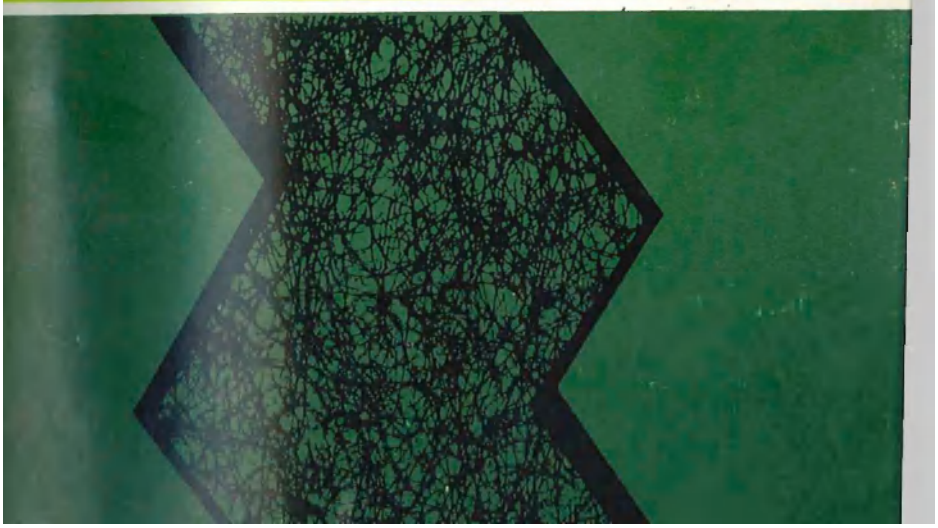
A STUDY FROM UGANDA

Culture and Mental Illness

John H. Orley



CULTURE AND MENTAL ILLNESS

A study from Uganda

JOHN H. ORLEY

Published for the
Makerere Institute of Social Research

EAST AFRICAN PUBLISHING HOUSE

EAST AFRICAN PUBLISHING HOUSE
Uniafric House, Koinange Street
P.O. Box 30571, Nairobi

First published in 1970

Made and printed in East Africa
by Kenya Litho Ltd., Cardiff Road, Nairobi

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FOREWORD

For many, particularly in Europe and America, and particularly for those unversed in the recondite matters which preoccupy social anthropologists and psychiatric epidemiologists, Africa is an interesting, rather exotic place where anthropologists occasionally collect fascinating data on "primitive" peoples with which to whet the cultural and literary appetites of the West. In the field of physical medicine, there is general acceptance of Africa's need for medical services to treat large numbers of people who are malnourished, diseased and infested with parasites. When, however, one talks about mental illness in Africa and indicates that there are acute problems in this field, eyebrows begin to be raised and polite incredulity is frequently encountered. For many, mental health (and that is a term not readily defined), or lack of it, are recent preoccupations of advanced societies and mental illness is something to be faced realistically and courageously as part of the price to be paid for social development. In more informed circles there is appreciation of the nonsense contained in such views, although it is certainly recognised that the forms and modes of expression of mental disease are intimately bound up with the social matrix in which the individual develops and are not to be properly understood within the limited framework of a narrow specialization. Genetics, the physical and biological sciences, and the social sciences of sociology, social psychology and social anthropology each have their own unique contributions to make to the focusing of medical techniques on the behaviour of the individual, which is psychiatry. Although the social sciences are particularly concerned with relationships between cultures, cultural change, and mental illness, they are not uncritical of the romantic fallacy of Rousseau, which has provided much of the impetus for attitudes which regard mental ill health as a prerogative of the advanced and sophisticated society.

On the mile high East African plateau mental illness flourishes unembarrassed by the relative absence of the trappings of Western civilization. This is a region of lakes and mountains and grassy plains, embracing many peoples from a variety of stocks within

its borders. To the North of Lake Victoria, in rolling green country, Makerere University College has stood as a developing centre of learning for some decades and it is from this seat of knowledge that devoted social scientists have gone out to unravel the problems of the varied societies and cultures of its hinterland. In so doing, a social science tradition has grown up which is respected beyond the boundaries of East Africa and it is in keeping with this tradition that Makerere University College has been the first college in East and Central Africa to establish an academic Department of Psychiatry within its Medical Faculty. New departments have many problems, not least of which is to develop and maintain areas of original research in the face of many competing demands — and in this particular instance, in the face of a queue of mentally sick folk whose numbers might astonish the armchair theorists descended from Rousseau. Psychiatric problems in Uganda are not over the hill of fifty years hence, but are standing now at the clinic gate. A fruitful and practical line of research might be one which would scrutinise the human and clinical problems represented within this queue and bring to the psychiatrist who has to deal with it some understanding of, and sympathy with, the individual persons who make it up. The recently established Department of Psychiatry has attempted to develop such a line of research through the work of Dr. John H. Orley and this is what this monograph is about.

Dr. John H. Orley is a unique researcher. He is a medical man, trained in social anthropology, and a psychiatrist to boot. A rare combination of skills, and one which, with persistence and dedication, he has brought to bear on the medical, anthropological and psychiatric facets of life amongst the Baganda. (The Baganda, one of the largest tribal groups in East Africa, inhabit most of the northern shores of Lake Victoria, and form the bulk of the peoples living in the area around Makerere University College). In carrying out his work, Orley has made use of the methods of the social anthropologist. He has lived amongst the Baganda, eaten their food and shared their lives, and if in this monograph the reader finds an occasional oddity of English construction, it is probably because John Orley has learned Luganda (the language of the Baganda) to a high degree of fluency and has spoken little of any other tongue during long periods of his sojourn in Uganda. He has come to think in Luganda and has taught us to try to think as our patients do. He has made vital contributions to our know-

ledge of how the Baganda approach illness, how they classify it, what there is in it that they fear, and, perhaps most important of all, how they communicate their discomforts.

There is no condescension in this work. Nor will the seeker after the exotic and the sensational be very stimulated by it. That is as it should be. For too long have the real problems of African psychiatry been obscured by the unduly publicised pronouncements of psychiatric tourists returned from witchdoctor safaris. Witchdoctors and bewitchments, the occult and the sadistic, are not the peculiar heritage of the African. They are rather the unsurprising accompaniments of poor social conditions, of fear, of ignorance and despair, and as such they are found, even today, in every civilization on earth. The witchdoctor is certainly an integral part of African cultures: he stands between man and spirits; he offers, and sometimes provides peace of mind to the distraught and anxious; he is regarded as an expert in matters cultural and spiritual and in matters of health; sometimes he is sincere, often a quack. He may be unhygienic, unskilled and avaricious — so is the back-street abortionist of London and other cities. His ethos may differ but his role and place in society is not so far removed from that of the Western priest; nor are his clients so very different in their intentions from the devout Christian seeking relief in the catechism, in penance and in the confessional. If we could be less Europe-centred or less Africa-centred, attention to such comparisons might well be a rewarding line of research in matters touching on human behaviour — more valuable perhaps than the heuristically sterile exercise so frequently indulged in of exclaiming at the witchdoctor, *genus Africanus,* as if such individuals comprise a separate, shabbily colourful dead end in human social evolution.

