you thinking of how you would share your adventure with your
varsity friends?"

She admires her son, who as a modern, educated youth with western concepts about gender embraces his pre-determined disposition and place in a Xhosa male hierarchy. Nonganza's son reconciles his different worldviews; this compares to Guinness's thesis where western education in Swazi youths was said to be responsible for their uncomfortable feelings of cultural dissonance. These comments need to be considered in the light of Mahone and Vaughan's (2007) critique on cultural dissonance theory.

Anxiety, however, is shown to be ever-present in circumcision, *"Left, right – pause. Left, right – pause. Left, right – pause …each time you paused, ready to take the next deliberate step? Their (the young girls, boys and women's) expectations were*

[89] 'Initiation: Coming of Age and the Mother's Pride', Nonganza's (2005)
"There was that newness of spirit.
I sensed your spirit had been raised to another level…
Voices of transition echoed in my mind.
'Freedom, exploration, independence come with responsibility,' I warned.
'I know, Mom, I am ready for it,' replied the new man".

[90] *"In its simplest definition, dissonance means a fundamental lack of agreement. Differences between cultures are inherent. 'Cultural dissonance' is the term commonly used to describe a sense of discomfort, discord or disharmony arising from cultural differences or inconsistencies which are unexpected or unexplained and therefore difficult for individuals to negotiate. Dissonance can be experienced by all parties in the cultural interchange and attempts to resolve discordant issues can be bewildering or distressing"* (Gordon and Yowell, 1999).

palpable". Nonganza shows that this complex dynamic cultural event with its subtlety of inferences and nuance is also a personal and family event. This is a ritual that inscribes intimacy with resilience, and this is shown in her circumcised son's demeanour and *"newness of spirit"*. His qualitative change has been instantiated in his very being, interaction and relatedness[91]. Moreover, she correlates her son's personal disposition with an inherited landscape in which there is a deep sense of belonging and ownership. Poetry captures this, revealing how stressful circumstances – when culturally and spiritually contained – can engender resilience. Poetry also appeals to myth and against the portrayal of her son's walk away from seclusion is a sense of the spiritual and psychological journey that he chose. The mythological quality of the poem is also a reminder of the magical aspects to the ritual[92].

Mager also argues that circumcision is intrinsic to Xhosa males identifying with an *"imagined"* amaXhosa community and this engenders resilient behaviour and attitudes. Circumcision is therefore critical in determining how men and women have *"constructed"* ideas about themselves in the world. A fundamental aspect of this is *"appropriate gendered behaviour and gendered meanings"* that are instantiated through the rite of passage and then manifest in *"age hierarchies, respect and avoidance codes"* (1999, p 133). This happens because gender-described meaning for men has been repeatedly inscribed into the bodies, psychology, and social dispositions of youth. This signifies their future status and authority; in particular, their responsibility for family and descent. In emulating their elders, these men sustain Xhosa-speaking society (Mager, 1995, 1999).

[91] Initiation: Coming of Age. Nonganza (2005)
"Your gait had changed; you seemed to walk tall with assurance.
Your steps were measured, deliberate and slow as you went down the hillock towards the crowd.
Your faces looked down slightly, like shy bridegrooms…
There was that newness of spirit.
I sensed your spirit had been raised to another level
These are the secrets that you will never share with me.

[92] This is not bewitchment but magic. The anointer, for instance, was a man of good character who greets the initiates at their coming out party and was said to have magical qualities. The use of white clay also has magical qualities that protect the initiates from witches. Magic and bewitchment – as part of ancestral forces – go beyond the mundane officials such as the teacher. In superseding earthly authority they keep evil away by enjoining the ancestors. The youths' transitional status was surrounded by magic but it was work and reflection that achieved each his manhood and a resilient posture.

Thus, as a Xhosa-speaking woman, Nonganza (2005) provides the context for women in this gender-based custom. She illustrates that women willingly participate in gender construction and reflects, *"With every split second of a pause, pride swelled in my chest."* This affirms that circumcision practices embed a sense of stability for amaXhosa men and women. She writes from the perspective of a lifelong sense of intimately 'knowing' about the rite of passage. Nonganza can recall her own experience of being a young girl in anticipation of her new husband; *"Curious girls flirtatiously dancing, hoping to glimpse.... The man I-Krwala and would-be husband"*. Her description is imbued with a sense of new initiates, mothers and families drawing a deep sense of comfort and resilience from circumcision.

Elaborating upon how gender constructs are instantiated, Strathern in "Women in Between" argues that *"cult performances and ritual may presuppose a formal antithesis between the sexes, in the example of their complementary contributions, or the dangerous influence one has on the other"* (1972, p306). Women being openly insulted in seclusion rituals could illustrate how circumcision exaggeratedly undermines what is female to define manhood. She suggests that these oppositional relations then present in ordinary life but are accommodated. Both Strathern (1972) and Comaroffs (1987) pose that gender is culturally situated as an oppositional construct and this serves to negotiate and mediate social and political relations. Patrilineal descent for Strathern means women have legal equality with men but not political equality. Legally, a woman is able to call upon either her husband's or her father's descent line to act in her interest.

2.5 Psychosocial stress

2.5.1 The absent father

The literature clearly indicates that a major stressor for youth is the absence of men who should play leading roles in the practice. Central amongst these was the father, but significant male relatives appeared to be missing from both maternal and paternal kin. Other roles, such as that of the surgeon and teacher were compromised because men were inadequately skilled to take up these roles. Although the literature describes that other men can be designated to take the place of absent fathers, kin or teachers, authenticity was critical to the initiate having a sense of wellbeing.

An initiate who was obviously unsupported, especially when this absence was the biological father, suffered stigma and, in comparing himself to his peers, stress. The father plays a critical role in circumcision because this event reflects his attachment to his son during his early and adolescent development and psychological growth. In Xhosa culture this reflects how well the son has been prepared and guided into manhood. Circumcision is thus a pivotal point and may serve to highlight other failings and abuses in the youth's life. The literature appears to illustrate that many of these associated problems suggest that Xhosa patrilineal descent has been slowly undermined.

Ngxamngxa (1971) argues that, symbolically, for manhood to be achieved the father must be present to claim his son to his descent line and shift the youth's ties away from his boyhood, initiating him to his *"status"* in manhood. His absence is therefore notable and it is around this very stressful symbol – the absent father – that many other psychological and social stressors cluster. Wounding and pain are one example of this and how important it is for an initiate to have his father's support during his operation. The psychological pressure on an initiate is incredible as he is watched over by men, the circumcision wound is inflicted and he must then shout *"I am a man"*. The initiate's immediate response to this pain and his ability to cope with his wound will speak to his integrity as a man and in how other men perceive him.

Other than Mandela's account (1994) of his own experience of the pain[93], there are very few records of this experience[94]. In fact ethnographic accounts seem to almost gloss over what would seem an anxious and, for some, a terrifying and painful experience. Mandela described being tense, anxious, and afraid of how he would react as he waited for the surgeon. He writes, *"Flinching or crying out was a sign of weakness and stigmatized one's manhood. I was determined not to disgrace myself,*

[93] Pain may or may not be the precipitating factor in certain neurotic conditions (sometimes emotional pain is far more significant than physical pain in such conditions). If pain was a precipitator, its effects would not only be immediate and would occur in situ, but in some instances people would even break down prior to any physical operation taking place. Some youths look forward to circumcision with a modicum of anxiety, especially nowadays when so many actually die in the bush (Personal communication, Professor Manton Hirst, 18 August 2006).

[94] No data has ever been collected on the topic of pain in the circumcision. (Personal communication, Professor Manton Hirst, 18/8/2006).

the group or my guardian. Circumcision is a trial of bravery and stoicism; no anaesthetic is used; a man must suffer in silence" (1994, p 25).

Mandela's personal reflection on this describes how anxiety may be provoked. He recalled going blank as the surgeon knelt over him, took the foreskin, pulled it forward and in a "*single motion, brought down his assegai"*. Mandela says of this experience, *"I felt as if fire was shooting through my veins; the pain was so intense that I buried my chin in my chest"*. His next report is critical as it places much of the data that will be discussed into context. He sees a perfect cut, but *"I felt ashamed because the other boys seemed much stronger and firmer than I had been; they had called out more promptly than I had. I was distressed that I had been disabled, however briefly, by the pain, and I did my best to hide my agony. A boy may cry; a man conceals his pain"* (1994, p 25).

Equally important is the manner in which an initiate relates to his peers, as wider allegiances were fostered through these relationships. It was said that when the initiates were wounded, the shared experience was symbolic of friendship and new legal ties. Thus initiates' behaviour, posture and relatedness are critical. However, alongside the stress of performance for present and future status lies the stress of stigma and injury for those youth less inclined to fight. In the past, these relations helped them to embrace a *"wider tribal authority"* rather than their family of birth (Ngxamngxa, 1971, 201-202). Aggression and competitive dancing was traditionally incorporated in the rite of passage to allow initiates to compete with each other developing their prowess for battle. Status within the male hierarchy was achieved through the initiate's skill in confronting his peers (Ntantala, 1993). Gluckman's (1956) thesis on the purpose of mock fighting amongst Xhosa youth elucidates how, during the initiation ritual, mock fighting offers a drama for the expression of conflict. The dramatic expression of cultural and personal differences amongst males and with their fathers teaches the initiates to co-operate. In Gluckman's thesis this fosters a cohesive society as gender divisions, family, individual weakness, and social rifts are acted out to promote well-being in mundane life.

An important stressor that is not well reflected in the literature is that manhood is not attained by being circumcised, but over a life time and this is a stressful realisation for

a youth who is unsupported by his father, family and kin. Breaking with tradition, Mandela described how he returned to look at the ashes of his seclusion hut and reflect on his lost boyhood, and he says, *"Looking back, I know that I was not a man that day and would not truly become one for many years"* (1994, p 29)[95]. Mager (1995) concurs, the *amarkhwala* or *"unripened fruit"* were not fully men, work matured them, and it was here they could earn *lobola*[96] for their marriage. This argues for the incorporation of urban values and ways of life, however, through this expectation stress is extended beyond the traditional domain. Furthermore, in respect of this a certain humility and cautious attitude is expected of the newly initiated man and this must be shown at all times. Any divergence from this brings comment, mockery and aggression, suggesting that some anxiety about the attainment of manhood may continue long after the coming out party.

It is so critical that a newly circumcised man perform in a manner that clearly demonstrates his attainment of manhood, that the possibility arises that a man who fails to make the transition may become mentally unstable and this might serve as a good alibi for his failure. His failure may relate to a personal sense of worthlessness, or speak to his inability to integrate into Xhosa male society. However, in becoming mentally ill, his failure is placed beyond his subjective control. He thus avoids taking final responsibility for his life and actions. Once admitted to hospital he then finds that he has access to other gains such as disability grants or other care. It is also possible that his psychosis might provide him with a dramatic expression of his feelings of inferiority and low self-esteem. These feelings may be engendered by his failure to make it in the real world because he was vulnerable. This invariably touches the sympathy of care-givers and others.

2.5.2 Selective factors for harmful stress

[95] Initiates began their coming out with a race to the river where the white clay was washed off. This washing in the river was said to remove such impurity and served as a confessional. On their return to the lodge, a praise song was sung and they were smeared with fat and red clay and anointed. New white blankets replace the ones from the seclusion period. Their fathers present these and the anointer draws the blanket over their head. The father then takes the new man and he stands with his back to his hut, which was burnt, with all his belongings from the seclusion period. It was taboo for the *amarkhwala* to look back on this burning hut. A staff was given to him and together with the men they proceed only looking forward to the village and the coming out celebration. It was taboo for an initiate to look back on the burning hut.

[96] *Lobola* or marriage payment for the bride.

Seemingly, Xhosa-speaking circumcision is nested in a cultural environment in which there are diverse and potentially harmful stresses. Thus, worries and problems about circumcision and other related matters accumulate over time and become stressful for youth and their families. This stress as feelings of more harmful anxiety is significantly worse for those individuals who are poor and vulnerable. This was evident in known idioms of distress. However, the literature also suggests that specific stressors are inherent in circumcision and these are felt every six months when the event occurs. Other evidence indicates that patterns of stress-related illness and the traditional mechanisms to accommodate this differ from in the past. These patterns are similar to those identified by Guinness (1992) for Swazi youth. She claimed that cultural discord was the root cause for patterns of mental illness in her study. This was attributed to the subordination of Swazi traditional culture to a more urban, western culture. In a South African context authors such as Van Vuuren and de Jongh (1999) suggest that patterns of stress and cultural discord present a more complex picture within Xhosa society. One critical aspect in this respect is the part that pathways to mental health care play in health-seeking strategies for stress-related illness.

Predominantly the literature and particularly that on the apartheid era describe a deeply embedded socio-economic poverty in a marginalised Xhosa-speaking community (Wilson and Ramphele, 1989; Posel, 1991; Guinness, 1992). Poverty continues today to have a devastating impact on local Xhosa-speaking people, possibly functioning as the key underlying stressor for mental illness (MacGregor, 2000). Poverty, and indeed related mental illness, can be understood as consequent upon the impact of the migrant labour system on Xhosa-speaking people. Migration meant that families and rural communities that were once rooted in traditional ways of life had to seek alternative strategies to survive. Thus, Xhosa-speaking people have been recorded as fostering relationships amongst extended kin to adapt to urbanisation, industrialisation, and later the socio-political exigencies that apartheid imposed on them (Russell, 1994; Allwood, 1986)[97]. Ethnographic accounts suggest that a strong cultural identity that is anchored by customs such as circumcision may have ameliorated their transition from a more traditional and rural life.

[97] Apartheid policies in South Africa were from 1948 to 1994.

Much debate has centred on a theme of cultural change and continuity, and this raises questions about how people who are autochthonous may perceive that change. Whilst the negative impact of change is reflected in media reports on injuries sustained by initiates in circumcision, interestingly, less is said on how resilience may continue to be engendered across the culture. However, in support of a negative perception of change in Xhosa society MacGregor (2000) describes that the harsh reality of life for people in Khayelitsha is shown in their yearning for cultural continuity and an *"ideal of a mythical past"*. MacGregor argues that nowadays violence, hunger, and poverty have been instantiated in this cultural landscape, and the prevalence of stress and mental illness in these communities demonstrate their desperate circumstances. This has resulted in a cycle where poverty perpetuates mental illness, and the burden of this impoverishes families and the community. Thus in 2000, she records that despite the integration and restructuring of mental health care, those who were mentally ill continued to be marginalised and reliant on families and relatives.

MacGregor's research demonstrates that the engagement of Xhosa and biomedical cultures has had a positive effect as patterns of mental illness and poverty are being addressed within the health system. Xhosa-speaking people understand and talk about illness and – even though it might be difficult – manage to access their disability grants. Such fundamental shifts accommodate people's changing perspectives about illness and, as MacGregor argues for the Xhosa, illustrate that they are, *"changing the ways in which people conceptualise their conditions with respect to aetiology, chronicity, and potential treatment"* (2000, p 251). Whilst this illustrates that people use pathways to care to cope with stress and mental illness, MacGregor's work points to an ongoing dependence on state grants – and this presents another potential social stress. In a democratic and diverse urban environment, disability grants may fail to address the root cause of stress or sustain effective pathways to treat and care for mental illness.

As poverty has been instantiated in the landscape, thereby fostering stress-related circumstances and events, so too have conflict and violence. Beinart and Mager argue that as early as 1940 court records show unacceptable levels of violence in the rural Eastern Cape. These authors suggest that violence and a corresponding rejection of traditional authority were a consequence of the pressure of colonisation and migration

on customary practices (Beinart, 1991; Mager, 1995). Beinart poses that a more fluid, class-based society slowly undermined the social ranking inherent in Xhosa traditional hierarchies. An ensuing social disruption manifested in aggression and violence. In circumcision, educated youths were ridiculed and attacked; whereas those in urban areas who were not circumcised were looked down on (Campbell in Ngxamngxa, 1971, p197). Gang-related behaviour escalated amongst men. Stick fighting became significantly more aggressive, with Mager stating that youth who had lost traditional occupations had little to do except fight. Of particular note is that Beinart and Mager correlate this increase in aggression with the breakdown of gendered relationships and more violence towards women (Beinart, 1991); Mager, 1995, 1999). Here the poorest and most vulnerable become victims (Mager, 1995).

Violence perpetuates stressful circumstances, and this is shown in Beinart's (1991) and Cock's (2001) discussions of how rifts and rivalries in urban environments have been intensified by emerging class structures and apartheid policy (Baldwin-Ragaven, 1999; MacGregor, 2000; Cock, 2001). Under apartheid the majority of urban Xhosa-speaking people experienced violence, repression, and disruption (Wilson and Ramphele, 1989; Cole, 1987; Swartz, 1998). Consequently violence erupted in the struggle for Crossroads in Cape Town where a mostly Xhosa-speaking community asserted their right to land and citizenship. Implicit in this advocacy were the competing claims of an urbanising people. This revealed historical rifts within Xhosa culture as traditional Xhosa-speaking people politically thwarted a more youthful, socialist, resistance movement in a political struggle between *"fathers against comrades"* (Cole, 1987).

The evidence in the literature indicates that urbanisation, rather than bringing the destruction of traditional culture, institutes patterns of change and contradictions that are stressful. Disparity between worldviews may induce stress-related factors because accessing either domain happens through education. Guinness (1992) argues that amongst Swazi youth, urbanisation and education have challenged traditional forms of schooling. This discussion has relevance for the present Xhosa practice of circumcision schools. Furthermore, an urban environment fundamentally questions assumptions about gender and morality that have been integral to practices such as circumcision.

That stress itself as a changing phenomenon is another important consideration in a discussion on stress-related factors in the context of a people who have migrated extensively. For example, stress happens in migration but when people move from one social or cultural context to another, despite being of the same culture, they encounter new and different precipitating factors. These potentially become operative as new and different independent variables and affect behaviour. Yet these variables might in fact have very little to do with the independent variables that were operative in the previous context in which the person lived. When stress is seen in this way it becomes possible that those men who are resilient learn to be discriminating and selective for factors that provide stability in their lives. Alternatively, it is possible that with urbanisation too many independent variables have become at issue, and Xhosa culture is less stable and more people are at risk for mental illness. Underlying both circumstances are socio-political and economic factors that have a determinative effect in that socio-cultural environment for stress and mental illness arising in circumcision.

Ameliorating factors against the harmful effect of stress were evident in the literature. Mager (1999) indicates that circumcision was kept alive because it defined Xhosa manhood and social groups. Despite her records of violent behaviour and aggression, Mager states, *"Initiation, with circumcision as the key element, remained the touchstone of Xhosa masculinities. Initiation signalled changes in personality, manliness, and identity"* (Mager, 1999, p 133). Mandela says of his own circumcision *"I became a man. In Xhosa tradition, this is achieved through one means only circumcision.... For the Xhosa people, circumcision represents the formal incorporation of males into society"* (Mandela, 1994, p 25). In later years, in a debate in the African National Congress where it was of concern that tribal practices continued, Mandela records that the prevailing view on circumcision was that *"it was a rite that strengthened group identification and inculcated positive values"* (Mandela, 1994, p 415)[98].

[98] Mandela's (1994) statement illustrates that increasingly circumcision has become part of African political and national discourse. This is distinguished from it belonging within its own cultural discourse and separately within a medical cultural discourse. In comparison, circumcision as practiced by Jewish people has remained within a religious and cultural discourse. In the context of the South African constitution this protects it from being a national political issue, and this allows for a decision-making and cultural integrity within Jewish people.

2.5.3 Historical evidence of change in practices

Conflict and cultural dissonance have long been part of Xhosa-speaking discourse. Even Nonganza's (2005) reference to cultural dissonance stands as a reflection of an ongoing debate in the literature. In this respect she makes an allusion that circumcision happens as a relevant, cultural form of education alongside western education. Other Xhosa-speaking authors such as Soga, Mandela and Mager have participated in this same discourse, shaping a changing sense of amaXhosa and African identity. Tiyo Soga's journals provide clear evidence for the incorporation of Western acculturation into Xhosa-speaking discourse. Soga in 1880 expressed his dislike for traditional circumcision, believing it was detrimental to Xhosa wellbeing – spiritually, morally, and physically (Attwell, 2005). His writing marks the beginnings of an African intellectual discourse on mental health and circumcision.

By 1887 Soga's significant literary contributions included vigorous debate on circumcision, consciousness and cultural change (Attwell, 2005)[99]. He spoke to the inclusion of a culturally distinct Xhosa-speaking people *"into a global and technological history, the retention of racial distinctiveness, and adaptability"* (Attwell, 2005, p 41). Evidently *"Soga embraced… the civilising mission but sought to establish a new point of departure within it, one that placed an African consciousness and identity within the larger framework of modern history"* (Attwell, 2005, p 47). The practice of circumcision was not, however, included in an African consciousness, as his dislike of the custom stemmed from his missionary and educational viewpoint. He had not been circumcised and this influenced his perspective. Evidently he had tuberculosis and his father sent him to school in Scotland. When he returned as an adult to work in Mgwali, Soga was stigmatised because of not being circumcised. It was recorded that *"at his (Soga's) mission station at Mgwali… he had to contend periodically with what he saw as the demoralizing resurgence of traditionalism, the white painted initiates (abakhwetha),*

[99] Discussing Soga's journals in Rewriting Modernity, Attwell described that Soga's father, a councillor of Ngqika, decided that he should rather join a mission station than be circumcised. He was sent for missionary education to Scotland where he married a Scots woman, subsequently returning to the Transkei to work as a minister. Soga later sent his sons to be educated in Scotland, asking them to be proud of and claim their black heritage as children of mixed descent. Attwell suggests that his call in the late 1800s for diversity has been little acknowledged (2005, p47).

some of whom were sons of elders in his own church appearing… in open mockery of the uncircumcised black missionary" (Attwell, 2005, p36)[100].

Soga epitomises some of the personal and cultural contradictions described in the literature. Stigmatised within Xhosa society and excluded from a dominant white culture and discourse, his life was deeply disturbed and he died at forty-two years of age from tuberculosis. His tragedy, as Attwell describes, is that Soga's discourse was dominated and appropriated by a western one. Yet, his journal reflected a quiet, authoritative, cultural integrity that advocated for Xhosa-speaking people to enter a western European discourse. Furthermore, his debate on circumcision remains relevant and critical. Gluckman (1956) was to later comment, (and this pertains to Soga's critique as a Xhosa man) that the strength of Xhosa-speaking culture has been an inherent propensity to absorb conflict and dissonance through customary practices, decision-making, and tradition[101].

Soga's writing illustrated that Xhosa-speaking people were struggling with a sense of cultural dissonance, with some advocating for social and political change. In Soga's time, however, the historical evidence indicates that most circumcisions were successful. This suggests that, as Hastrup and Elsass explain, *"Cultural survival therefore implies not the conservation of a preconceived identity anchored once and for all in an objectively existing (reified) culture but continuing control by the agents of a particular culture, of the shaping of local history"* (Hastrup and Elsass, 1990, p 307). Thereby, *"there is no culture outside the living reality of thought and action"* (Ardener, 1978, p 39). Thus, an immediacy and inevitability exists in the very nature of cultural practices for individuals such as Soga to act as *"agents of the social system and of history"*, generating new dilemmas and changes in practices (Hollis in Hastrup and Elsass, 1990, p 306).

[100] Rev. Tiyo Soga would not allow youths at Mgwali Mission, near Stutterheim, to attend circumcision and this caused some dissension at the mission. The youths, however, absconded from the station to attend circumcision. (Personal communication, Professor Manton Hirst, 15 August 2006).

[101] Gluckman (1956) argues that cohesion in the social order requires rituals such as circumcision to make an open statement of conflict, as this is implicitly embedded in relationships within the society. Social conflict exists in forces such as bewitchment – which can thwart a youth's seclusion period. The open display and acknowledgment of this conflict in the context of ritual events manifests as rebellion but not revolution. Rebellion means that the parties in conflict can be incorporated into the social order. Revolution, for Gluckman, is conflict that disrupts and radically alters the order.

These changes, so well described and felt by Soga, became salient across Xhosa society. With a relentless urbanisation, the evidence suggests that change began to instantiate a sense of cultural dissonance and this was evident in the disruption of traditional practices. Furthermore, Xhosa people had inadequate language skills and education to enter an increasingly dominant discourse for urbanisation (Leff, 1980). Yet, in their cultural context, circumcision had prepared them to be responsible and well-resourced men. These tensions and an increasing sense of cultural disruption remain evident in the literature for well over a century. There is an elemental interplay between historical, political, and cultural forces; the impact of this on Xhosa identity, psychology, and disposition becomes the subject matter for poetry, autobiography, and photography, the media, and politics (Ntantala, 1993; Mandela, 1994; Gasa, 2003; Nonganza, 2005). These accounts illustrate the continuing and elemental nature of this transformative ritual in modern urban and rural landscapes. This suggests that feelings of dissonance remain an integral part of Xhosa-speaking cultural consciousness and discourse[102].

The evidence suggests that within Xhosa society cultural dissonance insinuates pervasive stress-related factors that place males who are vulnerable for mental illness at risk. This is partly because stressors and challenges that were previously surmountable have the effect of provoking anxiety in initiates and their families. Moreover, against this distress and dissonance is a youth's personal fear of not being circumcised or of failing in circumcision. As was demonstrated by Soga, his not being circumcised affected every aspect of his life, leaving him isolated, ill and stigmatised. Instinctively, youth know that circumcision will determine their very identity and most intimate of relationships, moulding their psychological and social development into becoming an ancestor. Thus, when cultural practices are in question then so too are the personal futures and descent lines of youth.

2.5.4 Cultural dissonance – a bricolage of symbols

Ntantala (1993) in her autobiography describes a sense of cultural dissonance when, as a child, her parents threaten her with, "*you will be sent away to live with the*

[102] If only for the fact that circumcision happens twice a year, every year it is present as a ritual in everyone's minds and expectations. Here, common dilemmas, stresses and concerns occur with the same frequency. This is heard in daily conversation and preparations every year, as after sixteen years old they decide to undergo circumcision or not.

(Xhosa) ochred non-school people" (Ntantala, 1993, p 38)[103]. These were amaXhosa, but *"Red Xhosa"*, who still embraced traditional culture, resisting education and urbanisation. Ntantala expresses her distress as a young girl who was part of an emerging culture of educated and Christian, Xhosa-speaking people who distanced themselves from traditions such as circumcision (Mayer and Mayer, 1971). Her rationale about this cultural disjuncture and the changes she experienced was that, *"A new culture, an amalgam of the old and new was emerging;… for had they not all, school and non school people, been drawn into the economy of the West?"* [104]

The literature therefore suggests that many Xhosa-speaking youth may enter circumcision with more inner turmoil and stress than they did in the past. Of equal concern is Beinart's (1991) description for disruptive forces in youth culture and Cole's (1987) for the social disruption of these cultural communities under apartheid. Furthermore, their new aspirations, as Beinart (1991) and Mager (1999) argue, are for status that is achieved through work and as an individual or problematically through violent behaviour in gangs. This is not the status of manhood earned in becoming a Xhosa person who is a responsible family man. These factors suggest that youth may enter circumcision with more anxiety and contradictions than in the past. However, the literature indicates that it is possible that those who are healthy have a clear sense of resolution.

An illustration of how deeply instantiated stress levels and cultural dissonance may be is evident in the nature of gendered relations. Circumcision confronts youth not only with stressful issues about education but also identity and gender, and this may instigate inner contradictions about their own gender-described behaviour. Gender-described aspirations alter with education and urbanisation and this brings contentious issues to the fore. Thus with urbanisation, gender for some men may remain unresolved at circumcision. Furthermore, circumcision has been challenged by other

[103] Vygotsky realised that language and psychological disposition in the child's development began to describe how culture was fundamental in the conscious construction of cognition and bodily disposition. Vygotsky's work describes why and how culture is embedded and transmitted down generations and across people who can communicate with each other (Van der Veer and Valsine, 1991).

[104] *"A new culture, an amalgam of the old and new was emerging; a culture that is the dynamic reality through which people express their desire to make their life worth living. For had they not all, school and non school people, been drawn into the economy of the West? Were some of them not already destined to leave these areas, never to return, but to live and die in the cities, mines and farms of South Africa, where they would be excluded from living any meaningful, fruitful life?"* (Ntantala, 1993, p 38).

gendered concepts of personhood and belonging. It therefore appears that as ideas about manhood shift away from traditional aspirations, gender-described categories inculcated in circumcision might negatively affect bodily dispositions, psychology, and mental health.

This happens because gender is a complex cultural phenomenon where, as the Comaroffs explain for Tswana culture, *"male and female production were not merely opposed and complementary, just as women and men were not simply opposed and complementary social beings"* (Comaroff and Comaroff 1987, p198). Any disruption of intricately entwined Xhosa-speaking gendered relations would – in the context of new aspirations for a more individually-oriented and work-based culture – place vulnerable men at risk for mental illness (Leff, 1980)[105]. A significant aspect is that a man who has professional, work-related aspirations learns to feel uncomfortable or have a sense of *"dis-ease"* in his traditional home setting. A man simply loses the ability to talk freely and openly about these new aspirations with his family and familiars.

Cultural dissonance suggests that the very symbols in the unconscious that anchor culture are questioned[106]. This was aptly described by the Comaroffs (1987) in the bricolage of symbols worn by the Tswana *"madman"*; his mine boots contrast to the strips of cowhide, *"tied to his knees, neck and wrists… long used to bind the body in healing and protection"* (1987, p 204). Male initiation amongst the Tswana, in the Comaroffs (1987) discussion, has retained its significance as a creative ritual about their myth of origin; "*The social world was born when the raw fertility of females was domesticated by men"* (Comaroff and Comaroff, 1987, p 198). In being consistently performed, the practice anchored their worldview. Culturally the practice allowed for the revealing and healing of illness and psychosis as part of an African sense of

[105] Leff argues that an ability to verbalise one's own psychology is reliant upon literacy skills, attained through education. Urbanisation or modernity in western cultures has integrated these into an *"introspective psychology"* where emotions are articulated and this forms a fundamental aspect of medical and psychiatric care. Leff argues that this process in Europe brought changes in the nineteenth century in mental illness presentations. Hysteria as a psychiatric predisposition was replaced with anxiety and this was consequent upon the loss of family and kinship structures during industrialisation. He argues that this is evidenced in African cultures today (Leff in Guinness, 1992).

[106] Ritual taboos and sanctions abound during the initiation period and many of these are implicit or unsaid in the various actions, activities, and instructions in the seclusion. Normal activities were changed which, as Van Gennep (1960) describes, allows in ritual for an inversion of what is ordinary and mundane. As this is done, so what is sacred or held in high status is denigrated, and the profane is elevated. This ritual inversion facilitates a later acceptance of those who hold authority and hierarchy in ordinary circumstances.

becoming for persons, society, and ancestors. A sense of loss, however, pervades this sad description of a now solitary Tswana madman.

Strathern, commenting about Geertz, addresses this sense of a stressful, culturally diverse, problematic world, saying *"this mood of lost authenticity – the idea that the world is full of changed, part-cultures – is not new"* (1992, p 94). The problem, Strathern argues, is the response to an *"unprecedented overlay of traditions"* in a world that is now so interconnected. For Strathern the heart of this debate lies in understanding how people rework their parts of culture into imagining the world differently and constructing the very necessary cultural fabric of their world to perpetuate what is comfortably known, yet lived creatively. Strathern (1992) argues that anthropologists (and Kleinman makes this true for doctors) are heirs to an ethnographic project which she describes as the *"modernist imagery of parts and wholes"*. She states, *"It made us see persons as parts cut from a whole imagined as relations, life, and, for the anthropologist, society. Conversely, in the discourse of systems and structures it was relations, life, society that creatively recombine the fragments and parts"* (Strathern, 1992, p 99)[107].

What distinguished the *"madman"* was his bricolage. However, what are missing from the Comaroffs' description are accounts of his psychotic disturbance and psychological distress. This hard reality – and not the softness of the bricolage – describes the world of those who suffer from madness[108]. Often falling out of cultural groups, those who suffer mental illness live on the margins of society, but unlike the *"madman"* may have a pathway to care into a psychiatric hospital where, as Leff (1980) argues, their disturbance becomes part of a biomedical and psychological discourse. Where circumcision had been the precipitating factor for their mental illness, then related symbols e.g. blankets, dogs, staffs, as discussed by Angulu

[107]Acknowledging ambiguity in culture and ethnography can pre-empt the anthropologist from interrogating their subjects and data which as Clifford states then suffers the fate of becoming cut and reassembled. In studying human behaviour the ethnographer like the archaeologist has to be precise and name and define each quality to reveal the nature of what has been observed. In respect of this Strathern clearly sets the agenda for anthropologists who sit at the interface of anthropology, human behaviour and mindfulness. Strathern refers to mid-century notions of procreation when stating, *"persons are natural hybrids: the creative recombination of already differentiated genetic material makes everyone a new entity. The past might have been collected into ancestral traditions, but the future lies in perpetual hybridization"* (1992, p 96).

[108] Patel et al (2005) record that the frequency and severity of mental illness is demonstrated by the 500 million people worldwide who suffer some mental disorder or impairment.

Oruvuejeogiua (1975) should appear in their psychotic content[109] (Mayer and Mayer, 1961). These were present as culturally-based hallucinations, delusions, or voices, thereby the very factors representing the precipitating event (Guinness, 1992)[110]. These symbols tie together the very nature of not only stress and circumcision, but psychosis and circumcision in this cross-cultural psychiatric context.

The challenge for anthropology, as argued by the Comaroffs (2002), is to make history and culture relevant in understanding how *"human beings create community and locality and"*, at an individual level, *"identity"*. They argue that people and cultures should be understood as, *"producing new forms of consciousness, of expressing discontent with modernity and dealing with its deformities"* (Comaroff and Comaroff, 2002, p 274). People incorporate traditional practices such as witchcraft and circumcision into their urban lives, and some express the disease they feel through mental illness. Thus, across a Xhosa cultural group in their local context, a particular epidemiological pattern for mental illness emerges. As circumcision has bridged the old and the new in donning the working man's cap and jacket for the new man, so too have healing practices as Xhosa people seek pathways to care that include traditional healing and biomedicine[111]. In this environment voices that are informed and self-reflective offer some discourse on the inner and outer dissonance that represents so much of mental illness. Strathern and the Comaroffs suggest that

[109] In the event of a man's psychotic episode, his social inhibitions are lowered and unconscious symbols become voiced and flamboyant. The extent, to which they were able to incorporate this discourse into their lives, but especially into getting well, is the subject matter of the thesis.

[110] Individuals, Strathern (1992) explains, embody original symbols which are conceptually part of a natural world and define a culturally oriented identity.

[111] Leff argues that urbanisation means that people from a traditional culture increasingly participate in a psychological discourse on their mental health and illness and this, despite inner dissonance, brings about their participation in western acculturation. An ability to verbalise psychological dissonance does not infer an increase in mental illness but alters its distribution (Guinness, 1992, p 50). In respect of this, and to understand the nature of this shift and its discourse, Guinness argues that, *"The move out of the confines of the hospital made it possible to explore psychiatric morbidity in the community and to link this with the hospital profile"* (1992, p 11).

elucidating the ephemeral yet tacit nature of cultural[112] symbols brings the possibility of restoring mental health[113].

2.5.5 Pathways to care

Meintjes (1998) cites no psychiatric admissions in his research on circumcision injuries. However, his discussion has abundant, implicit references to probable psychological injury which, it can be inferred, impact on families, peers, and others. It would therefore seem important to establish evidence for pathways to mental health care and in support of these he argues for ethnographic research on psychological harm[114]. His point is persuasive given his clinical and personal experience with Xhosa-speaking people in the Western and Eastern Cape Provinces. Although conclusive evidence is absent on psychological morbidity in respect of circumcision, the literature on stress and mental illness advocates for culturally appropriate research and interventions in the primary health care field when issues are of concern (Goldberg and Huxley, 1992).

In this regard, Goldberg and Huxley argue that, *"there is an accumulating corpus of knowledge about the way in which people's social environment determines both the form and timing of common mental disorders";* their argument is that it is the domain or level[115] where mental illness behaviour first presents that is critical (1992, p 3). This means that this critical life stage event needs to be understood in terms of stressors faced by youth and their families in their decision-making process within a

[112]Defining stress within a cultural group is difficult because defining culture and cultural practices has itself been fraught with challenge for anthropologists. Whilst difference between groups of people is seemingly obvious to the naïve observer, defining, describing and validating the nature of that difference is an intricate procedure (Kuper, 1992). In describing culture, anthropologists seek to define the nature of social relations that are on the one hand illusive, yet on the other existent, as in the human body and behaviour. Thus, inherent in the academic discipline of anthropology is a quandary about its discourse and theoretical premise. It is often seen erroneously, more as a descriptive art rather than science, as its subject matter is the ephemeral and unpredictable nature of human behaviour.

[113] Jones alludes to this and a suggestion that it is an imprecise tool, when he argues for a *"scientific anthropology"* as the means to understand cultural evolution. Jones (2005), discussing niche construction theory and anthropology's place in understanding genetics, states, *"a number of anthropologists are scrutinizing how culture can put selective pressure on our genetic make-up… the study of cultural evolution is expanding rapidly within scientific anthropology"* (2005, p 16).

[114] Of concern too were stories about initiates who died in the bush or failed to return home. Their bodies' whereabouts were unknown (Meintjes, 1998)

[115] Goldberg and Huxley state, *"There is a filtering process at work between the community and the wards of the psychiatric hospital, which is selectively permeable to those with more severe disorders"* (1992, p 4). They describe five levels with filters between each. The first is at a community level and is illness behaviour, the second at a primary care level, the third, mental health disorders presenting at a service. The fourth is total morbidity and admission for psychiatric care and the fifth, psychiatric in-patient treatment and care.

Xhosa-speaking cultural context. Local explanations about the practice and other traditions then inform mental health care *"need"* and how it should be assessed. Stress-related illness is then not addressed by the health system as a statistical incidence or category, but by the people who are suffering who motivate for pathways to mental health care.

Patel et al (2005), however, point out that the bulk of mentally ill patients are dealt with in the community by primary health care practitioners, but those who suffer from psychotic mental illness are seen first by tertiary services. The data on admissions for psychotic events is of concern, indicating that mental illness symptoms may not be either appropriately assessed or perhaps followed up and treated. In respect of this, Kleinman and Benson (2006) recommend that the patient's cultural orientation and illness history should inform their pathway to *"diagnosis, treatment, and care"*. Mental health outcomes, as argued by Njenga et al (2005), are improved when a patient is discharged with a diagnosis that has considered their cultural circumstances and the related precipitating factors. Culture-bound syndromes are of particular relevance, as it is known that psychotic symptoms that have their origin in a cultural event resolve with a culturally appropriate mental health intervention.

In optimal circumstances, Goldberg and Huxley (1992) additionally point out that an early intervention in the community may prevent hospital admissions. Although this holds true within biomedicine the literature illustrates that culture – and indeed extended kin and community – may pose confounding factors in establishing pathways to care. Finding information about cultural practices such as circumcision can be difficult, especially when cultural taboos are such a strong feature. The evidence in the literature suggests that three situations exist which illustrate the problematic and stressful nature of communication around circumcision. The first is that cultural taboos have stopped any open discussion of psychological harm. The second counters this, arguing that the practice has been safe and brought mental resilience and wellness; the few cases for psychological disease illustrate youth who are vulnerable for severe mental disorder[116]. The third possibility takes up Leff's (1980) thesis that education as part of urbanisation has facilitated people from more

[116] In a personal communication Dr. Manton Hirst noted that after extensive research into medical records in the locality of King Williams Town in the Eastern Cape he could find no evidence that the circumcision practice in the early 1900s brought either significant physical or psychological harm. This suggests that the practice was safer than evidence suggests it is today.

traditional cultures to willingly seek pathway to care into the psychiatric services, but they are prevented from doing so by traditional authorities.

Essentially, Guinness argues that a biomedical explanation replaces a supernatural one as a means to legitimately present mental illness symptoms. Leff states, *"As people began to verbalise their psychological suffering instead of somaticising it, there was less need for hysterical reactions"* (Leff in Guinness, 1992, p 35). Cross-cultural psychiatry supports this thesis (Mkize, 2003; Kleinman, 1995; Lambo, and Sartorius et al, in Guinness, 1992). A cross cultural psychiatric explanation for an increase in presentations argues that stress and the pressure of urbanisation increases the risk for – and cases of – mental illness. An alternative argument is that urbanisation brings a change in the way that symptoms of anxiety and mental illness are understood, articulated, and presented.

The issue is raised of whether biomedical professionals can really understand or address need, or whether therapy is appropriate when cultural practices are silent and lack transparency. Facilitating transparent and effective care requires that knowledge is made available and negotiated within communities who willing participate. Therefore, another question arises as to who has ownership and authority to disclose information or advocate for change. In the light of this, media reports demonstrate that despite government interventions to organise culturally appropriate care, injuries and abusive practices frequently happen (Meintjes, 1998). Of additional concern is that the initiates' right to a safe circumcision is abused and parental authority and negotiation undermined.

2.5.6 Summary and conclusion

Social science and ethnographic studies demonstrate that circumcision remains a critical life stage event for manhood amongst the amaXhosa people (Hunter, 1936; Krige, 1937; Pauw, 1963; Wilson and Mafeje, 1963; Mayer, 1961, 1971). Works written within an autochthonous African perspective include Soga's monograph (1931), Mafeje with Wilson (1963) and Ngxamngxa (1971), Ntantala (1993), Mandela (1994), Gaza (2003) and Nonganza (2005). New themes emerge from these writers, revealing how Xhosa-speaking people are accommodating socio-political change. However, the predominant theme was that circumcision begins a life-long process of

"becoming a man" for youth. This process across generations is elective, holding to an ideology about timeless ancestors in descent-based patrilineal traditions (Bloch, 1986). For this reason the father, his related kin and designated officials, were essential in securing a safe ritual transformation. Circumcision was shown to engender and assigns roles, status and hierarchy to men and women, children and dependents – where concepts about equality and vulnerability, resilience and psychological harm had particular relevance.

The literature review suggests that the majority of Xhosa-speaking youth go to circumcision and return well. However, there is a clear indication that some youth do not have this harmonious experience[117]. As the scientific literature indicates, a select few who are genetically and psychologically predisposed will become mentally ill; stress-related factors within the culture and specifically around circumcision practices will contribute to the onset of their illness. Guinness (1992) and MacGregor (2000) both clearly describe stress-related mental illness existing in a Swazi and Khayelitsha local context where low grade anxiety, nerves, and stress may result in psychotic events. Stress-related conditions could therefore be described as a cultural expression of stress. However, with urbanisation and social change, a discourse on stress, mental illness and bewitchment has changed to a more biomedical one on emotions and psychology. Pathways to care have in part been transferred away from traditional healers to the health system.

In summarising the evidence from the literature, the following outcomes would appear to be relevant to stress-related illness and psychotic disorders following circumcision. Those youth who had an inherited disposition would be more susceptible to suffering with psychotic illnesses such as Schizophrenia and Bipolar Disorder. Some few might experience altered states as in cultural bound syndromes. Transient psychosis, in the context of a cultural bound syndrome is the one circumstance where the trigger is more easily identifiable as the psychosis happens immediate to the event and resolves with appropriate treatment. In this lies a

[117] Gluckman argues that circumcision was primarily undergone out of self-interest. Custom thereby *"guides customary modes of behaviour"* and these were *"validated by mystical beliefs"*. Individuals acting out of self-interest choose to act into custom and establish relationships that sustain that social arena (1956, p 14). Despite diverse and conflicting relationships, a circumcised man will act to sustain the 'social order' because it is in his interest to do so. His discussion suggests a pragmatism and resilience in personal psychology.

possibility that certain youth may have a spiritual crisis, possibly related to their becoming traditional healers. In respect of more general stress-related illness, considerable anxiety and stress may exist for those youth who are more emotionally sensitive or have identity and sexuality crises[118]. However, circumcision must be significantly stressful for it to trigger a response such as anxiety or psychosis in vulnerable individuals. Defining stress-related triggers is difficult, as most often a lapse of time exists between this and the response, which questions whether the particular response is consequent upon the supposed trigger.

In respect of stress and mental disorder following circumcision, consideration has to be given to the fact that individual vulnerability is nested in familial and social relations that perpetuate (but may also ameliorate) stressful circumstances and anxiety in an inevitably culturally-described environment. Taking this into consideration, stressors that are relevant occur in two domains. Firstly, stressors within the practice such as anxiety about pain, wound healing or liminal experience are inherent to the rite of passage and have the potential, in those who are vulnerable, to have a more immediate and acute pathological impact; other stressors, in this respect, that exacerbate circumstances for vulnerable initiates are absent fathers, trauma, and failure in the organisation of the ritual and this affects relationships, the experience of pain, and the containment of aggression[119]. In the second domain were those psychosocial and environmental stressors that have become worse over time and now jeopardise the safety of the practice, creating stress and anxiety for youth, their families and the community. Critical amongst these were stressors related to poverty and migration, and conjointly the effects of cultural dissonance such as urbanisation and education. These stressors meant that much psychosocial stress was incremental in nature because primary support mechanisms had been eroded or violence had become instantiated in daily life.

[118] For males without emotional problems, circumcision is an extremely stressful and anxiety-provoking event. In the case of males with emotional problems, circumcision is undoubtedly an event that can precipitate an acute psychotic reaction with sudden onset. The removal of the disturbed youth from his familiar home environment with its emotional support network, and the circumcision operation itself, are undoubtedly significant factors. (Personal communication, Professor Manton Hirst, 8 March 2005).

[119] Practices such as the ritual rely on inherited offices for apprentices to be trained as surgeons, teachers, and healers. Beinart (1991), with some caution, has argued that these offices are not filled because of an increasing influence from proletarianisation and class differences within Xhosa society.

On a fundamental level, in the context of circumcision, stress and mental illness meant that anxiety arose in initiates when deviations from accepted practice occurred because each person was required to fulfil an intimate and symbolic role. This extended to wider kin and the immediate community, who needed to participate in a functional sense for manhood to be accepted (van Vuuren and de Jongh, 1999). It is when these primary conditions cannot be met in circumcision that vulnerable youths become at risk for mental illness. However, these individual cases are illustrative of deeper concerns and ruptures within the fabric of Xhosa-speaking culture, suggesting that mental health is more tenuous than it was in the past.

CHAPTER 3 – RESEARCH METHODOLOGY

3.1 Introduction

The purpose of the study was to investigate the links between stress, circumcision and mental illness in Xhosa speaking patients presenting at Valkenberg Hospital. Qualitative research methodology was employed to provide rich, descriptive data. The study had the intention of promoting informed psychiatric practice to better understand the presentation of behavioural disturbance when this was related to a culturally defined stress factor such as circumcision. Improved referral procedures and better treatment for initiates suffering from mental health sequelae was the intended outcome.

3.2 Research Design

3.2.1 A personal stance in the research

Qualitative methodology belongs within my disciplinary home, anthropology, and has become a crucial part of my clinical work in medicine and in primary health care[120]. Miller and Crabtree (1998) describe having the same affinity with these disciplines with their research being driven by their social science backgrounds and their clinically applied anthropology in a primary health care setting.

Some reflections on my own role in the research are salient. I was trained in anthropology and psychology in Britain and came to South Africa in 1995. In my training there was always a sense that I was to be an anthropologist within Africa because I was born in Zimbabwe and had grown up amongst autochthons or original African people. This shared intimacy despite cultural or ethnic difference means that anthropologists have an ethical obligation to reflect on and defend the rights and beliefs of those people. In so doing they examine their own sometimes uncomfortable but implicit assumptions. In many senses though I have found that as an anthropologist I am intellectually rooted in British anthropology and more familiar with that genre and a relative newcomer in this respect in South Africa. I have,

[120] Powdermaker states, *"A scientific discussion of field work method should include considerable detail about the observer, the role he plays, his personality and other relevant facts concerning his position and functioning in the society studied"* (Powdermaker in Golde, 1986, p 2).

however, worked in the medical field here, and feel I have been assimilated into this intellectual domain. What this reflects for me personally is that I have experienced varied degrees of cultural dissonance in South Africa. There are similarities and differences here with both my experience in Zimbabwe and in Britain.

I feel comfortable claiming ethnographic expertise amongst Xhosa people in Cape Town as I previously spent six months carrying out research in Gugulethu in 1989. This was with Dr. Ramphele's project on Children in Crossroads and at a very difficult time in South African history. This study has incorporated that fieldwork experience with a wealth of background knowledge and data from my doctoral fieldwork. The data represents selected material from my journals which record both fieldwork experiences. I have however, sought to not culturally and geographically describe Xhosa people as confined to previously pre-determined areas within the city. Rather the ethnographic field has consisted of the areas in which most Xhosa people; in particular the five subjects and diverse health care practitioners live and work daily. I therefore did not define the subjects' experience in hospital as culturally separate to their home life. Ethnographic data resulted from my research in the hospital, work with colleagues who agreed to discuss these issues and many visits to Gugulethu and Khayelitsha to meet the subjects, my friends and visit clinics. Ethnographically a significant limitation was that I was unable to live in Xhosa-speaking cultural areas and I relied on an interpreter to understand what was said.

I therefore have a personal sense of being a participant observer in this South African ethnographic field, yet, for this postgraduate research I have not left the field. Anthropologists, to gain objectivity and a new perspective, usually leave their field of study to reflect upon and analyse the data. As this has not happened it may have compromised my ability to be objectively analytical and therefore to generalise. There are, however, substantial benefits gained from having lived in Cape Town[121]. First amongst these is familiarity with people and events such as circumcision. As a local cultural practice, this now seems a more ordinary part of life, yet the rite of passage still inspires a sense of awe. I realise that I am privileged to witness this deeply embedded and valued autochthonous practice. Despite this familiarity a

[121] The discourse about circumcision is pervasive within a local context but this inevitably crosses diverse cultures within a cosmopolitan city. The practice, however, is largely limited to Xhosa-speaking people. However, some white, coloured and Jewish men have been circumcised.

significant problem has been the distance that exists between me and most Xhosa-speaking respondents in the study. Socio-economic and political factors continue to widen the gap that exists through language difference, ethnic diversity, but more importantly race, class (often represented as inequity) and gender.

Other compensating factors derived from remaining in the field have included my being able to participate in an emerging democracy where cultural diversity is protected by the South African Constitution. Authenticity and rigour have come from my now prolonged contact with local culture and the health system. This has allowed a constant evaluation of my own and others' perspectives on circumcision and its related issues. Clinical experience as an anthropologist in multi-disciplinary teams in psychiatry and general medicine has also given me privileged insights and invaluable information. From the discipline of biomedicine I have learnt the value of using complementary methodologies, interpretive practices, and research strategies that are required to validate evidence in a medical forum (Patton, 1990; Denzin and Lincoln, 1998). To some extent this has meant that the descriptive value afforded by anthropology has been subordinated to a medical paradigm and evidence based medicine.

Although my work is based in medicine, I have never, nor could I, lose my role and practice as an anthropologist. My official status and how I am perceived by others is as a medical anthropologist. This has substantially informed much of my lived experience and thinking, especially in my work in the Faculty of Health Sciences, University of Cape Town. From my apprenticeship in the disciplines of anthropology and psychology and all of the above I have learned a sense of knowing about what is relevant, how to understand the field, and how to engage to develop the nature of the research. My clinical work has been observational and my research has run alongside this.

Diverse problems have come out of this close association and engagement, challenging my work and research, and at times it was difficult to separate the study from work-related insights[122]. In this and other respects I have learnt that what is

[122] This refers to my work on the wards in Valkenberg Hospital where the majority of nurses are male and Xhosa-speaking. Once the topic of the study was known they interacted with me differently and I observed them more closely and was cautious (for ethical reasons) in how I engaged with them. Thus,

most important and very hard is sustaining ethnographic research. This requires a faithful, long-standing application by the anthropologist to being an observer, recorder, interpreter, facilitator, and often an advocate[123]. This intellectual endeavour structures the accumulating data and emerging theory and this averts a sense of being overly immersed in the field (Golde, 1986). These issues and the following discussion represent common problems for the anthropologist in ethnographic research.

These circumstances for an anthropologist – as a trained observer – have meant that I have to be self-aware and conscious of my different roles; recognising when I need an observational gaze for my research. Otherwise a danger is that psychologically and indeed in social interaction, I fluctuate from being too personally involved to being overly observational or too aware of the socio-cultural implications of the broader project. One illustration of this was that I was recently confronted, when supervising a project in genetics, with the issue of what happens to initiates who suffer from haemophilia? I had never considered this issue and found myself at risk of pursuing my own research agenda with the informants.

Another aspect of being in the field and inevitably coming to value and rely on research subjects and others is over-involvement. Having a sense of emotional distance from the subject matter is thus a related and complex matter. All the current study subjects were psychotic, possibly dangerous, and very vulnerable, yet the most significant data was collected during their psychiatric admission. It was here that they shared their stories and inner world with me; partly because they needed help. It was therefore difficult to detach myself and be objective about their suffering and circumstances. Golde describes this as an anthropologist being aware of their obligation in reciprocal relationships. The anthropologist comes to feel an unconscious sense of wanting to give back to the people she is studying (1986, p 10). This differs from a sense of ethical obligation as it is rooted in feeling and emotional interaction. When reflected upon this may be of therapeutic value to the

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my research inevitably came to dominate most of my working life there, informing my perspective for the study.

[123] As a qualitative researcher I know that if I remain in the process and am engaged, the search will inevitably reveal subtle layers of information and knowledge - data. From this data, patterns and relationships will emerge, some of which I may have anticipated from previous information and reading. Most of the data develops from listening, watching, and analyzing and this reveals patterns of social interaction that can be interrogated. Eventually these inform the discourse and study.

anthropologist and engage him or her in advocacy work on the subject's behalf. The reverse can also happen, where anthropologists are rejected or thwarted and leave the field angry and disillusioned.

My apprenticeship in ethnographic and participant observation research developed my personal stance as an anthropologist. This places an obligation to take professional responsibility for my having gained access to this field. My immersion in it will leave behind social and political effects for which I am responsible. In this study, my gender, ethnic status, and class have brought uncomfortable and difficult moments including ethical challenge to my right to enter a discourse that held taboos against women and non-Xhosa-speaking people. My privileged access[124] through biomedical culture to young circumcised men remains an issue for debate. My voice, as a woman's, joins those of other women, and most importantly Xhosa-speaking women who are aware of the taboos and silences in circumcision but seek to appropriately address the concerns that arise.

My femininity, as a culturally acquired gender characteristic was, however, critical to some of my success in the research and the long-term strategy. To provide some insight into this, my Xhosa is poor, but my inability in the language and feminine stance protected me in many senses because I heard and learnt what I was allowed to through my interpreter. However, once the study subject could speak English he was fully able to communicate with me and it was entirely at his discretion what he chose to share with me. At this point what he disclosed was contextual to our ethical agreement in his informed consent. If the limitations of the study speak to this, my stance as researcher has always been to respect the traditions that I bore witness to and to place them into an appropriate discourse. I learnt through this to be silent, when not to say things or repeat information and to sit quietly with eyes downcast and respectful. My justification for this research strategy is that qualitative research is a process of interpretation[125] as is any encounter in the clinical field.

[124] Read Ethics for considerations about the ethical implications around my access to circumcision practices through patients who were mentally unwell.

[125] Stake (1998) states, *"In being ever reflective, the researcher is committed to pondering the impressions, deliberating recollections and records"* (Stake, 1998, p 99). Stake thereby argues that the researcher must have interpretive and observational skills and must be reflective. This entails that he or she is meticulous in collecting data and records, and from these seeks to find deeper levels of meaning.

My role as a mother, especially of two sons who are now in their thirties, as a wife, and then later as a divorced single parent have also inevitably brought a style of interrogation and influenced my perspective in the data collection process. In this my stance as researcher has always followed a personal desire for equality amongst all people and Mouton's recommendation for participatory research that it be, *"authentic involvement; equality in research roles, accountability to, responsibility for and empowerment of the social actors involved"* (1990, p 402).

3.2.2 The rationale

The intention was to use qualitative research methodology, in particular that from anthropology e.g. ethnography and observation to investigate cases where young Xhosa-speaking males had suffered severe mental illness within one year of being circumcised. The rationale was to interrogate each subject's mental illness history in conjunction with their cultural background and circumcision. This entailed accumulating data that was worthy through anthropological methods that probed for embedded meaning in Xhosa-speaking circumcision and separately in biomedical culture. Some anthropological assumptions about Xhosa family, language and kinship were taken as a conceptual framework to guide the research.

In respect of the rationale the value of qualitative methodology in the biomedical context needs to be elucidated. Biomedical research has tended to prefer quantitative methodologies and descriptive and inferential statistical evidence. Qualitative research has thus been described as compromised by researcher subjectivity, as data is more anecdotal and descriptive (Patton, 1990; Denzin and Lincoln, 1998; Campo, 2006). Miller and Crabtree explain that within biomedical research, *"the notion of small size, purposeful, or information-rich sampling strikes them as anecdotal and not trustworthy"* (1998, p 302). In comparison qualitative researchers place a high priority on information-rich knowledge because it informs them about human being interaction and conduct. Anthropology more recently has been described as offering, *"Conceptual frameworks, substantive knowledge and methodological insights"* (Lambert and McKevitt, 2002, p 2091). Negative aspects in this field include that it can be intuitive, has less intentionality, is cumulative and often framed or filtered by the researcher before it has been reviewed by a wider audience. This begs the

question of when generalising of the data begins[126]. This then has implications about its authenticity and reliability[127].

The study design required information-rich sampling; however, the challenge was to ensure that data was relevant in anthropology but equally to medicine. The methodology had to be rigorous enough for the data to yield information that potentially could promote better and more informed care-giving practices and pathways to care for Xhosa-speaking youth. A discourse on the strength of qualitative methods e.g. narratives, focus groups and case studies has grown over the past decade in the biomedical field (Lambert and McKevitt, 2002). A necessity to better understand patients, patterns of disease, and the promotion of health and prevention of illness appears to have instigated this change. Qualitative research remains useful within selected fields and specific research strategies that require in-depth insight into phenomena. Launer recommends that in psychiatry for instance, narrative research should be used to give a wide interpretation of patient stories and doctor-patient interaction[128]. Anthropological skills have also been used to interrogate biomedical research methodologies and culture (Launer, 1999; Lambert and McKevitt, 2002; Lehoux et al, 2006)[129].

The rationale requires that anecdotal evidence[130] will have added value over and above that from finding the total number of newly initiated men presenting to hospitals with mental illness. In validating the intrinsic value of anecdotal evidence,

[126] A number of problems occur in the generalising of data in qualitative research. If the researcher starts making assumptions about data too early, the issue arises of whether he or she potentially excludes valuable evidence. Another is that given the role of observer as researcher, even if data is collected and left unexamined, how can appropriate generalisations be made when evidence is subjective and anecdotal? The relative value of evidence is then at issue as, seemingly, such evidence should remain as a unique or infrequent event or circumstance. Alternatively, nothing may suggest that being typical or unique; it is so in other events and circumstances.

[127] Authenticity and reliability are at issue because most stories are reported, often by another person, and may be idiosyncratic. Moreover, a patient, especially if mentally ill does not necessarily give reliable evidence. The report as testimony may therefore be worthy as a case history but not in general terms. In comparison, it is worthwhile to find out that one event has statistical relevance across a group, as this evidence has potential benefit to many.

[128] Launer (1999) states that qualitative research and a narrative approach is of special importance in mental health care because psychiatry, in terms of the medical field, is peculiarly culture bound and cases have cultural relevance; requires meaning that has sociological, religious and political inference and the discipline has its own complex and conceptual language.

[129] Anthropologists following in the footsteps of doctors who have turned to medical anthropology such as Kleinman and Helman increasingly work in clinical, research and ethical teams in health system settings where they evaluate and assess information.

[130] Cases provide anecdotal evidence and this is difficult to generalise from. Generalising was necessary for uniformity and confirmation of the cultural information and to establish general themes about mental illness and circumcision.

Campo (2006) describes its capacity to generate creativity, describe, and question depth and relevance. It is also an indicator for further enquiry. Campo therefore argues that it stands at the "*intersection of science and language"*, which is where he places medicine and clinical skills. In this regard Miller and Crabtree (1998) argue that this skill belongs to the qualitative researcher and the clinician who both require a keen, but learnt sense of knowing to deduce evidence. *"Knowing"* Reason argues is a skill that intuitively guides a trained researcher to sense what is unique, or has *"typicality"* and what can then be generalised. Reason refers to this as *"critical subjectivity"* that *"rests on the high-quality, critical, self-aware, discriminating, and informed judgments of the co-researchers"* (1998, p 267). Knowing gives anecdotal evidence authenticity and reliability but this is anchored in experience, skill, and intuition gained through apprenticeship.

One important consideration for anthropologists is that good ethnography demands complete immersion for a year at least in fieldwork. This *"renders the world strange"*, enabling the anthropologist to take a more objective view on the human relations that he or she is witnessing and journaling[131]. Spending time in the field is essential because, as Denzin and Lincoln's state, *"to study the particular is to study the general because he or she must be studied as a single instance of more universal social experiences and social processes"* (1998, p xiv). This statement only holds true when the researcher has been in the field for long enough to be able to distinguish the particular from the general[132]. This teaches the researcher to understand the subtle and important nuances in the socio-cultural environment, reducing bias and inaccuracies. Unlike quantitative research, qualitative methodology needs to thoroughly and repetitively interrogate the field, the participants, and the data that has arisen.

[131] Good fieldwork in anthropology lasts for a year and should be amongst people who have a different culture. Fieldwork in this study took two years to complete, to get the minimum number of men for the sample. Observations occupied much of the time in between and were invaluable in elaborating each case. Time spent in the field is essential and when duration is compromised the research must provide other methods to probe data to a sufficient level and depth. Without this the data quality remains superficial and a summarised version of what is really happening on the ground.

[132] Qualitative methodology has been used in rapid and strategic research, termed *"rapid reconnaissance"* (Patton, 1990). Its advantage is that the researcher can enter the field quickly and strategically investigate the relevant emerging phenomena. My personal experience of developed world researchers conducting this as 'parachute research' in the field at a health systems research station in the Limpopo Province, South Africa is that it is often intrusive and insensitive to local culture.

3.2.3 Clinical case studies

The core of this qualitative study is the case histories[133]. Case researchers, Stake argues, look for what is common and what is particular or unique. Data is usually gathered against the following criteria:

1. *the nature of the case*
2. *its historical background*
3. *the physical setting*
4. *other contexts, including economic, political, legal, and aesthetic*
5. *other cases through which this case is recognized*
6. *those informants through whom the case can be known*

(1998, p 90)

Case-based research facilitates the accumulation of data from a number of individuals e.g. males within this sample group. Baseline knowledge that arises from the interviews between the researcher/subject dyad is enhanced by collecting data from a number of diverse sources e.g. family, clinicians and the use of different data collection techniques. Such a process of interrogation of the data is known as triangulation and comparison and intends to question, support or preclude data, thus ensuring validity (Stake, 1998). Stake describes triangulation as *"a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretations"* (1998, p97). Flick notes, and this is relevant to the subject matter of circumcision and mental illness, that triangulation *"serves to clarify meaning by identifying different ways the phenomenon is being seen"* (Flick in Stake, 1998, p 97).

Participant observation was particularly important in *"identifying different ways the phenomenon"* or clinical case was understood. Miller and Crabtree (1998) argue for the use of participant observation because it augments the case study, revealing different levels or domains of knowledge that might otherwise have been ignored. Through observation the researcher learns intuitively about the patient's cultural

[133] Case studies cross anthropological and medical research methodology. The following comments are self evident but a useful explanation. Case studies were fundamental to the research design. As clinical evidence cases sit comfortably in the biomedical field, adding validity and rigour to the qualitative methodology and data set but are equally useful in social science based research where the narrative has relevance (Miller and Crabtree; Stake, 1998). The case, as an example, facilitates an understanding of that particular person and illuminates associated issues. As such the case itself may add value in its typicality but is also open to being part of a sample group (Miller and Crabtree, 1998).

orientation in his mannerisms and attitudes. However, as an observer, he or she also watches the clinical encounter and has knowledge of the doctor's clinical perspective. Data capture must reflect the complex nature of this interaction and its related information.

Participant observation means noting what is said and done in the clinical context whilst being aware that the patient is rooted into a culturally defined ordinary world in which you as observer will become involved. The case-based methodology thereby had to consider that inherent in each case study were conflicting worldviews. Each subject was nested in two critical domains, that of a biomedical world which included his manifest psychosis, behaviour in the clinical setting and feelings about his illness; and that of his circumcision and initiation to manhood[134]. These contrasting and exclusive worldviews and their subject matter and taboos meant that the one potentially precluded any investigation of the other. In ordinary circumstances both circumcision and mental illness are taboo subjects and discussing them brings stigma and shame.

3.2.4 Ethnomethodology

A central problem with *"case studies"* in the context of more ethnographic and phenomenological methodology is that of necessity the case study early on defines the data set. This constrains and restricts the nature of the data and its collection. Although the study relied on case studies they are almost an antithetical method for an anthropologist who should seek to see the world from a frog's eye view and to intrude as little as possible into the world that is being viewed. Even techniques such as triangulation inevitably filter the data, which is of concern in a classical anthropological method where the essence of the encounter, the phenomenology of the experience, is crucial.

An anthropologist in the ethnographic field allows all available information to emerge and, with minimal interference, faithfully records his or her observations. It is acknowledged that some material will remain unexamined but reflected upon in relation to the known literature and gathering databank. Having left the fieldwork

[134] Swartz and Drennan (2000) discuss how language and cultural differences between clients and health practitioners in South Africa have affected access to health care services and for Swartz and Drennan to mental health care.

locality, the data is analysed and it is only then that themes and correspondences are defined as they emerge from the data set. This period is vital as the anthropologist employs his or her own philosophical and social science insight (which is grounded in the literature) in conjunction with discussions in the field to delineate critical themes. This process is called triangulation and for a study to have validity this technique should have been used to design the research methods. These complex qualitative techniques have been greatly undervalued in a *"scientific"* dismissal of qualitative research and anecdotal evidence.

Triangulation is a *"method… to check and establish validity"* in qualitative data in terms of it accurately reflecting the real situation and worthy in terms of evidence (Guion, 2002)[135]. In designing the study the technique was used to elicit themes, correlations and differences in the data for them to be worthy evidence. This was done through the use of *"methodological triangulation"*, which established a base line of validity across the data sets through using different methodologies e.g. case studies and participant observations. In addition to this the use of different fieldwork sites afforded *"environmental triangulation"* to compare information, themes and data. Thereby, information gathered on circumcision customs in the Western Cape was compared and contrasted with that from the Eastern Cape. In the analysis phase *"data triangulation"* begins a process of consciously working through the relationships within the data. Thus, data from interviews is compared with that from focus groups and this information contrasted with that from observations in the field. Finally, *"theory triangulation"* in the form of supervisions and consultations with other professionals helped to define and synthesise the material.

These case studies as life histories lay within a broader research context that encompassed the two previously mentioned domains – the psychiatric one and a Xhosa-speaking cultural one. Ethnomethodology was therefore used as a research strategy to give a holistic interpretation of the men's lives. Insight into their sense of belonging as men within a Xhosa-speaking world was considered against that of their unwanted, marginal experience of being mentally ill. Patton argues, and this is

[135] Guion (2007) describes 5 types of triangulation: data, investigator, theory, methodological and environmental. Investigator triangulation was not used, as doctoral research requires a single investigator.

applicable, that ethnomethodology[136] interrogates, *"How…people make sense of their everyday activities so as to behave in socially acceptable ways"* (1990, p 73). The method seeks to understand when and how group members feel and unconsciously know that they belong within that group or culture. For this reason it is rooted into phenomenology and asks, *"What is the structure and essence of experience of this phenomenon for these people?"* (Patton, 1990, p 69).

The method was used to structure the accumulation of data from the local or ethnographic field in which the case studies and research were situated. A phenomenological approach allowed the rich anthropological and ethnographic detail and insights that were observed to be recorded over the entire duration of the study and across the geographical field. This included gathering data from the wider field such as community events, rituals[137], field trips to rural hospitals and clinics. This methodology made the naïve[138] assumption that Xhosa-speaking people share a core essence; that there is something essential in their culture and custom that coalesces in circumcision. Their experience of this is a mutually shared one, and my experience and witnessing of their stories allowed me to represent elements of that experience (Patton, 1990).

To mitigate the negative and constraining effect of the case study approach, this method was employed as an ethnographic technique during interviews with patients. Patients were encouraged to speak for themselves uninterrupted, and their psychotic content was taken as relevant and meaningful[139]. This intended to convey a phenomenological portrayal of the patient's condition (Kockelmans, 1987). Johnson's comment on this approach is that it is *"deductive, engaging in a constant dialectic of data collection and analysis which are done concurrently"* (1987, p 287). This avoids

[136] Denzin and Lincoln (1998) describe that ethnomethodology uses phenomenology, interviews and interpretive practices to gather data on how human beings construct and give meaning to their actions in social situations. This technique is usually carried out in a local culture or context where researchers are able to explore ideologies and stereotypes to understand how they are used. The strength of this is that it allows for an understanding of a situation but recognises the inevitability of social and personal change.

[137] During the research I was invited to Mr. Mangesi's coming out party as a friend of their family.

[138] This assumption was verified by the literature. However, phenomenology argues for a naïve description of things as they are and a detachment from references in the past.

[139] 'Meaningful' applies in a phenomenological context where everything he said was understood to have value to the researcher. This is an anthropological and not a biomedical position. This also took into consideration that I, as part of my doctoral degree, would interpret and analyse the material to find the themes and information that had most relevance for my thesis.

some of the preconceived ideas and formulation of clinical history notes which have a more linear and highly filtered, or categorical, medical aspect.

Ethnomethodology thereby informed case studies, but in tandem other strategies such as interpretive practices were used to explore themes that emerged (Holstein and Gubrium, 1998; Stake, 1998; Miller and Crabtree, 1998). All data, as it naturally arose, was therefore relevant in a knowledge gaining process. The field of enquiry takes into consideration that the researcher has to be flexible and must move from an intimate interview with a subject who is reliant on trust into the wider group using a multi-method approach. This, Miller and Crabtree argue, means that the researcher can respond to environmental circumstances and allow for and instigate repeated cycles of data collection, interpretation, and interrogation in a cumulative, testing, reflective process[140].

In concluding this section, Miller and Crabtree encourage a mixing and matching of research methods in a multi-method approach. They advocate for a multi-method approach to bring change in biomedical culture and practices through changing *"consciousness in the medical setting by changing the language and the paradigm that physicians now use"* (1998, p xxi). This is of value to this study which addresses improved referral practices and mental health care for initiates. Miller and Crabtree argue that, *"qualitative clinical researchers must move from behind their walls, engage the clinical experience and its questions, and practice humility and fidelity within a community of discourse at the walls"* (1998, p 309).

3.3 Setting

The setting was Valkenberg Psychiatric Hospital situated in Observatory, Cape Town. The cases were all initially collected from the closed male admission wards. They were then followed up in the surrounding largely black, low socio-economic areas of Cape Town, namely Langa, Khayelitsha, Atlantis, Gugulethu and Milnerton.

The setting, in qualitative research, has particular significance as it describes the geographical location and situational context of the fieldwork. Holstein and

[140] Patton (1990) says that inductive and deductive analysis should occur during data collection.

Gubrium's argument is that, *"all knowledge is always local, situated in a local culture, and embedded in organizational sites"* and it is this that the researcher wants to capture (1998, p xvii). Qualitative researchers also often place more emphasis on cultural rather than geographical boundaries and these may extend beyond the original setting. The study thereby delineated Xhosa-speaking people in Cape Town and by dint of this the setting at times extended to the Eastern Cape. In the urban setting, Xhosa-speaking culture bore the impact of Western urban culture, modernity and the influence of diverse other cultures. This differed substantially to the values inherent in a more traditional, rural Eastern Cape setting. The setting needs to be open to interrogation and as Patton insists *"getting close to the data"* means engaging in the setting and getting one's hands dirty (1990, p 48).

In this respect fieldwork in the different domains, the hospital, the clinics and the community, had challenging and sometimes dangerous aspects and yet were often facilitative and welcoming. A psychiatric institution requires vigilance and preparedness to avoid confrontations with patients who may be violent. The townships surrounding Cape Town have been hedged with taboos defending cultural differences that partly exist naturally but were enforced by apartheid policy. Whilst most areas were safe, discussing issues such as circumcision or mental illness required caution and consideration. I was a stranger in most settings asking to discuss issues that were taboo. Golde states, *"The stranger is threatening on two counts; first, she is strange, unknown, different, unprepared for; and second, she can neither be relied upon to behave in familiar ways nor trusted to respect people's needs and feelings."* (1986, p 7)

Interviews in the community were conducted in the men's homes or in the street outside. This setting had both positive and negative value. For instance the setting could have compromised the men, given the sensitive nature of our questions (into mental illness and circumcision practices). In most cases it allowed people to feel more comfortable and engage less formally than in the clinical setting. These community settings also allowed us to observe the men's interaction with their family and others. This was most relevant in gaining some understanding of how mentally well they were. Depth of information was greatly enhanced when we were able to build up a relationship that allowed us to have sustained and frequent visits in their

home. Some of these community interviews had, however, in consideration of confidentiality, to be carried out by Mr. Mangesi and two other interpreters on their own. Whilst this meant that I had to rely on reported data rather than first hand information this was often the only appropriate way to enter the setting.

It is important to note that the setting that was most successful for follow-up was the outpatients department, a clinical setting within Valkenberg Hospital and another in the tertiary Groote Schuur Hospital. Here, of their own volition, Ayenda and Xolile chose to engage in lengthy interviews over many successive months. This setting offered them some anonymity, therapeutic care and some safety. On occasions it brought back memories of their admissions but this neither deterred them from returning nor affected their recovery. These interviews were very successful both in terms of convenience and content. Being able to rely on regular, scheduled meetings at a particular time helped the data gathering process. However, this did compromise my being able to observe each man in their familiar setting and to gain a more anthropological insight into their person and relationships.

3.4 Sample

Patton states, *"sample size depends on what you want to know, the purpose of the inquiry, what is at stake, what will be useful, what will have credibility , and what can be done with available time and resources"* (1990, p 184). He argues that the sample size must fit the purpose of the study providing information-richness which reflects the observational and analytical quality of the researcher, but the strategy and final comment must be justifiable under peer review.

The nature of and number in the sample group was driven by two factors:

a) Clinical cases presenting at Valkenberg Hospital admission ward.
b) The qualitative but more importantly anthropological enquiry.

The intention was to find all cases amongst Xhosa-speaking men that presented with psychotic illness within one year of their circumcision. Any case that presented to Valkenberg Hospital had relevance. The study set a limit of between five to ten cases. This meant that at the lower limit the sample group had sufficient relevance for the

phenomenon to be worthy of interrogation. At the upper limit maintaining methodological rigour in a qualitative investigation would have proved difficult.

The anthropological methodology asked for data from individuals in order for the collective wisdom about the custom and any related illness to be explored. Two elements were vital. Firstly, the process had to allow for much of the data to arise of its own accord, with the researcher taking an observational and non-directive stance. Secondly, it was not the sample group per se, but each individual who was critical. His life story was invaluable evidence as were his links into his community. He provided the clues that gave insight into customary practices and beliefs. Thereby, how each man felt about stress and pain in circumcision was important, but the purpose of the study was to find out if there was a culturally based idiom surrounding circumcision, pain, and stress. This then would be compared to other idioms around events such as childbirth.

3.4.1 Inclusion and Exclusion Criteria

Patton (1990) argues that these criteria require judgment and negotiation in a qualitative design. Inclusion criteria primarily required that men were admitted to Valkenberg Hospital with psychosis within one year of their circumcision. This period was extended in Ayenda's case as his psychotic event happened just outside of this period. This did not prejudice the study findings. Unathi presented for his first admission to a psychiatric ward in the Eastern Cape but on all accounts met the other factors for inclusion. His case enriched a comparative anthropological enquiry.

In the study men had to be first language Xhosa-speakers and to have undergone circumcision within that cultural tradition. Both parents did not have to be Xhosa-speaking. This takes into account that there are important ethnic similarities and differences across African people. Diversity in the custom and practice, and rigour in the study design required that an exclusion factor be put in place to delineate one language group and cultural practice.

Age was another important inclusion criterion, and initially set at between sixteen to twenty-five years. However, Ayenda presented at twenty-six years old and on all other criteria should have been included. Two aspects were then found that changed

the age for inclusion. The first was that many young men at present are paying for themselves and undergoing circumcision in their mid to late twenties. Family and personal instability is a factor in this as many prioritise work over traditional custom. An elder also explained that in the past men only went after thirty as this was the age of manhood and taking responsibility for self and a family of procreation.

An exclusion factor was if the psychosis was in the context of a medical illness, and HIV dementia was a case in point.

3.4.2 Selection Process

My early participation in the closed male psychiatric wards was the best kind of pilot study as it informed the selection process and subsequent data collection. Observations over this period led to formulating a study design for the selection of case studies in the clinical context.

Once permission had been granted by the hospital to carry out the research, I had general access to the wards. As part of the study procedure and to facilitate the selection process I informed health professional staff about the study and asked for their assistance in recruiting possible subjects. The hospital interpreter who became my first study interpreter recruited most prospective subjects. I then interviewed them and their carers for inclusion in the study until I was sure that they were suitable or not. Ongoing interviews and observations on the ward rounds helped to obtain their informed consent, bolster the data collection process, and recruit them into a study that required long-term, follow-up procedures.

In terms of recruitment, my work on the ward on a regular basis meant that I was aware of patients who might be likely candidates. Nurses also often informed me if they thought someone might be suitable. Psychiatric consultants and registrars tended to confirm information rather than refer subjects. On one occasion a medical student significantly assisted the selection process. This broad based selection process meant that at least nineteen other patients were interviewed to see if they were suitable and one extensively followed up in his community setting. He was later excluded from the study.

The study initially sought referrals of admissions from psychiatrists. This proved not feasible in a hospital setting where access to cultural information is most often through the nursing staff. The selection process was made more difficult because of poor communication. Cross cultural communication in a developing world psychiatric setting is problematic, as culture-specific information is sometimes hidden. Language deficits exacerbate this divide. Communication across disciplines – especially the nurse-doctor interface – hinders the sharing and passing on of relevant information, especially to an outside researcher. The fact that this divide often mirrors the cultural one adds another complication.

Two particular problems arose in relation to the selection process and my access to patients. The first problem was that my research question required co-operation from the Xhosa-speaking staff in order to get access to patients, medical information, and circumcision practices. These staff sometimes thwarted the recruitment and selection procedure because of their cultural beliefs about circumcision. The second was getting medical practitioners and consultants to assist in the selection procedure. This required that registrars on admission of a patient asked one question on circumcision and initiation alongside the demographic information for patient admission, and that I then be informed immediately of that man's condition and relevance to my study. This procedure, at this level of the system, never succeeded.

3.4.3 Total Number of Participants

Five males aged between eighteen to twenty-six years of age who had been admitted to the psychiatric ward and who met the study criteria formed the sample group. Their cases included their cultural demographic histories and a DSM IV[141] clinical assessment. Where feasible a subsequent psychiatric review was carried out. In the community it was neither feasible nor ethical to bring clinical staff and assessment techniques into this setting. The sample group was followed up for longer than a six month period.

[141] American Psychiatric Association. (2000) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR Psychiatry)*. Fourth Edition. Arlington: American Psychiatric Association.

3.5 Method and Instrumentation

3.5.1 Case Studies

Five case studies, as the minimum number, were suggested in the original proposal and these were collected. These cases fulfilled a number of criteria. As examples they were illustrative of the psychiatric and cultural phenomenon and this inferred their relevance across that community. As Patton (1990) argues, the case study method focuses primarily on each individual's story and less on the correlations between the case studies. This meant the research followed through each life history and psychiatric outcome. This was important because all cases were selected on the basis of their psychiatric admission but it was difficult to predict their psychiatric outcome. The cultural factors in circumcision appeared to influence each individual case study and its outcome. The case study method also meant that stereotyping of this Xhosa-speaking cultural group was avoided, as each case bore its own testimony to the ritual and its practice. However, the correlations between their stories about their circumcision validated their participation in the study. Each case thereby was representative but the case study method allowed for an expression of diversity in personal circumstances, beliefs, and practices.

The five cases were subjected to a rigorous in-depth interviewing process. This placed each individual's experience of his illness and initiation into the context of his family, cultural background and mental illness history. Patient records formed a critical aspect to each case history as they provided relevant information on demography, life events, and mental illness history. These were all valuable logs against which new information could be compared and when relevant, confirmed.

3.5.2 Interviews and Participant Observations

Once cases had been identified, a process of semi-structured interviewing and participant observation began. This process had to respond to the circumstance, mental health and availability of each subject. Other family members and friends were also interviewed if permission had been given by the subject or his guardian. Interviews, focus groups, and meetings outside of the case study relied on access and a verbal, informed consent process.

Interpretation, in conjunction with the interpretive method within the qualitative methodology was critical to the success of each interview. Firstly, a Xhosa-speaking male interpreter was needed for all first and many subsequent interviews. The interpreter needed to be male, first language Xhosa-speaking and circumcised. This provided equal interaction between the interpreter and respondent in terms of their status as men and the interpreter being able to comprehend more subtle inferences and innuendos. The interviewing process had to rely on the interpreter's assessment of two aspects. The first was the man's mental health and the second the success of his circumcision and seclusion. Interpretation then became part of the interpretive qualitative methodology. Elaborating on this, Patton (1990) suggests that the interpretive nature of qualitative research begins with the study protocol, which itself is an interpretation of the issues and "the problem". This interpretation then becomes the driving force behind the study design and data collection, and each phase is interpretive of the next.

Janesick (1998) points out that it is not the unstructured, conversational nature of an interview that provides qualitative information, but the interpretive process that guides and informs the discourse within the interview. In the study, the strength of a three-way conversation between the subject, the interpreter and me was key in gaining a qualitative insight into the lives of the men, the symbols and imagery they used, their feelings, beliefs and hopes. When the interpreter and I were comfortable it was easy to probe into deeper aspects of the phenomena under investigation and a process of unravelling and revealing began, which took into account that meaning was often layered by psychotic imagery and then lucidity.

This three-way interpretive process employs Patton's (1990) recommendation that interviews should draw out the inner perspectives of the man in a manner that allows the researcher to enter his world. To facilitate this process a set of questions were used to gather information against a cluster of known phenomena. My role was to insert these into the interview. An informal conversational style was used and this allowed the interpreter and me to go through familial greeting patterns. Our intention was then to talk with the subject and respond to him so that once the issue of circumcision arose it could be comfortably developed. This lay very much with the interpreter who needed to allow information to emerge in whatever direction he chose.

My purpose was to probe areas of interest and pursue that line of discussion, bearing in mind that the interpreter had to frame the questions to fit comfortably into his conversation with the subject.

The strength of the conversational interview is that the interviewer can be highly responsive, individualised, and has in-depth conversations. It is particularly successful where interviewing takes place with the same person over time, or within the same setting. The weakness is that it is open to interviewer effects and in this study, interpreter effects. Over time the original set of questions had questions added that had arisen from interviews with other subjects.

Flexibility in qualitative research is argued for by Janesick (1998) and this is apt in a study where admissions and psychotic patients were both unpredictable; study interviews were erratic, lengthy, interrupted and time consuming. Thus, notes were made during the session and this was possible because the subject was often talking in Xhosa with the interviewer, who would then translate the relevant information. Because of these delays, participant observation was possible. Observation is a crucial clinical skill in working with people who are mentally ill and very important in assessing the men's state of mind and wellness in the study. The interviewing process, attitudes, gestures, and behaviour were also recorded. No interviews were tape-recorded as consent is problematic for this procedure in a cross-cultural psychiatric setting. Tape recorders can alarm a patient and potentially bias the interview. Notes were elaborated on and added to immediately after the interview when the interpreter was debriefed, and then again when I had reflected on the session.

3.5.3 Key informant interviews

The same interviewing process applied to all study interviews. One group of key informant interviews was selected against the cases. When family members were interviewed the subject's achievement of growth milestones in childhood, and the family's perceptions around circumcision and mental illness were explored. This was sensitive information and difficult, either because the man had been through circumcision and this was not appropriate to discuss, or in other cases family were unavailable. When possible, questions were asked about the subject's circumcision

and seclusion to determine if the initiation procedures were adhered to. These questions were asked with caution so as not to reveal confidential information about the man's mental health status or that he had inappropriately disclosed information about his ritual process. Questions were also asked about the man's peer group to see if his process was in any way intrinsically different from other contemporary groups.

A second group of formal and informal key informant interviews took place with Xhosa-speaking elders, traditional healers, teachers and men aged forty to fifty years in different settings. I had anticipated that these issues would be hard to explore, but the converse was true, and often it was older men who were most vociferous about their feelings about circumcision. One limitation in getting these was that many men were unavailable from June to September each year, and again in December to January when circumcision takes place.