This "colourful" aspect of African life is not Orley's major concern, nor is it the major concern of the psychiatrist working in Africa as he contemplates the queue of patients outside his clinic. We *are* concerned with a veritable explosion in the number of patients, but while planning for twenty years hence, we are not otherwise cheerfully supervising an assortment of local medicine men in their psychotherapeutic endeavours — no more than are our colleagues in London or New York. We *are* concerned with that queue of patients though. We must receive them, *understand* them, diagnose, treat and counsel them; be aware of their unspoken dreads, reassure their families, rehabilitate them and use

all our skills and resources (including local psychotherapeutic outlets) in so doing. We are eager to know, certainly, how many people in Uganda suffer from depression (and other ailments), but how can we start to find that out if we do not *understand* and know the modes in which the local patient expresses depressive symptomatology? What words does he use? What do his gestures mean? What fear is being expressed by the patient from Buganda when he complains of dizziness?

These questions, amongst others, are what Orley has set out to answer, and his concern with this sort of understanding is absolutely basic in psychiatry, for the subject is concerned above all else with communication.

This Monograph is a contribution to the social anthropology of the Baganda, and will undoubtedly be of great interest to the social scientist. But for the psychiatrist, for his colleague the physician, and for the medical planner, it must be a necessary handbook. We are fortunate in this part of Africa to have it. I suspect that psychiatrists, let us say, in the various parts of England, would benefit greatly if they had more guides to understanding of this sort available. The Baganda are not the only people with their own way of looking at things, and far too often it is assumed that the practitioner in his own culture has, as part of his birthright, an implicit understanding of all his patient's communications. I doubt very much if this follows. There is a need for this type of research to be done wherever psychiatry is practised, and I hope that Orley's adventures in this field will stimulate others, even in more developed societies, to re-examine themselves and to ask how much they really understand in the answers following the opening question, "Well now, what's the matter . . . .?"

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AUTHOR'S PREFACE

This book reports the results of a study designed to clarify the categories of thought amongst the rural Baganda corresponding to western notions of psychiatric disorder and related conditions (Note 1).* Apart from classification, I also examine the traditional beliefs concerning the origin of these disorders, how they are thought to progress, what forms of treatment are thought to be available, and the attitudes towards those so affected. The work was carried out mainly in Kyaddondo and Kyaggwe Counties. There are many immigrants from other tribes in these areas particularly in Kyaggwe where they form about half of the population. The immigrants in most cases have integrated well into the life of the Baganda and in many cases the second generation call themselves Baganda (Note 2). Of necessity therefore, I have given examples from events amongst immigrant families, but I know that the Baganda neighbours saw nothing strange or foreign in these events. Apart from informal contacts, the work was carried out by the application of semi-structured interview techniques to one or more people at a time. This allowed subjects to give examples or to expand on points that interested them. I also treated cases of mental disturbance and epilepsy and used the opportunity to question patients and relatives about these illnesses. About 20 leprosy patients were interviewed and I treated a variety of other illnesses, at the same time asking about the beliefs concerning as many illnesses as possible in order to compare these with beliefs about mental illness.

For three months I worked with Probation Officers concerned with cases from the areas studied and some time was spent investigating the social background of patients admitted to Butabika Hospital, the local mental hospital, (usually just known as Butabika to the Baganda). At one stage I used a questionnaire with forced 'yes' or 'no' answers. This was administered to 29 Baganda men of all ages from 18-90 years old living in rural Kyaggwe. These were selected purely on their willingness to answer the questionnaire, which was for use in another connection.

*The numbered notes in the text are to be found at the end of the paper.

There were, however, questions included of relevance to this study and the answers to these will be quoted where indicated.

There has been very little previous work on the concepts of mental illness in Africa. It would not be appropriate here to review the previous literature but for those interested in further study of this subject, Edgerton (1966) gives a brief review and an extensive bibliography (Note 3).

1

CONCEPTS OF BODY FUNCTION AND DEFINITION OF DISEASE NAMES

In this study I shall be using many disease names. It is of course not possible to translate Luganda words for disease as used in a loose way by villagers into rigid western diagnostic categories. The dictionaries tend to give these translations but for instance the majority of the many words translated "syphilis" should not be so translated. A mother may say that her child has had *lukusense* (measles) ten times, presumably because many other conditions presenting with a rash are called this. Sir Harry Johnston (1902, vol. 2, p. 644) says of plague, "curiously enough, although it is incessantly talked of by the natives, no ascertained case has ever come under the observation of trained medical officers, and the Baganda are apt to apply their word for "plague" to any virulent disease which carries people off suddenly." In the case of syphilis, there has been mistranslation, but in the case of plague this is just a tendency to use the word loosely since when pressed for a detailed description they will describe an illness that could in fact be bubonic plague. In the case of *ensimbu* (epilepsy) this word is used for a particular variety of fits and not for all forms of epilepsy. In the text, I shall use a rough English equivalent where possible rather than the Luganda name of an illness. Cases where the English word refers to the western concept will be clear. Before using these disease names, I will define what the Baganda mean by them.

Before discussing Kiganda concepts of mental illness it is first necessary to look at their concepts of body function relating to thinking and feeling. The Baganda believe that *both* the heart *and* the brain think (*okulowooza*), but this probably represents an incursion of western thought, for it is still possible to find older people who say that only the heart thinks. In fact the idea of attributing any function to the brain itself, as opposed to the head as a whole, is probably new. The head was probably thought only to dream but as far as the brain itself is concerned, the belief most likely to have antedated European influence is that it supplies the

mucus to the nose during a cold. The heart is thought not only to be the centre of emotions such as fear, anger, joy and jealousy, but in the past it was also considered the place where wisdom and memory reside. It is said to rule the body, its orders being transmitted by means of the blood vessels, which are after all seen to radiate to all parts of the body. Whereas older people believe in the primacy of the heart, the young normally say that the brain and the heart work together, the heart deciding things and sending a message to the brain which in turn passes it on to the body. Some informants seem to reverse this process between heart and brain. Although the dictionaries give a word for nerve, *akasimu*, it is not used in everyday language and there is no notion of it transmitting messages from the brain to the body. If the head of a person is cut off, one is left with a headless corpse, *kiwududu*, suggesting that the essential life of a person is in the head, but the explanation of this is that if the head is cut off, then the blood escapes and the heart dies and it is for this reason that the person ceases to be.