A third group was targeted within the biomedical establishment. The purpose here was to interrogate their knowledge of circumcision practices and how they thought this related to mental illness or wellness. Interviews and discussions with specialist and non-specialist staff in Valkenberg Hospital and clinics in Khayelitsha and Gugulethu were conducted. Most of these interviews were more straight forward and conducted in English without an interpreter present. All key informant interviews intended to probe a local arena for local knowledge either about Xhosa-speaking custom or the psychiatric services and health system. An explicit intention was to sensitise the medical profession to the phenomenon and its medical and social implications.

3.6 Data Collection

The data collection[142] required visiting the hospital at least once a week to see all male admissions within the prescribed age category. Xhosa-speaking male nurses were asked to find out once per day if any patients might be suitable for the study. Dr. Soga, as a Xhosa-speaking admissions registrar was also asked to help with recruitment. Although admissions were expected to come from Valkenberg Hospital it had to be taken into consideration that some relevant admissions might have been to

[142] The discussion on the data collection contains information from and acknowledges the contribution from my supervision sessions with Professor Robertson during my development of the study design.

the emergency psychiatric admissions ward at Groote Schuur Hospital who were not transferred to Valkenberg Hospital.

Once a possible case had been identified, informed consent was a critical part of the procedure as was the man's psychiatric assessment and diagnosis. It was necessary to work quickly to recruit the subject and at the same time determine whether he was indeed suffering from a mental or medical illness that might preclude him from the study. His medical folder or clinical records were therefore a crucial part of the data collection as they showed the diagnosis and detailed the patient's illness history whilst on the ward. Working with a psychiatric registrar during data collection was important in this respect and more so when he or she remained involved with the case. This aided the reassessment of the original diagnosis. In general the psychiatric assessment was done by the registrar and his diagnosis confirmed by the consultant. The subject would then be interviewed until his life story was revealed. Once his circumcision was confirmed, a process of negotiation with him and collaboration with all staff brought him into the study.

When a man had been recruited into the study, consideration was given to two aspects in his follow-up interviews. These aspects directed future data collection. These were, firstly to record his recovery process or alternatively his relapse as data on his psychiatric outcome. Secondly, to explore circumcision practices in his case study and in a broader Xhosa-speaking society. The fact that all the subjects had been mentally ill influenced or biased the data in the second category. Another factor that influenced this data was age. Circumcision is a trans-generational interaction and age defines the critical limits in which a man is to be circumcised, but also those boys and youth who can attend, against those generations who are to take responsibility for different stages in the ritual. It was therefore important to interrogate each subject to find out if this trans-generational interaction had happened successfully in his circumcision. Yet, interviews about this or with other men, because they breached the confidentiality within the circumcision potentially biased the data. Another factor of concern was that my age and Mr. Mangesi's and his status as a circumcised man, may have affected the power and social dynamics when collecting data from the men, their families, male elders, and clinicians.

As an anthropologist it was important for me to observe and then discuss the patient's condition with a psychiatrist and Professor Robertson and Professor Hirst acted as my supervisors. The consequent use of DSMIV (American Psychiatric Association, 4th Edition, 1994) psychiatric categories did not intend for study purposes to label or define the man in any manner. The study intention was to find out about each man's life story as part of an interpretive process. Separately, I had to learn about the psychiatric clinical arena where insight was essential to the study question.

Collecting case-based data over the duration of the study meant tracking the subject's account of his circumcision experience. In each interview he was asked to recall his experience and how well he felt during his circumcision to corroborate existing data and elaborate on it. Finding out about how he understood stress, remembered and recalled it during circumcision, and then at the time of interview was important to assessing his state of mind during that vulnerable period. In later interviews my work in the clinical arena enabled my having some naïve interpretation of his mental state. There is a corollary to a methodology where a subject's recovery is tracked over time. This is that the research and clinical interventions over this period may affect how he relates to his circumcision and the role that it played in his illness. This is particularly true for Xolile as Dr. Soga intentionally incorporated his circumcision into his therapy. This may have influenced how he remembered and related to his psychotic episode.

Relevant questions[143] were used in each individual case and repetitively after the first interview. This measured truthfulness of response and changing perceptions and built reliability and validity into the data. More questions were developed against each case and then added to over time. For instance the question, *"Did you have any dreams or visions in the bush?"* had been used in interviews on the wards with Xhosa-speaking male patients who had psychotic imagery, memories or delusions about their initiation period prior to the study. This question was repeatedly used in a sequence of interviews. Then it was adapted to include whether the man had remembered his psychotic experience, hallucinations and visions and when he first remembered these.

[143] See Questions Appendix 3.6.

In asking these questions it was important to find out how mental illness featured in decisions and coping functions around the event and ritual procedure. In terms of discourse, I and others in the health system were obviously aware that circumcision came up in different ways during patient care in mental illness episodes, but the issue was, could the reverse be true – was mental illness considered in the custom and practice? Thereby, another set of questions arose as to how we framed circumcision in Western biomedical practices and clinical care. From this came the issue of how these men and Xhosa culture may frame hospital experiences? Furthermore, the ritual shares many similarities with the phenomenological and experiential seclusion for mental illness. How men compared both experiences, having been in both in such a short time frame was critical.

Despite my regular screening it was very difficult to find cases. Once a case was found, it became necessary to follow up immediately on any health professional staff who knew his case and to talk to members of his family or his friends. Poor communication was a persistent problem, and because the patient was psychotic and vulnerable, he and I both relied on his social network to find out about his life. Follow up in the community was even more difficult, because of access in such a poor and often chaotic social and geographic landscape. The interviews therefore had to happen immediately a man left hospital and this meant that in most cases they were still significantly disturbed.

A problem with data collection in qualitative research is that it struggles to find its own cut off point for recruitment. By the end of the first year of data collection there were insufficient cases and information to develop a thesis. In extending the data collection for a longer period, Professor Robertson and I also considered if it was not necessary to find cases by broadening the criteria and sites in which subjects could be recruited. At one stage it was felt that I should extend the study to hospitals in the Eastern Cape. At this stage visits were made to all local community clinics in the relevant recruitment area and to the emergency psychiatric admissions ward to find out if they knew of any potential cases that would meet the study criteria. These proved fruitless as local nursing staff felt it was unheard of, or recalled only one or two known cases where mental illness coincided with circumcision. It was felt that

any admission would be an emergency one and families would take a mentally ill man very quickly into a hospital where he could be secluded until he was well.

Over the following year more people within Valkenberg Hospital knew about the study and informed me about possible subjects and the sample was completed. Once fieldwork was completed some time was spent looking through the medical folders of patients to see if any possible subjects had been missed. My conclusion was that all possible subjects presenting to Valkenberg Hospital during the study period were recruited into the study.

3.7 Data Analysis

There are no rules for the interpretation of qualitative data as each data set is unique to the researcher and research subject matter (Patton, 1990). However, increasingly in the field of medicine new strategies such as thematic analysis and computer-based analysis programmes have developed new strategies to correlate, define, and assess data. These can include the researcher's subjective experience of the data set, its collection and fieldwork experience through their selecting relevant themes or words to frame the analysis. Despite this, the criticism remains that it is difficult to duplicate a qualitative researcher's data or the analytical procedure; validity and reliability is therefore at issue.

To facilitate the analysis of qualitative data, Miller and Crabtree (1998) have drawn up an organisational system to guide analysts so that they get the best outcome from their data. Defining and analysing the data set is the first critical step. This happens through a process of immersion or crystallisation where data is collapsed together and then developed into an organised system through *"segmenting the data, and making connections"* (1998, p 302). They suggest that the method of analysis should be determined by a scale where at the structural or more quantitative end of the scale a *"detailed codebook is used in quasi-statistical analysis"*. This results in themes and subsets being coded and numerically ordered so that the exact number of references to a particular subject can be validated and described. At the qualitative end is the phenomenological approach which is descriptive. They argue that this gives a good *"translation"* for clinicians who tend to find the results from qualitative research less

worthy than those from quantitative methodologies and more confusing (Miller and Crabtree, 1998, p 302).

3.7.1 The organising system

The organising system for my analysis of data did not include a detailed codebook, rather as an anthropologist I relied on an ethnographic technique of repeatedly reading the collected data and redefining categories and themes as they emerged[144]. Once themes and categories had been established, the data from the subjects and other interviews were collated and ordered into this analytical framework.

The widest and most significant category was the cases. In collating this material for analysis, each case was organised to contain the original data collected from interviews in the hospital and later data collected in the community setting. Clinical and demographic notes were added to these, as was up-to-date clinical information from the men's hospital files at the end of the data collection[145]. A case study history was then written up for each subject. This collated all the most significant aspects of the interviewing, collateral and records. During this process themes were highlighted and recorded in word processing documents. Case studies were written up in the language that the interpreter had used in his translation to keep them as metaphorically close to the original conversation as possible. Miller and Crabtree argue that it is important that data be written *"into the texts of that discourse"* (1998, p183).

In addition to this data set, key note interviews with the subject's family or friends who were important to him were collated as a subset. With separate subsets for the community information and biomedical interviews and ward round notes. Some data remained in my field journals and key themes were coded. This second set of data from focus groups, key informant interviews, newspaper articles, lectures attended and field trips underwent a similar organisational procedure. The importance of this second set was that it was used to validate and contrast the subjects' experiences and stories. This data added to the more general information and was more phenomenological.

[144] See Results 01 and Results 02 in Appendix 3.7 and 3.8.
[145] The men's medical files were re-examined to check if they had any further admissions and to correlate data.

3.7.2 Segmenting the data and making connections

The study was a descriptive one and as such lies more at the intuitive and information rich end of the scale described by Crabtree and Miller. In segmenting data and making connections as the analyst, I was required to immerse myself in reading and reflecting on all the data. This meant a phenomenological engagement with the content where the meaning of metaphor and nuances was revealed. This acknowledges Schutz's contribution that researcher subjectivity is critical in explaining how study subjects experienced, produced and made meaning from their social reality (Schutz in Denzin and Lincoln, 1998, p 138).

Themes were drawn out, coded and checked and the data again segmented as part of an interpretive process. Patton describes themes as structuring and segmenting the data, creating sets and subsets of information with relevant connections (Patton, 1990). Themes represent the knowledge sets that begin to coalesce around certain topics, individuals or events during the interrogation of the data. Some themes are self evident and some serve to highlight emerging themes. These contrast and compare with, or may even contradict existing themes. When themes converge then patterns can be discerned in the data set (Patton, 1990). These are far broader trends within the data and may represent converging themes. Patterns within the data can describe knowledge systems or stand as testimony to a particular cultural practice, e.g. circumcision is a pattern that draws other themes into its rationale.

The rationale behind the collation of themes and patterns is, as Miller and Crabtree describe, a *"specific analysis filter through which the text material is perceived"* (1998, p 303). The study had existing perceptual filters in circumcision practices and mental health, yet needed to maintain an ethnomethodological stance. Undoubtedly these filters defined the data, framing certain themes and to some extent circumscribing the ethnography. Miller and Crabtree, however, allow for the fact that data analysis is a longitudinal process developing over time and that its nature may change.

Another factor to consider in the process of discerning themes and patterns is that singular idiosyncratic events, particular words or symbols or indeed a person may

emerge as a distinctive or unique event or anecdotal occurrence. Because of their unique quality, these need to be noted and their meaning investigated. Thereby, the Xhosa word describing penis or blanket in the text is marked and its connecting themes analysed, particularly as it stands as a definitive symbol in circumcision. Its use must be noted whenever it occurs but its exact description must also be explained.

In making connections the data underwent two more phases of re-organisation or segmentation. A second phase took all the key themes and collated them into documents recording the data against some of the themes. This developed a discussion or story with different perspectives against each theme. In another phase the case studies were once again examined and the final and more detailed studies written. This met Professor Hirst's recommendation that it was the case studies that were central to the thesis.

In respect of language, it is important to add that the data analysis embodied a process of reducing the material and language into concepts that were explicable in English. The original and rooted meaning of words and language in their original Xhosa dialect has therefore been somewhat compromised by the interpretive and analytical process. However, as with all interpretation this conveys a message which needs to be read, negotiated, and mediated and this validates this compromise. In these terms the thesis has been written more for a medical than an anthropological audience. Patton argues that, *"For scholarly enquiry, the qualitative synthesis is a way to build theory through induction and interpretation."* (1990, p 425)

Miller and Crabtree suggest that, *"when the analysis nears completion, the research process shifts to decisions about telling the story"* (1998, p 305). Qualitative research must do this and more, if the value of anecdotal evidence is to be understood as scientifically and socially worthy. Unlike quantitative research which seeks to be definitive, the strength of qualitative analysis is its ability to look at the broader field and to delineate key factors, themes, patterns and stories. What has appeared to be anecdotal evidence is then open to investigation or to be described in narrative. Furthermore, what is conveyed is the complexity of human interaction and drama within its local context. An honest rendition of the thesis means that the researcher, as a qualified observer and narrator, then positions him- or herself to enter the discussion

in developing the thesis. The philosophical and scientific structure of the analysis in qualitative research also means that the real depth of insight and broad academic and intellectual stance open it to multi-disciplinary enquiry[146].

3.8 Ethical Considerations

This section explicates the ethical procedures that were carried out in this interdisciplinary research project. Seven focus areas will be described below.

3.8.1 Procedural requirements

The study protocol with ethical considerations was accepted by the Postgraduate Programmes Committee, Faculty of Health Sciences (FHS), University of Cape Town (UCT) on the 4th April 2001 and passed by the Research Ethics Committee (REC)[147]. Permission was obtained from the Valkenberg Hospital superintendent and the Head of Day Hospital for the Cape Town Metropolitan area, to collect data from patients[148]. The protocol was presented and defended at the Department of Psychiatry research protocol meeting (March 2003). In November 2002, a revision was accepted by the Research Ethics Committee for the inclusion of retrospective data from patient records[149]. In respect of ethics and my academic background, I sit as an anthropologist on the Research Ethics Committee (FHS) – where I excused myself during consideration of my protocol. I also sit on the Bioethics Committee and have lectured on the IRENSA programme[150].

[146] A central feature of this study has been that analyzing the data has been a continuing development of themes and definitions during the writing of the thesis. The thesis has shifted from a more anthropological description to a more evidence based study in psychiatry. In a sense writing (especially for an anthropologist) requires describing and relating interconnected relevant themes. The task in writing for a medical audience is to distil evidence that is core for the thesis through defining key factors that have relevance in the medical context. This process has to be undertaken with supervision and means that data analysis becomes emergent rather than definitive at a point in time.

[147] See appendix 4.

[148] See appendix 4.

[149] See appendix 3.1.

[150] International Research Ethics Network for Southern Africa (IRENSA): Diploma in International Research Ethics. September 2003-2007. The University of Cape Town Centre for Bioethics received a grant from the Fogarty International Centre of the US National Institutes of Health to support bioethics education in South Africa and neighbouring countries.

3.8.2 Compliance with Guidelines

Guidelines that had particular relevance, and were complied with, are the World Medical Association (WMA) Declaration of Helsinki, October 2000[151], the National Health Act 61 of 2003[152], the Mental Health Act of 2002, and the Children's Bill [B70 – 2003 Reintroduced]. Compliance with the Faculty of Health Sciences Research Ethics Committee protocols was observed.

As an anthropologist, I observed The (WMA) Declaration of Helsinki (October 2000)[153] because the research was based in the medical field where study subjects were patients. The declaration was originated with the intention of guiding, *"physicians and other participants in medical research involving human subjects"* (WMA Declaration of Helsinki), thereby protecting their rights. Due consideration was given to the fact that the five subjects were patients – their personal and medical details remain protected by the medical ethic of patient confidentiality. *"Freely given informed consent, preferably in writing"* was obtained with the assistance of a Xhosa-speaking interpreter[154]. Copies of written informed consent were retained[155] (Declaration of Helsinki 2000, pt 22). Consideration was given to the fact, that the material gathered was of a sensitive nature in terms of its cultural, gendered, legal, medical, and political implications.

The research complied with the WMA Declaration of Helsinki[156] in ensuring that the rights of the five subjects, who were transiently incapacitated, were protected. In

[151] 52nd WMA General Assembly, Edinburgh, Scotland, October 2000
Note of Clarification on Paragraph 29 added by the WMA General Assembly, Washington 2002
Note of Clarification on Paragraph 30 added by the WMA General Assembly, Tokyo 2004.

[152] The National Health Act, 2003, revised regulations 23 February 2007. This act re-iterates regulations for research ethics set down in the Declaration of Helsinki. Of interest, is that any form of health research which involves human subjects must be managed and conducted by a suitably qualified principal investigator. The investigator should have extensive experience in the field of health research, and be a resident of South Africa (Chap 1. 2c)

[153] The WMA Declaration of Helsinki (October 2000) states that subjects must be adequately informed of the study's aims, methods, sources of funding, conflict of interest, institutional affiliations of the researcher, anticipated benefits and potential hazards, the discomforts entailed, the right to abstain and the freedom to withdraw consent.

[154] All patients received ongoing psychiatric care in multi-disciplinary teams in which I was often involved. Their capacity to comprehend the informed consent process was therefore part of an ongoing discussion within the ward. Subjects had to make their own judgment about agreeing or refusing to participate.

[155] A copy of the written consent was placed in the subject's hospital folder.

[156] WMA Declaration of Helsinki (October 2000), Paragraph B. 24) states, *"For a research subject who is legally incompetent, physically or mentally incapable of giving consent or is a legally incompetent minor, the investigator must obtain informed consent from the legally authorized representative in accordance with applicable law. These groups should not be included in research*

respect of recruiting minors, the protocol set the study population age, at sixteen to twenty-five years[157]. As the law at the time, provided that minority ended at twenty one years of age[158], two patients who were minors gave their assent. Approval was asked from their parents or legal guardians for them to be included in the study. This complied with the National Health Act 2003[159], in that adolescents are required to give their assent prior to the parents' informed consent.[160] This procedure was followed for Xolile and Unathi – and their written consent obtained.[161] The National Health Act 2003[162] was adhered to, ensuring no harm to any subject.[163]

The research adhered to legislation that protected the cultural practices of these Xhosa-speaking male subjects. This took into consideration Marshall's (2006) critical assessment that, *"Although sensitivity to cultural context is emphasized in international guidelines…investigators working with diverse populations throughout the world face myriad challenges"* (Marshall, 2006, p 25). The law as defined in The Children's Bill[164] has regulated that male circumcision, as a cultural practice, has the potential to cause harm.[165] Circumcision of male children for, "cultural reasons" is

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unless the research is necessary to promote the health of the population represented and this research cannot instead be performed on legally competent persons".

[157] Few youths are circumcised in this culture at sixteen.

[158] 2nd July 2007 an amendment to Children's Bill has changed the age of majority to eighteen years.

[159] The National Health Act, 2003 states that 'non-therapeutic research' means any research not directed towards the benefit of the individual but rather towards improving scientific knowledge or technical application.

[160] International Conference on Harmonization (ICH) / WHO Good Clinical Practice standards. Revised 2000.

[161] The National Health Act, 2003 states that vulnerable persons means those whose willingness to volunteer in a research study may be unduly influenced by the expectation of benefits associated with participation.

[162] The National Health Act, 2003 states that minimal risk means the probability or magnitude of harm or discomfort anticipated in the research is not greater in itself than that ordinarily encountered in daily life

[163] In terms of the Guardianship Act 192 of 1993.

[164] Children's Bill Article (2.2.1) Circumcision of male children as a ccultural, religious and social practice that has the potential to harm children has been regulated.

[165] Children's Bill Article. Progress Update (13th March 2006) states in respect of girls and circumcision;

(2.2.1) Cultural, religious and social practices that have the potential to harm children have been prohibited or regulated.

Female genital mutilation and female circumcision

Traditional leaders protested against the prohibition against female genital mutilation, but the NCOP upheld the prohibition. A definition of Female Genital Mutilation (FGM) has been added which makes it clear that FGM includes circumcision and that such practices are prohibited. A definition of circumcision of female children was inserted to clarify that circumcision means the removal of the clitoris.

Virginity Testing

The NA banned virginity testing. The NCOP re-opened the debate and heard a number of submissions on the topic. They proposed a compromise by introducing an age threshold. The practice is now prohibited if the girl is under the age of 16 years. For girls over 16 years, the testing can only be

therefore restricted to youths over the age of sixteen years. Youth may be circumcised with their consent and after counselling. This regulates the practice, and secures their right to cultural practices, as set down in the South African Constitution[166]. An amendment to the Children's Bill states that, *"medical and religious circumcision"* can be allowed at any age, but *"cultural circumcision"* is prohibited below the age of sixteen[167]. In interviewing the subjects, circumcision practices were acknowledged – as a *"rite of passage for Xhosa speaking people who as indigenous Africans respect kinship and their ancestors"*.

In terms of compliance with anthropological ethical statements[168] the MRC Ethical Guidelines (1993) comment that, no *"best practice"* for ethical conduct has been formulated for social science research. Social science research is generally subject to approval by the institutional REC. Academically, an anthropologist is taught to have an ethical responsibility to the communal and cultural or ethnographic context of the study. Like the physician, he or she, must be accountable to her academic and collegial relationships. The anthropologist, however, has an obligation to be analytical and to pursue knowledge, through retaining a critical and individual stance. This critical stance includes evaluation of all ethical discourse and conduct. Furthermore, the anthropologist should be concerned about rights to intellectual freedom – and this in the context of their protection of human rights. Hastrup and Elsass (1990) offer the perspective that, objectivity is impossible for the anthropologist saying, *"there is no way in which the anthropologist can claim to be*

performed after counselling, in private, and with consent of the child. The results may not be publicly disclosed, and the child must not be marked. Regulations will prescribe the conditions under which the procedure can be carried out.

[166] **South African Constitution: Bill of Rights** (see previous Footnote No.49).

[167] WHO Human Rights (2002) publication states, *"effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children"* shall be taken.

[168] MRC Ethical Guidelines 1993. 3.1.1 Medical ethics

Ethics is the science of criteria, norms and values for human action and conduct. It is engaged in reflection and analysis of morals concerning whether an act is good or bad and how it influences our basic quest for meaning, our search for humanity and our attempt to create a humane society. Its intention is to safeguard human dignity and to promote justice, equality, truth and trust. In a nutshell, ethics is critical reflection on morality.

Medical ethics is not only about the moral behaviour of clinicians, but about ethics and health care. It can be described as the reflection on moral actions within the framework of health care. Its objective is to promote health, to care, to heal, to alleviate pain and to prevent suffering.

Ethics for health research is the enterprise that determines norms and values to guide the systematic reflection and scientific evaluation or assessment of clinical knowledge and any form of experimentation or survey, with the prime objective of promoting health care. Its sole intent is to benefit patients, to alleviate pain and to prevent suffering.

outside the material; subject and object merge in a world of 'betweeness'" (Tedlock in Hastrup and Elsass, 1990, p 302).

3.8.3 Informed Consent

Informed consent was taken from all subjects, and ethically carried out with the necessary information supplied and there was no coercion[169]. In meeting Campbell et al's (2001) recommendation that consent is *"about being informed"*, and not *"about the signing of the consent form"*, each Xhosa male patient/subject was engaged in a decision-making process for him to choose to participate. Kottow emphasises a pragmatic negotiation for consent where, *"informed consent continues to be a desirable goal, but pragmatic reasoning stresses the circumstantial difficulties of fully respecting autonomy in clinical situations"* (2004, p 565). The imperfect nature of the consent process, particularly with psychiatric patients who were emotional and unstable, was thus met. This recognises that their participation has inestimable value – but that perfect understanding was not required. No harm was ensured in the informed consent process, as questions were asked to establish that the subject had been fully informed. Permission to visit the subject's home was requested and assurance given that these visits would maintain the confidential nature of the research.

3.8.4 Competence

The MRC Ethics in health research guidelines (1993) states, *"consent must be given by someone who is legally and factually capable of consenting"*. As the competency of all subjects was at issue, a number of measures were put in place to protect their ethical and legal rights. The primary measure to ensure this was that their informed consent procedure was made comprehensible to them by employing a Xhosa-speaking interpreter[170]. The interpreter was first language Xhosa by birth, circumcised and had some training in interpretation.

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[169] Section 12(2c) of the Constitution of South Africa Act, No 108 of 1996, states: *"Everyone has the right to bodily and psychological integrity, which includes the right…not to be subjected to medical or scientific experiments without their informed consent"*. MRC Ethics in health research, updated Feb 2006. The wording is identical to that used in the United Nations Covenant on Civil and Political Rights (1966).

[170] An example of the male nurse's cultural competency in framing the original consent form is described in the following commentary. He acknowledged that *"amongst the Xhosa's this is a male dominated custom"*. The more subtle aspect of this was his reassurance that we would be *"confidential in our relations and dealings with you and your family"*. He included that *"mental preparation should*

Competency depends on autonomy; however, this may be compromised when a subject's understanding is limited[171]. This potentially happened for two reasons. Firstly, Campbell et al argue and this has relevance that, *"a psychiatric patient's actions do not fit the pattern of personality and self-regarding interests that constitute autonomy"* (2001, p 159)[172]. Secondly, the subjects' language may have limited their competency to understand this complex interdisciplinary research. Facilitating subject competency entailed asking a psychiatric nurse to assist in the preparation of the informed consent.[173] He translated the document into Xhosa and back into English to ensure it was correct. This made what was implicit in language and culture, explicit[174]. This took into consideration Campbell et al's (2001) recommendation that *"all explanations must be in non-technical and readily understood language"* (Campbell et al, 2001, p 223). The inclusion of an interpreter and format of the consent and interview process intended to engender trust in the researcher/subject/interpreter relationship. Trust relations[175] enhance competency and these were also evident in our undertaking to keep all information confidential and the subjects' identity anonymous. This protected their rights in respect of mental illness, stigma and cultural taboo.

Each subject was only included in the study on the basis of a psychiatric DSMIV (American Psychiatric Association, 4th Edition, 1994) diagnosis from a psychiatric consultant. Their informed participation happened when it was agreed that they were competent to understand what was being asked of them. The decision to take

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be done before because there is circumcision anxiety or fear of the unknown and the boy should be told of the expectations".

[171] Fitzgerald et al, argue that *"measures are needed to assess the autonomy of study participants to give consent freely in the context of severe poverty, sex inequality, and little access to basic health care"* (2002, p 1302).

[172] In the study, these circumcised men's sense of personhood, identity, and new sense of self-regard was potentially fragile and this required sensitivity. Of further interest in this respect is that very little evidence or literature exists, in the South African context for successful culturally based psychotherapy with Xhosa-speaking patients, particularly where circumcision may be a traumatic aspect. I relied on Professor Manton Hirst who has worked extensively as a psychologist in the health services in the Eastern Cape for advice. The men themselves sought the help of traditional healers for therapy.

[173] See Interviews with Health Professionals in Appendix 3.3 and 3.4.

[174] The Xhosa-speaking male nurse helped me to understand some of the cultural and ethical dilemmas that I faced in the research process. He clearly defined what taboo was and how it should be respected. Our ethical conduct intended to promote respect and aid in the development of subject competency. Explanations were gone through carefully, so that when he was well, he could choose to be in the study or not (Campbell et al, 2001).

[175] Campbell et al stress, *"the special level of responsibility that attaches to psychiatric care because of the inherent and exaggerated vulnerability of the psychologically disturbed person"* (2001, p 163).

informed consent was discussed with the psychiatric consultant[176] and nurses on the ward. This process happened over a number of interviews and this allowed the man to become familiar with us. This ensured that despite their transient incapacity their autonomy as, *"status as a person, with the power to decide and act in his or her own best interests"* was acknowledged (Campbell et al, 2001, p 12)[177]. Particular attention was paid to any potential threat to their competency and autonomy (Kottow, 2004). Campbell et al (2001) for instance argue that people suffering from mental illness because they are tainted are treated differently in clinical environments and this causes them to react problematically[178].

3.8.5 Taking informed consent

All interviews were carried out with the psychiatric consultant being informed. Verbal consent was taken from all the subjects[179]. In taking consent, the interpreter read the information in Xhosa – explaining as necessary[180]. This took considerable time, as we allowed time for the subject to consider our request and discuss it with his family. In this period some patients relapsed, and the process had to be re-started. In this qualitative study the informed consent process extended into the community where interviews and focus groups happened. In respect of this, all participants e.g. family, community members, were informed of the process and their consent asked for and given.

[176] WMA Declaration of Helsinki (October 2000, Paragraph B. 15) states, *"Medical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given consent"*.

[177] Loss of autonomy means that the boundaries protecting a person socially, legally and politically are compromised. Guardianship is one means to re-institute those boundaries when a person's self-rule may be in question. Autonomy in psychiatric patients is of particular concern as their personality and identity maybe confused and there is a sense that they lose their personhood. In comparison children are seen as having capacity but are not capable of autonomous action, as they are not capable of self-rule. Minors may also be seen as lesser persons and this can be problematic. Competency is therefore part of the requirement for autonomy, and this is an age-related requirement. Autonomy is affirmed when a person has constitutionally attained his or her majority. The ages for autonomous consent vary, as majority can be achieved before this through marriage or for women through childbirth.

[178] Campbell et al (2001) explain that people suffering from mental illness have intrapersonal difficulties, as in identity issues, and interpersonal as in social problems.

[179] See written consent documents in Appendix 3.3 and 3.4.

[180] The chapter on Ethics uses the word *"interpreter"* and not the name of the interpreter. This is because it is the function that is being referred to in a generic and theoretical sense. Elsewhere the name of the interpreter, who on most occasions was Mr. Mangesi, is used.

The benefit of having an interpreter in the informed consent process is elucidated by Campbell et al (2001), who recommend having a third party to provide information, ensure understanding and obtain consent. In this process, quality and depth of information is enhanced. Furthermore, as the researcher I was able to observe the patient's reactions, adding to the authenticity of the data. In a study on levels of comprehension, Fitzgerald et al (2002) found that including an interpreter was beneficial in improving comprehension. Interpreters also reduced intimidation from authority figures, as subjects were more willing to participate, but equally felt they could decline.

3.8.6 Risk and potential benefit

All subjects whilst in hospital were vulnerable because they were psychotic and detained. Once they returned home, their mental illness and circumcision made them vulnerable to being stigmatised in their community. However, stigma could have arisen if it was known that they were participating in the study. This was of concern given that most of the research had to be carried out in the community. My ethical position placed me with an obligation to collect ethnographic material and to act in the patient's best interest. In this respect, I am a woman, *"white"*, and *"European"*[181] and I was working in an area of culture, Xhosa-speaking circumcision, where there were explicit taboos against women entering the discourse[182]. Of relevance, was that my work and research in a medical institution had provided me with access to privileged information on these men.

Medical and intellectual discourse had secured the boundaries that legitimated my investigation of this cultural space and yet, this brought problems of misrepresentation. This was critical in that, in the clinical domain these Xhosa subjects lost their cultural voice and authority, as their, *"traditional structure of*

[181] To maintain confidentiality I had to rely on Mr. Mangesi to carry out the interviews and follow up in the community. I only went into someone's home or tried to interview them when I was personally invited and when Mr. Mangesi felt it appropriate. I also did not intrude on conversation that I felt might compromise the man in respect of secret aspects in the initiation. I strictly observed that I could only know what a woman and a non Xhosa-speaking woman could know. I clearly stated that it was my intention to understand the course of their illness in the context of their experience.

[182] A privileged position meant not bringing harm through being inappropriately intrusive. However, the circumcision taboo requires that women do not ask questions about it. The counter to my not becoming involved in this discourse, is that my position on the ward was not different to any other white female in medicine, who had to engage with patients and endeavour to be non judgmental; especially in respect of gender. Ethically, I can only be on a ward with an explicit intention and everything I witness must remain confidential to that setting.

decision making appear(ed) powerless" (Hastrup and Elsass, 1990, p 303). Thereby, to ensure that they were fairly represented, it was necessary to meet the study requirement that they be followed up after discharge. This established a sound ethnographic record of their lives that, *"rest(ed) on moral commitment and the use of knowledge"* – rather than advocacy (Hastrup and Elsass, 1990, p 302).

One ethical justification for the study was that once I joined the multi-disciplinary psychiatric ward round, I had to reflect upon, engage with, and disseminate the evidence that increasingly became available to me. By placing the information in the public domain I brought transparency and potential beneficence.[183] This position acknowledged the cultural and personal dissonance in which I was immersed. Resolving this dissonance requires reporting on and publishing the results, which is a stated ethical obligation. This provides psychiatric practice with insight into circumcision practices, reducing the potential for harm for future patients.

One potential benefit to the subjects was that – unlike many other patients – they had some access to mental health care. Of more general advantage was that the results would inform mental health service delivery. A more sympathetic and informed approach for better care for Xhosa youths and their families was another potential benefit. Cultural sensitivity which enhanced respect and justice was thus fostered in this clinical setting. The rationale for the benefit of a researcher-patient discussion on circumcision states that, if ignoring the consequences of the ritual could bring harm to the patient, then it should be discussed. Moreover, where mental harm is a consequence of a cultural rite, especially where trauma is involved, then there is a medical and ethical obligation to investigate.[184]

3.8.7 Limitations

Accessing patients in the hospital system was difficult and this, on many occasions, compromised the recruitment of subjects and the informed consent process. This meant that in the case of two subjects, verbal consent rather than written informed

[183] Paragraph B. 27. WMA Declaration of Helsinki (October 2000) states, *"In publication of the results of research, the investigators are obliged to preserve the accuracy of the results".*

[184] Transparency around cultural issues in a medical potentially reduces harm. However, in South Africa, the literature suggests that there has been little attempt in clinical arenas to communicate with patients in the context of their language, customs and beliefs (Swartz and Drennan, 2000). Recent changes to medical education at this university have sought to redress this problem.

consent was obtained. Verbal consent was acceptable as, *"situations in which the omission of consent (or proxy) is permissible are those in which totally non-invasive procedures are proposed, and the obtaining of consent would be impractical or possibly even alarming or harmful to the participants"* (Campbell et al, 2001, p 225). Employing interpreters for the consent process also meant that caution had to be exercised that they did not stigmatise subjects by reacting inappropriately or creating suspicion during follow up in the community.

Research with psychiatric patients has limitations in that the initial consent is always at risk of being withdrawn. Psychiatric patients have impaired cognitive functioning and moral reasoning and may act arbitrarily, withdrawing consent or giving it without fully realising the implications. Obtaining informed consent after a subject had been discharged was, however, very difficult. Men disappeared into their community where their silence was understandable, given the taboos around circumcision. This also meant that Professor Robertson and I, for reasons of patient confidentiality and stigma, decided against asking for interviews with the peers or teachers about circumcision.

3.9 A personal note

There are vast areas of silence that I have learnt to incorporate into my self in order not to do harm and to retain objectivity. Listening to stories about violence and injury, and witnessing acts of harm and aggression has personal consequences, all of which have enormous moral and ethical implications. In respect of this, whilst an anthropologist tries to be objective, it is not possible or ethical to allow oneself to be intellectually anaesthetised from these experiences. It has been important to engage honestly, emotionally and reflexively with issues of violence and stigma. As a person born in Africa, it is here that ethically I can stand as an advocate and offer an insightful perspective.

CHAPTER 4 – RESULTS

4.1 Introduction

The results describe the research data in respect of the demographics and case histories that is informed by other sources of data. This is followed by a description of the key themes on stress-related circumstances around Xhosa-speaking circumcision practices.

4.1.1 Demographics and case histories

A retrospective record review of patient files in Valkenberg Hospital from 1996 to 2001 revealed twenty-four cases where circumcision was cited as an issue in their illness presentation. During the period January 2001 to June 2004 twenty-seven possible subjects were interviewed on the ward as part of the study research. These patients were screened on the basis of circumcision issues being described as a feature of their psychotic episode on admission to the hospital. Five cases were included in the study and the remaining twenty-two patients excluded. Twenty subjects were excluded after their initial interviews as they did not meet the study criteria and two were followed up for some months and then excluded. Evidence is presented from five Xhosa-speaking males who were admitted to an acute psychiatric ward, Valkenberg Hospital, within approximately one year of their circumcision. Their case histories record their preparation for circumcision, psychotic episode and follow up after discharge. The demographics of the cases are described and this summarises some of the commonalities amongst them. The results report on the case histories of the five subjects and their individual life circumstances. Around each subject clusters a domain of information about their personal circumstances and this includes interviews with their family, health professional staff and community members.

4.1.2 Themes on stress

Themes about stress in circumcision that were prevalent in the cases and for Xhosa-speaking people are described. These have an inevitable focus on how stress is experienced by Xhosa men who are vulnerable for mental illness. Their experience of stress would appear to exceed the norm endured by most circumcised men.

Similarities and also the men's idiosyncrasies are thereby examined. Whilst much of the description about stress relates to the case histories, the analysis has been informed by the wider data and evidence from focus groups, interviews, and observations collected during the research process. These other sources of data are described in the following section.

4.1.3 Wider data and evidence

Other sources of data included *key informant* interviews in a Xhosa-speaking community context. Specifically these were with four young Xhosa-speaking males who had successfully completed circumcision. Interviews with a traditional surgeon's assistant and an elderly man in Khayelitsha provided other crucial information. Much data was gathered in my interaction with the four Xhosa-speaking male interpreters who assisted me. Their own experiences and observations of the subjects qualitatively informed the results. These and other informal discussions were also recorded in my journal notebooks and inform the broader analysis and discussion. In this respect, conversations with Dr. Manton Hirst were critical in adding to a depth of understanding about the practices and in refining its collection process.

Within Valkenberg Hospital key informant interviews were carried out with two consultant psychiatrists and separately with one registrar. Three senior Xhosa-speaking male nurses in Wards 15 and 16 in the hospital were interviewed. Important *participant observations* include those on ward rounds in Valkenberg Hospital over the three year period. Other information has been gleaned from observations on ward rounds in Tintswalo Hospital over a two year period and my participation in interviews and focus groups for the SANPAD mental health survey in Khayelitsha and Agincourt district (2001-2005).

Key informant interviews were complemented by data from my *participant observations* in many community, family, and health setting forums. Separate to the case histories is a set of data that draws on the perceptions of Xhosa-speaking people in the wider community. This includes information from my participation in four *multi-disciplinary workshops* held in Khayelitsha Site C clinic with nurses, doctors, medical students, and members of the community. These were discussion forums to raise community and health issues around the custom. Further data came from two

field trips to SS Gida Hospital in the Eastern Cape where I participated in their multi-disciplinary team initiatives in the local rural villages and clinics. This intended to address prevention procedures for injury and care for youths prior to and during circumcision. During this time two formal interviews with the nurse in charge of the prevention strategy, one with a traditional surgeon's assistant, and two with the nurses had particular relevance.

4.2 Demographics

Table 1.1 Case Studies – Admissions to Valkenberg Hospital and follow up.

Subject	**Date of Admission**	**Length Admission**	**Follow-up End**
Xolile 20 years	February 2001	*(1st admission)* 43 days	March 2003
Unathi 18 years 19 years	May 2001 April 2002	*1st admission* 36 days* *2nd admission* 67 days	May 2003
Ayenda 26 years 29 years	October 2001 May 2004	*1st admission* 45 days *2nd admission* 40 days	January 2004
Lindelo 21 years	November 2002	*(1st admission)* 43 days	December 2002
Mpumi 24 years	January 2003	*(1st admission)* 7 days	June 2003

** Admission to Mount Ayliff Hospital in the Eastern Cape.*

Table 1.2 Psychiatric outcome against age of first admission

a) Schizophrenia and Bipolar Disorder.		
i.	Ayenda	26 years old[185]
ii.	Unathi	18 years old
iii.	Lindelo	21 years old
b) *Brief Psychotic Disorder*.		
i.	Xolile	20 years old[186]
ii.	Mpumi	24 years old

4.3 Commonality in the subjects

I obtained all subjects over a two-year period with follow up extending in two cases to three years. The ages of the men were from eighteen to twenty-six years of age – which places them as young men[187]. The study set the age criteria as between sixteen to twenty-five, but no subject was found less than eighteen years old. Ayenda presented with mental illness when he was twenty-six years old. All subjects were first language isiXhosa speakers and were unmarried at the time of their interviews.

All men presented with a severe psychotic breakdown and had been admitted to the closed male wards at Valkenberg Hospital. In terms of length of admission, Mpumi had by far the shortest stay in hospital but was most relevant for the study. The remaining four men had first admissions of approximately forty days. Unathi and Ayenda both had second admissions. Unathi's first diagnosis of Schizophrenia, from Mount Ayliff Hospital, was queried in his second admission. His diagnosis was changed to that of a Bipolar Disorder.

[185] Ayenda as a case study could represent a situation where circumcision forms one stressful experience in the onset of severe mental illness. Follow up in his case was more successful and carried out over a longer period of time than for Unathi and Lindelo.

[186] Xolile's case could represent a situation where a Brief Psychotic Episode occurs as a culturally related syndrome in the context of circumcision. He was interviewed over some years and this made him a more reliable subject than Mpumi.

[187] Dr. Manton Hirst states, *"Youths participate in circumcision and by passing through this they become men."* As the cultural context of these men's lives is important, the terms that are used in this study are *"youths"* for Xhosa-speaking males prior to admission (Field notes. 15 August 2006).

Within the sample group of five cases, written informed consent was taken for three subjects and verbal consent for two. Both the men who gave verbal consent declined giving written consent but agreed to being followed up. In both cases each willingly participated and meetings were sometimes on their instigation. Verbal consent was taken at each meeting to ensure that they agreed to be part of the study. Two cases, Xolile and Ayenda, were followed up for three years. This has provided considerable detail on their social lives and illness history. Both gave good accounts of their adherence to their medication. Ayenda has been the only subject known to be readmitted to Valkenberg Hospital. The remaining three subjects were constantly followed up over the two year period, but interviews with each proved to be extremely difficult. This was mostly due to their illness, cultural differences, and poverty.

Table 1.3 Date and place of circumcision against date of admission

Age circumcision	**Date Circumcision**	**Date of Admission**	**Place circumcised**
Xolile 20 years	December 2000	February 2001	Cape Town
Unathi 17 years	June 2000	May 2001 April 2002	Eastern Cape
Ayenda 24 years	June 2000	October 2001 May 2004[188]	Eastern Cape
Lindelo 21 years	June 2002	November 2002	Eastern Cape
Mpumi 24 years	December 2002	January 2003	Eastern Cape

[188] Ayenda had this second presentation after the data collection period ended.

4.4 The Case Studies

The case studies will be presented as follows:

a) Their psychotic episode augurs an onset of Schizophrenia or a Bipolar illness where the prognosis is a long-standing chronic mental illness.

   i) Ayenda 26 years old
   ii) Unathi 18 years old
   iii) Lindelo 21 years old

b) Their Brief Psychotic Episode forms part of an adolescent and cultural phenomenon and could be described as a cultural syndrome. Given an appropriate intervention this psychotic episode would resolve.

   i) Xolile 20 years old
   ii) Mpumi 24 years old

The case studies are an ethnographic description of the data from diverse sources e.g. patient files, interviews, and collateral. The format intends that cases are accessible within medical disciplines but are more narrative about what happened. Some liberty has been taken in allowing the data and, thereby, each of these men "to speak for or represent themselves". This illustrates what they found stressful in their lives. Including this information elucidates these Xhosa men's personal and cultural orientation, showing how different their lives were whilst ill in hospital. To bring authenticity to their narratives the hospital notes are left as they were written in the patient notes.