Whereas there is confusion about the relation of heart and brain, it is generally felt in these days that wisdom, *amagezi*, is a property of the brain. Wisdom is thought of as being of two kinds. The first is *amazaale*, "that with which one is born" (*okuzaala*, to give birth) and is usually translated as commonsense; in fact it refers to that which is required in preparing food, herding goats and cultivating. The other is *amayigirize*, "that which is taught" (*okuyigiriza* to teach), referring to school work and perhaps best translated as knowledge. My impression is that the relationship between the two is less clearly emphasised amongst the Baganda than it is in Europe, so that if a child fails at school, then this is more likely to be attributed to laziness or bad teaching and there seems less tendency to attribute failure to 'not having the brains', a phrase which sums up a common European attitude. It was sometimes stated to me quite emphatically that a child at the bottom of the class may have something wrong with his brains, but the difference between a child who came top of the class and one who was in the middle position was that the latter was lazy. This helps to explain the enormous importance attached to school education, since it is seen as opening all doors almost regardless of inherent intelligence. Apart from the danger that such an attitude combats the notion that education encourages people to think for themselves, it tends to support the idea that someone

is fit for a job purely on the basis of having completed a required number of years in school or other place of training. At the lowest level it goes with the idea that the object of school education is principally to equip someone with the necessary attributes to earn money. Thus a child who completes 7 or 8 years primary education and then fails to obtain a job is usually thought to have wasted his parent's money, since he will spend his lifetime cultivating, a pursuit which unfortunately is widely thought of as only requiring *amagezi amazaale*.

There are 3 words used for the heart, each with different connotations. *Omutima* refers principally to the actual organ within the chest, *omwoyo* refers rather to the soul which resides there, and *emmeme* is used for a small bone at the base of the sternum. There is also a second *emmeme* at the base of the spine, loosely associated with the anus in the same way that the first is with the heart. There is also a rather ill-defined idea that a person may have two hearts, one restraining the other, where Europeans might speak of the head controlling the heart. The verb *okuwulira* is usually translated "to feel", but encompasses hearing, smelling, touching as well as understanding and obeying. It does not express the feeling of emotions, which are thought to be *possessed* rather than *felt*. A person may have anger, sorrow or happiness in his heart, or he might be caught by anger or sorrow. The difference between anger and sorrow is not stressed to the same extent as in English, and it is not uncommon to hear an interpreter using *'okusunguwala'* (to get angry) as a translation of 'to get sad', nor would he really feel he had made a mistake even when "corrected". If one wishes to speak specifically about the grief of mourning or of a friend's departure then the verb *okusaalirwa* is used, but even then I have heard of men mourning at a funeral being said to be *basunguwadde* (angry) (Note 4). The heart itself has ears (that part that Europeans also call auricles) and deafness is said to be due to these ears being closed. It is thought that if a person eats the auricles of an animal's heart he will become deaf. In particular, a disobedient child is said not to hear or obey (*okuwulira*) with these ears. I particularly noted that disobedience in young people manifests itself by a pretence at having failed to hear when they are called. In a small girl of three this was carried to the point of putting her hands over her ears when her aunt called her and she did not want to go. Disobedience associated with insolence, *ekyejo*, in a child, is said to be in the

heart, whereas behaviour that implies that the subject has not properly understood what he was asked or told to do, *akamago,* is said to originate from the head. Of all the emotions only anger is sometimes connected with the head, and a disposition to become angry easily, *akabango, akalangala,* or *akazoole* is said to reside in the head, possibly because they are associated with not understanding well.

Apart from the siting of the emotions and the process of understanding, the Baganda distinguish between permanent and temporary states affecting the head. Things which change a person temporarily, such as beer or possession by a spirit, are said to catch a person *on* the head (*okukwata ku mutwe*), whereas when someone is more permanently strange they may be said to have the strangeness *in* the head (*alina akazoole mu mutwe*). A person's customs, habits, and manners are referred to as his *empisa.* This includes the idea of *personality* in reference to a person, but of *customs* in relation to the *people as a whole* (*empisa za Baganda*). These customs and manners are said to reside in the heart, a well mannered person being said to have a good heart and a bad mannered person a spoilt one. It may also be said of a bad person that his heart is as black as his body (*ye addugala omwoyo n'omubiri*). A child's bad habits are supposed to come from its mother and its good habits from its father. If a child behaves well the father is thanked, if it does wrong the mother is abused. This is not so much a serious belief as an indication of the position of the wife in a home.

The Baganda have a tendency to think of their illnesses in terms of that part of the body affected. Thus a cough may be referred to as *ekifuba* (chest), provided that the context indicates that illness is being talked about. By changing the prefix of the word, one can indicate different diseases of the chest. Thus there is *akafuba* (consumption or tuberculosis) and *olufuba* (asthma). Because of this already established way of thought, the Baganda seem to have readily taken to the idea of a group of illnesses within the category "diseases of the brain" (Note 5).

Diseases of the brain

These are of four main types:

1. Eddalu. This is *violent madness,* and a person so affected will typically throw stones, abuse people, run around naked and will

not eat food. A person ill in this way is said to have "fallen mad", *agudde eddalu*. Apart from this principal kind there is also a milder form called *eddalu ly'akazoole* or *ly'akalogojjo*, in which the person speaks strangely and apparently fails to understand well what is happening around him. He may be abusive but not physically violent and he does not refuse food. Although the two names are interchangeable, *ly'akazoole* would seem to refer more to those who are abusive, and *ly'akalogojjo* to those who are out of touch with their surroundings, a condition also described as being mixed up (*mutabufu*) in the brain or head. It is accepted that such a person may easily fall violently mad and then revert to being mildly mad. Whether the patient eats food or not is considered to indicate the severity of the illness. In a very large number of cases admitted from a police station under an Urgency Order to the Mental Hospital, 'refusing food' is frequently listed as an indication that the patient requires to be treated (although it would not be given as the sole reason).

Those who have *akazoole* or *akalogojjo* probably tend to be chronic schizophrenics. Many schizophrenics do have a tendency to become violent and in such a state they become incoherent and would be recognised as a case of simple *eddalu*. Schizophrenia has less tendency than other forms of mental disturbance to undergo natural remission and the Baganda recognise that *eddalu ly'akazoole* is more difficult to treat than *eddalu* itself.

2. *Ensimbu*. This is epilepsy and typically refers to what are known as *grand mal* seizures. In this, a person suddenly falls to the ground unconscious and begins to jerk his whole body. This may last a few minutes, but occasionally may be prolonged. During the fit he may urinate, froth at the mouth and bite his tongue. Following this the patient usually sleeps for an hour or so and cannot remember afterwards the events that occurred in the fit. Some forms of epilepsy do not fall into this pattern and because, as will be seen, a stigma attaches to this illness, it sometimes happens that a patient who does not urinate during the fit is said not to have *ensimbu*. Yet there is always the haunting fear that any periodic illness with sudden onset of strange behaviour might be *ensimbu*, just as there is always the fear in a Muganda's mind that any skin disease will turn out to be leprosy. Epileptic fits may occur daily or only once or twice a month. In the latter case the Baganda usually relate them to the presence of a new or full moon, but especially a new moon. The word *ensimbu* is

usually used in its plural form (e.g. *zimusuula,* "they throw him down" or at the time of a fit they may be said to have caught the patient, *zimukutte*). This is probably the equivalent of saying 'he has fits', referring to the repetitive nature of the attacks. The plural word *ebigwo* is also used for this illness (from *okugwa,* to fall), and epileptics are said to 'fall fits' *okugwa ensimbu.* Some epilepsies are said to be of the *nzimire* type. The word is rarely used and few are certain of its meaning. It tends to be used for mild forms and occasionally for dizziness or for the feelings (aura) that sometimes precede a fit. Billington (1968, p. 564) also confirms that it is an aura that distinguishes this form of epilepsy. The only case I saw who claimed to suffer from this form used to have only one fit a year.

3. Obusiru. Foolishness is recognised to be of two types, congenital and acquired, and is used for people whose behaviour appears to be that of someone considerably younger than he actually is. This is not to be confused with *akasiru,* 'dumbness', which is a disease of the mouth, although it is generally recognized that the same person may be afflicted in both ways. A foolish person, *omusiru,* may be referred to by many names. These are usually characterised by the prefix *ki* — which is typically used for inanimate objects. In fact the word *kintu* or *kintuntu,* meaning a thing, may even be used in reference to such people. (It is quite common for the root of words to be doubled).

4. Kantalooze. Dizziness — also known as *kamunguluze, kanzungu* or *kaboyi.* There seems to be no difference in the concepts expressed by these different words. It is considered to be an illness, not merely a symptom, and is thought of as 'the brother of epilepsy', in the same way that sleep (*otulo*) relates to death (*olumbe*). Like epilepsy it is said to catch people. *Kantalooze* is usually attributed to a weakening of the blood and if it remains untreated is thought to lead to epilepsy, which is presumably why it is sometimes over-emphasised as a symptom by many patients. Aall-Jilek (1965) mentions that in Tanzania the Wapogoro believe that children should not turn around quickly because they will get dizzy and this is again regarded as a preliminary symptom of epilepsy.

All four conditions discussed above are considered to be diseases, *obulwadde.* Being ill usually implies feeling pain, but this can be made explicit by saying that a part of the body hurts,

okuluma, (literally, to bite). In general *okuluma* is used to express pain more forcefully and a mild skin disease such as *oluwumu* (a fungus infection of the neck area) is said to be an illness but is never said to hurt or bite (Note 6). Hunger and thirst are also said to hurt. Just as a cough may be called *ekifuba* (the chest), so when one is asked what is wrong with a mentally ill person, the reply is *'omutwe'* (the head), although this term is also used for headaches. While acknowledging the present classification as the 'correct' one, both 'violent madness' and 'foolishness' are described by older people as having originally been thought of as diseases affecting a person's heart. Epilepsy and dizziness were diseases of the head and in the case of epilepsy this is indicated by what is probably a fairly old custom of cupping the head to cure it. When referring to madness however, the brain is said to be mixed up or spoilt. The Baganda resemble Europeans in having doubts at times as to whether some forms of deviant behaviour are an expression of illness. A man of fifty used to walk around the village shouting in a mildly abusive way and there was a division of opinion as to whether he was mentally ill. He did in fact tell me of some symptoms from which he was suffering and the medicine I gave him for these also stopped his shouting. The response to medication was acknowledged to be an indication that he was indeed ill. A lame or blind person is not said to be ill, but on the other hand about half the women that I asked thought of childbirth as an illness. This may reflect its dangers in isolated communities.

Because of the tendency to relate illnesses to parts of the body there is a category of fever known as that of the brain (*omusujja gw'obwongo*). No one seems certain about its nature, but everyone agrees that the western doctors know. In many cases, especially in children, fever is attributed to that part of the body that feels hottest to touch, thus *omusujja gw'ebyenda* (fever of the intestines, sometimes translated as typhoid), merely means that the stomach feels particularly hot.

Diseases of the heart

There are two conditions of the heart which in some cases may represent neurotic illness. Hard, but not too rapid beating of the heart, similar to what one might feel after hard exercise, is known as swinging (*omutima gwewuba*). It is best thought of as a thumping, and is a symptom that may be associated with a

minor degree of heart failure. There are however two illnesses in which the word *emmeme* is used and these are *emmeme etyemuka*, (it is agitated) and *emmeme egwa* (it falls or fails).

Emmeme etyemuka. This refers to the pounding of the heart with fright and may be used merely to refer to feeling startled. It is most commonly thought of as an illness, in which apart from the beating of the heart, the person experiences an intense fear which can cause him to run away and hide in the bush. In one case studied, the fear was accompanied by a desire to seize an axe or stick and strike anyone who approached. People who run from the house without warning, and hide in the bush for no apparent reason, may be said to have this even before it has been confirmed that they also have palpitations (Note 7).