Case studies and the origin of the data are presented in the following format:

Case Study Information	**Origin of data**
On admission:	Patient folder and study interviews.
Personal and Family History:	Clinical notes and study interviews.
Prior to admission:	Study interviews.
Admission note:	Patient folder.
Interviews with the subject:	Study interviews in hospital.
Recovery:	Study interviews in recovery.

4.4.1 Case Study – Ayenda

On admission

Ayenda was a 26-year-old Xhosa-speaking male who was admitted to the closed ward in Valkenberg Hospital in October 2001 suffering from a first episode of psychosis. He had been referred in by G.F. Jooste Hospital[189] with a history of a few days of insomnia and bizarre behaviour. Prior to that history he was described as being completely well, but angry because he was discharged from work. He had been circumcised in June 2000. The admission notes stated that *"He denied using any harmful substances e.g. drugs or alcohol. He presented as a thin man of medium height who was noticeably very thin faced with narrow eyes. He appeared to be disassociated."* This was his only severe sickness. A genogram in his notes showed him as an only child. His father was wrongly recorded as having died before he was born. His mother who was sixty-five years old was living in the Eastern Cape. He was brought up there by his uncle (mother's brother).

[189] G.F. Jooste Hospital is a secondary hospital in Mitchells Plain, Cape Town.

Personal and family history

Ayenda was his mother's first child and the only child of her relationship with his father. He had three half sisters. In our interviews Ayenda claimed that he did not know his father until he was circumcised. This contradicted the evidence in his hospital notes. Ayenda's childhood was spent with his mother's family in the rural Eastern Cape (he had her clan name). His childhood was very unhappy because his mother was poverty-stricken and dependent on her family (maternal uncles) who were unkind and abusive. He often went hungry. When Ayenda was seven years old his mother left to work in a nearby town. He remained with his grandmother to whom money was sent and his mother visited once a month. He left school in Standard 6 (Grade 8)[190]. He spoke very little English.

In 1996 Ayenda left the Eastern Cape to look for a job in Cape Town. He stayed with his uncle (mother's brother) and in 1999 moved to his own house and became a driver's assistant. In June 2000 he took leave to be circumcised in the Eastern Cape. He returned immediately after to Cape Town. He described feeling well after circumcision but different, he was now *"a guy."* Soon after his return he was involved in a fight at work and discharged. This happened some months before his admission.

Of his circumcision he said that his mother had to find his father to be "in the bush" with him, as they had never married. Ayenda saved for his circumcision and his uncle (mother's older brother) took him to the bush and chose his *amakhankatha,* who was a good teacher. Evidently his uncles visited him in seclusion and the other initiates accepted him. In the party afterwards his uncle and father were there and the elders gave him instructions on how to behave. He was in the bush for four weeks.

Prior to admission

Ayenda had recently been dismissed from work for fighting. It was reported that he tried to stab a co-worker. He claimed he was innocent. On his account he "*started*

[190] Standard 6 (Grade 8) is the first year of senior school in South Africa. Children begin schooling in Grade 1 when they are 6 or 7 years old. Standards were used in the education system prior to 1994.

to become sick" whilst at the police station. He also recalled being tied with ropes before coming in to hospital.

Admission notes

The collateral described him as behaving strangely for five days. Evidently, *"he had been taking off his clothes and was running through the streets. He appeared to be hearing voices …He said he was not sleeping because his body ached. He had been attacked by a taxi driver in the last week and was afraid that 'they' were still looking for him. On physical examination he had bi-temporal wasting, wounds on his neck, wrists, and elbows and on both arms."* Different accounts were given about these injuries. One described a fight with the police, another fighting at work, and a third that he was tied-up with ropes to a taxi and pulled along the road.

Ayenda was diagnosed on Axis I of the DSM IV (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 1994) with *"schizophrenia of a disorganised type (single episode in full remission) and as depressed."* Axis II was *"deferred"* and there was *"nil"* on Axis III. On Axis IV was *"having financial stress, occupational stress with a job loss and no social support."* On Axis V his score was rated at 60-70.

He had a forty-five day admission. Six days into his admission he was *"paranoid with persecutory delusions and depressed but was making good eye contact."* He denied using any alcohol or dagga. During this time voices told him that *"he was a dog"* and he was described as *"religiose but not delusional."* His speech was reported as *"coherent"* and his *"affect was blunted"* but his *"mood was happy."* His insight was poor. He spoke about his circumcision. Within the next three days his condition severely deteriorated and over the next twelve days he remained very ill, *"screaming, urinating in his bed, paranoid and with persecutory delusions."* I met with him during this time. After twenty-one days he was reported as *"being withdrawn but denied having hallucinations or delusions."* He had side-effects from the medication. At forty-two days he was still in the closed ward and was evidently *"withdrawn and psychotic."* It was noted that *"he did not interact with others and continued to have persecutory delusions – particularly about his family being after him."* He was soon after discharged in January 2002.

Interviews with Ayenda during his admission

This account describes information from a series of consecutive interviews with Ayenda whilst he was on the ward. When first interviewed Ayenda said he was *"well but not better."* He described visions when sleeping and said he was angry. He heard voices and these wanted him to go to his father. He was surprised that his family did not visit him saying, *"they wanted him to do those things in the bush, to circumcise, but he knew he was circumcised. They were the witchcraft"*. He recalled he was circumcised the year before, on the 8th June 2000 and came out on the 4th July. He was circumcised alone. He then contradicted what he had told us before and said his father took him to circumcision, *"slaughtered a goat for him"* and collected him. During seclusion, *"there were no problems, no dreams, or hallucinations. For eight days he wore red paint and his abakhwetha clothes. Then for six months his jacket and cap and then just his cap"*.

When asked for informed consent he requested that we ask his mother and read the consent slowly. His hair had been shaved and he was neatly dressed. He then became angry and insisted that his blanket from circumcision was in front of him. His admission notes stated that "*he became disturbed and demanded his clothes from his uncle."* A week later Ayenda told us that, *"his English was better when he was in his job but weak now."* Of circumcision, he said, *"it is too difficult to explain because you are a woman. My circumcision,"* – he muttered something about *"clear thinking, afraid sometimes, not afraid now, and dreamt in school."* He then stated, *"He was a dog."* He had no obvious facial grimaces but kept repeating *"I am a dog"* then "*you are a dog."* He claimed it was better not to have voices as, *"he had no bad voices, no visions, and no dreams."* He went on, *"when he was a boy there was nothing. From when he was a man, he was starting to fight from the first day"*[191]. Eight days later it was difficult to have a conversation with him and he dribbled thick heavy saliva (a medication side effect). The patient notes described him *"as struggling to become well."* He was also aggressive.

[191] Field notes 14/11/01

Recovery

The interviews cover the period from March 2002 to February 2004 and were carried out on his request in the outpatients department at Valkenberg Hospital. A psychiatric registrar agreed to sit in to assess his condition in the period March to June 2002. She was not first language Xhosa-speaking. In June 2002 she assessed him as suffering from *"Schizophrenia which was predominantly negative with vague ideation"* he was *"not delusional. He was well enough to not need psychiatric follow-up."*

On being discharged Ayenda walked to his old employers to demand his job back but they forbade him to come near the factory. He then moved back into his own shack and his account of this was recorded in my notes as follows: *"His shack was warm, although there was no electricity and he had to fetch water. He had food with friends but did not drink (alcohol) or smoke cigarettes. The case that his employer brought against him about the fight meant he lost his job and it was difficult to get one."* He had no disability grant as his application with a referral note had not been given in to the clinic. He worried and described this as, *"my heart feels heavy – maybe, it seems life is hard. Yes,"* he said, *"I feel sad but – I comfort myself. I have no experience of tears. Life changed after I left work."* When asked if he was hearing voices, he said, *"No, just those near"* but that sometimes *"my brain gets stuck… I just think and think, till I fall asleep."* He knew he had been sick, but said he was *"now normal"*. At the end of the interview the psychiatric registrar described him as having, *"no thought disorder or hallucinations, however, he was depressed"*. She asked if he was experiencing any psychotic symptoms and he replied, *"no strange things, but I am unsure if people are trying to read my thoughts and control my body"*.

From June 2002 to March 2003 Mr. Mangesi and I met with him on several occasions and during this time his life was stable. He lived alone[192], had some friends, took his medication and over time, *"the voices disappeared"*. He had his disability grant of R1600 per month, with some back pay[193]. He tried to look for work in factories but *"has no luck now"*. When asked about his illness he replied that he would not say he

[192] He later described that he liked to live alone because he liked to control himself. When he mixed with his family he had to answer questions, which he felt he could not answer.

[193] In March 2003 Ayenda phoned to say that he wanted to see me urgently about the disability grant, which need to be renewed. We met and I explained about the letter that had been sent to him and that his disability grant finished in April. He was required to go to the government offices on the 9th April 2003. Mr. Mangesi then explained everything to him so that he would not fail to ask for a renewal.

was well, but *"going well – I am strong as a man, amandla"*. Mr. Mangesi described Ayenda's condition in the following manner, *"sick"*, he told me, was *"gula; but ucabambane was psychotic. Mental illness was iybamabane. Ukugula encompasses all sickness – and this he was not"*.

As he recovered he developed insight into his illness and realised that others knew he was mentally ill. He described how "*people who were nearby*" suspected that he was mentally ill and tried to hurt him. I asked how he protected himself and he replied *"I stay away."* He felt aggressive – as if *"someone has tried to hit me or joke about me and then I become angry"*. When asked if he had any visions or voices, he answered, *"it happens sometimes but it was not – it was a funny thing"*[194]. Mr. Mangesi asked him, *"If he felt that as he became ill after his circumcision it made him unwell*?" He gave some description of his circumcision in Xhosa and informed us that he *"would not talk about it even if there were problems"*.

By March 2003 Ayenda appeared to have recovered and was prepared to talk about circumcision. I revisited some of the events he had described when he was psychotic. One was a concern for a girlfriend and baby; however, he could not *"remember anything about a baby"*. Another issue was about two black and white blankets from circumcision. One should not have come out of seclusion but been burnt in the hut. Of the other he said, *"The father brings you another blanket to cover yourself when you go home and you keep that blanket for the rest of your life."* He remembered giving this to his aunt because *"there were people he did not like there"*. When asked how he felt about being a man, he said, *"I feel strong and nothing… I feel 100% a man… I am accepted by Xhosa-speaking men and nothing is said about me. By women, maybe yes."* I asked how he saw his future. He replied *"Before I used to work and make money…but now… there was this disturbance and illness and it was affecting him with his plans and dreams."*

After May 2003 I did not need an interpreter as Ayenda was able to communicate in English and in these later interviews this description about his circumcision emerged. He felt he was accepted after his circumcision at his work, *"I respected custom and wore my cap. I was not different amongst those who were circumcised on that date*

[194] Field notes 8/7/02

together with me." When asked if he had strange dreams in seclusion he said "*No, there were no evil things, I was not sad."* The pain he said *"was bad, in the beginning. It was then not bad"*. He described being afraid. However he recalled that he had mixed well with the other initiates. He paid R5 000 for his circumcision. I asked if he was proud that he was circumcised and he smiled uncertainly saying, *"It is not the same as when I was a boy as there is no manly authority or manliness now, this is a big difference."* When asked if he heard voices before his circumcision, he said *"No, nor did I feel sad."* I asked if he thought that he might be a healer and he replied that he did not think so, but *"I really do not know, as one cannot be a traditional healer out of the blue."* There was a traditional healer in the family – his sister who had died.

In June 2003 Ayenda claimed to hear *"no voices and did not feel or act rough or violent like I did before"*. Every day he went to the factory to look for work but did not get it because of *"those people I heard in the voices and who followed me"*. He believed he was bewitched and this began *"in October 2001 when I was from the Eastern Cape. I was a man already. Things started from when my sister got sick and was vomiting and weak. I took her to a doctor in the Eastern Cape who told me that there was nothing wrong with her. But she died within weeks, in July 2001"*. The traditional healer then gave him three herbal medicines.

About his illness Ayenda described, *"I did not know what was happening to me, but felt that I was sick in my mind and something in my body… All my body was now well, but sometimes people say that I am a person who likes to be mad. I did not like madness or being mad – it was a sickness and it was being bewitched, and it was something that was made by the witches because there was no one that can be born mad."* I asked if he had heard the word or term *"mentally unwell"*. He said *"Yes, I think so, but do not know."* I asked if he had heard the words "schizophrenia" and separately, "*psychotic"*? His reply to both was, *"No, I have never heard this word. What is the meaning of that word?"* I explained that psychotic meant hearing voices and having visions. He said, *"Oh – that was something that was happening to me."*

Ayenda also believed he could get well by himself, *"to become a part of what I was before – to be properly well"*. I asked him what would 'being well' mean to him? He

said, *"I am alive and before I was alive but not yet sometimes – something was happening to me that was not good."*[195] He wanted to be part of his family however, *"There was something that I was supposed to do, but the witches wanted to destroy that."* He was supposed to find *"lobola"* for a wife and children and have a home. In the Eastern Cape he had family, his own land and cattle.

In the November he had a job, had worked for ten days and was to renew his application for his disability grant. He decided to leave getting the grant as the medication and herbs were helping him and he had no voices. I asked him what being stressed meant to him and he said, *"It was that I liked to think so much. Stress"*, he said, *"was when you thought so much or there was frustration."* I asked if he had been stressed before his circumcision and he replied *"It is my own culture and culture was there and the culture I had to do when I was going to the circumcision. Culture – was our tradition for Xhosa people."*[196] He said, *"I was afraid, nervous, I did not know something that was happening and there were many problems there. Sometimes people did not come back from the bush, and some were taken by witches, and some became like psychotic persons."* I asked how long before going he was stressed. He said *"Not too long – it was doing it then and then passing it."* Months before however, he was stressed. I asked if he was stressed in the hut and he said *"No – not then. The circumcision was passed and I had only the pain and something before that was completed, and what the amakhankatha did stays in the hut and he uses herbs in the huts or houses."* I asked if he was afraid and he answered, *"Yes – not so much."*

Of the pain in circumcision Ayenda said, *"Pain was the whole body and I had stress for a few hours and after that you were well. The pain was less after a few days and after eight days. The stress gets less and the fear less and one feels good and with other abakhwetha and you were protected by the amakhankatha."* He explained that when he left his burning hut he was well and positive about his life. When asked exactly when he felt like a man he described *"You were given instructions at cutting and have a few words from the old men and learn the new rules and instructions and a secret language. You feel like a man at circumcision and then through that, this was reinforced and you cannot think like a boy."* Of particular interest in relation to this was his description of being covered in white clay. I asked him about the white

[195] Field notes 13/8/03
[196] Field notes 13/8/03

clay and if at any point he felt he had been through a death[197]? He answered that, *"You do not feel dead because you feel visible and this is different from invisible. You were the same like other people only the white colour but different – you were an abakhwetha."*[198]

My last meeting with him was in early January 2004. Ayenda was sitting in the waiting room talking with others instead of lying sleeping in the waiting room. He described, *"a few voices – sometimes these were worrying, and he tried to control them by himsel*f". He said he did this by *"keeping it to not be minding about that"*. Sometimes it was once a day and *"It happened like dreams and there were many voices but I was awake."* He thought it was stress that caused them but he was, *"less stressed but over the last few weeks I had had more stress and I did not know what was happening"*. He was worried about a letter from his 'brother' asking him to visit his mother who was seriously ill. He wanted to go there for a few days when he had the money.

He described a sense of feeling weaker because *"when you were a man there were many problems that face you and there were many jealousies. You have to do many things as a grown up and others, like the witches, do not want you to grow up. Because I became a man these problems came to me"*. I asked if his circumcision made him strong to face his sickness and he replied, *"Yes."* He could not explain this because *"I don't know how I can support my statement of strong in my mind... You lose the something before a boy and turn a new page to become a man. In your mind you were changing and you think like a man not like a boy."* He thought *"nothing about being sick, and there was nobody who could, because sickness happens any time and nobody can think about it"*.

Second admission

The last I heard from Ayenda was a phone call in late February 2004 in which he sounded very well and was working. I left him to contact me. In July 2005 while checking records for this thesis I discovered that he had a second admission in May 2004. He remained in hospital for seven weeks. He was diagnosed as a relapsed

[197] This question was an attempt to capture Van Gennep's association that the initiate in being covered in white clay enters his liminal period, which is a symbolic death or no-mans land.
[198] Field notes 27/11/03

schizophrenic from no obvious cause but possibly over-medicated. It was argued that his medication should be re-started.

4.4.2 Case Study – Unathi

On admission

Unathi was admitted to Valkenberg Hospital in April 2002 after being referred in from the Gugulethu Community Health Centre[199]. This was his second admission as he had been diagnosed with Schizophrenia in December 2000, at Mount Ayliff Hospital, Eastern Cape. The notes stated, *"When he was eighteen years old and still at school he was circumcised. This was in June 2000. He became ill after this in December 2000 and admitted to hospital."* Evidently *"He was well following discharge and on medication."* His family, however, described that he had a steady decline in his mental health and consequently his father brought him to Cape Town for treatment. His parents were asked for consent for an HIV test (to exclude this illness from his diagnosis).

Personal and family history

Unathi was born in the Eastern Cape in February 1983. He was the first born in a family of four children; two sisters aged sixteen and six years and a brother of thirteen. His parents were married, employed, and supportive of him. His father described his childhood development as *"normal and healthy."* He had friends and a girlfriend and did well at school, but failed one grade. His family relationships had become strained since he had been diagnosed as suffering from Schizophrenia. No one in the family was known to have had a similar illness. Although Unathi's first language was Xhosa, his father was not a *"Xhosa but a Sotho"*[200]. He went for circumcision to his mother's patrilineal line, and his father disagreed with this decision. His uncle argued that his illness could have been because of conflict between his mother and father. Evidently they had *"disagreed about him from his birth."* He was circumcised in June 2000 and this had gone well. He became ill within six months of this event.

[199] The Gugulethu Community Health Centre is a primary care community clinic in Gugulethu. This is a largely Xhosa-speaking residential area in Cape Town comprised of informal and formal housing and shacks. Although most people were disadvantaged this is one of the older more established formerly 'black' communities and is substantially more settled and comparatively wealthy.
[200] Field notes 20/10/02

Admission at Mount Ayliff – December 2000

On admission Unathi was sedated as he had visited a private doctor. His mother said he had been behaving strangely for two weeks, *"he woke early and disappeared; would not be corrected; was drinking and smoking dagga and had sudden poor personal hygiene"*. He presented as a well-dressed young male who had lost weight and had a large (but not painful) lump on his head. It was reported that *"he tended to be highly emotional, well oriented, had hallucinations about his ancestors who came at night to instruct him and he obeyed their commands. He had no insight into his illness but was said not to oppose treatment"*. Over the next month he became very ill with a period when he had akathisia[201]. He was diagnosed as having Schizophrenia twelve days into his admission and shortly after discharged. Within a few months he became aggressive and was re-admitted to hospital. He was later discharged home where his mother described him as *"having strange behaviour and constantly washing himself … changing his clothes, claiming to own a car … and running away"*. By June of the following year he had returned to school and the psychiatrist described him as having an *"organic psychosis"*.

Admission notes from folder

On admission to Valkenberg Hospital he was described as a nineteen year old Xhosa-speaking male who had recently arrived from the Eastern Cape. He was *"left handed and single. He was brought in by his father and uncle, who gave the account of his condition as he was sedated"*. Physically it was noted that he had a number of stab wounds on his right chest and left arm and more recent scratch marks on his back. He felt that *"worrying might be the cause of his illness"*. He had completed his schooling to Standard 7 (Grade 9) in 2000. He was currently unemployed, enjoyed soccer and reading. He drank and smoked. His father said he was *"a good person, quiet… loved his relatives and family and enjoyed his studies. He was not particularly clever"*.

[201] DSMIV (American Psychiatric Association, 4th Edition, 1994, p 679) neuroleptic-induced acute akathisia is subjective complaints of restlessness accompanied by observed movements e.g. fidgety movements of the legs, rocking from foot to foot, pacing, or inability to sit or stand still. These develop within a few weeks of starting or raising the dose of a neuroleptic medication.

Since his admission in 2000 *"He had wandered off, run away and was seldom at home …prior to the Monday before his admission he had started being violent, fighting, and throwing stones for no reason."* On presentation he was *"hallucinating, talking to himself, claimed to be a doctor or teacher and to own very expensive cars". "He thought that others did not know anything. He did not sleep but wanted to be on the road or going somewhere."* Under the heading *"Culture"*, his notes stated *"that he had been through the normal rituals and was circumcised in June 2000 and his illness started in that December"*. His father said that since his first admission he had remained on medication and initially showed some improvement. In December 2001 he became unwell and the family took him to a number of traditional healers which did not help.

He was diagnosed on Axis I as *"suffering on his first admission from Schizophrenia and substance abuse"*, but on his second admission to Valkenberg Hospital – *"Bipolar Disorder or Schizo-affective Disorder"*. Axis II was *"deferred."* He had a sixty-seven day admission. One day into his admission he was said to be *"grandiose with no evidence of hallucinations"*. He did not appear to have *"much insight into his illness and was generally not distressed"*. Within five days he appeared to have improved but was still 'grandiose'. Unathi, the notes reported, *"felt unhappy and said he had lied about the voices of his grandfathers and ancestors and visual hallucinations."* Evidently *"His memory and judgement were not good and he did not know what day it was or where he was."* Twenty-six days into his admission it was suggested that he was suffering more from a Bipolar Disorder rather than Schizophrenia and his diagnosis was changed. He then *"improved initially but… relapsed"* as he did not respond to treatment. He was described as *"having some delusions and hallucinations, was over familiar, with poor attention span, restless, grandiose, and tangential. He had poor judgement and insight"*.

On discharge he was said to be neatly dressed and engaging appropriately. However, he had *"some delusions and felt that someone had put magic on him and people were jealous of him. People were bewitching him; they were jealous about him and wanted to destroy his future"*. His insight was said to be *"improved but not good" (in nursing accounts).* He said he had been smoking dagga. His uncle said he would remain in Cape Town to get his medication.

Interviews with Unathi during his admission

Because Unathi was so ill when I interviewed him, I had to rely on information from the nursing staff, students, and the little that was available from his father and uncle. These people corroborated that the onset of his illness came soon after his circumcision. His uncle gave verbal consent for him to be part of the study.

Recovery

Unathi was followed up from September 2002 until May 2003. In September Unathi's uncle said he had gone back to the Eastern Cape where it was believed that his family and the traditional healers could support him. They did not know if he would return. In late October 2002 Mr. Mangesi met his uncle who described him as *"better and still in the Eastern Cape"*. Unathi did not want to come back to Cape Town *"as the people who made him sick were in the Western Cape"*. The uncle brought Mr. Mangesi a sheep and some *umqombothi* and told him about Unathi's circumcision. In November the uncle left for the Eastern Cape and promised to let us know what had happened to him.

Unathi evidently returned to Cape Town in February 2003 and Mr. Mangesi arranged to meet with him at a school in Khayelitsha. He did not come but his aunt explained that he had gone back to school and was doing well. Unathi was described as *"living in Khayelitsha and showing no signs of illness"*. She *"did not know his address"*. In March 2003 Mr. Mangesi visited him, only to find his house locked. Conflicting information emerged which suggested that the aunt was possibly *"hiding something"* from Mr. Mangesi as she *"tried to get rid of him"*. Noises *"like a man shouting"* came from the house. The aunt evidently slept over at the *mlungu's*[202] house and she was described *"as not looking nice but evil"*. In April 2003 Mr. Mangesi visited and the neighbours said *"They did not know anything because the door was always locked."* In May it was the same - the door had been locked for two weeks. Mr. Mangesi said that he suspected Unathi had been locked in the house.

[202] *Mlungu* is a slang word for a white person and this was probably her employer. It was most likely that she was a domestic worker.

4.4.3 Case Study – Lindelo

On admission

Lindelo was a twenty-three year old Xhosa-speaking male, admitted to Valkenberg Hospital in November 2002. This was his first admission. It was reported that he was unmarried and lived with his mother in Atlantis[203]. He was referred in from Stikland Hospital[204], *"heavily sedated"*. The patient folder described him as *"aggressive, dis-inhibited, hallucinating and behaving strangely"*.

Personal and family history

Lindelo grew up in the Eastern Cape with his mother, father and four younger sisters. However, he and his sisters often moved between both his mother's and father's families and across a number of villages. He did not have good relationships with either his mother or father. He left school in 1996 in Standard 3 (Grade 5) and found a job in Cape Town where his mother lived. His father had worked in the mines in Gauteng but had died within the past eighteen months. Lindelo worked in a factory and had taken leave to go to circumcision. The year before circumcision Lindelo became unwell when his father died and his mother had a nervous breakdown. The story told was that his mother wanted him to go in December 2002, but his extended family brought the date forward because he had not been well. They said he was bewitched and felt that if he was circumcised this would stop. He was circumcised in Gatyana village in the Eastern Cape. He said that there were no problems in the bush.

Prior to admission

The mother's story was that Lindelo started to behave strangely, was sent for circumcision, but remained unwell. He was then sent to faith healers but after *"being with the faith healers he was worse"*. He became aggressive and his patient file stated that he *"attempted to rape children, and had made inappropriate sexual approaches"*.

[203] Atlantis is located on the West Cape Coast and, once a small settlement, is now more of an outlying suburb to Cape Town.
[204] Stikland Hospital is a secondary hospital in Cape Town.

Admission notes in the folder

Lindelo was twenty-three years old on his first admission to Valkenberg Hospital. He was reported to be *"aggressive, dis-inhibited, hallucinating, and behaving strangely"*. His notes said that *"his mother or grandmother (mother's mother) was a traditional healer"*. He said *"He only drank African beer at festivals or Christmas."* He had seven days of seclusion at Stikland Hospital and then referred in to Valkenberg Hospital. Lindelo had a forty-three day admission and was diagnosed in terms of the DSM IV Axis I as suffering from a *"psychotic episode possibly Schizophrenia or Bipolar secondary to circumcision, and as having visual hallucinations"*. On Axis IV *"the recent move or death of his father"* was noted. A note was made that *"his employer had requested a sick certificate"*.

Early in his admission he was described as *"very disordered, passive, with loosening of associations, bizarre, psychotic, and grandiose and sexually dis-inhibited"*. It was argued, *"He was more psychotic than manic. He believed he was a dog."* Five days into his admission it was reported that *"He was calm, orientated to time and person, but not to place. He had no good account of himself or insight into his illness. He had a previous history of using dagga. He said that his father had passed away in 1997 while working in the mines."* He then improved and was interviewed on a ward round about his circumcision. He was discharged into his mother's care with follow-up at the Atlantis clinic. His mother was advised about his medication. She said she would take him to a faith healer.

Interviews with Lindelo during his admission

A Xhosa-speaking male nurse informed me, *"that a subject for my study, Lindelo was on the ward"*. Evidently his mother had said, *"He was such a good boy and so helpful and now there was this awful and unpredictable change."*[205] At the time of our meeting he was praying to God to give him direction. He had no English and appeared disturbed. He would suddenly jump up, shouting aggressively, *"that there was a sign just now"*[206]. When Mr. Mangesi tried to get informed consent from him,

[205] Field notes 28/11/02
[206] Field notes 29/11/02

he shouted *"You are a man so I say yes to everything in these papers here."*[207] At a subsequent interview he greeted Mr. Mangesi saying, *"I see this man, but I do not know his name, but he knows me."*[208] He described growing up in the Eastern Cape and showed us an old stab wound on his hand. His friend David had stabbed him. They had been circumcised together. He then became incoherent saying, *"I was looking after my penis in the bush, and wearing blankets so as not to get cold. To be a man you have to be strong, as long as you experience pain."*[209] Whilst living in the Eastern Cape he had moved about doing *"piece jobs."*

He came to Cape Town in June 1996 to be with his mother. He had a number of jobs and finally went back to school in Atlantis. He was in Standard 3 (Grade 5) in March 1997. Then his father passed away and he went to the Eastern Cape to bury him. When he came back evidently the school had closed. From 1997 to 1999 he had worked in a factory. He recalled that he lost this job *"because I was happy, very happy and people were noticing me and that I am sick"*[210].

Recovery

After discharge in December 2002 we tried to contact Lindelo's mother but she always seemed disturbed. Eventually in March 2003 she asked if we could meet. When asked about Lindelo she would not say where he was but, *"he was fine"*. In April 2003 Mr. Mangesi visited the aunt who was a traditional healer in Khayelitsha. She informed him that Lindelo and his mother were working on a farm in Philippi[211]. When Mr. Mangesi brought up about his being unwell and being sent to circumcision to become well he described that *"she changed"*. He described her home as very disturbing and her *"as a bit crazy"*[212]. In May 2003, he met Lindelo's mother at the aunt's home. Her account of Lindelo was that although he was doing well, he still became ill and then *"sat and rolled his eyes, looked up and shook his body. He followed instructions when working and got on well with people. At night he shouted and screamed in his sleep like someone was going to attack him"*. This happened

[207] Field notes 29/11/02
[208] Field notes 2/12/02
[209] Field notes 2/12/02
[210] Field notes 5/12/02
[211] Philippi is a more rural socially disadvantaged area on the outskirts of Cape Town. It is a largely Xhosa-speaking settlement.
[212] Field notes 17/4/03

when he did not take his medication and *"He then disappeared and was violent. When they gave him his medication he became calm after an hour. The medication helped him to communicate with people and when he ran out of medication she could not handle him."*

On the next occasion Mr. Mangesi described the mother as *"hiding something"* and *"she was very thin and not necessarily mentally ill, but perhaps an alcoholic"*. Both she and Lindelo were still working on the farm and earned one hundred and fifty rand per week between them. She would not bring Lindelo to meet with us. Evidently they had gone back to the Eastern Cape for a short time, but the mother found it difficult to cope with him there as *"he could not live without his medication"*. Mr. Mangesi got the impression that things with the mother were *"very bad"*. He thought that Lindelo *"might possibly hit her and that she was definitely hiding something"*. He said, *"This brings up issues about authority given to men in circumcision."*

4.4.4 Case Study – Xolile

On admission

Xolile was a twenty-one year old Xhosa-speaking male, admitted to Valkenberg Hospital in February 2001. His admission came two weeks after his circumcision. He lived with his grandfather (mother's father), grandmother (mother's mother) and mother. He was the oldest in a family of five, three girls and two boys. All his siblings were still at school. They lived in Langa[213], Cape Town. His grandfather and mother were reported as being very concerned about him. He was enrolled as a law student at university.

Personal and family history

Xolile was born on the 7th August 1980. He said *"I come from a large Xhosa family, which was originally from the Eastern Cape."* His mother and father were Xhosa-speaking and had never married. He was able to give his family name and his clan name on his first interview in hospital. His clan name was to his maternal grandfather who had been born in the Eastern Cape. His maternal grandparents reared him and an

[213] Langa is within the more disadvantaged areas of Cape Town but like Gugulethu is more established and a better off formerly 'black' residential area. This is a largely Xhosa-speaking community.

older brother who died on the 14th February 1999. Xolile was adopted to his mother's descent line and circumcised to this grandfather, by his uncle (mother's brother). His father's side of the family came from Khayelitsha but was originally from the Eastern Cape. His father came for his party when he came from the mountain[214]. There was a traditional healer on his grandfather's side of the family. Xolile insisted that he did not have *ukuthwasa*[215] . He said that he knew of no mental illness in his family.

Xolile described being well in circumcision. Prior to his circumcision *"All the rituals to become a man had been done."* The grandfather agreed with this story and said Xolile remained well after he got back for his party on the 12th January 2001. He did not smoke *"dagga"* (cannabis) in the bush. Xolile reported that, *"I was on my own, but I had a normal circumcision"* and was not ostracised. He said, *"I was bewitched because my peers were jealous of me."* He described them *"as having no schooling and they were violent"*. One account of the onset of his illness was that after circumcision, in the first week back he went to a private doctor and whilst there *"felt dizzy, the sickness started"*. He then saw a traditional healer but when this did not help his grandfather took him to Groote Schuur Hospital.

Apart from his circumcision, the other significant event prior to his admission was his failure at university. However, when asked about university he had told us that, *"everything over the past year had been normal"* and his marks were *"great"*. He stayed in the shelter attached to the house and did not party, drink (not even traditional beer) or use dagga (cannabis). He failed because he was too poor to afford food or books. He had very good grades at school and got matriculation exemption (Grade 10) and had a bursary.

Prior to admission

Although reports of the onset of his illness were at times contradictory, Xolile's own account of his breakdown was, *"in January or February 2001 I received a letter stating I failed some subjects. I suddenly became anxious all the time, for the whole day I was scared… hearing screaming sounds – through my ears and in my head."* Xolile said, *"After this I went to go to the Spaza shop and I almost fell down. I came*

[214] Xolile called his circumcision 'going to the mountain' rather than 'the bush' on occasions.
[215] *Ukuthwasa* – a calling to become a diviner.

back home and when I went to sleep I started to see visions of people chasing each other". On the second day he was then taken to the Community Health Centre by his grandfather.

Admission notes in folder

Xolile had been delivered at home and although premature did not require ventilation. He first talked at ten months old. His schooling record was good, but he repeated Sub A (Grade 1)[216] when he had an injury to his hand. He never made friends easily – but got on well with people. His *"sexual history"* stated that he had a girlfriend. His first admission note stated, *"After returning from circumcision the patient presents with bizarre behaviour but has an abscess on his arm. The grandfather was present at the circumcision, which went well. Minimal blood loss and no evidence of sepsis. No history of substance abuse."* He was described as *"displaying funny gestures but was well groomed"*. At the time of admission he was said to be, *"objectively hallucinating and had been admitted via the psychiatric emergency ward"*. He had a three-day history of acute onset of psychotic symptoms. Xolile had a forty-three day admission and was diagnosed on Axis I as suffering from *"Acute Psychosis /Schizophreniform Disorder, with a proviso of psychosis secondary to a general medical condition."* Axis II was *"deferred"*, Axis III named *"his right arm abscess"*, with Axis IV raising the question of a *"stressor"*. Axis V was *"impaired, sent to closed ward."*

In the first days of his admission Xolile was reported as *"remaining drowsy, incoherent and mumbling, with poverty of speech, delusions, and hallucinations, and was thought disordered"*. Seven days after being admitted he tried to abscond. The next day he was described as having *"an acute psychosis but able to engage. His auditory hallucinations came and went but he was orientated to month/year/person and place"*. He developed akathisia within the next two weeks, but by the third week had improved significantly and because he was *"Apsychotic sent to the open ward."* He then became *"very sick, could not speak and his lips and mouth were tight"*. He said at this time, *"my illness started when I saw something at home"* he muttered about *amafufunyane.* He was afraid that when he got home he would be sick. He was

[216] Sub A is now Grade 1 and when a boy is 6 or 7 years old.

described as *"being anxious, perplexed and having persecutory delusions, possession of thought, passivity, and limited insight"*. He became psychotic again.

Thirty days into his admission his psychosis was described as *"atypical"* and his medication was changed. *"He was better engaged… had moments when he was lucid…. He was objectively hallucinating… had decreased buzzing in his ears and was still disoriented to time, place, and date."* He later injured his hand hitting it against a window. Over the next ten days he became *"more calm and relaxed, friendly and co-operative. He was coherent, and denied having perceptual disturbances, delusions or possession of thought or passivity phenomena. His insight and judgment was adequate"*. His notes recorded that *"He was not happy doing law."*

Interviews with Xolile during his admission

When first interviewed by us, Xolile was thirty-three days into his admission and knew he was in hospital. He remembered that he had failed university and that he had been for circumcision on 16th December. He stayed in for four weeks and came out on the 16th January. He said, *"All went well, I felt fine."* At his next interview he was appropriately dressed but his eyes were very bloodshot, yellow, and staring. He was very thin. Xolile said, *"All was well during my school years and whilst in the bush but I am ill now. I felt well after the bush."* He said, *"I am not in the bush (now) and that has made me unwell."* He agreed to give informed consent and be in the study. Xolile remembered our previous meetings. He insisted he was fine talking about his circumcision. He felt much better; *"quite normal… as before I had voices in my head"*. In hospital his account of his circumcision was, *"I was well when I was in, and when I was circumcised, and in the hut, and when I left."* He specifically said he did not feel pain, fear, and apprehension. He described having dreams which he could not remember and *"They are not important now."* He came out and was at his party *"'umgidi' and felt weak all the time and became weaker. I felt dizzy and ill in my stomach – and my grandfather nursed me and gave me food"*. In this account he was taken to Langa day hospital.

Recovery

Xolile was followed up from May 2001 until January 2005. We first met him in his grandfather's home after his discharge. He told us, *"There are no voices; no visions and I have no complaint with the medication."* He claimed, *"I no longer want to study law. My grandfather is watching over me, reminding me about my responsibilities as a newly circumcised man."* He described, *"I had to take off my cap and to always wear my jacket*[217] *and must follow ikquala. From day to day I do nothing – watch TV, read magazines."* Six weeks later he was doing a computer course at Fountain House[218] in Observatory. It was at this time that he fully described his circumcision and the preparation for it. He said, *"I have done the rituals to become a man. These begin at an early stage and done before I went to circumcision for instance imbeleko*[219]*…I had it done in Cape Town one week before going. It can be done at fifteen to twenty years old if there are problems."*[220]

In October 2001 Dr. Soga, a Xhosa-speaking psychiatric registrar agreed to see him with me in the hospital. He arrived dressed in the clothes of a new man with his cap and jacket; his mother was with him. He had a vivid memory of coming into the emergency psychiatric ward and then being taken by ambulance to Valkenberg Hospital. Of this event he remembered that, *"his grandfather talked for him"*. He recollected, *"I (Xolile) was not there – I could not concentrate on what was happening."* He said, *"I heard voices, screaming in my head. I had hallucinations. I was afraid of how 'crazy' I was and afraid it would happen again and take away all of my dreams."* He remembered that from the 12th January until the 20th January he was in seclusion and well but became ill and was admitted on the 20th January. Two days before this date he learnt he had failed. *"It seemed,"* he said, *"that all the expectations and aspirations of manhood were lost when I learnt of my failure and having to stand as a man."* He says that prior to being mentally ill, he had never felt *"any such illness before, or dizzy as I did then"*.

[217] The working man's cap and jacket is put on by all new men or *abafana* for the six months following their circumcision. They must be seen to wear this at all times and must behave respectfully and cautiously especially with other Xhosa males.
[218] Fountain House is a rehabilitation home for the mentally impaired which offers sheltered employment and training.
[219] Imbeleko – is the first ritual for a Xhosa boy in which a goat is slaughtered and respect is paid to the ancestors. This ritual happens any time from six months to six years old.
[220] See Case Study for Xolile in Appendix 1.7.

Our second interview with him and Dr. Soga was in November 2001. He continued to improve and had no dizziness and was sleeping less. He kept to a daily routine and took his medication after ten in the evening. He complained that since his illness *"I have been stressed, done nothing, and doing nothing makes me stressed because I think this will be my life."* He felt better on the new medication and, *"also because of our interview sessions"*. His mother initially seemed happy with him in the interview but when Xolile told us that he could not talk to her she became angry. She lashed out that, *"Circumcision had changed now. Before,"* she said, *"women could not see what was happening, but now they can go into the seclusion and it was better."* Xolile said that he had learnt to speak with men and not to her and that his relationships with women had changed.

Xolile requested to see us in December 2001 as he wanted his disability grant renewed and to go back to university[221]. He told us about his brother's murder and how awful it was to live in Langa with gangs and murders going on and the stigma of being mentally ill as, *"they did not understand me when I was ill"*. The issue of violence was to come up again during a later interview when we asked about a bad cut he had on his lip. He claimed that *"When boys are in the bush they learn to fight with sticks and that was how I cut my lip."* His mother contradicted him saying *"his cut lip happened as he was disrespected because he was ill"*. His mother believed that his illness was because he was bewitched and she sent him to traditional healers as *"they could take jealousy and ill intent"*. *"Bewitchment"* he said *"was because of chaos in my community."*

In our interview in January 2002 Xolile said he had to register to study law on 4th February[222]. He agreed to see us on a regular basis. He felt *"well, but his eyes were not so good in the light, but he was keeping taking the medication"*. Dr. Soga revised his diagnosis to a *"Brief Psychotic Episode."* Following this meeting I did not see Xolile until 2005. Mr. Mangesi visited him on a regular basis at his grandfather's home but he was never there. A neighbour told us that *"He was doing very well but*

[221] In our follow up interview I reported back that the university administration said that they would consider his application once his outstanding fees were paid.

[222] At this time he wanted his disability grant renewed and Dr. Soga was very direct with them about his disability grant. She insisted that he had been given R4, 000 over eight months and none had been saved. She was however, concerned about him being highly stressed at university and not on treatment. She therefore felt he needed therapy and an extension of his disability grant for maintenance.

did not want to be reminded of his illness and did not come home often." In January 2005 Xolile contacted me to ask if I would act as his referee for re-entry to the university and after being interviewed he was re-admitted. Of his interviews for my study, he said *"that they were a true reflection of what had happened"*. He explained his disappearance in 2002 as his trying *"to distance himself from what had happened in Valkenberg Hospital and in becoming mentally ill"*. He felt *"he was more at terms with this and with how to manage himself and his illness"*. He had worked as a salesman and during this time went to the library and began to realise he could study again. He however, did not want to stay at his grandfather's home as *"each day he and his brothers and sisters had no food until their mother returned from work. Then they ate what she had managed to pay for with what she had earned that day"*.

4.4.5 Case Study – Mpumi

On admission

Mpumi was a twenty-four year old Xhosa-speaking male who was referred into Valkenberg Hospital from a nearby hospital in January 2003. He had been unwell for a week. He was described as being short and of average build. The notes stated *"He was not oriented for time or place… the voices in his head and ears were much better."*

Personal and family history

Mpumi was born in the Eastern Cape and he went to school there until Standard 7 (Grade 9) in 1997. He had two brothers and one sister, an older sister had died. Both his parents had died recently. *"His father died because he was bewitched and he did not know the cause."* His mother died after his father from tuberculosis. He remained in the Eastern Cape with his uncle (mother's brother) until after his mother's death. His uncle and nine cousins were in the Eastern Cape. In 1998 he moved to Cape Town and got work. In December 2002 he went for circumcision in the Eastern Cape and at the same time *"put a stone on his uncle's grave"*. At the time of his admission he was working in a carpentry shop and lived with his cousin.

Admission notes in folder

Mpumi's patient file described that, *"He was a labourer…had fits and was psychotic over the previous six days…had been walking up and down the house, was aggressive, and had auditory hallucinations and voices in his ears. He had no history of using cannabis. He had a seven-day admission at Valkenberg Hospital."* His diagnostic assessment was on Axis I; *"query Schizophrenia/ Brief Psychotic Episode."* Axis II was *"queried"* and Axis III stated, *"Better than what it seems."* Axis IV was *"none elicited"*, except *"has just received circumcision in December"* and Axis V was *"Good."*

On the first day of his admission it was noted that Mpumi, *"Smoked and chewed tobacco and would have several beers. He was casually dressed and did not know where he was and his behaviour was inappropriate."* Within a day he became more ill *"in terms of his orientation and began behaving in a bizarre way"*. Over the next three days *"He was confused and sedated"* but by his third day was *"quiet and had no voices."* On the fourth day he was described as *"sleeping well and was orientated to time, place and self. He felt strong and wanted to be discharged. The voices and noises in his head were better. He was calm, dressed well, was open and willing to answer questions …His feeling was elevated and he was less psychotic. He wanted… to go back to work, to find a girlfriend and to start a family."* Six days into his admission he was *"Alert, not depressed, and not psychotic. There was no evidence for Schizophrenia. He understood what had happened and what he needed to do. He believed the medication had helped him."* He was assessed as having an acute psychotic episode. He was discharged to a nearby clinic on his current medication for six months.

Interviews with Mpumi during his admission

In January 2003 I was informed by a sixth year medical student[223] based in Valkenberg Hospital that she had found a *"boy"* who went to the Eastern Cape for circumcision and returned well but soon after became psychotic. I went to the

[223] As one strategy to find any patients who were suitable for my study, I had informed all of the sixth year medical students – who as part of their clinical rotations had to work in Valkenberg Hospital – about it. I asked them to please screen their young Xhosa-speaking male patients to find out if they had gone through circumcision in the past year.

hospital to find him but he had been discharged. His story was confirmed by the senior Xhosa-speaking male nurses[224]. The nurse described Mpumi as *"probably getting too much frustration"* as he was twenty-four years old and unmarried. He said *"people would be pressuring him to get married"* as with circumcision *"it made a difference when you had to wait to do the party"*. Mpumi was old for circumcision and the nurse wondered who gave his circumcision party as his parents were dead[225].

Recovery

Between February to June 2003 Mr. Mangesi and I tried unsuccessfully to get written informed consent from Mpumi. Mr. Mangesi did, however, meet with him on a number of occasions. Inevitably after we had arranged to meet Mpumi, he would not come as he would be *"working in Cape Town and had little free time and worked very long hours"*. On another occasion we visited his shack in Langa and met his cousin. She showed us a bill from Valkenberg Hospital for R4, 000 which Mpumi could not pay. His home was a one-roomed, wooden shack with cardboard lining.

Mr. Mangesi learnt that his (Mr. Mangesi's) cousins knew Mpumi well and had been at his circumcision party where, *"Everything had gone very well for him."* He described him as *"A very quiet person who did not like to talk, he was more hesitant"* but he was said to have *"a look that he did not trust."* Mr. Mangesi said that all the time his eyes were *"very moving – especially when he talked about what happened with his illness and how he was doing. He was very cautious about saying anything about his circumcision"*. In May 2003 Mpumi was more relaxed and *"talked"* about the study agreeing to sign the consent. Mr. Mangesi described that *"He did not seem dangerous or mentally unwell. But when he talked, his eyes moved around as if he did not trust anyone. It seemed as if he was still a bit ill, in his eyes and the way he moved his head. He spoke freely but did not make sense."* Evidently he agreed to sign the informed consent and he said *"He was happy to talk but that he would not be going to Valkenberg Hospital again."*

[224] The young interpreter who worked full time in the hospital and to whom I paid a monthly sum to find out if any patients were suitable for my study said that he did not tell me earlier on because the nurses 'sabotaged' him.
[225] Field notes 7/1/03

In early June 2003 Mpumi could not meet us as he only left work at seven o'clock and was home at nine o'clock at night. He had free time on a Sunday, when he finished work at six. Mr. Mangesi described him as, *"he was better now than he was."* They read the consent papers through in Xhosa and he agreed to sign them but avoided doing so. Mr. Mangesi then saw him at six o'clock on that Friday to get his informed consent and *"He was more relaxed but it was uncertain if he was taking his medication, however he was recovering well."* When Mr. Mangesi went to the next meeting he was told that Mpumi had left his work to return to the Eastern Cape on a family matter.

4.5 Themes related to stress

The results focus on the nature of stress in these case histories that may have led to feelings of anxiety and extreme nervousness for these men. In these already vulnerable individuals a deep sense of anxiety may have contributed to the onset of their psychosis. The bio-psychosocial model will be used to inform the presentation of the data. This suggests that biologically these men had some genetic predisposition or hormonal or chemical imbalance.

The results inform the thesis that the men's predisposition for mental illness interacted with stressors that were psychological (trauma or poor coping skills) and social (cultural dissonance or violence) in nature. This instigated and affected the course of their mental illness. Whilst their predisposition for mental illness is not the subject matter of this thesis, stress-related factors are relevant. These will be discussed in respect of environmental stress; psychological and social stress, and stress in circumcision. An important underlying theme is that stress also has a positive effect in circumcision and leads to resilience in men. Another key aspect is that many stressors are considerably culturally prescribed and interwoven in behaviour and psycho-social patterns of relatedness. Understanding the role stress plays in the onset of mental illness entails unravelling and describing how it occurred in the fabric of these five Xhosa men's lives and around the practice across Xhosa society.

Table 1.4 Themes related to stress

Environmental	Social and psychological	Stress in circumcision
Cultural change	Father/son dyad	Stress in circumcision
Migration	Patrilineal descent	Participation
Poverty	Decision making	Pain
	Family and community	Peers and teachers
	Return to the mother	Drugs and alcohol
		Language, culture and symbols
		Dreams and visions in the bush

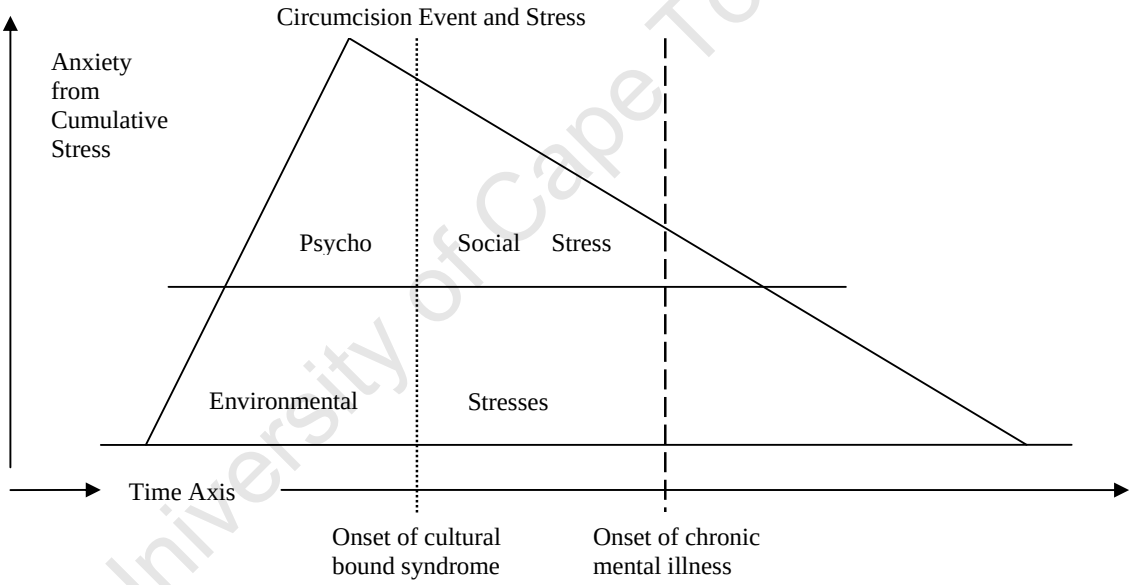

Figure 1 Cumulative stress and anxiety in circumcision

4.5.1 Stress in relation to psychiatric disorder in the study

The results indicate that in the cases of Ayenda, Unathi and Lindelo who suffered from Schizophrenia and Bipolar Disorder as severe psychiatric disorders, harmful stress appeared to be of a more environmental and psychosocial nature. This included the fact that when circumcision practices were problematic or poorly orchestrated then stress became traumatic for those who were vulnerable. In the cases of Xolile and Mpumi who appeared to have psychiatric diagnoses for Cultural Bound Syndromes,

stressors were most significant in circumcision. Circumcision induced an altered state and increased their anxiety. However, each case will show that there were other significant stressors such as environmental stress e.g. migration and psychosocial stresses e.g. recent deaths of family members.

4.6 Environmental stress

4.6.1 Cultural change

Many stresses amongst the five subjects were similar by virtue of their shared linguistic, cultural, and social backgrounds. Experience of stressors around cultural dissonance and change were therefore also common amongst them. Each man, however, expressed personal and historical aspects that were unique. Circumcision as a primary bond was the most critical cultural stressor shared within their generational group of Xhosa-speaking people. Differences arose between them in this respect. Xolile, for instance was the only man circumcised in Cape Town; the others were circumcised in the Eastern Cape. Neither Xolile nor Unathi had to make significant journeys to be circumcised. Whilst Xolile was rooted into and saw his future in Cape Town, the others wanted to become Xhosa-speaking men with families rooted into a traditional, rural domain[226]. Cultural homogeneity as tradition was potentially protective for these men. One illustration of stressful change in this respect was that Xolile did not identify with many of the feelings about Xhosa tradition that the others expressed.

4.6.2 Migration

Stress occurred in relation to migration in different ways. Firstly, long journeys are stressful for vulnerable individuals, but tradition required that Ayenda, Lindelo and Mpumi return to the Eastern Cape for circumcision. Although this rural landscape was familiar the journey brought additional stress to their circumcision. They then had to leave after *"coming out"* to return to work in Cape Town and could not rely on extended kin who in the past would have fostered their six months' apprenticeship as new men. Equally stressful was that their futures lay in a more challenging urban

[226] On circumcision these four men stood as members of their descent lines by virtue of their ancestors being buried and remaining in the Eastern Cape. The reason they migrated to Cape Town was for work opportunities. They stayed with extended kin in order to sustain their property, family, and rituals in both domains.

environment. An ameliorating factor could have been that the data showed a close similarity in expectations of and reliance on the extended family between a more urban Cape Town and a rural Eastern Cape. Migration between kin is a common experience. Despite the presence of extended family all men, except Xolile, struggled to get support from extended kin – either in rural or urban circumstances. This is because Xhosa-speaking people also share a residual and historically related poverty[227].

Migration has brought about a stressful and competitive discourse between urban and rural Xhosa-speaking people. Authenticity and having the right and safe procedures for circumcision was claimed by each domain. This led to "blaming" for injuries and problems around "the way custom is done". Problems variously attributed included stressors as in the breakdown in families or disreputable surgeons/teachers. Failure to follow *"tradition"* was imputed to migration and poverty.

Distinctive differences do occur in practices both between the Eastern Cape and Cape Town and within local areas in each domain. This has led to stressful implications because safety and accountability has become an issue. There have always been variations that describe local practices where the way the operation is done or how wounds are bandaged differ. But, recently, poor access to traditional resources showed have indicated other concerns e.g. dietary restrictions falling away, too many initiates being in one hut, limited space and no water in seclusion areas. New health system regulations have challenged bad practices and these interventions differ between a more urban Western and a rural Eastern Cape[228] e.g. screening for sexual infections.

4.6.3 Poverty

Poverty and migration were closely interlinked and influenced educational opportunities and employment prospects. Violence was also related to the stress and the instability that poverty and migration brought in an urban environment. Poverty, poor education, and mental illness were key factors that brought a cycle of stress,

[227] Poverty here refers to a socio-economic description of poverty. All subjects and their families fell below the US dollar poverty datum line of a minimum of US$2 per day per person. All except possibly Mpumi had experienced extreme poverty with times when they were unable to get food.
[228] See Interviews with Mr. Mabuda in Appendix 2.2.

anxiety, stigma, and abuse in the men's lives.

In terms of education being an enabling factor, to surmount poverty and mental illness, only Xolile received a standard of education and social advantage that could have significantly changed his poor circumstances. This was demonstrated in that his work following his illness was reasonable; he worked as a salesman and then decided to return to university. Whilst education may have been protective for Xolile, the other four men were more at risk as their education in the Eastern Cape was poor. Lindelo left school in Grade 5 (approximately 11 years old), Ayenda in Grade 6 and Unathi and Lindelo in Grade 9 (15 years old). Their ability to speak English was poor and consequently they struggled to find work and to settle in an urban environment. Ayenda and Mpumi both got reasonable but lowly paid work. Lindelo's job as a farm labourer was abusive. Unathi it appeared never worked.

Violence and unacceptable levels of aggression were recorded for all men following their hospital admissions. Xolile and Ayenda spoke most of a fear of being attacked in circumcision. The possibility of antagonistic behaviour was a persistent threat and anxiety provoking. This was also evident as a consequence of stigma from mental illness. The reasons men were attacked were as follows; because of having a good education (Xolile), poor education (Ayenda); migration resulting in homelessness and joblessness (Lindelo, Unathi, Ayenda) and stigma around mental illness (Xolile, Ayenda, Lindelo, Unathi). The instigators of aggression were family, other initiates, gangs and community members. However, aggression as a consequence of political and social 'diversity' was also evident in this urban environment. Aggression, especially when men were psychotic, came from co-workers, taxi drivers, and the police during their admission to hospital. Ayenda and Lindelo were both responsible for inflicting criminal violence on others. Mpumi and Xolile were very passive at the time of their admissions. Mpumi was the least affected by violence and aggression and this could be attributed to his diagnosis and some ability to hold his integrity as a Xhosa male despite being ill.

4.7 Social and psychological stress

A number of themes arose about stress in family relationships from the case histories.

These demonstrated that all the men's relationships with their fathers in all their early and adolescent development were problematic. Each also had problematic issues with regard to attachment and relatedness to significant other family members. Ayenda was extreme in this respect and Lindelo in his later years had exceptionally difficult relationships. Unathi, Xolile and Mpumi appeared to have strong attachment to their mothers, but with the onset of their illness and adolescence these relationships were strained. Ayenda and possibly Lindelo seemed to have poor coping strategies because of inadequate protection and maternal support when children. This was also affected by the aforementioned social stressors.

4.7.1 Father/son dyad

In a Xhosa cultural domain, the most significant stressor in circumcision was the role of the youth's biological father. The son had to choose to be circumcised but it was preferable for the biological father to take his son for circumcision. This did not happen in any case. Moreover all men were at some time described as having family problems by other Xhosa people. The father taking his son and being present held more status and became the measure against which the successes of other youths' circumcisions were judged. An absent father brought stigma to the son and family. Each case differed in the way in which their families either conformed to or diverged from the norm. Stress thereby also arose because it is culturally accepted that certain social factors need to be in place to support the youth's psychological transformation and circumcision.

The data gave a clear indication of the degree to which each of the five men's biological fathers was present in the ritual. The data also revealed whether they were present before, during and after as ongoing support figures and was informative about their quality of interaction. In terms of being present in their circumcisions; Lindelo and Mpumi's fathers had both died. Their fathers' deaths were recorded as significant stressors for their mental illness in their hospital admissions. In later interviews, they recalled having reasonable relationships with them. Unathi's father was Sotho-speaking and not included at circumcision. He had supported him until his first hospital admission. The fathers of Lindelo, Ayenda and Xolile had migrated away for work when they were growing up and were not supportive.

Ayenda and Xolile's fathers were present but had not married their mothers. Both were claimed by their mothers' clans at birth and circumcised to their line of descent[229]. Ayenda and Xolile were anxious and preoccupied about their fathers not claiming them. Xolile's father lived in Cape Town but his grandfather cared for him from birth[230].

Xolile's case was insightful in understanding the stress in relations in circumcision as his grandfather took him and Mr. Mangesi disclosed, *"His real problem is… he was circumcised to his mother's clan and he himself described his grandfather's reluctance to talk… this is humiliating for a boy in circumcision."* This evidence shows the significance of close male kin in fulfilling the "role of the father". Further, on first being interviewed Xolile provided his family and clan name and a genogram to his maternal grandfather. He had a sense of personal stability that reflected this care. With regard to his biological father, once well, Xolile spoke about his absence, expressing little anxiety about his absence.

Ayenda's uncle (mother's older brother) took his father's role[231]. Of his father he said, *"I first met my father when I was going to the bush and that was the last time I met him… I use my mother's clan… at twelve years old the sangoma came and cut me to bring me out of boyhood into her clan… I will inherit her property."* This secured his right to ancestral protection, land, and negotiation for wives and authority in that line of descent. Whilst Ayenda's story testifies to the importance of affiliated kin this family kept him poverty stricken and abused in childhood[232]. This was evident in his personality and disposition as he demonstrated extremely poor coping strategies.

Stressful circumstances existed for a youth and his family when the father was absent because there was a loss of intimacy. This was worse when the father was not there in

[229] The mothers in these cases were interesting as their circumstance mirrored that described by Schapera (1956). He recorded then that young women were marrying later because men had migrated and polygamy was not being practised. He argued that greater independence for women meant more liberal sexual mores and increased pregnancies in unmarried women.

[230] Hunter (1956) describes the function of clans on farms as regulating relationships in terms of the patrilineage, marriage and extra marital relations. Clan names are used for polite address and to acknowledge relatedness. Despite this the clan was less based on territory than on tribal affiliation. In circumcision youths took the name of a Xhosa chief circumcised in the same year as them (1956, p 394).

[231] The mother's brother or *malume* has a key, often-legal role in African traditional practices.

[232] His story reflects a familiar pattern experienced by many Xhosa-speaking children who live within extended family, mostly in more benign circumstances.

childhood and adolescence. This meant that psychological resolve to endure circumcision was compromised. These youth were also less obviously supported in terms of resources. A good circumcision meant the father saved for his son's circumcision and oversaw it day by day. These resources were still at issue but more evident for Xolile, Unathi and Mpumi. The absence of the father became evident in the manner in which the men expressed themselves in respect of their fathers and their anxiety was more noticeable when they were severely ill. Of note is that the data indicated that initiates were unable to relate empathetically to a relation who stood in for the biological father. This, however, did maintain the principles of the wider patriarchy.

4.7.2 Patrilineal descent

The biological father's role is underpinned by patrilineal descent[233]. In the study *"descent"* was not spoken about, rather the *"role of the father", "being a man"* and *"listening to the ancestors"* expressed relations through descent. *"Fathers"* were more referred to in the context of the family. In this respect the circumcision today supposes a cultural norm for the family in respect of the biological father, one wife[234] or mother, and children. This suggests a loosely bound nuclear family within extended kin. Kin from the mother's and the father's line participate but the patrilineal line on the father's side should take precedence. When the mother's clan took the youth to circumcision, then her descent line officiated.

The primary bond in this respect is that between father and son. This lies in a complex web of gender and peer-based relations and descent affiliations. As a blood related bond the tie between the youth and his biological father[235] has precedence over

[233] In patrilineal descent the bond between father and son is critical. Every youth is circumcised to his father's or maternal grandfather's line. The rule is that the father should take his son to be circumcised and bring him from the bush. The youth should choose to go to circumcision with his peers. The father anchors a youth's journey into manhood, his ancestors and to becoming an ancestor. The father also takes him from his mother and family orientation into a collegial world of men. This is ranked in terms of peers who are circumcised together in an age graded hierarchy based on seniority. The older a man, the closer he is to his ancestral line. In the event of the father being absent, designated kin will stand in for him and often this is the father's brother, who is also seen as 'a father'.

[234] Wives, in the plural refer to the practice of polygamy which was more prevalent in the past. In a polygamous household the son would leave from his mother's house to go for circumcision. In the study the only time wives were mentioned was in terms of their place in the home and at the coming out party.

[235] Schapera, I (1956) described that relationships between children and their parents have changed. Migration of men to work has meant a loss of male authority; a decline in respect for the ancestors

that of adoption or incorporation. These patrilineal ties and this dyad were symbolically echoed in the blood, the foreskin, and red ochre and in images that repeatedly occurred in the men's language, stories, dreams, and psychotic imagery. These images appeared to work in synchronicity to empower the process of transformation, mirroring the circumcision over generations in the descent line. Because the father-son dyad takes precedence, when the father was absent any replacement by affiliation kinsmen tended to be viewed as a negative deviation from the norm.

For these reasons circumcision was more successful when the father and son were intimate. This was suggested in Mr. Mangesi's saying, *"The foreskin is eaten by the boy and given by the father. The father and foreskin have your blood and this is a part of you."*[236] The foreskin is cut from the youth and given to the father, who then gives it to his son to eat. Father and son are linked through blood[237] and descent and in this act he partakes in his son's transformation.

Mr. Mangesi's description gives a sense of how close youth are to being in an altered state. This has particular relevance in Mpumi and Xolile's cases where their psychiatric diagnoses were for cultural bound syndromes. Interviews with other patients, traditional surgeons, and nurses described the immense psychological disturbance that this act demanded. One patient spoke of the revulsion he felt when eating it and of *"going mad"* at the moment that it was placed in his mouth[238]. This act is potentially more disturbing when no trusted relationship, in particular one's father anchors the giving. In a trusted relationship between father and son the act appeared to be assimilated more easily. A factor that may reduce anxiety was that youth and fathers have all followed the same custom over many generations. It is therefore more mundane than mystical. Mr. Mangesi recalled, *"You go in and you are nervous and then you are cut and there is no pain and your father is there."* This illustrates the protective role the father has and how a sense of honour becomes a compensating factor for stress.

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further undermined it and the circumcision ceremony has weakened as an educational and disciplinary institution.

[236] Field notes April 2003

[237] Symbolically the foreskin stands as part of the father-son bond and after circumcision becomes passed between them for the youth to eat it. When the biological father carries out this action it is more meaningful because they have shared intimacy since the son's birth and now share a line of descent.

[238] See Interviews with Patients in Appendix 2.4.

4.7.3 Decision making

The father-son dyad anchors decision making, reducing stressful relations. Stressful circumstances were, however, evident in a wider decision-making process especially amongst significant male elders. When the biological father was absent this decision-making process was more stressful as these elders and relatives kept to the guiding principles for patrilineal descent, sometimes ignoring the youth's concerns and feelings. Senior male Xhosa-speaking nurses in the hospital were complicit in this process.

Lindelo was a case in point. The decision to have him circumcised was taken by older males in his family as a strategic and therapeutic intervention to stop him being bewitched and for him to behave more responsibly. It was clearly hoped that circumcision would functionally shift his personality and psychological attitude. Despite or perhaps in the event of his father's death he was sent to circumcision because he was behaving strangely. This behaviour was deemed "boyish or wilful", but he had over-reached the license given to a youth in this society. Insight into this decision came from a Xhosa male nurse who argued that usually *"The boy chose when he was ready to go but Lindelo had not."*

In Lindelo's case the degree to which he was mentally well enough to go for circumcision was of concern. Furthermore his circumstance indicates how anxiety provoking the decision-making process can be. Although Lindelo was an exceptional circumstance his case points to the function of older Xhosa men in a psychological assessment of youths' abilities to manage stress and their describing critical junctures for circumcision and manhood[239]. This illustrated the stressful nature of familial and community decision-making processes. As a norm – consultation, reflection, and deliberation – happen so that youth who are unwell do not go. Manhood is chosen by youth and earned by those who meet the responsibilities and obligations it entails. A *"strange youth"* may well therefore remain a boy and dependent. In Lindelo's case the authority of the patrilineage was brought to bear on him. His being included into African descent would have been understood as a benevolent act.

[239] One other case, where there was some comparison, was a patient who was unwell because he was caught up in his parent's conflict over his circumcision and was confused about his own decision.

4.7.4 Family and community

In the case studies extended family relationships were evident on a day to day basis but often were problematic or absent. Extended kin were functional in facilitating living and working arrangements and these brought visiting obligations. At circumcision the nuclear family appeared to be more critical because it brought together the youth's biological father and mother and distinguished him from his siblings. Following circumcision the data showed that men were no longer in dependent roles in their families. They held responsibility for their mother and all younger members of the family. This meant being a man to an older brother and having a legal and caring role for an older sister. A man maintained a respectful distance from this sister. In the study family members spoke for the men, affirming their status. Xhosa people must bear witness to a youth's circumcision and manhood. Each holds an already given family- or descent-based role and in this capacity they can judge his achievement.

The study limitations mean that case study data is missing in respect of testimonies from other initiates as peers, from teachers, and surgeons[240]. This information could have better described how each man integrated with his peers and in circumcision activities. In their interviews these relationships were not spoken about[241]. This could be because they were mentally ill and struggled to sustain their relationships from circumcision. This was evident with Ayenda, Unathi and Lindelo and to a lesser extent with Xolile. The exception was Mpumi who had a brief admission and returned to work and friends, and refused to disclose about circumcision.

Traditional healing is ubiquitous in Xhosa-speaking communities and ran as a theme in the case histories. This provided evidence on how stressed or anxious men were and how they managed their illness. The case histories suggest that in the early stages of illness most saw a traditional healer. This was because something was 'not right' and either he or his family feared bewitchment within the family or of their person.

[240] See the section on Ethics. It was very problematic to speak to the men's' peers as this could have compromised them not only in terms of the secrecy of circumcision but also disclosed their mental ill health.

[241] The circumcision fosters relations with peers; wider kin-based obligations and a responsibility to senior members of the patriarchy. Equal value should be given to relationships with peers, and these are intentionally developed within the circumcision.

Bewitchment was stressful. In their accounts – all, other than Mpumi, gave some explanation as to why they were bewitched. Bewitchment was given as the reason for their illness and this was clearly distinguished from their being mentally disturbed.

Within the broader community *"bewitchment"* was given as the rationale for moderately disturbed behaviour and "mental illness" for when men were acutely ill. Bewitchment was also consistently described in their mental illness symptoms. Psychotic imagery and mental illness symptoms confirmed beliefs about bewitchment in the community and lead to people concluding that someone who "behaves strangely" is bewitched[242]. One indication that a man was getting well was the manner in which he framed bewitchment. Those who became well spoke about bewitchment as part of township life, but its force was not described as all consuming. In contrast those men who were chronically ill continued to feel they were bewitched and this distressed them.

It appeared that none of the five men had mental illness conditions that were traditionally prescribed as *"ukuthwasa."* Xolile said there was a traditional healer on his grandfather's side and he knew this was inherited. Evidently, *"His grandfather's brother on his mother's side…was a traditional healer, an igqirha or like a sangoma and who was still alive in the Eastern Cape would pass his being an igqirha down the line."* He had no traditional healing powers and his grandfather agreed with him. Xolile's comment illustrated how questions on training as traditional healers or healing opened up discussion on how people were ill and why. In contrast if people were asked if anyone was mentally ill they struggled to answer. People felt safe talking about healers and they felt secure when *"what was strange"* was being looked after by them. In comparison, speaking about the psychiatric hospital and being mentally ill was terrifying and stressful.

In the event of violent or psychotic behaviour in the community it was Xhosa-speaking people who decided a man had unusual and unacceptable behaviour or was dangerous. Their behaviour was still attributed to witchcraft. The police or medical services were called to assist. The police were involved in Ayenda and Lindelo's

[242] Hellman, E. *"Accusations of witchcraft and sorcery are an expression of quarrels, and further foment them; those believing themselves to be injured are bitter against those they believe to be guilty…but those accused are not socially ostracised."* (1956, p397).

cases as they were a danger to themselves and to others. When asked to recall this period these men described either *"having no memory"* of that period or of *"being crazy"* and being tied and chased. All five admissions were clearly very disturbing for all concerned.

Stressful relations between the men and their families were evident during their admission to hospital and when they returned to their homes. Once the men had been admitted to hospital, their family members disappeared and in most cases no one visited the patient whilst he was in hospital. This was also true of their employers. Xolile was the only reliable case where the grandfather and mother continued visiting and spoke openly with the medical staff. It was clear that relatives were afraid of their mentally ill, sons or nephews, or perhaps of the hospital. It seemed their psychotic episodes had brought chaos and the men were seen as potentially dangerous and to be avoided. They also did not understand what had happened. During their recovery periods all five men alternated between taking their pills, consulting a healer, and visiting a clinic or general practitioner. They all had a rationale as to why this was done and when.

4.7.5 Return to the mother's home

There were two critical aspects related to stress, in these men's return to their mother's home after circumcision. The first relates to the fact that this return to the mother's or women's domestic domain is stressful for all men. This is the new world in which they had to prove themselves as men. The second aspect is that for these five men the onset of their illness happened at different times, in this new world.

4.7.6 Stress in the domestic domain

There was no evidence, even for Lindelo, that any of the men were considered remiss during their period as new men. Having thus successfully completed circumcision these men returned to their mother's and childhood home and this proved to be stressful. In respect of a stable parental home Xolile, Ayenda, and Lindelo returned to their mothers' clan and home as distinct from their parents' homes. Mpumi returned to his mother's brother's home in the Eastern Cape. Unathi was the only one who returned to his parental home with his father and mother there (but to his mother's clan).

The data suggested that those men who had strong support from the mother and family e.g. Xolile and Mpumi, were better able to adjust in the following six months. This said, all spoke of the fact that their previous intimacy with their mothers had changed and in many ways they became 'silent' to the mother. In so doing they assumed responsibility for her and the family. He was expected to earn a living and contribute to supporting them. Ayenda spoke about how stressful it was to meet these expectations. This period of transition was therefore anxiety provoking, often because men did not know on whom they could instinctively rely.

Further anxiety came from their being under the authority or watchful gaze of men. This was done to reinforce their masculine disposition in terms of attitude, behaviour, and psychology. Empathetically and socially they had to be more with their peers and older men. Training for this began as initiates in their learning a secret language that oriented them into a new coded male language and knowing when to be silent. Dr. Soga spoke of this when she said to Xolile that, *"The ritual was making psychological shifts real."*

4.7.7 The onset of psychotic illness

The onset of their psychotic breakdown happened for the five men, in this period of transition after their return. The evidence showed that the onset of psychotic illness in Xolile's and Mpumi's cases came immediately after circumcision and within days of 'their return' home[243]. This holds significance for their suffering Cultural Bound Syndromes. In Mpumi's[244] case the onset of illness followed his journey back to Cape Town and work.

Onset of illness happened for Ayenda, Unathi, and Lindelo in the months of apprenticeship, after coming out. The data in general showed the stressful nature of these months as *abafana* to be undervalued or less spoken about. It is possible that in comparison to the drama of circumcision this period seems mundane. It is also

[243] In his behaviour the newly returned man has to be seen wearing his cap and jacket and behaving respectfully and with humility.

[244] Mpumi, despite being ill and having no parents, was better able to fend for himself and very quickly defined his boundaries and secured his manhood. Xolile struggled through and eventually separated psychologically from his mother and grandfather, whilst completing his six months as a new man. Xolile, more than any of the other four men, was involved with and protective of his siblings.

possible that it is purposively underplayed because it is so stressful. Elders expressed a quiet attitude about this period but young men seemed to party and take risks. What was clearly illustrated was that a very real and conceptual division exists between the world of circumcision and the *"new world"* that is represented by the domestic space of the mother's home. Xolile and Mpumi's cultural bound syndrome may have demonstrated how potentially 'mind altering' this transition can be.

In the case histories of Ayenda, Unathi, and Lindelo who suffered from Schizophrenia and Bipolar Disorder, this was a period of unrelenting chronic stress where diverse stressors from poverty to migration and intense psychosocial demands impacted on their already vulnerable persons. Ayenda left his mother's family soon after circumcision for Cape Town. He had good recall of this journey and expressed a positive attitude. Against enormous odds he tried to secure a place for himself in a *"new world"* and in his job. Months later Ayenda returned to the Eastern Cape to care for his sister who died. His psychotic breakdown followed soon after this event.

In this transition phase Lindelo returned to Cape Town with his mother, but he remained unwell. His admission to hospital came four months after his circumcision. It was important to note – that when he was interviewed in hospital – he did not show the caution or respectful attitude of a new initiate. Xolile and Mpumi had this respectful gesture even when they were ill. Complicating factors for Lindelo was his mother's mental illness and their constant moving from place to place. In respect of Unathi, following his return from circumcision it appeared that he did behave appropriately and wore his cap and jacket. However, his first admission came within months of circumcision.

4.8 Stress in circumcision

The rule is that the youth must choose to be circumcised. This states the ideal and it appears that other than Lindelo, all did choose to go. This suggests that throughout the rite of passage – an extremely anxiety provoking procedure – they had integrity. This is because initiates enter the event as immature initiates and their social emergence as men is conditional. Through circumcision youth enter the definitive state of "manhood" and in this, over time, they become Xhosa men. However, even

though descriptions about circumcision seem stressful, it was never said to be so. In screening for stress-related factors many diverse comments emerged as to what was stressful i.e. being circumcised in Cape Town as opposed to the Eastern Cape. Evaluative comments were also made as to why it might be and this sometimes attributed blame. Such comments included social circumstances such as being circumcised into your mother's patrilineal line; your father being absent; a poor *amakhankatha*; or bewitchment from not being properly prepared.

Another stress that was relevant to social status and stigma in Cape Town was having a poor circumcision party and if your family were very poor. Social status was also problematic for those initiates who paid for themselves. Ayenda and Mpumi did pay for themselves, but this was not seen as an achievement. In fact this brought more anxiety and stigma, especially if he had organised his place in the event. This circumstance was exacerbated if an initiate had no close kin to support him. Stress around income, work and kin being supportive was again evident in the expectation that the new man must be responsible, marry, and have children.

4.8.1 Participation

The data on the men's participation in circumcision came in the first instance when they were acutely psychotic. What was said to be stressful therefore had a particular bias and collateral from family and others e.g. work colleagues and nurses assisted in understanding the nature of stress in their circumcisions against their distress as mentally ill patients. Their circumcisions all lasted for roughly four weeks and interestingly all said, *"There were no problems in the bush."*[245] This was the common phrase used and it is possible that there was a cultural imperative for them to make this statement. This suggests that they remained mentally well enough to manage any stressful circumstances and the procedures. Xolile, Ayenda and Mpumi claimed to be well and this was affirmed in their later accounts. Xolile and Mpumi's accounts were more reliable because their psychosis went into remission. Unathi, from his family reports remained well, but Lindelo as previously noted may have been mentally ill. It is noteworthy that Unathi's and Lindelo's families claimed there were *"no problems"*.

[245] This thesis will use the term *"in the bush"* to describe the circumcision period. It is also referred to going to the mountain and later on in this text a Xhosa-speaking medical student described it as *"he had been to the Eastern Cape."*

4.8.2 Pain

Evidence suggested that the preparation for circumcision taught youth coping strategies to face pain and stress. Traditional healers and elders prepared them psychologically and spiritually for pain. They also taught them to endure the stress of being wounded and vulnerable as it was believed that this exposed the initiate to attack from witchcraft and evil intentions. Wounds were sometimes pulled at in the seclusion and Lindelo described, *"I was looking after my penis in the bush, wearing blankets so not to get cold. To be a man you have to be strong, as long as you experience pain."*[246] Coping strategies meant that initiates were protected, but these also trained their responses and future behaviour.

The data indicated that the anticipation of the operation, the experience of pain and the memory of this brought considerable apprehension and anxiety to the men. Pain also had many and diverse psychological and social implications in that men were expected to respond to pain and circumcision with gender described behaviour and this was anxiety inducing. This was shown when questions about pain were avoided, left unanswered or pain was denied. One man said, "*In the hut and when I left the circumcision seclusion I was well. I did not feel pain or fear."*[247] In general, although some men when suffering psychosis spoke about pain in circumcision, most denied having experienced it.

Their silence spoke to the taboo of not speaking about pain or showing fear. Xhosa male nurses described that in circumcision an initiate had been given a standard response to deny pain. This engendered respect and resilience but also induced stress. The evidence indicated that resilient behaviour around pain and stress was demanded for a man to become closer to his ancestors. The operation cut the youth from old ways of behaving – and opened his path to his ancestors and patrilineal descent. Mr. Mangesi alluded to this when he linked the experience of pain to 'forgetting' and this to being silent or secretive[248]. One reservation in this, is that the men's mental illness,

[246] Field notes 2/12/02
[247] Field notes 21/3/01
[248] Silence meant 'not being heard' which suggested that even if pain was spoken about it – it would not be heard. Any feeling or experience of pain was expressed and dealt with in silence – it was not shown.

may have changed how they responded to and remembered the circumcision experience, and pain.

Ayenda was the one man who in later interviews, did speak about pain in circumcision saying, *"The pain was bad but in the beginning, it was not bad later on."* Mr. Mangesi commented that *"It was difficult for a man to admit to the pain."* Given the taboo – a number of reasons present as to why he did so. Firstly, his mental illness may have meant he let his guard down and secondly, he came to trust us. He was also less convinced about the authenticity and value of current practices and questioned the values imposed on initiates.

The expression of pain was complex and required culturally described behaviour that was bound by rules. Mr. Mangesi said that the denial of pain was *"binding Xhosa-speaking culture differently to others"*. How pain was expressed also changed, as a man left circumcision behind him. Overtime, his response shifted from being silent in the operation, to actually denying having any sense or memory of pain. This was integral to being a Xhosa man. Mr. Mangesi described the secretive nature of the experience and expression of pain as, *"There is a reason for patients in forgetting the events of the past. Some of the questions we ask touch on issues that are secretive. They know that they must respect this and my command (or asking) cannot be heard, especially with females. So they have to deny. The question of pain is secretive and you cannot voice this out. Xhosa men work together differently."*

The data also revealed that considerable protection and containment had to happen for initiates because they were wounded. The seclusion was forbidden to outsiders and categories of people such as women who would weaken the youth. Trust was therefore at issue and this makes any experience risky and stressful. Further, the individual youth had to demonstrate that he alone could physically survive the pain of the wound by demonstrating the psychological strength needed to do so. The white paint and the binding of the penis culturally hid the youth and his wound from further injury during this vulnerable painful period.

4.8.3 Peers and teachers

The data on 'aloneness' arises out of investigating how well these five men integrated in circumcision with their peers and teachers. During circumcision the initiate must assimilate to the group and he must be accepted by them. However, circumcision also deliberately shifted relationships around the individual initiate, so that he could openly acknowledge these new allegiances. These changes were stressful. Mr. Mangesi gave this explanation to me after one interview. *"In circumcision you must eat all of the sheep from the head to the tail…. If you have been to circumcision you have to know whom you are equal to and who not. If after two years you visit, you cannot command in the bush, but after five years you can start talking and commanding. This gives authority."*[249] Here older men and teachers painstakingly show initiates that even the act of eating, means knowing your status in a male Xhosa hierarchy.

Being alone therefore has cultural implications and the concept was fundamental to circumcision. The ritual practically orchestrates a sense of belonging amongst peers but also sets rules as to when and how it is appropriate to be alone. This trains a man's personality, behaviour and conduct in terms of cultural traits such as resilience in manhood. Thereby the degree to which each man was inappropriately alone was at issue. Xolile and Ayenda remained more alone during their stay in the bush. Ayenda's said, *"I was circumcised alone. I had a khankatha – yes and there were no problems with him."*[250] Lindelo was in the Eastern Cape for his circumcision and said he was with a childhood friend the whole time. Unathi's uncles said he was not alone and at eighteen years old and circumcised in his home this would be likely. Mpumi was also not alone for the same reasons. Being alone whilst in circumcision and suffering rejection or malice is an increased stress for a vulnerable individual.

This information was critical, as psychiatric assessments also describe any strange or isolated behaviour, as an indicator for possible mental illness. Strange behaviour induces stress in the person and in those around him or her. The degree to which each man felt incorporated, into the group or cultural process was important. So too, was whether he was perceived by others to have been included. The probability is, that if

[249] Field notes 29/10/02
[250] Field notes 23/10/01

any of these men were mentally ill, they would have isolated themselves or been marginalised. Being inappropriately alone – was therefore at issue. This may have indicated that, as with Lindelo, the youth went into circumcision suffering stigma and stress in the hope that this would make him less strange.

4.8.4 Experiences of witchcraft

All men followed tradition and prepared for circumcision by seeing a traditional healer. This protected them from witchcraft. As a theme witchcraft ran through all the stories. Only Mpumi did not claim to have been bewitched. The other four claimed to have been bewitched and as a consequence were disturbed. This suggested that something had gone wrong in their relationships or with the ancestors. Other than Xolile, none of the four, claimed to have been bewitched in circumcision but inferred it had happened afterwards. In the bush, most recalled being stressed about the dangers that witches bring, initiates. Bewitchment was closely related to jealousy about their manhood.

On the ward bewitchment manifested as fear and stress and they felt these forces were following them. Bewitchment formed part of their paranoia, and the psychosis in which, as patients they lived. Most often they stated that *"their trouble"* was not illness, but bewitchment. Further, their psychosis – the auditory and visual hallucinations – made their bewitchment even more convincing. During follow-up this rationale changed and another logical story about their having been bewitched emerged. Ayenda's account is insightful and given two years after his admission. He said, *"But if the evil spirits are there they could be doing something… I used to hear those voices. They used to affect me in my body strength…Yes, I think I was bewitched – I have gone to a witchdoctor. I was bewitched in 2001…I was a man already."*[251]

Mpumi never mentioned bewitchment or being bewitched. In this regard, Xolile also distanced himself from these beliefs, when he was well. In his early interviews Xolile recalled, *"There was black magic and witchcraft surrounded me (in the bush)."*[252] He expressed mounting anxiety – about his different intellectual abilities – to his peers,

[251] Field notes 9/6/03
[252] Field notes 9/4/01

whom he feared were jealous of him. He explained, *"Friends in the bush, because of my being a good careful person, bewitched me. Witchcraft is real because it is the social pressure from those beliefs."* This quotation was given when he was well and illustrated how he adopted a more westernised rationalisation about witchcraft beliefs. His reflection shows insight and an 'intellectual grasp' of what had happened to him. After Xolile returned to university, he became circumspect about any accusations around witchcraft.