Emmeme egwa. This may affect either or both *emmeme*, and manifests itself in a general weakening of the body and failure to eat. The *emmeme* are thought to disappear slowly during the course of the illness and require medicine to bring them back. Although it is said to affect adults only, cases in children have been noted. These were associated with the protrusion of a small length of bowel through the anus in the case of the *emmeme* at the back, or with pulling in of the stomach where *emmeme* at the front had fallen. In children there are various organic illnesses that could cause such symptoms, but in adults one may be dealing with a psychiatric disturbance (Note 8). It was presumably this condition that Sir Albert Cook came across and reported in the usual tone taken by many physicians and surgeons towards such disorders. He wrote of "the stalwart man with a frame of Hercules, who wastes ten minutes trying to persuade you that his heart has fallen from its right place" (1954, p. 124). The importance of the heart in African thought was emphasised by Muwazo (in Muwazo and Trowell 1944, p. 149). "Africans of the present day resemble Europeans of previous centuries in regarding the heart as the centre of life; the soul is also thought to reside in or near the heart. Africans consider that the heart is normally motionless, they have no knowledge of the circulation of the blood. The exact position of the heart is not understood clearly, but the whole of the front of the chest and the upper abdomen is regarded as a dangerous area. Palpitations and any sensation which can be interpreted as a movement of the heart are considered to be specially dangerous, for the soul may be moving and may leave the body, and life may thus be in danger. In some patients fever is chiefly

noticed and attributed to the cardiac palpitations which accompany slight exertion, especially if anaemia is present; and many Africans are anaemic. Many phobias centre in this region and other signs of the effort syndrome, as seen in the advanced races (*sic*), are common . . . . . ". He goes on to state that many of these cases are probably neurotic and others are malingering. These latter "naturally complain of the heart, for this would appear the best illness to feign. It would never occur to them to feign a peptic ulcer or blindness, for diseases of the 'heart' or the 'soul' are, in their opinion, the most serious."

Other diseases of particular interest to psychiatrists

Amakiro. This is typically an illness afflicting women within a day or two of giving birth and it may often cause the death of the mother or of the child at the time of birth. The name however may be given to any illness occurring at the time of childbirth. It is thought to be due to adultery committed with many different men during pregnancy and can be prevented by the use of medicine. The attitude of the Baganda toward sexual relations is reflected in their comments on this illness, in that they consider that a large proportion of women have to use this medicine (the alternative preventive measure of not committing adultery is not considered a very practical proposition). "Many men" appears to mean anything from five upwards. To go with a smaller number is presumably considered as remaining relatively faithful. *Amakiro* is classed as a disease of fornication (*obulwadde bw'obwenzi*) along with the venereal diseases, although it is not thought to be catching in the way that the latter are. It is sometimes called *ebigere* (feet), a reference to the fact that the woman walked about to other houses. It can be recognized because it leaves certain marks on the body, and although it may in some cases kill the mother or child, it more typically affects the woman, causing her to try to eat her baby. The child may have to be taken away from her. Because behaviour is sometimes disturbed, the illness is acknowledged to affect the brain even though it is not a disease of the brain. Madness following childbirth (puerperal psychosis), has, of course, been recognized in western thought for a long time and the fantasy of the child-eating mother is also widespread (Note 9).

Eyabwe. This is a sudden illness, striking only small children, during which the body gets hot but the feet are cold (Note 10).

During this illness the child may shudder with feverish rigors, or even have convulsions. It is interesting in this context to note the fairly frequent reports by patients that their child had such an illness, but that it was only after convulsions had recurred in the absence of fever that they realised that it was suffering from epilepsy. It is probable that in some cases the fever has been associated with brain damage and the subsequent development of epilepsy, whilst in other cases it has precipitated epilepsy in a person already predisposed, and in whom epilepsy was very likely to appear anyway. The word *eyabwe* itself means 'theirs' (the children's) and refers to the fact that it is thought to be brought by "their bird" (*ennyonyi eyabwe*), which is an eagle. This is a reference to the suddenness of the onset of the illness, just as a bird of prey swoops down to catch its prey, and also to the fact that during a convulsion the eyes turn up as if to see the bird flying above them. If such a bird is seen the women with the children may shout up at it *"Omukulu, mukulu mukulu . . ."* "the child is an old one, old enough to be fetching water", hoping to deceive the bird into thinking that the child is too old to be attacked. There are various other preventive measures, such as the tying of a small bell on to the left wrist, the noise of which will frighten the bird, or attract the mother's attention if the child moves to fend it off (Note 11). *Eyabwe* can also refer to "their insect" which lives in the ground (*eyabwe eya wansi*), usually a spider (*nnabubi*). Cases of *eyabwe* caused by this insect turn their eyes down instead of up during a convulsion (a rare enough occurrence to make this a rather unusual form of the illness).

Kigalanga. This is a very ill-defined disease, affecting women and children but not men. It is usually thought of as a disease affecting the stomach and in children may produce vomiting with a sudden onset of fever. In women it produces stomach ache and may also cause sterility. The name tends to be given to illnesses which come suddenly and in which the stomach is implicated. I have seen three cases which had been called *kigalanga,* but which apeared to be cases of epilepsy. All three were females and since none had urinated during a fit, the relatives were reluctant to call it epilepsy. Two of the patients experienced peculiar feelings in the stomach before the fit (Note 12). Because of the terrible social implications of epilepsy the family of someone with fits would always, where possible, prefer to diagnose them as something else such as *kigalanga* or *eyabwe.*

Akasumagizi. This is the name of a small kingfisher bird and refers to its habit of nodding off to sleep (*okusumagira*). The word is used for a similar habit in human subjects, and whilst some people say that this is not a disease others are quite sure that it is. Some translate it as 'a sleeping disease' and in fact some types of epilepsy (particularly *petit mal*) cause the sufferer to have periodic absences which could well be described by this Luganda name. The illness is said to be brought by eating the bird, it having been put in the food by an enemy. Sleeping is said to be a function of the heart, not the head, which continues the work of dreaming during sleep. This illness is said therefore to affect the heart. It is of interest to note that amongst the Baganda closing the eyes of one's own volition is not considered necessary before going to sleep; rather the eyes are left open until one goes to sleep and then they close naturally.

There is also a rather ill-defined illness called *okulalama,* (to throw one's head back) a symptom that would be seen in infections of the brain, particularly meningitis, possibly in tetanus and also in the convulsions which may accompany a severe fever in children.

Diseases associated with neurotic disorders

Medical workers in Africa see a large number of patients with rather ill-defined pains in the head, chest and stomach. Many of these are probably of organic origin but there are a few such illnesses with Luganda names which lead one to suspect neurotic conditions.

Akawango. This is persistent headache on top of the head, usually lasting for months or years (one man who came to see me claimed to have suffered from it every day for 20 years). The word presumably comes from *ekiwanga,* the skull, and in practice the illness is sometimes just called *ekiwanga.* The majority of such cases are almost certainly associated with stress and anxiety and are what are loosely termed tension headaches. This condition is sometimes thought to go on to involve the brain and thus may bring more anxiety and quite severe depression. It should not be confused with persistent headache occurring around the eyes which is called *muteezi.* Those people who have suffered from this say that it usually follows a cold and I would suspect that it is due to sinusitis (an inflammation of the cavities in the bone adjoining the nose). Migraine is another possible cause (Note 13).