It was interesting how families and neighbours were pulled into these stories, often increasing their already stressful circumstances. In addition, the terrifying reality of a psychotic family member or friend convinced the community that bewitchment was an evil curse, and this was seen as deserved. Family and others often concurred with patients or each other, on a version of a bewitchment story. For instance Mr. Mangesi felt Xolile was bewitched and ill because, he was urban[253]. Bewitchment was thus shown to bring moral censorship and reinforced tradition. However, agreement on what was orthodox tradition constantly shifted. Another example of the cause of bewitchment within the community stated, *"If one takes his son from his wife to school (circumcision) then other boys and children are jealous and may not be as well as him. They may make him ill and so you have to be 100% well. Some people become ill when there and some it helps. Ayenda took himself. There were no people watching over him or giving interest in him for instance his family in Gugulethu. When did you say he became ill?"*[254]

4.8.5 Drugs and alcohol in circumcision

All five men denied taking drugs or using alcohol whilst in the bush. The study question that was asked related specifically to behaviour around substances whilst in the bush[255]. In the past the use of drugs or alcohol was expressly forbidden, but today the data and media reports indicated that some initiates break this rule. Although the taboo remains very strong it is possible that peers may have encouraged the use of alcohol or drugs in risk taking behaviour e.g. Unathi.

[253] Field notes, 18/9/01
[254] Field notes 30/10/02
[255] It should be noted that the study question and answers differed from a question on substance abuse in their admission notes. This information was required by the health teams in the hospital as a screening and diagnostic tool.

Xolile and Ayenda both denied using drugs or alcohol, especially cannabis. Xolile was circumcised in Cape Town and closely watched over by his family and grandfather. In Ayenda's instance he returned to his family home and paid for his own circumcision. He would be unlikely to have compromised this personal investment and was concerned to not 'lose face'. Over a three-year period of knowing him he showed extreme caution about alcohol or drugs. He also had remarkable insight into his vulnerability and on his second admission had in fact been taking more medication than was prescribed. Mpumi returned to his family in the Eastern Cape and his story suggested that he maintained his integrity as an initiate and would have followed tradition.

Unathi and Lindelo were the two cases in question. Unathi and his family both confirmed that he had used drugs and alcohol when he went missing from his home. His denial was suspect, given this evidence and his two hospital admissions. Lindelo was an unreliable informant and as he was unstable when he went into circumcision may have been vulnerable to peer pressure.

4.8.6 Language, culture, and ritual symbols

The use of language and cultural symbols were clear indicators of stress and mental illness. Ayenda's psychotic imagery centred on him "*being a dog"*. This is an interesting association, as this evidence describes how degrading language can be used in rituals e.g. references that women or boys were dogs. Rituals are said to explicitly degrade those who have status and respect, as part of the process of transformation. However, such words and behaviour cannot be out of place but must remain within the context of the ritual. This is illustrated in Ayenda's use of imagery which went as follows, *"Circumcision is too difficult to explain [to me] because you are a woman. Circumcision… afraid sometimes… dreamt in school. I am a dog.*" I asked if he heard voices and he replied, *"Only your voices now. I am a dog, I am a dog, I am a dog."* After the first two days he said, *"You are a dog, you are a dog… repeatedly. It is better not to have voices and I have no bad voices, no visions, and no dreams."*[256]

[256] Field notes 14/11/ 2001

Another image, suggestive of culturally relevant symbols that manifested in the men's psychotic imagery was their circumcision blankets. These play a central part and symbolic role in circumcision. Ayenda's distress, when acutely ill, about the loss of a blanket, mirrored his *"dis-ease"* in seclusion. He recounted, *"One (blanket) that he got before he went home from the bush, from when you are leaving, and the father brings you another blanket to cover yourself when you go home and you keep that blanket for the rest of your life."*[257] The blanket referred to the distress he felt about his father's role in his circumcision and this became part of real and imagined stressful aspects of his life. He later remembered giving his blanket to his aunt who died. But he gave it to her because *"there were people he did not like there"*.[258]

These remembered symbols, linked into events and practices that marked a symbolic passage in time, during circumcision. On some occasions these symbols and memories brought solace and resilience as is suggested in the following quotation. Xolile when suffering from psychosis referred to his experience of the hut burning as he was leaving the circumcision seclusion saying, "*When the hut is burnt you are feeling well and leaving something I was doing as a boy and now I am going forward to do something. I was not stressed about the burnt hut because I can't stay there anymore. I was stressed about my new life and because I did not know what was happening. The pain disappeared. There is no fear, it happens to all abakhwethas and you feel good and there is a celebration and you feel strong. When you are a man you feel good and it is part of you doing better things now, better than before."*

Ayenda, months after his first admission to hospital, gave this reflection on the symbolism of the white clay that covers the body and face during the seclusion period. This insightful recollection, illustrates the marginal status of initiates. It is enlightening, in terms of how stress and anxiety is felt, but also how cultural bound syndromes or altered states may be potentially destabilising. He told us, "*With the white clay you feel like a person – like others but you are on other land now in anther position and after you complete washing then you are a person like the others. You do not feel dead because you feel visible and this is different from invisible. You are the same like other people only the white colour but different – you are an abakhwetha."* He then becomes unsure about whether this is visible or invisible. He

[257] Field notes 5/3/2003
[258] Field notes 14/3/03

says, *"You are different because there are many somethings that are happening and there is difference but it is too secret."*[259]

4.8.7 Dreams and visions in the bush

In a cultural context dreams and visions can herald bewitchment and need to be watched for and dealt with in seclusion. There were no accounts of disturbed dreams for any of the five men. This assessment may, however, be inaccurate because confidentiality in the research meant we could not interview other initiates or teachers. To distinguish, between dreams, and hallucinations in psychosis, each man was asked whether he had experienced any vivid dreams, visions, hallucinations, or heard voices whilst he was in the bush. This was asked when he was a patient on the ward and subsequently after discharge. All five men said that they did not remember having any unusual dreams, visions, or voices, in the bush. These answers implied that none appeared to be psychotic during their circumcision. Lindelo remained the only one whose answer seemed problematic.

In the cases, nine months after his hospital admission Ayenda confirmed what he had first told me saying, *"I had no dreams and no visions. The group accepted me."*[260] Ayenda in this reference made a distinction between everyday dreams and the disturbance of visions. Moreover, visions would have made him seem strange and his peers would not have accepted him. When asked the same question nearly a year later he affirmed this and remembered his pain in circumcision. He said, *"No, I had no strange dreams. I did not see anything. There were no evil things and I did not see anything."*[261] A possibility exists that he was hiding his symptoms but he was always very honest about the visions and voices he experienced and talking about them made him less afraid. Xolile and Mpumi like Ayenda also made distinctions between the voices and visions of their psychotic episode and their dreams in circumcision. These men recalled and others agreed that their dreams during seclusion were not out of the ordinary. They did not lose their orientation in the bush.

This perspective is important in understanding the psychological wellness of these individuals, but also the marginal and stressful experience of the bush. Some young

[259] Field notes 30/10/ 2001
[260] Field notes 8/7/02
[261] Field notes 27/05/03

men, I have spoken to, who remained psychologically well following their circumcision, claim to have had visions and voices during circumcision. These were very disturbing at the time. The evidence from these accounts suggested that most initiates, including those who became ill learnt how to distinguish the dreams of the everyday from those that were strange and disturbed.

Culturally, dreams in seclusion were understood to be a means to understand a man's capacity for psychological resilience. Thus the quality of their dreams was important. This was later shown in that, although the men were mentally unwell and hallucinating, there was an unsaid expectation of themselves and from significant Xhosa-speaking *"others"* that they should be resilient. These other people ranged from family members to nurses. Resilience meant that they were strong in mind and in their behaviour, and showed this in their intentional action.

4.8.8 Other considerations

The sad reality for all five men was they had few resources to support themselves. Indeed other than Xolile, who had limited means, all suffered desperate poverty. What appeared to be evident was that the patrilineal descent system that had circumcised them had ceased to function politically, geographically or in terms of supportive kinship. Poverty and migration had also altered the nature and possibility of having intimate relations, especially that between father and son in circumcision. It also appeared from the data that because of these factors, the very ideological structure of patrilineal descent was at issue, as was the continuing significance[262] of circumcision. All men expressed some doubt about its present value. When asked if he was proud to be circumcised Ayenda was uncertain. He felt that circumcision had changed. Amongst this generation of men in Cape Town, circumcision did not seem to prepare them for their tasks in manhood. This was because circumcision changed their attitudes and behaviour, affecting gender-described behaviour relevant to Xhosa people and not for a modern cosmopolitan city. The social networks that were empowered through patrilineal descent had therefore, become less relevant and not supportive.

[262] Schapera, I (1956) comments that there was a far greater diversity in beliefs, customs and practices than under an old tribal tradition. This includes differences in opinion between the young and the old and between the sexes.

Furthermore, in the study, the fact of taking up a Xhosa man's life tasks was a daunting prospect, as many of the skills acquired in circumcision gave them no psychological, educational, or social advantage. Ayenda, for instance, wanted to be responsible and marry, but he had no income and his savings paid for his circumcision. He remained alone and mentally ill and there was no supportive patriarchy. All men had intentions to earn a respectable status, which traditionally meant acquiring *lobola* for a wife, land and cattle but this was out of context with the urban poverty they lived in and their being mentally ill. They wanted families, jobs and homes and expressed resilience and preparedness to find these, but could not.

Another important aspect in their lives was that diversity and democracy had brought each man into a biomedical pathway to care, during the acute phase of their illness. Their admission treated their acute psychosis and ameliorated their anxiety. This offered them some therapy and chronic care but the biomedical domain failed to appropriately engage with their cultural backgrounds and this very significant event.

CHAPTER 5 – DISCUSSION

5.1 Introduction

This chapter describes the stress-related circumstances and mental illness histories of five Xhosa-speaking males who were admitted to Valkenberg Hospital within one year of their circumcision. It was apparent from the data that circumcision played a significant role as a precipitating event in the onset of their mental disorder. This statement is qualified, as the evidence demonstrates that circumcision practices have changed, and in this culture initiates and their families face many more diverse problems and worries than they did in the past. Diverse stressors were shown to be inherent in the rite of passage, in their psycho-social circumstances, and in a shared socio-cultural environment (Szabo et al, 2005, p 119). These contributed to their feelings of anxiety, placing them at increased risk for psychotic disorders. The culturally prescribed nature of their psychotic presentations was revealed in culturally-based hallucinations, delusions, and voices e.g. *"I am a dog"*, illustrating the nature of their precipitating event (Guinness, 1992).

Their diagnoses suggested that each man had some genetic and biological predisposition for known psychotic disorders (Holzman, 1996; Alexander et al, 2005; Kaliski, 2005). The data intimated that the precipitating stressors they suffered corresponded with or were related to each man's particular predisposition or vulnerability (DSM-IV, 4th Edition, 1994). Thus whilst stresses, as previously stated were culturally prescribed, each Xhosa man's life held a unique quality in how his illness manifested and was experienced. In respect of the complex inter-relationship between genetics, psychological disposition and a socio-cultural environment, Strathern's comments on mid-century notions of procreation pertain, *"persons are natural hybrids: the creative recombination of already differentiated genetic material makes everyone a new entity. The past might have been collected into ancestral traditions, but the future lies in perpetual hybridization"* (1992, p 96). Taking this into consideration, the thesis addresses how each of these five men, who were diagnosed with a DSM-IV psychiatric disorder, struggled in their own way to overcome the adversity of mental illness and meet the cultural demands placed upon them as newly circumcised men.

The psychotic disorders suffered by the men in this study will be described in respect of two outcomes. The one outcome refers to Schizophrenia and Bipolar Disorder as representative of more severe long-term psychotic disorders. The second refers to Brief Psychotic Disorders or altered states in the context of Cultural Bound Syndromes. The nature of stressors that preceded the onset of illness in each outcome appeared to be different (Allwood and Gagiano, 1997). The discussion on these two mental disorders has a focus on the men's perceptions of stress in the context of the journeys they underwent in circumcision and in suffering from mental illness. It is important, therefore, to remember that stress must involve significant *"threat and loss"* to bring about a pathological response (Katona and Robertson, 1995).

I. Precipitating stresses for Schizophrenia and Bipolar Disorders involved more chronic stress. This was evident in the onset of three of the men's psychotic illness after months of their adjusting to manhood and the circumcision event. Their personal circumstances were exacerbated by other anxieties relating to unsupportive family, poor attachment in childhood, and trauma. Underlying these stressors were environmental stressors such as poverty and migration.
II. In the other two cases, stressors that were to precipitate their Brief Psychotic Disorder as Cultural Bound Syndromes appeared to be inherent in the rite of passage. Their experience of cultural bound syndromes was indicated in that their psychotic breakdowns happened immediately upon their leaving seclusion. This suggested that a liminal experience in circumcision was conflated with an altered state upon leaving. The particular vulnerability of these two men meant that they struggled psychologically to leave their altered state and re-enter more ordinary life. Additional evidence for this diagnosis was their remarkable recoveries.

Following this analysis is a description of themes on stress in a more general sense. Select themes will be highlighted in this introduction and these will be detailed and elaborated upon in the later discussion. These themes differ from the previous analysis in that they draw on the wider data from focus groups, interviews, and field trips, expanding upon information from the life histories. In this broader analysis other perspectives emerge as the voices of Xhosa people are heard – and importantly those of men who remained well after circumcision. These offer a comparative

perspective. Furthermore, how harmful stress was perceived and may have influenced the onset of mental illness was explored across Xhosa-speaking culture. This provided important insights into local idioms of distress around circumcision.

Stress in the study was shown to be a complex phenomenon. Whilst stress was potentially harmful, paradoxically circumcision requires that Xhosa people induce a stressful, challenging event where feelings of anxiety often compel a youth to go. Although anxiety can become pathological, e.g. overwhelming fear or traumatic injury; circumcision continues to have cultural relevance, inculcating resilient behaviour and coping strategies in males (van Vuuren and de Jongh, 1999; Gasa, 2003). The sometimes personal nature of stress e.g. psychological harm was thus juxtaposed with stress that was of a socio-political or cultural nature e.g. crime and violence. Of all stressors, the most important was that of the father who was absent at circumcision. This was because as Ngxamngxa (1971) described, the youth chooses to go for circumcision but it is the father who – in a momentous symbolic gesture – claims the initiate to his father's descent line and manhood.

In respect of harmful stress, all five men reported adversity during their circumcision and some of the stressors they experienced proved to be common to initiates. Each respondent described significant social and sometimes psychological stressors affecting their childhood or youth. These all too often were prevalent across this community. Critical among these were experiences of having absent fathers, working mothers who were single parents, disrupted family lives because parents and kin migrated for work. As stated in this regard, the most significant and commonly spoken about stressor was when the biological father was absent at circumcision. Although the practice accommodates deviations from the norm, the father has an unquestionable role to fulfil (Mayer, 1971; Ngxamngxa, 1971; Mager, 1999; Van Vuuren and de Jongh, 1999).

The importance of the father's role was constantly emphasised in the data. One Xhosa woman encapsulated all that the father, circumcision, and mental illness meant in her comment, *"It is important to know your father when you are a boy so that when you go to the initiation you go to your father's clan because you can go mad if you do*

it wrong to another clan." [263] This is a local Xhosa idiom, around which other stresses cluster accentuating his absence. For instance, when he was not there initiates were not properly prepared, or had not developed early coping strategies and were anxious. Of interest was that fathers were not blamed for not being there; possibly because people empathised with the fact that a stressful, poverty stricken life had often prevented them fulfilling their role. Paradoxically, this same environment held strong kinship bonds and ancestral customs which bore testimony to a resilient patrilineal custom.

A related stressor is that the attainment of *"manhood"* is actually a lifetime process *"of becoming"* and not achieved in circumcision (Mandela, 1994). This concept highlights the embedded symbolic nature of circumcision in reaffirming cultural and gender relations. This also describes why circumcision is inherently stressful. The corollary to this is that when cultural practices come under duress, stresses challenge ritual performance and the wellbeing of initiates. As cultural dissonance, these challenges question the value of this rite of passage, thereby undermining its function and purpose, i.e. to assimilate men to their patrilineal ancestors. In an ideological sense Bloch (1986) argues that circumcision as a rite of passage is elective and happens across generations for timeless ancestors. Amongst African autochthons, ancestral customs are, however, more a lived reality of their worldview than an ideology – and circumcision has, as Ngxamngxa (1971) insists, a more ordinary function. The ritual facilitates a spiritual shift for psychological transformation and the social transition of youth into Xhosa manhood. As an almost instinctual custom, Xhosa-speaking people submit season by season to a cultural impetus to bring the ritual to fruition[264].

When all is well the ritual harnesses the productivity that these stressful rites of passage induce. However, small shifts – such as unavailable resources or how duties

[263] The original Xhosa given by Nomonde Jwambi was, *"kubalulekile ukumazi utata wakho xa uyinkwenkwe ukuze xa usaluka wenzelwe ngesiko likatata-wakho kuba ezinye iziduko zisitrongo kumasiko awo unga phambana xa usenza ngesinye isiduko na xa benze wrongo"* (Field notes, 13/07/07).

[264] Traditionally a man's circumcision was remembered by season and significant events in the family, lineage, and environment. Twice a year, at the time of circumcision for youth in June and December, people in the community-at-large prepare for the event. Only a certain subset of peers and their parents will be involved in the ceremony – which affirms age-graded peer ranking in those males. Infertile young women can cross the male boundary into the circumcision seclusion, but fertile women cannot. The seclusion and coming out party therefore reveal the young women who have become fertile alongside their male peers.

are performed – potentially disturb its functionality thereby inducing anxiety and undermining the integrity of the process. The intricate nature of this web of purposeful duties is illustrated in this quotation: *"His malume (mother's brother) chose his khankatha…. He was a good teacher. Every day his uncles visited him in the bush. His cousin cooked food for him. She is Noloyiso… she is sixteen years old and she brought the food to him."* As cultural dissonance this disturbs not only duties and responsibilities but also the meaning and structure of symbolic rituals.

Gordon and Yowell (1999) argue that cultural dissonance *"is a sense of discomfort, discord, or disharmony arising from cultural differences or inconsistencies which are unexpected or unexplained and therefore difficult for individuals to negotiate… attempts to resolve discordant issues can be bewildering or distressing"*. Guinness (1992) argues that dissonance shifts cultural wellbeing and this manifests in patterns of mental illness. Dissonance in the study was evident in how Xhosa males – especially students at university – spoke about masculinity. They had different aspirations from men in the past in terms of work, family, and leisure. This undoubtedly, influenced the attitude and commitment with which they, as initiates, went into circumcision but also their later emerging sense of identity (Mager, 1999).

A further complexity is that gender and concepts of personhood and status amongst the amaXhosa are subtly different to those described amongst people of other descent in Africa (Mager, 1999; Tangwa, 2000). This is illustrated in that Xhosa manhood is anxiety inducing, because masculinity and also descent and marriage prospects hang in the balance at circumcision. Gender can become definitive at key points in the ritual, as after circumcision when the initiate shouts, *"I am a man"*, but at other times gendered distinctions become blurred. Circumcision and seclusion, for instance, entailed a mediated crossing of people with different status and gender designations between male-dominated domains and domestic arenas where women hold more authority during the ritual. As such, females participated in the rite of passage and had an equal, but different role. However, a youth who was uncircumcised remained a boy and dependent in the female domain. Although he belonged with women, suggestions of femininity were not necessarily implied.

This evidence begged the question of whether these men's mental incapacity had affected their status as men. In general it appeared that because they had gone through circumcision and remained well afterwards their manhood was unaffected[265]. The following comment from a young Xhosa-speaking colleague[266] is relevant and indicates that manhood is achieved not in, but through a process of circumcision, *"If psychotic after the bush and in hospital it is very difficult. I have no experience of this. If you have fulfilled all the roles then you are a man. But if you go to hospital and do not fulfil all the roles then you are not a man but a half man. Everything is important. If you see the hut burn then you turn into a soul statue and this is quoted in the bible. The same party is held for the abafana at the end of six months. Then you are asking now will you excuse me from this and can I take my clothes off?"* Thereby, as seclusion had been a dangerous psychic and physical journey which they had prepared for with traditional healers and endured, they were expected to show resilience in how they coped with illness. Close parallels were drawn between the world of psychosis and that of bewitchment.

Reports on problems in circumcision feature consistently in the South African media at circumcision times[267]. These describe injury, anxiety, and trepidation for many men and their families[268]. The study was to corroborate much of this, indicating the grave concern for initiates' safety and rights (Meintjes, 1998; Van Vuuren and de Jongh, 1999). One significant aspect, undervalued in these reports, is psychological harm and the mental health consequences of unacceptable levels of fear, pain, and anxiety in "botched" circumcisions. Some ambiguity existed in how mental health interventions were viewed by Xhosa-speaking people as traditional taboos often deter initiates and their families from accessing health services. The data does provide evidence of a functional but problematic pathway to mental health care which seeks to address problems within a primary health care context (Goldberg and Huxley, 1992).

5.2 Psychiatric disorder following circumcision

This thesis argues that two possible psychiatric outcomes were presented in the cases of the five men in the study. Exploring the nature of these outcomes draws on the

[265] Field notes April 2003.
[266] Appendix 2 (CD) 2.3 Interviews with Xhosa People – Xolile April 2003
[267] Special Assignment on SABC3 (Tuesday 14th August 2007).
[268] See Bibliography for media references.

explanations of two health professionals; a consultant psychiatrist and a Xhosa-speaking male psychiatric nurse from Valkenberg Hospital, Cape Town. Their explanations offer a local and psychiatric interpretation of the phenomenology around circumcision, stress, and mental illness. These two different outcomes for Psychotic Disorders are suggested from the evidence presented in the five case histories;

a) Psychosis in the context of Schizophrenia and Bipolar Disorder.
b) Psychosis in the context of a cultural bound syndrome.

Some background explanation precedes these professionals' discussion on mental illness in the context of circumcision practices. Firstly, the fact that circumcision remains a critical life stage event across the culture means that stressors contribute to the onset of psychiatric disorders. Furthermore, changes in the practice that are problematic increase the risk for those who are vulnerable and impact across this socio-cultural environment, increasing the likelihood of stress-related mental illness in Xhosa-speaking people (Goldberg and Huxley, 1992; Gilbert, 1992). The potency of this rite of passage for Xhosa men is witnessed in the culturally contained harmonious transitions and resilience of most men. However, when circumcision practices are fraught, cultural discord occurs in families and in the community (Ntantala, 1993).

One consequence of this socio-political change is that more discomfort and stress is felt by initiates as personal dissonance, affecting the onset of psychotic illness in those who have a predisposition. One important consideration, however, is that because circumcision still critically defines those men who are seen to be socially acceptable, mental illness may be a safe haven for those who have been marginal or feel inadequate. This suggests that mental illness may become an option for a man not to confront his own social and psychological life issues. This is a potentially very powerful strategy, enabling his access to scarce resources and an alternative status.

In this respect it is also important to note that a pathway to mental health care for these men was not unproblematic, as culturally their intuitive pathways to care would have been to traditional healers. A phenomenological perspective needs to consider this in their mental illness histories, as this infers that their access to biomedical care potentially brought them feelings of cultural dissonance as described in the literature

(MacGregor, 2000; Swartz, 2002). However, the literature also records a long history of the amaXhosa's socio-political engagement in diversity[269] and this has meant that rather than seeking traditional healers to assist when they were ill, they sought or were brought into a mental health pathway to care (Goldberg and Huxley, 1992).

On admission to hospital these men's circumcisions were incorporated into their DSM-IV (American Psychiatric Association, 4th Edition, 1994) assessment as a stressful life event contributing to their psychotic illness. This biomedical rationale proffers a different interpretation on stress, Xhosa-speaking circumcision, and mental illness to that which would be considered in a traditional domain. Dr. Bauman, a consultant psychiatrist in the hospital to which they were admitted, offered his rationale on the perceived relationship between circumcision and mental illness. His analysis is useful as it incorporates a phenomenological viewpoint and a cross-cultural psychiatric perspective (DSM IV, 4th Edition, 1994; Njenga et al, 2005; Edwards, 2005).

Dr. Bauman argued that, *"Circumcision plays a part in how the illness is expressed – it is an emotionally tense, challenging experience and demanding and this brings on the expression of the illness. But over time any other stressful event would do the same. Anxiety states for instance can be reversed with circumcision but not Schizophrenia. It would trigger a full-blown psychosis. Elders and supervisors are probably reluctant to proceed if people are not strong enough. Ayenda became a man at twenty-six years and this is odd. If you were this age and not a man in the community then you would have 'dis-ease'. Circumcision could bring about psychosis and prodromal features would be there beforehand but they would not be specific. It would be more like depression or anxiety. The circumcision is a trigger and was enormously powerful and this overwhelms the individual placing them gravely at risk."*[270]

[269] The literature poses that this conflict is not recent as the literature describes the amaXhosa experiencing conflict about circumcision for well over a century (Attwell, 2005). An early significant rift happened when traditional amaXhosa people embraced circumcision whilst an emerging culture of educated and Christian, Xhosa-speaking people chose to distance themselves from traditions such as circumcision (Mayer and Mayer, 1971; Ntantala, 1993).

[270] See Interviews with Health Professionals in Appendix 2.1.

In comparison to this, the literature and the data posed an alternative explanation to this biomedical perspective. This argues that cultural strategies and healing practices to cope with conditions similar to those described here as mental illness have long existed. This takes into consideration that one explanation for mental illness is bewitchment. Thereby traditional forms of mental health assessment and therapeutic healing for youth in general, but specifically those who may be more vulnerable were incorporated into customary practices. It appeared, for instance, that some vulnerable youth were deterred from going and coping strategies, e.g. containment and supervision, put in place for others in the ritual healing process. This is suggested by the fact that there appears to be very little injury or deaths in circumcision in the past (Turner, 1915; Barker, 1962 in Meintjes, 1999). The inclusion of this cultural discourse into psychiatry improves a phenomenological understanding of the aetiology of mental illness in Xhosa-speaking males in this age group, who may be at risk for mental disorders (Rowan, 1993 Meintjes, 1999).

The evidence in this study argues that, culturally, custom may distinguish two critical points when youths can be excluded from circumcision or the seclusion.

i. Before circumcision – some youths will not be put forward or may exclude themselves from circumcision and they will not become Xhosa men.
ii. During circumcision – a select few will not leave the circumcision seclusion. The evidence for this is hearsay and describes initiates who died in the seclusion, with their families knowing that they remained boys. In the past their bodies were not returned. Other cases were recalled where initiates were marginalised or never collected from seclusion because members of their family and patrilineal line disowned them. It is feasible that this anecdotal evidence describes those initiates who became psychotic during circumcision.

A Xhosa-speaking psychiatric male nurse offered this perspective on mental illness in circumcision, and this expands on the previously mentioned local idiom: *"It is quite likely that boys can be mentally ill prior to admission and then sent to circumcision to*

change their behaviour and (it is hoped) that this will turn them into men. After circumcision the men discover that they are still strange."[271]

He described three possibilities:

1. *Mental illness - sent to circumcision - remains unwell.*
2. *Trauma - because of vulnerability and isolation in circumcision.*
3. *Physical injury – depression.*[272]

This explanation is based in his experience of customary practices and suggests that stress in circumcision is known to engender resilience, being of psychological benefit to those youth who have *"strange behaviour"*. Furthermore, he recognises that the converse may be true, circumcision may have no benefit; as a psychiatric nurse he argues that these men may suffer with mental illness. His analysis confirms the possible outcomes suggested for the onset of psychotic illness in this study.

His argument for mental illness as a consequence of trauma in circumcision allows for the following reflections. If the operation or the inculcation of liminal states is not managed properly then injury and psychological harm may result. He affirms the possibility that disruptive social circumstances[273] or officials who have ill intent or lack moral substance jeopardise the success of the ritual (Mayer, 1971; Pauw, 1973; Van Vuuren and de Jongh, 1999). This is especially true when customary screening practices – either in preparation or after – to protect and support newly initiated men have fallen away. These disruptive practices instil the potential for harmful psychological consequences by exacerbating existing anxiety.

It is also important that the onset of illness for all the men was after circumcision. Two cases demonstrated that the rupture at the end of seclusion into an altered social and personal space was critical in the onset of their psychotic illness. For the other three cases, the period after seclusion left them possibly experiencing some

[271] His explanation is the inverse of Dr. Bauman's in the sense that as a nurse trained in psychiatry he builds diagnostic categories into a Xhosa discourse.
[272] This Xhosa-speaking male nurse said, *"Nowadays women say they do not want traditional surgeons because they turn our men into women"*. See Interviews with Health Professionals in Appendix 2.1.
[273] 'Disruptive social circumstances' refers to when the circumcision seclusion was poorly managed and fathers did not support their sons or monitor what was happening to them. Alternatively, youths may have come from poverty-stricken backgrounds where they had gone hungry or they had unstable social backgrounds and had been abused.

"prodromal features" in an unsupported, stressed, six-month period of adjustment to manhood. This speaks to these health professionals' concern that some men may endure low grade mental illness symptoms during and after circumcision. The issue arose of whether circumcision in their circumstances either embedded coping mechanisms that prevented anxiety or increased their levels of stress? This relates to Alexander et al's (2005) discussion on the importance of supported psycho-social circumstances, but here refers to familial and cultural support in ritual practice. The study data revealed, however, that the coping strategies of the two men diagnosed with Schizophrenia and one with Bipolar Disorder appeared to be compromised on leaving seclusion and over the following months particularly as they had very little support from their fathers and extended kin. The onset of their mental illness then deterred these qualities from emerging. In contrast, men who remained well had left circumcision with coping mechanisms that were psychologically embedded and they employed these strategically in intimate relations and social interaction (Nonganza, 2005).

Despite this evidence, Ayenda and Xolile – after their diagnosis with a Brief Psychotic Episode – showed a capacity for endurance when they were mentally unstable. This was evident in the way they spoke about a sense of spiritual 'dis-ease' and what was expected of them as men. Through this they also tried to prevent their psychotic imagery from disturbing a sense of equanimity and their posture as Xhosa men. Unathi and Lindelo struggled to make these distinctions because it seemed that their insidious symptoms and invasive psychosis overwhelmed their capacity to be reflective.

a) Psychosis in the context of Schizophrenia and Bipolar Disorder.

Discussion on these psychotic disorders explores how stresses around circumcision contributed to the onset of Schizophrenia in the case histories of Ayenda and Lindelo and Bipolar Disorder in Unathi's case. The discussion will briefly examine the relevant DSM-IV criteria for a diagnosis for these disorders. Ayenda's life history will then be used to illustrate how stresses in his circumcision contributed to the onset of his psychotic illness.

All three cases fall within the modal age for onset for Schizophrenic illness and for Bipolar Disorder. Schizophrenia occurs in men between the ages of eighteen to twenty five years[274]. Ayenda was the oldest and closer to the upper limit for onset – which is the mid-thirties. Bipolar Disorder was diagnosed for Unathi. This disorder is cited as equally common to men and women with lifetime prevalence in community samples of 0.4% to 1.6% (DSM IV). In both disorders their psychotic disturbance had to be such that they were unable to meet the ordinary demands of life, and of a pathological nature with objective hallucinations, delusions, or voices. For a diagnosis of Schizophrenic Disorder symptoms had to be active for six months and the evidence was that all three remained unwell. The DSM-IV suggests that there is an over-diagnosis of Schizophrenia in non-Western cultures and an under-diagnosis of Bipolar Disorder[275]. It is of interest that recovery from psychotic episodes would appear to be more rapid in developing countries.

Ayenda and Unathi both had second admissions for acute psychosis, which tended to confirm their diagnoses[276]. Regarding their particular vulnerability for these disorders, stress appeared to function as chronic stress before and after the circumcision event. The rite of passage imposed an additional burden to already existing stresses, increasing their anxiety leading to the onset of psychotic illness (Katona and Robertson, 1998). Other contributing stress-related factors included their psychological disposition and the already described environmental stressors.

Case Study – Ayenda

Ayenda's life story will be described to illustrate how diverse but typical stresses in this socio-cultural environment contributed to the onset of his psychotic illness. The

[274] DSM-IV (American Psychiatric Association, 4th Edition, 1994) Schizophreniform Disorder resolves after six months and there is much less decline in function. Onset can be abrupt or insidious. A better prognosis is associated with an abrupt onset, particularly where symptoms are more positive or flamboyant.

[275] DSM-IV (American Psychiatric Association, 4th Edition, 1994) In respect of Bipolar Disorder the first episode in males tends to be a manic episode. Approximately 10%-15% of adolescents with recurrent Major Depressive Episodes will go on to develop Bipolar I Disorder. There is evidence of a strong genetic influence for Bipolar Disorder. Individuals who suffer with this disorder can be fully functional between episodes.

[276] What differed about Unathi's and Lindelo's life histories to Ayenda's was that they had more family support but both, on discharge from hospital, disappeared into their community and could not be found. Reports about them suggested that the stigma around their mental illness and their increasing dysfunction meant that they were locked into rooms, did not get their medication, and were possibly maltreated. The environmental stressors that will be described for Ayenda would have equally affected their poor outcome.

data indicated that Ayenda was psychologically vulnerable and anxious during circumcision. This was significantly more so than his peers, and his residual feelings of distress did not resolve when he left seclusion. In the year prior to his admission he suffered from persistent and harmful anxiety and insidious psychotic symptoms.

Hospital admissions

On his first admission, Ayenda was described on Axis I of the DSM-IV-TR as suffering from Schizophrenia, of a disorganised type (single episode in full remission), and being depressed. This diagnosis was confirmed on his second admission. On Axis IV of the DSM-IV on his first admission, it was stated that he had financial and occupational stress with his job loss and no social support. His circumcision was noted as a recent stressful experience. There was never any evidence to suggest that he suffered from a substance-induced psychosis. His first admission was for forty-five days and his second for forty-seven days. In both admissions he moved through a pattern of being somewhat coherent and engaged and this fluctuated with his experiencing deep psychotic periods. He had bizarre behaviour and was at times aggressive. He had no visitors and in his second admission, despite my contact details being in his file, no one contacted me for collateral.

Contributing stress-related factors

Ayenda's circumcision was extremely stressful for him as in many senses it highlighted how disadvantaged and dysfunctional he felt in his life. His sense of failure in circumcision was evident in his troubled, fearful, and hesitant descriptions. In hospital he expressed a deep feeling of unworthiness and feared his family wanted him, *" to go a second time to the the bush to circumcise. I know I am circumcised. They are the witchcraft"*. Of note was his vivid, culturally-prescribed psychotic imagery around circumcision and his obsession with culturally negative symbols, e.g. being a dog and lost blankets. Furthermore, he did not convey the sense that circumcision was essential to his personal sense of well-being. Corroborating evidence that all was not well for Ayenda came from his employer – who reported that on his return from circumcision he was over assertive and gave a sense that he

had re-invented himself[277]. Other Xhosa workers said he did not behave in the manner of a newly circumcised man. He thus had no support from other Xhosa men, his father, family, or friends.

Psycho-social stressors that were deeper in nature were to contribute to Ayenda's distress in circumcision and the onset of his illness. The recent death of his sister, the abuse he suffered as a child and, related to this, the absence of his biological father were critical stressors. His father's absence meant that he was raised by his mother's family and they were responsible for the abuse he suffered. His condition was made worse when his mother left to work and this increased his poor sense of self esteem. The fact that education was withheld from him added to his burden, especially as he later showed an intellectual capacity for reflection and expressed anguish at this loss. With regard to his being abused as a child, and his later being stigmatised in circumcision, it is important to note that Ayenda had a strange physical appearance. This may have been because he was malnourished and neglected in childhood, but this also raises concern as to whether he suffered with mental illness then and this was not treated.

Ayenda moved to Cape Town to get work a few years before his circumcision. This was done to escape his mother's family. Although there were many positive aspects in his move, particularly in that employment gave him independence, financial resources and a new home, his migration brought other, more stressful circumstances. Critical amongst these was his personal decision to pay for his own circumcision, despite his maternal uncles' intention to not circumcise him earlier. His decision brought their intentions into consideration. A number of reasons might exist for their decision and these include: Ayenda had a low status in the family as an unmarried sister's child; he was mentally disturbed and seen as dependent; limited resources that were evident in his being malnourished meant they (his mother's paternal clan) could not afford to circumcise him.

What is significant about each of these reasons is that they suggest that Ayenda was vulnerable within this community. His early psychological harm may have been the sole reason for this and this illustrates how damaging cultural customs and institutions

[277] See Case study for Ayenda in Appendix 1.1 and 1.2

can be when they reaffirm problematic hierarchical stances and related sanctions. In circumcision his vulnerable disposition was further exacerbated by an unsupportive family and socio-cultural environment. His coping mechanisms and any learned responses to stress were therefore diminished (Katona and Robertson, 1995; Alexander et al, 2005). Thus his decision to go to circumcision clearly reflected considerable anxiety about his status. An alternative explanation about this is that Ayenda may have decided to be circumcised to stop early symptoms of his emerging mental illness. In any event his distress suggested his desire for status in manhood, cultural acknowledgment, and family acceptance from his maternal – and importantly paternal – kin.

A positive incentive to Ayenda in respect of circumcision was that his father would be expected to come to his circumcision. However, weighted against this was that his circumcision was reliant upon a father who had been absent, and a maternal family and community who had neglected his early development. His paying for his own circumcision also did not earn him status; it rather increased his vulnerability as a man who pays for himself suffers some stigma. Additionally, poverty was to bring an underlying stress throughout his life, as did the necessity of migration to fulfil cultural rituals. He also suffered a deep sense of cultural dissonance.

Stresses contributing to his second admission

This insight into the nature of distress suffered by men with mental illness such as Ayenda is important. Ayenda became depressed after his discharge when he did not get better. Instead his mental illness made him dependent on a health system that failed to be of therapeutic or clinical support to him[278]. It also became apparent that he had very little insight into his mental illness condition. He spoke of realising he was *"mad"*, and associated this with being bewitched. When I explained that he had been mentally ill, this resonated with his sense of discomfort with himself and the world. Despite desperately trying to get work and finding odd jobs, his illness and the related stigma prevented him from securing employment. He continued with some

[278] Ayenda's second admission demonstrated that the primary health care services failed him in providing adequate care, detailed background notes on his illness history and no insight into his adherence to his medication or his therapeutic process.

reluctance to rely on his disability grant[279]. Poverty and stigma increasingly became harsh and isolating factors for him. Although he managed to have a few friends; none knew him well enough to offer him any security or support. Alarmingly, what increasingly distressed him was his negative sense of self-worth and a feeling that his manhood had been compromised. Finally, although his traditional inheritance was in the Eastern Cape he could neither afford to return nor to rely on his mother who was old and ill. He also feared becoming ill if he returned.

b) Psychosis in the context of a Cultural Bound Syndrome

A phenomenological description of the possible stressors in circumcision that may lead to the onset of a Brief Psychotic Disorder in newly circumcised men who are vulnerable precedes a case discussion on Mpumi, who was diagnosed as suffering with this disorder. The diagnosis of a Brief Psychotic Disorder as a Cultural Bound Syndrome in the context of circumcision was relevant in two cases, Xolile and Mpumi. Dr. Bauman, who cared for Mpumi, made this observation about another relevant case, *"A brief psychotic episode is in fact a natural and physiological response to stress. It is self limiting and transitory. It does not suggest a grave vulnerability that subsists through life."*[280] In some individuals psychotic symptoms may occur following a marked or extreme stressor, and in such cases Brief Psychotic Disorder would be considered as a possible diagnosis. The DSM-IV (4th Edition, 1994, p 844) states that cultural bound syndromes denote, *"recurrent, locally-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category"*.

The onset of a Brief Psychotic Disorder[281] in a newly circumcised man could be described as a Cultural Bound Syndrome on the basis of the following evidence.

a) The existence of local idioms in respect of circumcision and mental illness.
b) The existence of extreme stressors in circumcision, seclusion and coming out.

[279] My notes described his grant renewal application process, which was extremely difficult for someone with diminished ability: See Appendix 1.2. *On arrival… he had lost this letter… back on the train and was very worried. He had to take this letter on the 12th May for his grant to be renewed….*
[280] See Interviews with Health Professionals in Appendix 2.1.
[281] DSM-IV (4th Edition, 1994, p 302) defines a Brief Psychotic Disorder as a sudden onset of at least one positive psychotic symptom or grossly disorganised catatonic behaviour. The disturbance must last at least one day but less than one month, and the person must have a full remission of symptoms and return to the premorbid level of functioning. The average age of onset is between the late 20s to early 30s. It is important to distinguish this disorder from culturally sanctioned response patterns.

c) An altered state with feelings of disassociation and depersonalisation, are culturally contextual to circumcision as a potentially traumatic event, and where most initiates enter some liminal state in seclusion.
d) The man's psychotic symptoms when treated – but most importantly, therapeutically addressed within his own cultural context would go into remission.

In psychiatry, disorders of disassociation and depersonalisation are commonly known. Psychiatric evidence places these disorders as common in a cross cultural context. Disassociation is an *"accepted expression of cultural activities or religious experience in many societies"* (DSM-IV, 4th Edition, 1994, p 477). In a cultural performance disassociated states are induced and probably felt in varied ways between members. Those more susceptible to entering a trance state may heighten the experiential aspect for those who are not. These states become pathological when an individual – or in some instances a group – fail to return to a more ordinary state of being. When this happens the person would be described as sick or *"insane"* by his own cultural group and in extreme cases diagnosed with a mental disorder by a consultant psychiatrist.

In respect of a liminal state or sense of disassociation for initiates in seclusion, Van Gennep (1960) explains ritual processes as having three distinctive stages, separation as in circumcision; transition or a liminal phase as in seclusion; incorporation or the coming out and return home. These phases were symbolically represented as white, black, and red. Analogous symbols in circumcision are the white clay[282], black staffs and black ointment smeared on the penis, and red in the ochre that covers the new man on his return to his maternal home and a state of fecundity and fertility[283]. The ritual process should ensure that initiates move between phases as the ritual is a reordering of life crises and temporal reality (van Gennep, 1960). This acknowledges that, in circumcision, an initiate's mind and body participates in each phase and it is dangerous to remain in between. Incorporation must be a consequence of separation

[282] The colours suggested by Van Gennep are richly mirrored throughout the data and literature. Of special note is the way in which colour and imagery are described in Ntantala's (1993) account and Nonganza's (2005) poem. From an ethnographic perspective, when Ayenda and a Xhosa-speaking nurse were told about Van Gennep's analysis they did not really agree with his description (see footnote 297).
[283] Van Gennep (1960) clearly indicates that separation and incorporation are acted upon, whereas the initiate is in limbo in the transition time and his psyche, mind, body and person open to the influence of ancestral time and thus bewitchment.

and acted upon or brought about by officials in the ritual. Thus, the rupture brought by fathers taking their sons from seclusion and burning their huts, must be followed with their being incorporated into the mother's home.

Harmful stressors, of concern for those men vulnerable for altered states, appear to be the trauma in circumcision and related anxiety and the liminal state in seclusion. Initiates' experience of extreme pain and anxiety in being circumcised may in the context of trauma[284] be clinically described as a *"threat to the integrity of self or others, which involves intense fear, helplessness, or horror."*[285] The trauma of circumcision is culturally contextual and therefore unlikely to be categorised as Post Traumatic Stress Disorder. However, in cases where the cultural context was severely compromised it seems possible that initiates could experience traumatic injury. Acute clinical signs from trauma occur within a month of exposure and an individual could experience a range of phenomena. These might be intense distress, physiological reactivity when exposed to symbols that remind him of the event with numbing, avoidance, detachment, and restricted affect. Another dimension to traumatic injury is that the reaction to the trauma may be latent and only re-emerge years after the initial experience. In circumcision it is not pain but related feelings of anxiety that, if unrelieved, might contribute to psychosis in those who are vulnerable.

This analysis is qualified by the fact that protective factors in harmonious transitions ameliorate the traumatic nature of the injury and psychological distress of seclusion. If protective factors are not instituted, e.g. if circumcision is perceived as dangerous or the initiate is unsupported by key figures, then circumcision may engender a sense of disassociation that is psychologically harmful. Protective factors were instituted when youth chose to be circumcised and submitted to the operation, instinctively trusting their fathers and officials. Trust was embodied when an initiate's decision to go for circumcision had been made in a supported manner with his father, family, and Xhosa cultural community. On the other hand, poor decision making in families diminished relatedness and trust. This was especially true when youth such as Ayenda had experienced poor attachment to their parents in childhood. He in particular did not have the coping strategies and psychological resolve to cope over

[284] The degree to which this injury is interpreted psychologically as trauma is at issue because of the cultural context.
[285] DSM-IV (American Psychiatric Association, 4th Edition, 1994) Post Traumatic Stress Disorder.

the following months (Alexander et al, 2005).

Alleviating the harmful effect of stress would, therefore, appear to require that the rite of passage is culturally well organised and authentic. This was illustrated in the taboos around food which offer initiates and their families a sense of containment, as does the care for the wound and teaching in seclusion. Stability is inherent in the fact that this behaviour is ritualised and remarkably unchanging over generations. In support of this thesis it is known that dealing with acute trauma at its inception in a supported and therapeutic manner alleviates the effects of harmful stress. This could be one of the reasons that post-traumatic syndrome is not described to date for circumcision.

The second way that harmful stress may contribute to the onset of an altered state when the initiate leaves the seclusion ground is through ritualistic procedures that nurture disassociation and depersonalisation, e.g. ritual chanting, white paint and dancing. Van Vuuren and de Jongh state that, *"… our increased knowledge of human neurological processes will enhance our understanding of ritual engagement… (and) could explain how ritual as technique, for example, dancing, drumming, fasting…(and) stressful ordeals works, both within and among participants"* to bring about psychological transformation (1999, p 182). Feelings of anxiety are integral in this, heightening a sense of awareness and inducing initiates to prepare for wounding, chronic pain, and isolation.

Testimony on this strange experience was given by males who remained psychologically stable after circumcision. They testified to a terrifying feeling of being wounded, and then left alone to suffer pain and fear. A sense of depersonalisation was expressed by one man. A further possibility exists that this sensation is heightened by the shifting of the mother-to-child bond. This is done to promote a new sense of personal identity and social relatedness for the initiate. The explicit intention is to alter the man's conscious awareness of himself, others, and his relationships, bonding him more to the world of men.

Adolescents and young adults – following a trauma – are known to experience depersonalisation, and this mimics a trance state and may be associated with

"coercive persuasion". Depersonalisation is highly effective in a ritual that is desirous of a communal expression of manhood. However, in understanding how a cultural bound syndrome may occur in vulnerable initiates, it is important to consider that a trance state can re-occur *"in association with perceived or actual events"* but this does not prevent the person from recalling events and circumstances. *"Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity, or other person"* (DSM-IV).

Despite their psychotic illness, Xolile and Mpumi both expressed a strong sense of identity and were surprisingly resilient. It almost seemed, and this is concurrent with their diagnosis, that their identity, which was anchored in a Xhosa-speaking cultural orientation, stood as a counterpoint to their psychotic illness. This identity as Xhosa men was, however, psychologically more accessible to them once they were well. In the months after their circumcision, despite their illness, this anchored their return to wellbeing and they responded to the demands of manhood. They were also more capable of functioning in a multiplicity of contexts and hence were adaptable. Here a quality of manly resilience that had been engendered in circumcision enabled them to meet the demands of a diverse and challenging urban society.

Case Study – Mpumi

Within six days of his admission, Mpumi's diagnosis was queried on Axis I as *"Schizophrenia or Brief Psychotic Disorder and changed to Brief Psychotic Disorder in the context of his circumcision"*. His story was that he had come from his circumcision in the Eastern Cape in December 2002 and within the month was admitted to the hospital, in early January 2003. Other stressors that may have contributed to his condition were his parent's death, his father's absence in the circumcision seclusion, and poor finances. These stressors may have been exacerbated in circumcision, and this heightened his existing anxiety and feelings of sadness about these losses.

Other criteria were suggestive of Mpumi suffering a Brief Psychotic Disorder in the context of a Cultural Bound Syndrome. Firstly, his response to his treatment and therapy was distinctive. He was admitted because he was psychotic with auditory

hallucinations and voices over the previous six days. His psychotic symptoms went rapidly into remission with treatment and he was discharged within seven days of his admission. Had he been suffering from Schizophrenia, as was first suggested, he would have had a less florid presentation. He would have been ill for longer, and certainly would not have presented to all the staff and others from early in his admission as well oriented. His wellness was then evident in his desire to leave the hospital. Secondly, there was never any evidence to indicate that he suffered from a substance-induced psychosis. Thirdly, and in support of this episode being a Cultural Bound Syndrome, a young female Xhosa-speaking medical student interviewed him and he responded well to her and Dr. Bauman's sensitive understanding of his circumcision. Following her intervention, the Xhosa-speaking male nurses took more interest in his case. This therapeutic encounter gave him an opportunity for a re-orientation in his own cultural arena but within the confines of the hospital. This was most effective because his psychosis was in the context of the stressors associated with his circumcision. Fourthly, following his discharge – as he became more consciously aware – he exercised caution about disclosing any information about his circumcision. This apprehension increased over time, suggesting that he behaved appropriately and with discretion in his Xhosa-speaking cultural context. Important factors to consider in the follow-up material that we (Mr. Mangesi and I) were able to gather were that he continued to have some residual illness, and this was suggested by Mr. Mangesi describing that his eyes were moving around and he did not trust anyone. However, his resilience and wellness was shown in that immediately upon discharge he returned to working long hard hours, six days a week. He was well supported by extended family, and he was obviously liked and respected in his social group. Six months after his admission, Mr. Mangesi described him as having recovered from his illness and as being very well.

Mpumi's case history contrasts to that of Xolile, who had a 43 day admission in Valkenberg Hospital. The length of his first admission stands against Xolile experiencing a Cultural Bound Syndrome. This long admission will be queried on the basis of two reasons. Firstly, his psychosis went into remission within months of his discharge and Dr. Soga changed his diagnosis to that of a Brief Psychotic Disorder. Secondly, although his hospital admission was long, he suddenly and quite surprisingly began to become well when we interviewed him about his circumcision.

He responded very positively to these interviews and was eager to engage with us. My later examination of his hospital notes indicated that Xolile had remarkably clear memories of his admission and stay in hospital. He also remained, and described being extremely anxious and terribly afraid, and tried to abscond within days of being admitted. The possibility that he was malingering because of his failure at university and in circumcision were important factors to consider, given that his psychosis did not go into an early remission.

5.3 Circumcision, stress, and mental illness

This complex interrelationship is explored from a phenomenological perspective. Two of the life histories, those of Xolile and Ayenda, have been selected as more data exists for these men. Each case is also representative of the two different psychiatric outcomes previously detailed, and this allows for comparisons to be made between them. Thus for example, Xolile was to recover after he was diagnosed with a Brief Psychotic Disorder; whereas Ayenda, who was diagnosed with Schizophrenia, sadly relapsed. The discussion does, however, include information from the other men's life histories and the wider data. Further, to convey a more phenomenological perspective, the discussion has drawn on anthropology to reveal a depth of meaning in the data.

The evidence suggests that stressors which were inherent in the circumcision may have precipitated the onset of psychotic illness as a Brief Psychotic Disorder. In contrast, circumcision and seclusion (when well managed) almost seemed to provide a protective environment for the three men diagnosed with Schizophrenia and Bipolar Disorder. The stress that contributed to the onset of their psychotic illness was early psychological harm, trauma, social problems and environmental stress. This was particularly relevant as chronic stress during the phase after coming out when they had to behave as new men.

5.3.1 Healthy and harmful stress in circumcision

Stress could be described as having a dual nature, as inherent in it is the potential for healthy or harmful adjustment (Katona and Robertson, 1995; Allwood and Gagiano, 1997; Alexander et al, 2005). Van Vuuren and de Jongh (1999), discussing Xhosa-

speaking male circumcision, argue that stress must be functional in a process of psychological transformation for the neuro-cognitive structures of initiates to adapt and change. Phenomenological evidence on psychological states of dissociation and depersonalisation (DSM-IV) also intimates that the success of these stressful transformation states lies in their being socially[286] supported by intimate relations. Thus it could be argued that when circumcision functions harmoniously these traumatic life stage events have the potential to engender resilience – and this has an effect across a cultural group.

Undoubtedly the beneficial social and psychological effect of circumcision is felt when men reflect back on it with each other, and this possibly reinforces their agreement to remain well[287]. The negative effect of stress contrasts to this and was demonstrated in daily discourse when safety or poor function was at issue. It was these feelings of anxiety that fed into a local idiom of distress. *"Botched"* circumcisions meant that stressful relations were built into personal and socio-cultural relations. These injustices were shown to have insinuated anxiety into a largely impoverished and disempowered society. What was significant was how fearful youth and their families became of this happening to them. Thereby, Xhosa-speaking women feared their sons would be victim to poor traditional surgeons. This burden was then felt in depression, identity crises, and distress. The literature suggests that those who become mentally unwell remain dependant on their family, isolated or reliant on their community and the State (MacGregor, 2000; Swartz, 2002).

However, in spite of substantial proof of stress in circumcision in the data and literature, unless they were asked, neither Xolile nor Ayenda used the word *"stress"* or said that they were stressed either in their circumcisions or about their illness. Their explanation of stress was suggestive of an everyday discomfort and carried a sense of not coping. *"Stress"* was categorically never used in relation to circumcision and it appeared problematic for them to imply they had not coped. It was also problematic for them to suggest that the period leading up to circumcision was

[286] Social support means intimate face-to-face relations in their own cultural context. The custom is a cultural one and should not be seen as any different from the circumcision practices of Jewish people, for instance. In this respect traditional authorities have a responsibility to inform themselves about safe practices.

[287] This was clearly described to me by a Xhosa-speaking male colleague who spoke happily of how well he felt when he met with his peers who were circumcised with him. It is also possible that men learn through this mechanism to hide or suppress discomfort and distress.

stressful. Circumcision, it was often asserted, was *"Xhosa-speaking culture"* and protected with taboos. Furthermore, the act of circumcision could not be spoken about and was not stressful because it was immediate and required action. The only times that stress was alluded to was when a youth or initiate was seen to be unsupported, especially by his father – either in circumcision or seclusion or in coming out.

Stress was most often used in the context of daily life in *"thinking too much"* or nerves because one had nothing to do (MacGregor, 2000; Swartz, 2002). Being stressed then set up a negative cycle. In this context it was mostly used by Xolile and Ayenda during their recovery periods when they were chronically ill. Xolile said that since leaving hospital, and with being ill, he had been *"much"* stressed. This related to him having nothing to do, and this made him more stressed. Part of this was his anxiety that his illness would affect him for the rest of his life. Ayenda used stress in much the same way. He stated, *"It is that I like to think so much and see on my skin that things are happening and I do not know what is happening to me."*[288] The consequences of this were emotional and psychological – *"being in the mind"*, but also, as illustrated, physical. This induced other emotional states such as frustration, anger, or more stress. However, it was denied that fear or stress could make a man mentally unwell.

A social implication of having too much time to think was that this prevented a man from doing what he wanted to do. Stress literally stopped a man from taking charge of his mind, life, and action. An association between stress and sickness or *"not being able"* was inherent in this state. Xolile implied that as he felt better on his medication and with therapy, so he was able to tackle his stress. Taking action to reduce stress was a vital part of managing it, and both Xolile and Ayenda expressed the need to do this.

In this respect the evidence showed that Ayenda suffered far more stress than did Xolile. This is important as it might explain how stress plays into early insidious psychotic symptoms prior to the onset of mental disorders such as Schizophrenia. Xolile, in comparison, became well, acted with intention, and managed his stress.

[288] See Case study for Ayenda in Appendix 1.2.

Ayenda's complaints about being stressed were an indication of his chronic mental illness. Because of his illness he found life more stressful – as even "his mind" was stressed, and he found this stressful. Mr. Mangesi said of him that he was a very tense, worried, and scared person who thought like a sick person, *"Whatever is happening to his head he is scared of it and waiting for something to happen."* Ayenda believed that this stress caused the voices he heard, and he tried to control these as they were stressful[289].

5.4 Psychosocial stressors

5.4.1 The absent father

This discussion on stress illustrated that it is important to discover whether the concept of stress as defined in an English word and European definition had meaning amongst Xhosa-speaking people. This requires extrapolating on local idioms for distress that links mental illness and circumcision, but especially in the context of initiates' fathers being absent in circumcision. This particular idiom categorically suggests that the major source of stress for initiates is if the biological father does not circumcise his son to his Xhosa patrilineal descent. The central significance of this role is widely supported in the literature (Mager, 1995, 1999; Van Vuuren and de Jongh, 1999). This idiom also speaks to western and biomedical literature about the importance of the father to his son's wellbeing during his adolescent development (Clarke-Stewart et al, 1988).

The life histories of the men in the study suggested that the role of the father in circumcision is complex, making circumcision stressful for father and son. The nature of his role and related stressors will emerge with the discussion. None of these five men had a father who claimed him to his patrilineal descent. Thus, although Unathi's father was there during his childhood, he was circumcised to his Xhosa-

[289] Consideration in the data analysis also has to be given to the influence of other stresses that Ayenda in particular, but also the other men, had suffered. Critical amongst these were their hospital admissions. The fear of *"not knowing"* when they were psychotic was stressful and this included a terrible sense of becoming psychotic again. This deeply affected those men who had second admissions. Xolile managed to surmount some of his fear of being psychotic by remembering it and thus acknowledging its impact. He then tried to keep it in its place in his past. He, however, changed his behaviour because of this stress and would distance himself from any person who had memories of him at that time.

speaking mother's patrilineal descent and not to his Sotho patrilineal line. Lindelo and Mpumi's fathers were dead. Despite Xolile's and Ayenda's fathers being present in their circumcisions, they were also claimed to their maternal patrilineal lines. It was apparent that not being circumcised to the biological father's line of descent meant a distinction was made in practice and in discourse, and less moral worth was therefore attributed to the initiate and his family. This was a significant stressor because as Dr. Soga said, *"Going to the bush means getting the spirit of the forefathers…. In African culture it means it allows the ancestors to enter you and take possession of your spirit."*[290]

In Xhosa custom, when the biological father does not fulfil his role in circumcision, a series of stressors were insinuated into the son's life. This was because circumcision highlighted that father's absence, compromising the son's psychological health and coping mechanisms. The men in the study spoke of this disadvantaging them in terms of status and social relations, particularly as they were deprived of access to resources both during and after circumcision. This made them more anxious and it appeared they struggled to have authority and a sense of equilibrium. This stress was exacerbated when the father had not been there during his son's childhood. As the idiom suggests, the father stands symbolically for the patrilineage and his vital role is inculcated into lived Xhosa culture[291]. This makes his presence essential to the psychological wellbeing of initiates. Despite this symbolic value, it is in reality his physical presence as the father in circumcision that anchors a youth's journey into manhood.

[290] Dr. Soga in a Ward Round at Valkenberg Hospital said, *"Going to the bush means getting the spirit of the forefather…opening the unconscious to the realm of the ancestors and the unknown… encountering the psyche or insane in one's Self. In African culture it means it allows the ancestors to enter you and take possession of your spirit. Thereby probing should be done in its own context or traditional frame. In the ward sanity and insanity is decided on in discussion with others – therefore one is always interpreting."*

[291] In respect of culture, stress and an idiom about the father's place in circumcision, it is important that this links into local concepts about mental illness. Mental illness could be described as being at one end of the social spectrum where all inferences have relevance because these demonstrate how people distinguish and categorise those people who are marginal in society. In addition, how mental health is discussed and contextualised within a culture clearly delineates how wellness is assessed (MacGregor, 2000). Thereby, issues about social change, psychological adjustment, and available resources may come into consideration because these relate to the broader issues that the society or culture find stressful. Thus circumcision and mental illness becomes an indicator for Xhosa-speaking culture of wellbeing amongst people.

A sense of time and ageing that was integral to a lived experience of a man's ancestors was central to the father's role, manhood, and the achievement of moral worthiness (Mandela, 1994; Attwell, 2005). In circumcision the initiate assumes an active engagement with his ancestors and his living relatives, all of whom are fundamentally in the world. Circumcision confirmed a social orientation upon him – affecting his psychological, behavioural, and attitudinal responses. Consequently, and implicitly, it appeared that a higher social and authority status was accorded to families where a more functional nuclear family orientation existed, and this was in the context of the youth's line of descent through his father.

The reason for this was that the father anchored and promoted multifarious patrilineal relationships and co-ordinated material and symbolic resources for his son (Ngxamngxa, 1971). This embraced a Xhosa-speaking metaphor for personhood which has its origin in indigenous African language and custom, *"'umuntu ngumuntu ngabantu' a person is a person through other persons."*[292] Under the guidance of fathers and elders, the initiate must be mindful of his person and psyche and must endure – and this brings a sense of personal and collective integrity. This in and of itself is stressful. The experience of pain, and the importance of not showing anxiety or fear, was also critical in developing integrity. The five men in their psychotic episodes each had memories and indeed psychotic imagery that illustrated this phenomenon. In these images and memories, artefacts such as blankets, staffs, white clay, food, and water were as much material markers of the rite of passage into manhood as they were functional symbols around the father that became instantiated into memory[293].

The father also protects his son and his patrilineage from bewitchment in circumcision. The evidence suggested that a son's safety is jeopardised when his relationship to his patrilineal ancestors is not acted upon. Thus, a youth who falls out

[292] This well known and well used phrase was most recently quoted in a letter to The Sunday Independent newspaper, July 22 2007, Letters to the Editor, Anthony Goldstein, *"Monare should put money where his mouth is."*

[293] Vivid imagery about blankets for instance was evoked in these men's psychotic imagery and could be attributed to an archetypal image of the father who is so elemental in circumcision (Jung, 1967). It is not hard to imagine the meaning of warmth and security that a man would give to a blanket given to him by his father in circumcision. Later when he was vulnerable in hospital, that memory would foster a sense of containment. The blanket would evoke not just the memory of his father and his being covered with the blanket as his seclusion hut was set on fire, but the feeling would bring a warm physical sensation.

of his father's line may be more vulnerable to bewitchment and mental illness. This would then be a logical explanation for his becoming ill. Artefacts such as blankets or white paint protect initiates from unseen forces. These, therefore, also embody the often conflicting relations and aspects of the lived and ancestral reality of patrilineal descent. These forces are stressful and the fear of being vulnerable to bewitchment through circumcision wounds was often alluded to during the research. Of note is that in seclusion these forces manifest in dreams and hallucinations and were mediated by teachers and elders.

The discussion has suggested that psychological harm may occur even when the biological father does take his son to circumcision. However, strategies to cope with this eventuality are embedded in patrilineal beliefs and politics. Designated kin such as the father's brother may stand in for the father. When this happens, as with Mpumi, it would appear that manhood, authority, and moral worth can be achieved – and poor familial circumstances surmounted by resilient men. A man must realise his predicament and choose to achieve status and worth in taking up his responsibilities to his family and a wider Xhosa-speaking society. He then surmounts the stigma and social disadvantage of not having a father. Most elders insisted manhood is shown in being a *"man of moderation in all things"*, in respecting all people equally and in being discriminating. It was also important to not be seen to judge a man, particularly in a definitive manner – as in a man being irreparably wrong. These tasks are anxiety inducing.

5.4.2 Psychosocial stress and patrilineal ideology

The evidence showed that a circumcised man must meet the responsibilities that his father and male kin place on him, and this includes his responsibility to have a family of procreation and initiate his son. Implied in manhood is an enormous personal responsibility to follow tradition and this can be stressful and an onerous duty to uphold. This requires personal resourcefulness as a man must cope with life and its difficulties. Ayenda stated, *"You have to do many things as a grown up and others don't want you to grow up…. Because I became a man these problems came to me."* When asked if his circumcision had made him mentally strong he answered, *"You lose the something before a boy in the circumcision and turn a new page to become a man. In your mind you were changing and you think like a man not like a boy."*

Thus, an unqualified sense of belonging for a boy in his family is replaced by the much more stressful requirement for independent action, thought, and responsibility to others.

The new man must observe this ordered patrilineal worldview, and the silence Xhosa men observe about their circumcisions demonstrates the fact that a new order is instantiated in practice and in mind – recreating a Xhosa-speaking cultural orientation. Xhosa manhood is defined on the man's body when he is circumcised. Circumcision is then mirrored in discourse, language, meaning, and symbolism. Mr. Mangesi said, "*'Nyama' is the skin, and meat which you eat and skin on the whole body. 'Incanca' is the penis of the boy and when in the bush it is called the 'iyinga' in bush language."* Circumcision, thus perpetually reaffirms gender-described social relations.[294] Mr. Mangesi said, *"The word penis cannot be used in a joke but only if someone says you have a big 'umthondo' then it is the sound of the word that makes men laugh."* Further, in this surgical reconstruction of this male symbol the patriarchy assumes its social and ancestral hierarchical status. This explains why it is so important for the father to witness his son's wounding. Additionally, this explains why denial of deaths, disorder, or dysfunction forms part of a patrilineal system that engenders resilience.

Scepticism about whether the custom does continue to prepare a youth for manhood is expressed in a comment from an elder. He alludes to unhealed wounds – not only in the practice of circumcision, but in the body of Xhosa-speaking culture. He described that it was dangerous to go for circumcision too young – before sixteen years old, and if a boy was not properly prepared. He said, *"If you go to circumcision and go through the process of being a man, then the process of being a man you hear, hear that you are one. But (when you are too young or not prepared) you don't do as you were told and that is when 'kids' get ill. A guy comes out and does not do the things that he was told to do and he does not respect them and then that affects him."*[295] As an elder, he understood that ideology needs to be linked to psychology and practice to engender resilience in the youth. Practices that are sound and well managed enable a youth to hear and become a man, and in contemplating these customs he in turn sustains the cultural orientation of other men.

[294] See Interviews with Xhosa people in Appendix 2.3.
[295] Field notes, April 2003.

Given these circumstances, youth going into circumcision expressed doubt about whether Xhosa custom continues to initiate men. Whether circumcision was then seen as integral to patrilineal descent was also in question, as the literature and evidence argued that the practice has become motivated by commercial interests (Mayer, 1971; Van Vuuren and de Jongh, 1999). Despite these doubts and covert stresses, the men explicitly denied any suggestion that there were problems in the rite of passage. These conundrums illustrate how complicated and stressful circumstances were for initiates. Furthermore, these cases which make an association between circumcision and mental illness raise issues about its purpose as a cultural practice. Whilst the psychiatric institution may hide the nature of their acute psychotic episodes, these men eventually returned to their communities and were mentally ill. Stories that they had been bewitched in circumcision dogged them in the community, but these did not infer that circumcision practices were at issue. However, when these stories were interrogated with other Xhosa people, they would always ask, *"Was his father there?"* If he had not been there, then in all their minds, all was suddenly revealed and the illness explained as bewitchment, but this questioned their worthiness as men.

5.4.3 Official roles in circumcision and the ritual process

A sense of healthy stress (Katona and Robertson, 1995) was vital for the safe function of circumcision and for initiates' transformation, and this relied upon the surgeon, teachers and host upholding their official roles. Evidence in the data and in media reports showed that initiates suffered injury when traditional surgeons and teachers were poorly skilled or absent from their duties (Meintjes, 1998). When this happened stress became more pervasive and increased levels of anxiety. This happens surreptitiously and potentially disrupts the transformation process – both in a physical and a symbolic sense. Of note was that successful circumcisions were officiated over by men who were autochthons, who were known to the community over generations or held an inherited office, and had been trained in apprenticeship.

The following evidence affirms that it was preferred for officials to be known by families and to some extent this contradicts that on charlatans being accepted (Meintjes, 1998; Van Vuuren and de Jongh, 1999). Evidently most youths chose

when they were ready to go for circumcision, were checked by traditional healers, and had to be *"100% normal"* to go into circumcision, otherwise *"it was known that they could die"*. Healers and elders recounted that a youth who failed to initiate did not enter the ancestral realm. The central importance of the surgeon's skill was remarked upon in the following excerpt, "*There are two incibgi in Gugulethu who are doing the job and they are best known as NdLovu."* What was absolute in their roles was that they embodied a sense of trustworthiness. This had been attained through their being circumcised and undergoing an apprenticeship with a traditional surgeon. The traditional surgeon's assistant – illustrating his skill – was to say of circumcision, *"The respect you earn is that you have taken that pain as a man – and you know how much you can ask…. The cutting of the foreskin means that you are a man. The pain is for the reason that you must take that pain."*[296]

The experience and discourse around the pain of circumcision, how it is remembered, and how it is described, all become part of a man's ability to embrace his manhood[297]. An experience of wounding, pain, and healing is embodied by the initiate during circumcision and this cognitive and emotional lesson is then lived out repeatedly over the course of a lifetime in the psychological and social expression of felt pain. *"You feel like a man at circumcision"* Ayenda said, *"and then through that and this is reinforced and you cannot think like a boy. You feel like a person – like others but you are on other land now in another position and after you complete washing then you are a person like the others."* This embeds a particular attitude and behaviour to the most instinctive of responses, pain, distinguishing Xhosa-speaking men. Those who fail to respond appropriately raise questions about their state of mind and status as men.

The embedded and symbolic nature of circumcision was revealed in the discourse on pain that emerged in our interviews. Mr. Mangesi's comments about our questions on whether men felt pain pertain: *"There is a reason for patients in forgetting the events of the past. Some of the questions we ask (in the research) touch on issues that are secretive. They know that they must respect this and my command (our questions) cannot be heard, especially with females. So they have to deny. The question of pain*

[296] See Interviews with Xhosa people in Appendix 2.3.
[297] See Case study on Ayenda in Appendix 1.2.

is secretive and you cannot voice this out. Xhosa men work together differently."[298] The quotation speaks to an intense, global or holistic experience of pain and anxiety and suggests a heightened awareness so that pain was forgotten or silenced. The quotation also signifies that the practice must function well to protect initiates from harmful stress. In interviewing the men, Mr. Mangesi pointed out that inevitably what we witnessed was codes of silence when questions about pain were asked. These codes of silence required denial and a display of physical strength that conveyed an attitude of resilience in mind and posture.

A Xhosa-speaking worldview thereby structures the felt experience of pain and anxiety and how it is expressed. The following statement accurately reflects the experience of a man who was well prepared and had integrated his experience of pain and healing into his manhood: *"It is not really stressful, as you already know, because you train yourself psychologically and everyone is positive. On the day they instil fear in you and tell you not to cry and after graduation it is not possible to talk because they would call you a cry-baby that you could not stand the heat. It is very painful,"* he said, *"and I would never want to go there again."*[299] There was a sense from this young man of great pride, and underlying this, his feeling that what he went through was almost madness, and he would like to remove it from his mind but never could because he chose to go. This describes a worldview that has integrated the experience of pain of circumcision – not only into its philosophy but into customary practices – so that even a simple greeting gesture infers and evokes an expression of manhood and kinship.

The issue of charlatans usurping official positions and traditional practices being corrupted was pervasive. This reflected evidence in the literature that integrity in circumcision was at issue. This was especially as a psychological and societal imperative to align and enskill generations for manhood and importantly fatherhood appears to have fallen away. Exactly how integrity in the custom has been compromised was shown to be nuanced and subtle. This was evident in the rumination of a Xhosa elder. He spoke on the importance of the act of hearing – as distinct from listening. He hypothesised that circumcision today is a more superficial listening to instructions and this has compromised an initiate's ability to *"hear"*.

[298] Field notes 27/5/2003.
[299] Field notes April 2003.

Hearing for him meant that the initiate remained receptive to learning and that knowledge and life-skills were embedded into his behaviour through this practice. Hearing required being active and reflective and the art of skilled teaching was essential for initiates to learn to hear.

Another dimension with regard to learning and the formation of identity and life skills was the importance of elders guiding initiates to understand the meaning of their dreams. It appeared that these had to be revealed and understood in seclusion. This had a pragmatic relevance for the protection of the seclusion from "psychic" forces, but the dream in circumcision could also be definitive in describing a man's inherent nature. When asked what happened to the process of attaining manhood if a man had a dream that was strange, one Xhosa-speaking man made this comment: *"The initiate would have to tell the khankatha what he dreamt or what the voices said. These would be told to the 'witchdoctor' who would tell him what the voices say (mean) and would explain what it was all about, for example that they are trying to kill him or the family is in danger"* (Field notes April 2003). The dream thereby was open to interpretation by the teacher who himself had authority over personal psychological issues and the ancestral realm. It is the teacher's responsibility to protect the initiate from bewitchment and to bring him to stand next to his ancestors.

This explanation is crucial because it demonstrates that a boy's unconscious and conscious disposition, his anxiety, and the stresses he faces in the future should be watched in the ritual. His cultural orientation must remain for his transformation to be successful. The circumcision as a transformation ritual intentionally manipulates an "uncomfortable liminal space" and this was known to be dangerous. Here what was most accepted and known in boyhood has been eradicated – including the past and possessions. This makes a youth very vulnerable both because he was in a world that was believed to be and was potentially dangerous, but also because he could – if psychologically unstable – be seen as the instigator or carrier of those evil forces. The circumcision seclusion is, in a very pragmatic way for these communities, a psychic space close to that of the ancestors, witches, and dreaming, and the initiates are psychologically and physically either within or on the edge of liminal time and space.

A Xhosa elder described this period in the following account. He gives a sense of "not-existence" and a fear of contamination from bewitchment and evil forces. He

explained, *"The white paint is for the witches not to recognise you and all in white they cannot see you or who you are – you are all the same. The evil spirit cannot recognise which is you and is looking for you – you are in danger, you are outside, you are close to death and near spirits. When you are cut the reason you are in danger is that the witches do not want the cut to heal but to make it worse and die and the khankatha sees to healing and the wound. If it becomes worse he will report it. The danger is that the witches attack blood and stop healing. It is the same with women when a baby does not come back."*

Danger has been shown to be integral to the extraordinary experience of the circumcision seclusion and inherent in the custom and practices. An elderly man said, *"Circumcision is a time of danger – not a dangerous time – but there you are actually taught about what you are going to be responsible for."* [300] This elderly man made a clear distinction between danger, and dangerous and how critical teaching was in containing and protecting initiates. There was danger because a youth was in a precarious position psychologically as the circumcision was part of his transformation to being a man. He was also susceptible to the danger that witches brought in seclusion. Dangerous in comparison described reckless behaviour or physical attack from outsiders.

The danger that the elder alludes to is that of evil forces, witches or foreigners or strangers who might break the boundaries of seclusion thereby violating its secrecy and taboos. This danger explicitly acknowledges the presence of dreams, visions, weird phenomenon, and bewitchment – either to thwart initiates' endurance or as warnings from ancestors. These play into this realm, setting tests for the initiate in his trial to achieve manhood. Navigating this surreal event is the challenge set for the initiate. This task is encapsulated in this comment from Ayenda, *"Circumcision is a matter of life and death and we might see you when you go there or not. If you die in the bush we won't see you again and you must take everything very serious otherwise we might lose you."* Ayenda's remarkable account about being covered in white clay illustrated his sense of being contained but fearful and his speech moved between

[300] Field notes April 2003.

rational explanation and ritualistic imagery[301]. His pragmatic language was notable, demonstrating that the ritual was in many senses a very ordinary ritual. His eloquence suggested that he was not suffering from psychotic symptoms at the time of his circumcision. What is highlighted, however, is the importance of hearing, and this is conveyed in his intuitive remembering of his journey. His cultural description provides rich cues into not only his psychological world but into circumcision and the culture that has nurtured him and holds his psychological orientation.

An interesting comparison is made when his description is compared with that of a young Xhosa man who remained well. He spoke to a later stage in the ritual, but the same meter and working through of cultural logic is evident in both his and Ayenda's description. In this second excerpt references were made to the time when the *abafana* or new men request to take off their caps and jackets, six months after circumcision. *"When the time comes then you are asking now will you excuse me from this (ritual period) and can I take my clothes off? If you have already taken off your clothes they will ask 'who undressed you and why?' Sometimes, nowadays young men take their coat off within a week. When you are wearing these (your abafana) clothes it is OK to be ill. You wear clothes like the English working class, a cap and jacket because the dress code has changed and so have the clothes."*[302]

It is interesting to reflect on these comments and ask whether mental instability was noticed or quite possibly ignored by officials. Firstly, it is possible that the period in seclusion may challenge stress-related anxiety; offering initiates a sense of containment. Through this men learn how to face stress, trust peers, and seek support from them and elders when endurance is needed. This, however, suggests that undue stress might be ignored especially by inexperienced teachers. Secondly, an aforementioned parallel appears to exist between a liminal state in seclusion[303] and the

[301] Ayenda was asked if when he was covered in white clay, he felt he had died in some way. This question referred to Van Gennep's thesis that the white clay represents a symbolic death for the initiate and a liminal phase.

[302] This man continued, *"It is now western clothing that is available. Very long ago we started westernisation because culture is dynamic and the coat is respectful. In the rural areas was the first place people wore coats and it means acceptance as a wise guy and reverence as in coats in church. It has not been used to assimilate to western culture but imitation is to have another outlook on the world and not through the eyes of a child"* (Field notes April 2003).

[303] A sense of the liminal is used to describe the near altered state of the minds of initiates in seclusion. This is because men who had remained well did not suggest that they had a heightened sense of awareness. Rather they suggested that things were strange. Mr. Mangesi, however, reported having hallucinations or seeing things that were not there.

altered state of a cultural bound syndrome. In the men who suffered with a Cultural Bound Syndrome, their particular vulnerability meant that they failed to psychologically disassociate from the seclusion and this state of mind. The burning of the hut, washing of the white clay, and indeed of the red ochre as part of ending the liminal phase, were shown to be critical in psychologically separating the initiate from his transformation process. Once again impoverished traditional support structures might also simply have failed to be sufficiently protective for these men.

The DSM-IV demonstrates that the nature of mental illness is defined by the pattern and phenomenology of symptoms. The same holds true for circumcision; sound practices consider and maintain normal and appropriate ritualistic behaviour. Yet, because rituals are *"extra-ordinary"* events, much of the imagery described sits comfortably within the milieu of psychotic imagery. Symbols in circumcision must, as the evidence shows, remain ordered in respect of the process and context of the stages in the rite of passage. Each ritual stage thus manifests in designated symbolic images: the loss of all possessions on entering, blankets, white clay, and staffs in seclusion, and these burn on leaving. Neither in circumcision nor afterwards can certain symbols and images enter an initiate's discourse. On coming out, the man who referred back to these images, risks that he himself will become *"matter out of place."*[304] Furthermore, the year after circumcision, which was a crucial period for the men in this study, inserts another period of apprenticeship in which they alter their behaviour. This reinforces taboos so that unusual behaviour in a man who breaks the silence of the taboos puts himself at risk of being marginalised by Xhosa people.

5.4.4 Identity, gender, and morality

"Man is different to male – it is 'indoda'. You are a man because of the way you behave. You are still not yet a man after circumcision as you work for this for the rest of your life. You walk differently and treat people differently."[305] In this quotation Gasa (2003) describes how manhood is undertaken in the act of circumcision. It is a life-long task with a prospect of not being worthy. It was evident in our interviews that there was a terrifying sense of failing in circumcision which was an inescapable physical, psychological, and social ordeal. If youth escaped, they aged as males but

[304] Douglas, M. (1966, 1970).
[305] (Field notes September 2003).

remained as boys. It is perhaps too simplistic to define this in terms of gender, as manhood is more encompassing – extending into an unseen patrilineal, ancestral domain. Thus, an initiate who left the seclusion and looked back at his burning hut risked losing his manhood or sanity. An initiate whose father did not fetch him from seclusion to burn his hut was left there still a boy. He was in a psychological and spiritual limbo and socially still a boy and in a marginal state[306].

Circumcision instigates a discourse that integrates gender-based distinctions that are relevant to the practice of circumcision, and these to a man having a sense of moral and psychological integrity. Through the practice, at a critical point in the reproductive life stage of males and females, instinctual, physical, and psychological responses are culturally organised by families and descent lines for marriage and procreation. An elder explained the intricacy involved in establishing gendered male identity[307]. He said, *"A boy has to go when he is…in his twenties as he has to maintain that process. He cannot be younger as it is necessary to maintain circumcision and to face standards and not stop (in development) drinking water. We went when we were thirty years old… because when you are a young man it is time to fool around… Then when a man takes full responsibility he does not do the things of childhood. At sixteen years old your blood is not pure, as it should be."* His discussion illustrates how moral reasoning is integrated into practice and attitude; that some change happens over time and although expectations shift this can be incorporated. This elder illustrates that circumcision establishes cultural nuances on how sexuality is expressed and relationships arranged.

Moral reasoning is thus linked in a very physical sense to the penis, circumcision, marriage and reproductive relationships. Gasa stated, *"Now your son finds himself naked with other boys of his age and they do not just look at the size of his penis but the type of the wound."* Circumcision practices mark generations or age-grades

[306] One Xhosa man who circumcised himself in his mid-forties was admitted to casualty and then Valkenberg Hospital suffering from acute psychosis. His action was seen by other nursing staff and patients as a joke, as the act of assigning manhood – the circumcision wound – has to be done in the circumcision by Xhosa-speaking men. Custom has allowed that some youth go to hospital for their circumcision, but this is looked down upon and this man does not have the same status.

[307] This elder explained that, *"The peak age (latest time) for circumcision is thirty years…. We went when we were thirty years old. But now things are getting faster and now people are married earlier…. If at sixteen a boy goes to circumcision then he sleeps around with girls. In the old days, children used to listen to their parents and did as they were told. They did have sex but not with a lot of girls. After thirty any action you do you are responsible for."*

passing on the responsibility of observing and initiating the next. This requires the participation of women in developing a Xhosa sense of moral behaviour. This has its origin in the maternal home and it is here that the new man will return to take responsibility for his family of procreation. Sexuality and fertility thus reside in the domestic domain, and this domain facilitates reproduction and procreation of descent lineages. This grounding for the family in roles and practice clearly mirrors that of the wider patrilineage. Hence the morality of the family replicates that of the broader political relations. But it is these very intricate gendered relations that induce anxiety in vulnerable men, particularly in the months after this event.

5.4.5 Attachment to the mother and the stress of returning home

Early attachment of a child to his or her mother and a supportive family environment contributes significantly to a person's psychological well being as an adult (Clarke-Stewart et al, 1988; Alexander, 2005). Separation from the mother during puberty and late adolescence relies to some extent on the quality of nurturance during these formative years, but also on the mother's ability to separate from her son, allowing him independence as an adult man. These more western definitions of psychological and social growth during adolescence would appear to remain fundamentally consistent across cultures and were distinctive in this Xhosa rite of passage.

Circumcision, however, apparently formalises a structural process to promote this transition. This was made evident in Ntantala's (1993) account, which illustrates how practices and relations in circumcision were incorporated into respectful attitudes that must be observed and acted upon. Separation through circumcision, *"becoming the son of the mother"* and not *"the mother's son"* entails months of stressful negotiation. Prior to going the youth must confront his mother's and his own anxiety for him, to find his own new identity. This anxiety often becomes the nexus of conflict between the parents and interwoven with family and patrilineal politics. Conflict occurs over which parental family should have more authority over the youth i.e. the father's descent line or maternal grandfather's especially if the biological father has not married his mother. These internal family dynamics are exacerbated by other fears, such as the initiates dying in the bush and their bodies not coming home.

However, the evidence suggested that as difficult as these psychosocial stressors were for the youth, it was the expectations on him to marry and find work on returning home that were equally stressful and problematic, but these required his personal resolve. One explanation for Mpumi's illness and stress was that according to custom he was expected to have married and had not done so. Although marriage negotiations were once elaborate social and political negotiations conducted by men's fathers and kin (Hammond-Tooke, 1974); the study suggested that today neither sexual relationships nor marriage happens in this customary manner. Further evidence about how intricate stressful relations were around marriage customs was that circumcision should sanction a man's relatedness to his father's descent. When this happens a man has a responsibility to his mother's paternal line but his primary allegiance is through his father. It can thus be surmised that a youth who is circumcised to his maternal line explicitly questions a patrilineal worldview. The stigma of this was clear and this insinuated anxiety into that youth's circumcision.

The issue of advocacy from women is suggested from this discussion. This raises the issue of whether advocacy may interfere with the breaking of the mother-son bond – as is implied in the taboos inculcated in the practice against women entering seclusion. Whether women called for circumcision to continue or protested the injuries and harm, in a sense they were breaking a gender-described silence. Concern was expressed that women protesting about the custom challenged conventional wisdom and taboos and this resulted in increased anxiety for initiates. These feelings and women's advocacy were shown to be deeply symbolic and embedded in Xhosa-speaking history. Gasa described, "*'umakoti' is the practice of circumcision when spilling of blood was disapproved by missionaries. In culture one feels a need to spill blood and slaughter and (of addressing) a feeling of being disconnected. Women were instrumental in re-embracing the circumcision after the missionaries' influence. A balance of rite of passage achieves this."*

In respect of advocacy in women, the study suggested that men listened to their recommendations but were reluctant to implement them. Furthermore, they were precluded from taking meaningful action either because they did not have sufficient intimate knowledge about practices or they professed complete ignorance about what

happened. They therefore struggled to appropriately protect their son's interest[308]. The study demonstrated that most women and their sons who fell under their mother's father's descent line struggled to find extended male kin who would watch them through the procedure as a father would. Added to these problems was that when a schism developed between men and women, rather than negotiation the potential arose for a further undermining of ritual values. This was partly because this inevitably invaded a silent orthodoxy in patrilineal custom. Perceptions then arise suggesting that circumcision is under threat and this in turn places youth physically and psychologically at risk.

5.4.6 Stress in day-to-day life

This description of daily stresses for Xhosa youth is a bridge between a discussion on psychosocial stressors and that on environmental stress. It illustrates the ill-defined and paradoxical nature of stress which at one moment can be personal, culturally defined and at another pervasive and insidious – political and environmental; it may be productive for some individuals but harmful for others. The discussion will first address daily stress in circumcision, seclusion, and coming out, and then look at more general stress in Xhosa-speaking communities.