Stomach aches of all kinds are usually referred to as *enjoka*. Whilst in general this word has the connotation of "worms", not all forms of *enjoka* are thought to be due to worms. It is worth mentioning here *enjoka ndigirigi*, which are said to be worms moving from the stomach and travelling round the heart, so causing palpitations. They can also be felt crawling about under the skin and over the whole body (a symptom known as formication).

Diminution of sexual potency is an important symptom but one that is not commonly reported because the rural Baganda feel extremely ashamed when discussing sexual matters. Nudity is also looked upon with great shame, and whereas in many parts of Africa it is not unusual to see naked men washing, perhaps with the penis tucked between the legs, the Baganda keep themselves well hidden when washing. Sir Harry Johnston (1902, vol. 2 p. 647) reports: "In the time of Mutesa a heavy fine was inflicted on courtiers who exposed their legs to view when in the King's presence", although he also mentions that women might be seen naked. Also (*ibid*, p. 648) "The chiefs and people became fastidiously prudish on the subject of clothing, and regarded a nude man as an object of horror". They also "substitute for any plain noun dealing with sex or sexual intercourse the politest and vaguest of paraphrases".

The Baganda have no initiation ceremonies at puberty, nor do they practise circumcision. Some think of circumcision as an act of indecent exposure — namely the uncovering of the glans penis. The non-Moslem Baganda think that it is a shameful thing to expose the glans in this way and I was told of a people living in a forest who were unfortunate in being born with small foreskins. A man with an eye to making money suggested that I should find a medicine to help them by increasing the size of the foreskin so that it would cover the glans. Presumably similar imagery induced otherwise naked ancient Greek wrestlers to knot a string around the foreskin to prevent it slipping back and exposing the glans. Laubscher (1937, p. 76) says of the Tembu of South Africa that the boys wear a covering for the penis called an *isidla*. Before puberty the elders are not concerned as to whether a boy wears an *isidla* or not, since the prepuce is considered sufficient covering. After the initiation circumcision ceremony no man must expose his penis, especially the glans penis, and the wearing of the *isidla* is compulsory.

The subject of the sexual fantasies of the Baganda deserves

a fuller discussion but a few points in interest can be noted. Semen itself is often loosely referred to as *amazzi* (water) and although both the 1952 and 1967 dictionaries give *amaanyi* (strength) as a loose translation of semen, this is not generally accepted and many villagers cannot understand why it should be so referred to. Nocturnal emissions of semen do not represent a loss of strength. There is no clear idea as to the origin of the semen, but most say that it comes from the back. The Luganda for kidneys, *ensigo*, also means seeds which suggest a possible connection with semen in Luganda thought, but I have never heard such a connection being made explicit.

Amongst western men the most prevalent phantasy concerning sexual potency involves the size of the penis and frequency of intercourse. Penis size to the Muganda is in no way connected with sexual potency but rather it is the length of time that the man actually takes to reach orgasm that is the measure of his potency. It is in this sphere that exaggeration probably occurs. The average time reported is about 30 minutes, an exceptionally potent man taking up to 40 minutes and a weak one only 5 minutes or less. In view of these high expectations and the fact that anxiety is an important cause for early ejaculation, it is hardly surprising that a vicious circle develops in which anxiety about loss of potency brings about yet further lessening of the time spent in intercourse. High frequency of intercourse is considered a measure of potency only in that it would be possible to continue intercourse after an orgasm and so thereby extend the time taken. In such a case impotence is thought to be imminent if there is failure to obtain a second erection following orgasm. An erection on waking in the morning is also considered to be the norm and if this fails to occur it can then start off the vicious circle described above (Note 14). Apart from being bewitched or poisoned, an important cause of impotence is thought to be venereal disease which might explain why, at least amongst the more educated, an excessive degree of anxiety sometimes centres around these diseases. The blood is thought to provide strength to various parts of the body by flowing first one way and then the other in the blood vessels. (It is not thought to circulate by going one way in some vessels and in the reverse direction in others). Lack of power in a paralysed arm is thought to be due to the blood not flowing properly. Similarly impotence is thought to be due to a failure of the blood vessels to the penis or to a

general weakening of the blood. This concern with weakening of the blood (which also produces dizziness), explains why patients are often anxious for blood tests at hospitals.

An impotent man may commit suicide because he will no longer have any control over his wives who might well leave him. In such a case, of course it is possible that a depressive illness brings both the impotence and the suicide. A sexually impotent man is known as *omufiirwa*, one who is bereaved. Most people agree that an impotent man should not pay poll tax since he is 'no longer a man' or 'he is like a woman'. The Fallers (in Bohannan 1960, p. 79) report that of 69 men in neighbouring Busoga who committed suicide in 1952-54, 8 were thought to have done so because of impotence.

2

A BACKGROUND TO BELIEFS ABOUT MENTAL ILLNESS

Mental illness needs to be seen in the context of illness as a whole as well as a form of deviant behaviour. It is first necessary therefore to look at concepts of disease in general amongst the Baganda. Not only do the Baganda ascribe diseases to certain parts of the body, but they also classify them according to three sets of dichotomies.

1. Those that come by themselves (*eza kyejjira*) and those that are sent or caused by witchcraft (*ez'eddogo*).
2. Strong (*ez' amaanyi*) and weak (*ez' ennafu*).
3. Kiganda and non-Kiganda.

This latter classification means different things to different people but in general the Kiganda illnesses are those that the Baganda believe to have been already afflicting them before the Arabs and Europeans came to their country. The Baganda imply certain things when they refer to illnesses as Kiganda. They think of them as 'strong' illnesses and they are usually sent by another, although there are many exceptions. There are traditional forms of therapy for them although in these days the traditional art of healing is thought to have been largely lost. Western medicine is not considered to be particularly effective in treating such illnesses. The underlying feeling is that Europeans know how to treat their own diseases (non-Kiganda ones, sometimes called *ez'ekizungu*, "those of the Europeans"). Those illnesses which are untreatable by western medicine or are difficult to treat, as in the case with mental illness, are thought therefore to be Kiganda diseases, and are of course strong since traditional forms of therapy are not often very useful either. The fact that the Government provides free medical treatment means that often people attend Government clinics in the first instance before trying traditional methods of healing. Since most people get better from mild illnesses despite medicine or with very simple treatment, this ensures the perpetuation of the image of Western medicine being effective for

'weak' illnesses. Europeans are renowned for insisting that illnesses are not brought by witchcraft, but because of the tendency to polarise these notions this means that Kiganda illnesses are those that are so brought. There are other reasons for strong Kiganda illnesses being thought to be brought by witchcraft. Madness, epilepsy and the other strong illnesses bring an enormous amount of trouble to a patient and his family and usually tend to follow a chronic course extending over many years, if not a lifetime. In order to cope with such a stressful situation, an explanatory model (paranoid in nature) is formulated by the family, which apart from helping them to talk about the illness, also absolves them from blame and opens up a course of action. No one bothers to use such a model when referring to a cold, but the 'strong' diseases are almost always said to be sent. It does mean, however, that if someone within a family suffers from a strong illness considerable suspicions arise and back-biting can occur.