An unappreciated but obvious stress is that circumcision used to happen over three months but today takes three weeks. This reflects a post-modern culture which requires that solutions to problems happen quickly and definitively. Circumcision takes place in the school holiday period and fits a calendar that defines relations for work in an urban environment. In this change what is lost are subtle differences or ways of doing things, e.g. the skill gained in a secret language. These changes have less dramatic effect and remain unnoticed. However, the effect from this undermines daily activities in the ritual process. This is felt in it becoming superficial, commercial, and stressful as valuable skills are lost.

Another example is the place of authority in the ritual. Youth learn how to take authority in seclusion. Circumcision, however, does not confer authority on men. This thesis argues that circumcision gives the man a right to acquire authority through

[308] Anecdotal evidence from women colleagues suggested that they were insisting on going into seclusion grounds to protect their sons because they are single parent families (Field notes 17/08/07).

his action and place in his community[309]. African society was often professed to be an egalitarian one where relatedness was reliant on a careful negotiation of authority in roles and behaviour. Relatedness relies on face-to-face acquaintance and an honest engagement with malevolent and benevolent forces. The "face" of a man after circumcision was, however, not just of his person but of his ancestry. Furthermore, poverty has other stressful implications as social status in this society is now gained through the size of an initiate's party and its success[310].

Accounts illustrated that appearing to be strange in circumcision brought stress to initiates. Youth could not enter circumcision unless they were well, clearly *"being strange"* – like *"being bewitched"* – was therefore feared and excluded. If men behaved strangely this brought derision, and this was suggested for Xolile and Ayenda. This stigma remained with them as personal attributes in manhood. These stressful circumstances continued in the months after seclusion, when a strange man might be ridiculed. The quiet integrity of the new man is watched and bespeaks his assimilation back into a complex world. Mr. Mangesi pointed out that Ayenda had been aware in the bush and knew the rules. Mr. Mangesi said, *"He should remember and show respect for his custom first. He was still mentioning no voices. He was not mentally ill when he was in the bush."* [311]

Moving between cultural arenas is stressful, but considerably more so for a new man who must engage in a diverse urban environment. Xolile and Mpumi both managed the stress of being newly circumcised men better than did the others. Being circumcised required that they obey a different set of codes, many of which were covert and behavioural. Their compliance with these would be shown in their masculine deportment. For all the men the subtleties of gestures and how they reacted was challenging. Mr. Mangezi said, *"If you have been to circumcision you have to know whom you are equal to and who not. If after two years you visit you cannot*

[309] Schapera, I (1956) described that amongst indigenous African people of South Africa relationships between children and their parents have changed. Migration of men to work has meant a loss of male authority and this has also been undermined by a decline in respect for the ancestors. Furthermore, the circumcision ceremony has weakened as an educational and disciplinary institution.

[310] In her discussion Gasa (2003) states, *"the circumcision used to be done in the paternal kraal and in the political instability of the eighties this was taken away, but it needs to be there because it is to be done in the ancestral home. In the drought in the 1980s and with poverty it has changed. One needs to slaughter every day in ritual and in drought this could not be afforded. They slaughter pigs and rationalise that this is alright but it is not liked because cattle bind to the ancestors."*

[311] Field notes 27/05/03.

command in the bush but after five years you can start talking and commanding. This gives authority. If an older man likes you they will include you and revere you." To place their cultural predicament into perspective, those who were chronically ill had to leave the physical and psychological containment of seclusion and return to a once familiar but now strange home. They would be increasingly confronted with anxiety, an increasing sense of personal and cultural dissonance, and the stress of re-entering a once familiar but now strange cultural environment.

In general, outside of circumcision, on a day-to-day basis stress was evident in three areas: a healthy normative stress; the stress of increased danger in a society under distress; and finally the stress of chronic illness. Healthy stress that is a normal part of life contains all our experiences and is productive because we have to take action and respond. Ayenda, for instance, despite having a hard life as a youth described where he grew up as *"a village and there were rivers and mountains – it was nice because I grew up there"*. This feeling of well-being meant he planned for his future – inevitably structuring stress into his life through finding work and returning to the Eastern Cape. Achieving each was stressful because his expectations induced stress.

Speaking of the stress of change, Gasa said, *"If you trace the context of practices you find that because of culture things are changing and different models of expression happen. There are different rationalities now for different families for different customs. The complications came in the 1980s and stopped many customs."* Xolile was stressed about his university and his failure and suffered an altered state on leaving circumcision. Although extremely stressed by his personal goal and chronic illness, he eventually demonstrated a capacity to respond normatively to positive stress and return to university. Thus, different models of expression of stress, as described by Gasa, extend from the healthy stress of personal goals in circumcision and education to the harmful stress of chronic illness.

Gasa refers to complications in the 1980s and this includes a stressful, impoverished urban environment that induced stressful circumstances. Two major factors were at issue in the study, namely food and personal security. Xolile was not the poorest of the five men, yet he often said that his family did not have enough to eat. In terms of personal security, Ayenda's property was stolen whilst he was in hospital and this

further impoverished him. There was no emotional or material compensation for him, there were no kin to commiserate with him and he had no insurance.

5.5 Environmental stresses

5.5.1 Cultural dissonance and resulting impoverishment

Issues of cultural dissonance were a dominant theme in the literature and this was mirrored in the data. The discussion employs Gasa's (2003) discussion on *The Making of Manhood in Xhosa Society, Challenges for Gender Equality* to reflect on a theme of cultural dissonance and mental illness in the study data. Although Gasa portrays a complex counter-argument to cultural discord bringing rupture to Xhosa society, the evidence suggests that cultural dissonance and related poverty and violence severely disturbed these men's lives and mental health. Gasa's discussion and the evidence in this study importantly contribute to a negotiated African discourse on the nature of wellbeing.

Cultural dissonance was referred to in the psychiatric literature as one significant factor to consider in the relationship between stress and the onset of mental illness (Leff, 1980; Guinness, 1992). Guinness (1992), in respect of Swazi youth, argued that cultural dissonance affected patterns of mental illness because a more dominant urbanised culture with related institutions for education had supplanted traditional practices (Guinness, 1992). Cultural dissonance amongst Xhosa-speaking people was also a prevalent theme in the wider literature (Mayer and Mayer, 1971; Mager, 1999; Ntantala, 1993; Nonganza, 2005). Harmful effects that arose with cultural change were attributed to increased levels of domestic abuse, and violence and injury in circumcision (Beinart, 1991; Mager, 1995, 1999).

Cultural dissonance as a discourse on stress and change was shown to be woven into community discourse around circumcision. Women, for instance, voiced their disagreement about practices because they wanted their sons circumcised safely but were too poor to protect and support them[312]. As early as 1956, Hellman cited a lack of parental control amongst some Xhosa-speaking people, and she attributed this to

[312] Hellman, E. (1956) expressed considerable concern over the plight of women stating, *"economic need, for many women, hard pressed to balance expenditure and income, resort to prostitution…has in practice come to be accepted as part and parcel of urban life"* (p 422).

the chaotic nature of urban life where families increasingly lived in isolated individual units. In the study, families headed by a single female struggled to rely on their paternal clans or extended kin to circumcise their sons. In the worst cases, despite their sons being circumcised, these women's extended kin failed to protect or support them or to safeguard their futures. Abuses, either as familial or cultural, were recorded in two cases, those of Ayenda and Lindelo, but Unathi was possibly locked away as well. This questioned, as suggested by elders, if moral values had changed.

Gasa (2003) however, denies a sense of disturbance from cultural dissonance – rather she claims a sense of identity, integrity, and incorporation of diversity for the amaXhosa people. She describes circumcision practices and the structuring of gender-described relations as essential to an amaXhosa sense of origin, community, and ancestors. This sense of belonging means that the amaXhosa people have incorporated diversity and change over time. Her imagery invokes the Comaroffs' (1987) sense of a worldview anchored by the consistent re-enactment of diverse symbolic imagery and practices such as circumcision. Gasa, moreover, sounds as if she – unlike the *"Tswana madman"* with his bricolage of different symbolic images – feels assured of a deep sense of origin and identity. Thus, Gasa attributes the bricolage and cultural dissonance to belonging within modernity and settlers.

Gasa said, *"Male identity and male circumcision has its impact on gender relations. But other factors impact on circumcision too. Drought and religion are key factors in circumcision. So too is Christianity which the Xhosa never fully embraced and ancestors worship and continuity of life is more important. My community of origin was all this and a rural one in the Eastern Cape… Modernity was despised because you did not know where you belonged. Settlers were missionaries. However, definitions of Xhosa are always fluid, such as the Pondo."*

Gasa (2003) and Comaroff (1987) both argue that gender is a complex negotiated phenomenon enacted in practices such as circumcision. This perspective is critical in understanding the nature of stress, identity formation, and patterns of mental illness. However, whilst the Comaroffs' (2002) argue that people create identity and community in producing, *"new forms of consciousness, of expressing discontent with modernity and dealing with its deformities"* (p 274), Gasa insists on a deeply

embedded sense of origin for the amaXhosa. She does not pose a sense of cultural dissonance from competing genders or worldviews. Gasa (2003) states, "*The essential thing for Xhosa is to co-exist with others and live and let live, and for perhaps political hierarchy it is as it is because of this belief."* Authority in her argument is positioned at a political level of discourse, but may incorporate a moral reasoning that arises from gender-based negotiations in circumcision.

Gasa's statement may better explain the conflict and consensus that was evident between men and women and their different lineages in this study. These contested relations around male identity and how Xhosa people coped with the inevitable cultural dissonance that this and urbanisation brought was evident in her concluding comment. She stated, "*Cultural chauvinism is not part of our thing and what we should leave behind. When practices are maladaptive this suggests not just an anomaly but a breakdown in society and against this is a defining custom for pure circumcision. Broken masculinity was broken by apartheid history. What is now contested is an issue of bestowing dignity in every relationship you have and this is the bigger picture"*.

Contested relations, evident in Gasa's sense of *"broken masculine identity"*, echo Cock's (2001) discussion on the impact of violence on male identity in South Africa. Gasa contrasts this with a sense of *"pure circumcision"* and dignity in the intimate nature of personal relationships. This resonates with the study data where it was the minutiae of everyday life and practices that substantiated identity and integrity in the custom, but also posed the potential for discord. Mr. Mangesi recalled how one initiate became mentally ill in the following story. The incident he related described how: *"One guy in circumcision did not slaughter but ate fried chicken and now he is talking to himself. This was because there was no blood in his circumcision and now he is not well. His brothers and sisters are all well and he is now twenty-eight years old."* His cultural explanation in this story posits that custom should not change, as those who deviate from tradition in circumcision will suffer mental illness. His story contains a salutary reminder of the centrality of blood and pain in instantiating moral codes and patrilineal descent. His explanation would be queried in biomedical culture as his vulnerability for mental illness, rather than this social stressor, would tend to be

seen as causal. Treatment, moreover, might alter the course of his destiny which in a cultural context has been prescribed.

Cultural dissonance was thus a pervasive and often disturbing theme indicating that significant tensions underlie Gasa's concept about Xhosa-speaking integration. Against her idea that integrity meant an ability to discriminate and incorporate diversity was a constant theme that diversity has brought internal dissension that has questioned trust and trustworthiness in relations. People from the Eastern Cape described those circumcised in Cape Town as untrustworthy. Those in Cape Town asserted that people became mentally ill after being circumcised in the Eastern Cape because they no longer followed tradition there. *"Culture"*[313] in these instances was used as a socio-political tool to manipulate power and status.

Trust was a stressful cultural issue, with the evidence showing that in most cases youth did not know each other in circumcision. More so, families who came together often did not have long-standing relationships where descent and intimacy were worked through and remembered over generations. Xolile described that in the townships youths come together as *"peers but strangers"*. Formerly it may have been possible for families to know each other well, and circumcision was more intimate and meaningful, leading to an initiate's balanced psychological development[314]. Yet the data showed that even seclusion is not secluded, and youth cannot be trusted to respect the taboos. Seclusion used to mean that initiates were not seen, as their disappearance in reality was mirrored in their being forgotten as boys in their mothers' memories. Yet grave concerns were expressed that this was not observed; moreover it was increasingly dangerous.

A theme that custom had diverged from its ritual structure because of expediency occurred in the wider data. In 1956, Hellman was to comment, *"Tribal institutions provide for one period of intensive training during the course of the circumcision*

[313] Culture in the thesis is lived. It is action from individuals who – because their practical consciousness is oriented in a Xhosa-speaking culture – instinctively engage at a family level in everyday practices and rituals. Culture thereby is evident as practice and this as genuine feelings of trust and knowing which sustain any encounter. Culture may alternatively be used in the context of being ascribed and used in a political and ideological sense.

[314] Hellman, E. (1956) describes circumcision as, *"that change from childhood to adult-hood, with its new duties, obligations and privileges, which is ritualized and dramatized in the tribal circumcision ceremonies"* (p417).

rites, which set a seal on all the earlier informal training. In urban areas, this final intensive training is lacking" (p 417). Circumcision rituals are business and provide employment[315]. This is problematic, as the data indicated that there was less concern for function in a rite that had contained an educational and training process for officials and initiates. Hence class, monetary gain, and a different status superseded traditional values which once held to an equitable sharing of resources and values (Beinart, 1991). People spoke of *"botched circumcisions and suicides"* because inexperienced surgeons carried out circumcisions to earn a living after *"learning for one season"*. In many instances problems also arose because resources such as water supplies and secluded spaces were unavailable.

Dissonance became evident in an aforementioned moral reasoning process. Acumen in moral reasoning that had been learnt in circumcision denoted a man's ability to engage in a gendered Xhosa-speaking moral discourse in which men attained status. This served in distinguishing those perceived to be more able men. In Cape Town, this skill included having an education and work, and this perspective at times enhanced life skills about personal moral worth from circumcision. Ayenda, however, and men like him who were stigmatised because of their illness despite being circumcised, were less able to engage in these discussions. This exclusion made these men victim to a process of cultural discrimination in which they could not succeed. This is not significantly different to what happens in other cultural groups, but may explain why, as previously suggested, mental illness and disability becomes attractive to those who are marginalised.

5.5.2 Violence and aggression

Circumcision, Gasa (2003) said, *"is a question of knowing who you are. Circumcision is not the defining moment. It is not important to be circumcised by seventeen or eighteen years old. Before this there are other rituals. At seven there is the marking of identity and learning to fight with aggression. In adolescence there is stick fighting and the beginning of fighting like a man – with poetry rather than beating the opponent to the seclusion. This defines a man – a man does not humiliate but wins in a dignified way as if the stick has dropped. It is not physical. It is hunting*

[315] Recent media reports and Van Vuuren and de Jongh (1999) cite that increasingly circumcision happens for commercial interest.

for manhood with dogs. But in adolescence you want to say how the animal died and that dignity was bestowed to the beast in its killing. As a boy gets older then killing is for the ritual and for paying respect and this is more critical. Blood binds to the ancestors and in this they intercede. Circumcision is the moment – the height of circumcision as manhood".

Gasa suggests that in men aggressive action is linked to moral reasoning in circumcision. Yet violence in circumcision appeared in the study as uncontained and destructive with gangs involved (Beinart, 1991). Elders complain that they have lost authority, are given no respect, and cannot identify with youth values[316]. Mr. Mangesi spoke to custom being misinterpreted, and that as a consequence men can be violent and cruel. An example of this was his expressing concern that Lindelo was hitting his mother. He said that this brought up issues about the authority that was given to men in circumcision. This and other evidence showed that authority was being misinterpreted as license and abused. Mr. Mangesi argued that such action was, in the past, subject to sanction from other men and formerly in traditional courts. This suggested that a once informal and formal arbitration process around moral issues and legitimacy had broken down.

Violence did not only happen in traditional practices but in the community. Xolile's account at one interview illustrated the levels of violence that ordinary people there face daily. In one interview he presented with his lip cut and we were told it was because he was *"disrespected, as he had been mentally ill"*. Dr. Soga explained that *"township rage"* existed, and all youths were tested by others to see who could survive, so they had to be worldly-wise to survive. His injury was not, however, part of traditional stick fighting as he had argued. Xolile, it later emerged, was hit with a brick and then punched on the lip. In this interview his mother finally became outraged and angry. She was anxious and told us that she was desperate for her son to leave Langa. She said that people were jealous of him, and he had become a target because of his studies. Her anxiety was all the more acute because her eldest son had been murdered by a friend.

[316] See Interviews with Xhosa People in Appendix 2.3.

This evidence on violence and aggression questions the nature of the morality now engendered through the circumcision. As culture changes so too must perceptions across a community. As suggested by Cock (2001) people have learnt to accept violent behaviour that was previously unacceptable because it is seen as essential to social bonding amongst men. Thus, male aggression that was channelled in circumcision into teaching men to deliberate on justice rather than resort to aggression has changed with other political influences[317]. This sense of justice was so instantiated that Hellman described how under tribal conditions a child is gradually developed and schooled, but the circumcision subjects him to a *"definite norm"* producing a law-abiding person. (Hellman, 1956, p 419) Given the description of the nature of aggression in the custom, and related instability in these communities, Cock's argument for a society deeply affected by apartheid and poverty seems appropriate.

Violence also raises the issue of intentional cruelty in circumcision. Circumcision requires a social agreement or contract that trauma – pain and the drawing of blood – is allowed. Consent is given[318], and the youth submits to allow his circumcision which others witness. In terms of stress this questions how cruelty or trauma is dealt with morally and psychologically. When circumcisions are botched then the nature of this social contract and human rights are placed at issue, both between the surgeon and youth, and in respect of familial and cultural authority. The five men in the study were, however, to undergo another trauma and that was a hospital admission for acute psychosis. During their admission a degree of violence inevitably happened, and this too was institutionally sanctioned. Their containment was because they were incapacitated and legally a danger to themselves or others[319].

5.5.3 Pathways to care, stress, and circumcision

[317] This statement posits that aggression and levels of violence were appropriately staged and strategically organized. In this regard Gluckman (1956) links circumcision into open displays of conflicting relations and preparation for feuding.

[318] Consent for circumcision (The Child Care Act, amended 2007) and clinical check ups are now a formalised process in most primary care clinics in Xhosa-speaking communities.

[319] Trauma in both circumcision and surgery may have a negative outcome. However, both are entered into with a positive outcome intended – as in the circumcision ritual, and frequently in medical culture trauma is induced for therapeutic reasons and has a beneficial effect. Containment poses its own moral question which requires an honest ethical and moral reasoning process as psychiatric admissions contrast dramatically to the containment in circumcision. Both, however, are socially organised and individuals have some trauma where there is a calculated risk that the outcome will be productive.

From the data it is apparent that all five men received vital psychiatric and indeed tertiary care for their psychotic disorders. The question in respect of Goldberg and Huxley's (1992) pathways to care was whether they received optimal care in respect of their condition, and if their stress-related problems were adequately addressed in the primary health care setting. One argument could be that a latent predisposition for psychotic disorder meant that in any event significant stress could trigger the onset of their illness, and available tertiary care was then critical. However, there was sufficient evidence in the data to suggest that significant psychosocial and environmental stressors existed in their lives, in circumcision, and the year following. There was little evidence that Unathi or Mpumi had suffered harmful psychosocial stress in their childhood or adolescence, but sufficient evidence for stressful circumstances and indeed trauma for Xolile, Ayenda, and Lindelo.

The data also indicated that key strategic opportunities in the primary health care field to address their and their families' stress-related illness and chronic mental illness symptoms were missed, e.g. schools, employers, traditional healers and church organisations (Swartz, 2002). In respect of early interventions, data on their mothers in particular, supported the evidence from de la Rey (2001) and Njenga et al (2005) that women in many African communities bear the burden of stress-related mental illness. In the five men, Ayenda's, Lindelo's, and Xolile's mothers were all described as having suffered with stress or mental illness. Ayenda said, *"I saw my mother's problems and she was suffering the whole time… she had to grow up with me in 'not a safe place' and she was not having a house, and I was looking like a street kid sometimes… I was seven years old when I was left at my grandmother's to take care of me."*

Other circumstances where the health system could have intervened to reduce Lindelo's and Ayenda's stress were apparent immediately prior to circumcision. For example, data on workshops in a local Cape Town community health centre[320] and interviews with a health system circumcision team in the Eastern Cape provided rich evidence of collaboration to address health and safety for initiates in the primary health care field. Furthermore, all men had consultations with traditional healers before their circumcisions and in ideal circumstances these could have informed

[320] See Workshops and Interviews with Mr. Mabuda in Appendix 2.2.

clinical services of their need. Mental health care need was addressed by clinics and general practitioners in respect of Xolile and Unathi. Of concern was the degree to which Ayenda had to rely on his own initiative to seek health care, manage stress, and get support[321]. This evidence shows young men moving between traditional and medical domains to access services for mental health care need (Leff, 1980; Guinness, 1992; MacGregor, 2000; Swartz, 2002).

Health system interventions to prevent pain and injury that were relevant in screening for and managing stress and mental illness were described by the circumcision team nurse in the Eastern Cape[322]. He mentioned three critical aspects to promote the care of initiates, given the problems happening in circumcision:

1. *There is not enough time for healing in seclusion.*
2. *Teachers are not always diligent in their care of initiates.*
3. *Interventions[323] can be seen as inappropriate and jeopardize the safety of an initiate. This is because if an initiate who is injured leaves seclusion to go into hospital, his exit and re-entry must be a collaboration between a traditional and a medical authority, and planned – otherwise he will fail to become a man and may be stigmatised or victimized[324].*

Another stressful circumstance in circumcision practices is the transmission of the human immunodeficiency virus (HIV). This has understandably increased fear and stress for initiates and families. The male nurse who looks after circumcision practices in the Eastern Cape described that risk of HIV infection happened when the youth's foreskin was ingested by either the father or son, and in the use of the same

[321] Local resources are crucial in the long-term management of stress and mental illness and reflected in social capital and traditional economic assets. Social capital reflects extended family and kinship but also traditional economic assets such as property and housing. This is of relevance because in health care management it is important to incorporate information about these assets. Thereby Ayenda could potentially rely on his inheritance of his mother's property through traditional and legal authority. This asset should be protected for him because of his mental health status, and in the long term this will be his means to survive. In the past traditional mechanisms might have safeguarded him in this respect, but his mental health and social isolation indicated that he was vulnerable. It was very unlikely that he could assert the authority needed to claim this inheritance as he was ill and feared returning to the Eastern Cape.

[322] See Appendix 2.1.

[323] In these interventions, initiates who have mutilated penises enter the biomedical domain for surgery. At this time, because this is a cultural practice, their mental health need may not be assessed. These injured men are then probably incorporated back into their cultural domain, where bewitchment might be described as causing their disability.

[324] Meintjes (1998).

blade in circumcising many initiates. When the father or initiate swallow the foreskin an assumption about physical, psychological, and spiritual health appeared to be embodied in this act. This bound the father-son relationship, family and descent. The tragedy of the HIV epidemic is that these relations can no longer be implicit because the body and social boundaries around age old customs have been called into question as the disease has physically and symbolically challenged these boundaries.

In respect of families engaging with a pathway to mental health care in the event of these five men's psychotic illness. Stress from their mental illness symptoms prior to their admission was not coped with well by their families or in the community, and it seemed people were reluctant to seek help from the health system in general. In some interviews family members suggested that they watched helplessly or alternatively tried to ignore that the man was becoming increasingly ill. Sometimes they seemed afraid of the health services and the consequences of their action, e.g. the stigma of mental illness. Thus, Ayenda and Lindelo had become acutely psychotic before, in desperation, people in their communities called the police who arrested them. Xolile, Unathi, and Mpumi were brought into hospitals or clinics by people who were concerned about them.

A discussion on stress and circumcision raises the following question in a biomedical context: to what degree does the circumcision intentionally simulate and manipulate trauma, to alter states of consciousness? The Child Care Act (amended 2007) sets down that authority figures, guardians and parents must take personal and collective responsibility for circumcision practices. They have responsibility for any harm or injury, done to an initiate. This raises human rights issues given that circumcision is potentially traumatic. However, consideration is given to the fact that from an ethical viewpoint circumcision in its cultural context, like surgery, stands as a therapeutic art for social incorporation[325].

[325] In Xhosa cultural terms, however, there could be no dualistic separation of mind or spirit from the body as is common in western European and biomedical culture, thought and practice. This divide would be an anathema in this domain. The ritual demands a holistic sense of mind, body, and spirit and in the seclusion these boundaries can be labile.

CHAPTER 6 – CONCLUSION

6.1 Circumcision – precipitating stress for psychiatric disorder

This is a descriptive study with qualitative strengths in respect of detail and in the longitudinal follow-up on cases. The scope of the study is however, limited because the evidence is meaningful but more anecdotal. The research has however, provided clear indication that quantitative research would be invaluable in establishing the nature and extent of psychological risk that initiates face. This takes the increasing vulnerability of initiates with botched circumcisions into consideration. Future research would need to counter the limitations of this study. For instance only one relationship between male circumcision and the onset of mental illness was examined. This described the onset of acute psychotic illness within one year of the man's circumcision. There are however, diverse other relationships and consequences for mental health that arise in circumcision procedures that should be studied. These were suggested in the descriptions of the issues in circumcision and mental illness episodes of the twenty-two patients who were not included in the study (see Appendix 2.4 Patients screened). Understanding the nature of their presentations might help in describing some of the causal factors for the onset of mental disorder among indigenous African-speaking people who practise male circumcision.

This discussion has argued that in the cases of the five men in the study, stressors in the event of Xhosa-speaking circumcision precipitated stress-related anxiety and because they were vulnerable, this contributed to the onset of their psychotic illness. The evidence has suggested that the psychotic disorders that the five men in the study suffered with were Schizophrenia, Bipolar Disorder and Cultural Bound Syndromes. With regard to precipitating stressors in the cases of Unathi, Lindelo, and Ayenda who suffered with Schizophrenia and Bipolar Disorder, the chronic stress they endured in their phase as *abafana* or new men was the most harmful for them. In comparison, it has been suggested that stressors that were inherent in the rite of passage precipitated the onset of Brief Psychotic Episodes in the cases of Mpumi and Xolile. As these men's psychotic illness happened immediately on their leaving circumcision, their psychiatric conditions have been described as Cultural Bound Syndromes. Further evidence for this psychiatric disorder lies in the fact that their psychotic symptoms

went into remission when the culturally instigating stressors in circumcision were therapeutically addressed. The nature of these symptoms and the delusional content of their psychotic imagery also spoke vividly to the circumcision.

The onset of their mental illness was, however, deeply affected by related psychosocial and environmental stressors that were exacerbated in the event of the ritual. This often also revealed these men's poor personal coping strategies to themselves and meaningful Xhosa others. The evidence illustrated, however, that the most significant stressor was when fathers did not fulfil their required roles for their sons in circumcision. Because the father/son dyad underpinned this patrilineal rite of passage, their psychological health and social relations were compromised. This particular stressor seemed to highlight the stresses, psychological harm, cultural dissonance, poverty, and stigma they had suffered and indeed continued to endure. A local idiom of distress illustrated Xhosa discourse and beliefs in this regard and warned of the possibility of mental illness in youth who were not circumcised to their fathers' line of descent. In as much as this warning signalled a possible onset of mental illness, it also contained an anecdote. This counselled that fathers, mothers, and families needed to engage with their sons at this potentially turbulent time in their sons' lives.

Stress at a turbulent time was shown to exist for Xhosa youth, because much of their adolescent anxiety became focused on their circumcision. This event was anxiety-inducing but entered into with the hope that resilience would be instilled into Xhosa men. However, in those at risk for mental illness the anxiety of this deeply embedded cultural and psychological transitional rite of passage became overwhelming. In particular, the event potentially exacerbated the psychological harm suffered by youth who had been neglected or abused. Dysfunction in personal and family relations was also shown to become problematic at this time. Cultural dissonance too, often had detrimental consequences for the ritual. At one level, Xhosa culture has been disrupted by urbanisation and – quite simply – circumcision functioned less well e.g. officials were not accountable. At another level, the fabric of Xhosa-speaking peoples' social lives and practices – which have been interwoven with subtle gender-based relations and hierarchies for patrilineal descent – had been disturbed. This has exacerbated stress and problems for initiates and their families who suffer significant

distress e.g. fear rather than anxiety about being circumcised.

Perhaps the fact that Xhosa elders warn of *"danger"* in circumcision is the clearest indication of the potential for stress-related harm and mental illness in initiates. Circumcision is a vulnerable period in a marginal space and time, and initiates were thereby masked by white so as to not be seen. The white is also said to be purifying in ritual events and this brings protection. Ultimately, danger and therefore anxiety, exists in the fact that the initiate can fail the physical and psychological tests in the seclusion, for his success is dependent on his resilience. If he fails, he is denied manhood, and the social and spiritual acceptance this brings. The study demonstrated that the youth is initiated into a complex phenomenal worldview and inherent in this are layers of restrictive taboos and circumscribed gender relations. What is crucial in this, at each moment, is how a youth is *"seen"* in the circumcision seclusion and as a man afterwards. Material reality is disguised and hidden and becomes insignificant, whilst what becomes significant is a world that crosses into that of the ancestral[326] and is labile. In this process the man must become *"a Xhosa man, who is the son or descendent of the man who is his father"*, and not *"the father's son"*. The youth must consent and the father should witness his circumcision.

Although the ritual evokes a sense of the extraordinary, the paradox is that the event must function so that it is methodically walked through. Thereby ordinary relations and practices are acknowledged and consolidated in a liminal state in seclusion. As the man's penis has been surgically restructured, so too are his psychological and social relations. In other words, for the youth to choose to be circumcised the ritual draws on the on-going relatedness of fathers to sons, and nephews to maternal and paternal uncles. The rule extends to the participation of traditional surgeons and teachers who should come from affiliated clans. Of prime importance is the blessing of women, who in a gender-based negotiation make an agreed withdrawal from the rite of passage. These mundane relations bring about a re-orientation of the initiate's consciousness and action and this happens simultaneously across his peer group. This shifts their psychological orientation and social bonding to the father-son relation and away from the intimacy of the mother-son bond.

[326] Hunter states, *"The ancestor cult sanctions right behaviour between relatives. Failure to fulfill obligations towards kin, particularly failure to show proper respect towards parents, is believed sometimes to result in illness sent by the ancestors"* (Hunter, 1956, p393).

6.2 Protective mechanisms against stress-related illness

These conclusions suggest that for those who are vulnerable, the most significant protective factor against the stressors associated with the ritual was that family members were present and related to each other. Social coherence – as in family members, especially biological fathers and extended kin – fulfilling their customary roles in preparation, circumcision and the year of apprenticeship was vital. This is because the embedded nature of social interaction around the injury was so important. This does not presuppose harmonious, familial relationships; rather as Gasa (2003) states, it acknowledges the ever-present tensions, arguments, rifts and change inherent in all people's and family everyday life.

As Gasa argued, it appears that when the practice was well managed, diverse social elements were orchestrated that encouraged resilient behaviour and attitudes in men and these were shown in them assuming responsibility for their family. This appeared to be protective against stressful circumstances, as in circumcision, where men learnt to discern when they were stressed, how to culturally express feelings of pain, and how to engage with their peers. The practice also brought them into relationship with supportive kinship, because circumcision constituted bonds of fatherhood, which potentially embodied trust and engendered authority for decision-making. Formerly the circumcision established a training ground for surgical practices and teaching so that an apprenticeship ensured sound skills for future generations. Thereby elders within a patrilineal descent system, and the presence of the ancestors, provided protection from an unseen world.

Despite evidence for cultural dissonance bringing psychological harm, protective mechanisms and life opportunities, especially for the mentally unwell were evident in the changes brought in the engagement of diverse cultures. These positive aspects arose in the diverse opportunities afforded to these men in education, travel, and importantly, their mental health care. The ability of Xhosa people to adapt to cultural change, yet retain a sense of cultural integrity, has been described by Gasa (2003) and illustrated in the new man's jacket and cap. Becoming a Xhosa-speaking man has meant embracing diverse practices and discourses, and coping with the exigencies of

life. A man must find a job, go to university and eventually marry and have a family. Whether he lives in a modern urban setting or in a rural home, he will be a Xhosa-speaking man.

6.3 Improving pathways to mental health care

The study data illustrated how important functional pathways to mental health care were for the five men in the study and their Xhosa community. Vital in this was that health services were integrated, so that a man who was mentally ill could receive treatment at the appropriate level of care. Health services needed to be responsive to need and cultural practices and this was shown to be problematic on many occasions. Clinics that already screened youth before circumcision, could have offered services to address anxiety and stress, but did not. The evidence did demonstrate that sound, culturally sensitive, psychiatric care was essential and this was clearly reflected in how well Mpumi became after his psychotic illness. When well managed, this appeared to offer Xhosa families a secluded, transitional space for their sons' healing because the hospital, like the seclusion, allowed the men to retain their integrity.

In respect of addressing stress-related mental illness and psychiatric disorders, a number of recommendations arise for discussion. In the context of the hospital setting issues about traumatic injury, human rights and accountability arise. For instance, very little investigation has gone into understanding how, or if, circumcision as a traumatic injury transforms identity and psychological wellbeing – and this raises issues about how biomedicine can address stress and injury in circumcised men. Furthermore, traumatic injury also raises an issue about safety in practices given that circumcision rituals engender an altered state though injury and seclusion. Protecting the human rights of youth requires that officials, who perform circumcision, take responsibility – not just for physical injury – but psychological harm. The evidence showed that circumcision is not a question of a right to cultural practice that happens intuitively through customary knowledge. The data clearly illustrated that generations of officials and elders have observed individual nature and cultural artifice to inform function and training in the practice. Knowledge, apprenticeship, and skill have anchored a custom that has responded to societal change when needed. This knowledge has in the past been integral to a discourse on morality and integrity.

Recommendations for culturally sensitive biomedical practices arise out of these concerns. Xolile and Mpumi's cases demonstrated how important it was to interrogate a patient's culture on admission to a psychiatric ward. Although, the DSMIV (American Psychiatric Association, 4th Edition, 1994) advocates that phenomenological and cultural aspects of a patient's presentation are interrogated, this can only be achieved through regular and rigorous application of these questions and issues during the patient's psychotic illness. This is especially true when the restoration of a man's wellbeing is dependent on health professionals referencing his cultural orientation. In these cases, when cultural disposition was evoked, so meaning and memory were triggered in a phenomenological sense and they began to regain a sense of who they were.

Circumcision, given the prevalence of the custom, should therefore be an essential question in screening male patient's clinical and psychosocial history in this local context. The depth to which this is done should be determined by the nature of the patient's condition, illness or pathology, and language orientation. The demographic picture of the client should incorporate the circumcision as a critical point against which other life markers are situated, as the event describes identity, development, and life stage achievements. Circumcision confirms if a boy or man is living in the context of either his mother or his father's family and lineage, as this has implications for his personal and social circumstances. This has particular relevance when guardianship is at issue – especially in the context of ethics, medical practices and the law.

Health practitioners could be better informed about the cultural practices of the people with whom they most frequently interact. As in the recently instituted problem based learning for medical students at this university, where culture is integrated into curriculum, these questions should be ethnographic, and not prejudiced or judgmental. Circumcision lies in the context of the family system and reflects a man's integration into that social milieu. A patient's history should be explored in the context of his biological, psychological, and social family dynamics and this in terms of known pathology. Any symbolic references that arise in this context need to be understood and explained for the health system to respond sensitively and appropriately. One

example of this was the significance of blood and slaughtering in the circumcision, as for example, it is believed that a youth cannot become a psychologically well man.

The further development of an already existing Xhosa-speaking medical lexicon[327] that illustrates the connections between medical and Xhosa concepts, and visa versa, is essential This medical lexicon has been incorporated into health professional learning in the Faculty of Health Sciences, University of Cape Town. However, what this study demonstrates is the ethnographic depth of knowledge and concepts that need to be explored with Xhosa patients, if they are to become well. For instance, the situating of body parts into Xhosa language and custom was one example of the essential nature of this innovation. More specifically, the use in Xhosa of the word penis to denote status within a male hierarchy, is illustrative. Here the joking relationship around penis size legitimated a man's status by the way it was said. This conveyed information about the success of his circumcision. However, it was the sound that was made, when said in Xhosa, that resonates and brings respect to a man. Circumcision fundamentally underpins what it means to know a person, and whether they come from a reputable family. Knowing such things, was said, to safeguard the instinctive nature of sexual relationships. Related to this is the current debate[328] that initiation for girls can help to prepare them for sexual practices. This draws on cultural information and applies it in a more modern context.

In respect of the primary health care domain, the importance of a viable mental health care system and pathways to care was clearly illustrated in the event of Ayenda's relapse. Ayenda had such poor follow-up in the primary care clinic, that despite desperately trying to remain well, he over-medicated himself. Ayenda had sought a number of other avenues to manage his illness and these too failed. His visits to traditional healers were supportive and provided him with a personal and social strategy to manage his stress. This undoubtedly contained him at critical moments, but he had reservations about how effective his visits were, in comparison to taking his medication. Traditional healing as a culturally appropriate intervention should

[327] These are in existence and the Xhosa-speaking Department at the University of Cape Town has a language course, books, and multi-media material that are used in the teaching of health science students.

[328] This debate formed part of our MBChB problem based learning programme in the Health Sciences Faculty at the University of Cape Town. Young medical students in their groups were asked how they were prepared by their parents to take up responsible adult roles and this included how they were taught about their sexuality.

have alleviated some stress. There is, however, very little collaboration with traditional healers in the health system and a necessary component in his health care was therefore undermined. Traditional healers might themselves have also been uncomfortable about referring him back into the health system at critical points.

Therapeutic healing, and in this respect the place that biomedicine holds in the psychological and identity formation of young Xhosa males, was shown to be of concern in all cases. Xolile's successful recovery and return to university, suggested that there is a place for cross-cultural psychological therapy in mental health care. Diversity, as is evident in the study and literature, is an essential part of a Southern African landscape. In spite of the problems brought by cultural dissonance, Xolile recovered from his illness and returned to university where he was prepared to challenge the adversity in his personal circumstances and cultural poverty. His therapeutic process was enabled by Dr. Soga, a Xhosa psychiatrist and healer, because – he argued – she understood what was distressing him. Her assessment was that, a significant aspect of Xolile's stress was his dependent relationship on his mother. Dr. Soga encouraged him to draw on the resilience built in his circumcision, and he adopted a positive attitude to the stressful circumstances he faced. This brought him support and affirmation from other men, as he was then seen to act independently and with some authority.

What is evident in the Eastern Transkei and Western Cape is that practices are being observed and challenged by women, families and their communities. Although some families do not want their son being circumcised in a hospital, they equally were reluctant to let their sons go for traditional circumcisions. Of interest was the surprising number of elderly men who supported hospital circumcision. Another factor in this debate was the cost of circumcision, especially when it was now known to be unsafe, and there were sound medical alternatives and lifestyles. Cost raises the fact that the circumcision was described as a market-oriented practice – it was done to get easy money - and therefore it was suggested it had become morally corrupt. This moral corruption did not so much relate to officials having to be paid, as to unreliable people taking advantage of cultural practices that should have had a moral underpinning. The motivating factor then became money, and not morality and manhood. This undermined the intention in the ritual, which sustains relatedness

amongst men and women, within Xhosa-speaking society. Other questions arose in this respect. For instance, Ayenda paid for himself and this placed his already vulnerable psychological health at risk. He entered circumcision through his mother's family but his right to participate was secured primarily through his monetary payment and he thereby derived less social benefit.

Effectively, circumcision sets a stage so that beyond this cultural sphere, all interaction and negotiation is subject to rules and injunctions about the "*other*". This otherness is relational; it is your peers within the circumcision or your community out of the circumcision seclusion; it is those whom are not Xhosa-speaking and therefore not part of circumcision custom[329]; it can be your ancestors as representative of another aspect of being. Whilst in practice the circumcision ritual suggests an exclusion of the other or those who are not circumcised; this is not true for discourse. In discourse, circumcision facilitates an inclusion of the other through hearing others, incorporating what is being said, and negotiating through relatedness. The discursive nature of moral reasoning, as taught in circumcision, opens the possibility for debate, and the articulation of attitudes and responsibility to others.

This thesis enters an already existing historical oral and written discourse on circumcision amongst Xhosa-speaking people. It offers insights from five Xhosa-speaking males about their psychiatric disorder and this has opened a fascinating perspective or window on gender, morality, and worthiness amongst men and women in this culture. The discussion has reflected on continuity and change, and the stress that this brings to a people and culture who believe that they have a cultural right to a practice that has, in fact, become increasingly stressful. One ameliorating factor, indicated by the evidence in the study, is that those who were vulnerable for mental illness had recourse to medical care. In this regard, an emergent African, democratic voice and discourse on diversity, culture, health and human rights has established a platform in which people and families can openly address cultural problems and concerns about practices such as circumcision. This recognizes the value of an African discourse about morality where, as Tangwa (2000) argues, equality amongst people has precedence. This outweighs an argument that transparency in the practice creates further divisions, and exacerbates already existing stressful conditions for

[329] Hunter, M. (1956) "the observances of the cult by affirming the power and importance of the ancestors enhance the importance of kin, as against friends and neighbours" (p393).

initiates. In doing so, this thesis argues for culturally-sensitive practices in the South African health system and pathways to care that bring equitable care for stress-related mental illness and psychiatric disorders (MacGregor, 2000; Baldwin-Ragaven et al, 1999).

CHAPTER 7 – BIBLIOGRAPHY

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CHAPTER 8 – APPENDICES

APPENDIX 1 (CD)

1.1 Case study Ayenda 1
1.2 Case study Ayenda 2
1.3 Case study Ayenda collateral
1.4 Case study Lindelo
1.5 Case study Mpumi
1.6 Case study Unathi
1.7 Case study Xolile
1.8 Case study Xolile collateral

APPENDIX 2 (CD)

2.1 Interviews with Health Professionals
2.2 Interviews with Mr. Mabuda
2.3 Interviews with Xhosa people
2.4 Patients screened
2.5 Prof. Judith Head
2.6 Workshops

APPENDIX 3 (CD)

3.1 Amendment
3.2 Ethics August 2003
3.3 Informed consent
3.4 Informed consent – Xhosa translation
3.5 Initiation Poem – Nonganza
3.6 Questions
3.7 Results 01
3.8 Results 02
3.9 Statistics

APPENDIX 4

4.1 PhD Proposal
4.2 Letter of Approval
4.3 Letter giving ethical approval for study
4.4 Letter on co-supervision
4.5 Permission to carry out research on the ward
4.6 Permission to carry out research in Valkenberg Hospital
4.7 Assistance from translator for informed consent
4.8 Amendment to ethical consent