'Strong' illnesses are sometimes called *olumbe* (death) and some older people say that all illnesses can be called this, since anyone may die from any illness. It is possible that the attitude is due to the fact that the effects of illness are usually more serious in the aged and the idea may reflect the old person's own decreased resistance to disease. The illnesses that do not fit this pattern are in an ambiguous position and there is a tendency for changes in classification to occur. Currently the Baganda classify some illnesses in the following way, (the first two showing the features of Kiganda illnesses *par excellence*).

	Sent by another	*Kiganda*	*Strong*
Violent madness (*eddalu*)	+	+	+
Epilepsy (*ensimbu*)	+	+	+
Polio	−	−	+
Common cold (*ssennyiga*)	−	+	−
Fever (*omubiri*)	−	+	−
Kabootongo (badly translated as syphilis)	−	+	−
Gonorrhoea (*enziku*)	−	+	+
Ettalo (swelling of a part of the body)	+	+	+

Assuming that polio is combated as successfully as it has been in Europe and America it can be assumed that this illness will pass the way of smallpox which is fortunately seen only rarely in Uganda. Fever and common cold are considered to have undergone changes in recent times, not only in nature but also in name,

the interaction between name and nature being complex, not simple cause and effect. So it is for some reason thought that fever (*omubiri,* the Luganda for the body) has become a 'strong' illness (*omusujja*) which may kill people, and similarly the common cold (*ssennyiga*) is becoming *lubyamira* which is probably best translated as influenza. The fact that antibiotics are now effective against gonorrhoea and syphilis is perhaps an underlying reason for confirming in more educated circles that they were brought by the Arabs and Europeans, although the majority of villagers think of them as traditional Kiganda illnesses. The villager's attitude may reflect the fact that to obtain an injection of penicillin usually costs about 10/- which puts it beyond their easy reach and there is thus a delay in getting treatment. If an injection is obtained it may be of some inferior type which does not work thus indicating that European medicine may not in fact be very effective.

The spirits in Kiganda mythology

Illnesses that are sent may be caused in several ways and in fact, although *eddogo* means witchcraft, when further inquiry is made it is seen that those illnesses that are sent include those that are considered to be brought by spirits acting on their own initiative, as well as those forces manipulated by other people. There are several works available which include chapters on the traditional beliefs of the Baganda and so it is only necessary to summarise these and in places to clarify the picture. The Baganda believe in several forms of spirits; *balubaale* (hero-gods), *mayembe* (literally meaning horns, but referring to spirits residing in horns or other receptacles), *mizimu* (the ghosts of dead ancestors), *misambwa* (spirits associated with certain animals, rivers, rocks or forests) and *kitambo* (a spirit usually causing people to walk naked at night and eat dead bodies). Difficulties arise when discussing the cause of illnesses with patients and their families as Bennett *et al.* (1964) discovered when asking about childhood diarrhoea. Although relatives admitted that a possible cause was *obusobe,* a ritual mistake made in pregnancy or infancy (*obusobya,* a mistake) none admitted that this was the reason for their own child's diarrhoea. The Baganda do, in fact, have a proverb *'Lubaale agoba nsonga' nga takutidde wuwo.* (A *Lubaale* punishes with reason, provided that it has not killed one of your own relatives). Although there are said to be some diseases which result from the breaking of certain taboos, it does not seem to be an important

reason in these days. *Amakiro* is thought to be brought by committing adultery during pregnancy and a rash may be caused in infants because the mother ate salt during the pregnancy (Note 15).

The balubaale (sing. *lubaale*) are of two kinds; those from the Ssese islands (*aba Ssese*), also called those from the lake (*ab' ennyanja*); and the Princes (*abalangira*), also called 'the ones from dry land' (*ab' olukalu*) and comprising chiefly the dead Kabakas. This is quite an explicit division amongst the people themselves and is reflected in the ceremonies. Those from the lake are the *balubaale* proper and indeed, the traditional Baganda name for Lake Victoria is *Nnalubaale*. There are also a few *balubaale* who come from outside Buganda and are thought distinct from the other two groups (Note 16).

Mayembe (sing. *ejjembe*) are also two kinds as Ssekamwa (1967) has well described. Those of the clan (*ag'ekika*) are passed on in the family which they help, and whose origin seems to have been as a medicine that used to be carried to war as a protection, which on the eventual death of the owner would in some way combine with his ghost to produce an *ejjembe*. Some of these have a national status such as Nambaga and Lubowa and really only differ from the *balubaale* in that they live in horns or gourds (Note 17). Many are now thought to reside in the Uganda Museum (Taylor, 1958, p. 197) but in fact I have been told that probably only the horns are there and the actual spirits themselves have been taken to England. This is used as an illustration of the power ascribed to the English *balubaale,* for it is generally believed that Europeans are frequently possessed by spirits.

A quite different form of *mayembe* is that of witchcraft (*ag'ekifalu*). Whereas all other spirits need a person to act as a spokesman for them, these have an existence quite independent of people and have a voice of their own. They are usually sent by their owners to kill others. They are greatly feared and most traditional healers claim not to deal with them. Anyone who does claim that he can treat people who are afflicted by them is thought quite obviously to have the power of controlling them and using them against people.

Mizimu (sing. *muzimu*) are the ghosts of ancestors. Apart from those of the Kabakas they are usually only remembered, and therefore feared, for as long as anyone living can remember the whereabouts of the grave. They can only cause either misfortune

or illness to someone of the same clan, and the most dangerous is that of one's father's sister (Mair 1934, p. 67). Sometimes they attack if they become annoyed at having been neglected, particularly if their graves have not been weeded and kept clean. They may also be sent to attack people by placing a medicine on the grave. There is nothing that can be described as an ancestor cult although Taylor (1958) apparently saw some small shrines erected to the ancestors.

Misambwa (sing. *musambwa*). These are benign unless they are wronged in some way. They reside in natural objects such as trees, animals, stones or rivers and if for instance one resides in a tree (usually a *muvule*), then that tree should not be cut down and attempts to do so will only result in failure and cause the tree to cry out. Even where success ensues one will find on returning the next day that the tree is growing straight up again as it was before being cut. This may be avoided by sacrificing an animal before starting and also calling on the *lubaale*, Namalere, for help. Those spirits residing in a wood will cause a person to get lost if he enters and will kill him if he takes firewood from it. Most people know of some local wood where this applies. Their origin is sometimes ascribed to the spirits of people who have wandered into the forest or have been given birth to by mythological figures at these places. (Note 18).

Kitambo. These resemble the family *mayembe*, but cause those whom they possess to be *abaseezi*, "those who walk naked at night, eating dead bodies", and even killing people. The practice tends to run in families, the father teaching his sons and in some sense a man chooses to serve it and is certainly not regarded as ill. Indeed if he, or anyone who walked naked at night, were caught he would be killed (Note 19). These spirits do occasionally possess people during ceremonies without leading them to be an *abaseezi*.

The spirits fall into two main groups. Firstly those that do not kill people but merely require to enter into some form of relationship with people, and be placated. These are the *balubaale*, the family *mayembe* and a few *mizimu*. On the other hand there are those spirits which are exceedingly dangerous and whose aim is to kill people. These are the *mayembe ag'ekifalu* and also most of the *mizimu*.

Illness may be brought by any of the above spirits except the *kitambo,* and also by substances (*eddogo*) prepared by witches and placed in such a way that the victim passes near it. If not combated, *eddogo* usually produces a more gradual or persistent type of illness. I was told of two cases which were certainly due to *eddogo*. One had a progressive wasting disease which lasted two years and ended in death and the other was a dementia. When walked over in the path it produces *ettalo,* a painful swelling of a part of the body, or it may produce *obusukko,* small sores over the legs. Poison (*obutwa*) needs to be taken by mouth and produces severe abdominal pain, vomiting and ultimately death if not treated and is sometimes called the *eddogo* of the Europeans. There is no difference in kind between *eddogo* and *obutwa,* and there is considered to be no essential difference in their mode of action even though the one is swallowed and the other can work from a distance. Similarly there is considered to be no difference in kind between those medicines which are given by mouth, those that are rubbed over the body and those that are worn wrapped in a piece of cloth around the arm or waist. This should be borne in mind by doctors who give patients bottles of tablets to take home. Some of those less educated in western ways can see nothing strange in keeping the medicine over the bed and letting its influence work from there.

The relation of these spirits to diseases and how this relates to treatment

The traditional healers are usually known as *abasawo abaganda* (Baganda doctors) and although some practise only the giving of herbal remedies or blood cupping, a large number are also possessed by the *balubaale.* There is no recognised period of apprenticeship to the healing art, since in such cases it is the *balubaale* speaking through the doctor who diagnoses and orders the treatment, and so the doctor himself does not need to learn anything (Note 20). In practice this results in there being no well defined body of Kiganda belief about the origin and treatment of illness. Time and again one comes across disillusioned patients who have been given different explanations for their illness by each doctor they visited (a situation not unknown in Europe also).

In these days at least, the *balubaale* seem to be the most important of the spirits. They are intimately concerned in the affairs of this world and are not content with an other-worldly

existence, but unfortunately can only share in this world through the use of mediums, whom they possess. This is seen as a weakness on their part. To be possessed by a *lubaale* is called *okusamira,* but this is an active verb denoting that the medium is doing something to or for the *lubaale* and it is best translated as "serving the *lubaale*" (Note 21). Certain people in the community are known to serve the *balubaale* at times. The *balubaale* usually make known their desire to possess someone by making that person ill, but not ill enough to kill him. They may also bring continued misfortune to a family. This forces the family to attend the doctor to find the cause of the illness or misfortune. The serving of *balubaale* runs in families and theoretically it can be excluded as a cause of illness in those families which have never had members serving in the past, although it is relatively rare to find such a family. It is generally considered that most family units (*enda*), consisting of brothers with the same father, their wives and all their offspring, (probably about 15 adults) will contain someone who serves the *balubaale.*

The traditional doctor will already be serving the *balubaale* and while in a trance he will tell the patient what has brought his illness and what steps need to be taken to cure it. If the illness is brought by *balubaale,* then they will usually need to be appeased by a ceremony lasting several nights. This is termed 'settling' (*okutendeka*) the *lubaale* and may be considered as an initiation ceremony. If in fact the diagnosis has been correct, *balubaale* will possess the patient during this ceremony and will give further instructions as to what needs to be done to appease them. These illnesses are varied and often rather ill-defined. Occasionally the illness sounds like psychiatric depression, in which the patient sits around doing nothing and is not able to eat food. Western doctors will only be mystified by these illnesses and will be unable to cure them. Certain *balubaale* are associated with particular illnesses. For example *Kawumpuli* is associated with plague and *Wanema* with lameness (*obulema*). These *balubaale* are thought to have the power to bring the particular illness and to cure it, although a more philosophical Muganda said that some *balubaale* were named after powerful illnesses, the names being thought to be appropriate for powerful gods. This association of a *lubaale* with a particular illness is a different order of belief from that concerning the origin of the more ill-defined diseases.

Sometimes the patient may go and live with the doctor over

a period of time. This may only be for a few days or weeks but can be for as long as a year. On the other hand the diagnosis may be made at one short visit and if it is in fact decided that the illness or misfortune is brought by *balubaale*, then the patient may return later to the doctor's homestead for a few days and stay while the ceremony is performed in a traditional round grass hut (*ssabo*). This may last several nights. The patient comes with as many of his family as possible. A few may be deterred for religious reasons and others may find an excuse because they would be expected to contribute towards the expenses if they attended.

The ceremony of 'settling' the *lubaale*

The ceremony itself takes place at night and songs pertaining to the *balubaale* are sung to the accompaniment of drums and rattles, which provide a strong rhythm. Anyone entering the *ssabo* has to remove his shoes and must sit with his legs tucked beneath him, these being signs of respect. When the *balubaale* have been causing more general misfortune in a family, then several members of the family may be prepared for serving them since it may be uncertain as to which of the family is required to start serving them. After some time a *lubaale* will be seen to be coming upon the subject. This will cause him to begin shaking his head and body and usually later to begin bouncing up and down on his knees in time with the rhythm of the music. Eventually he may stand up and begin to dance energetically with the music, staring ahead in a trance-like state. When the song is ended, the subject collapses to the floor exhausted and is questioned as to which *lubaale* possesses him. When it is known who it is then the subject is treated as if he had become that *lubaale* and is completely identified with it. He is greeted and made welcome and if he is one of the dead Princes he would be greeted with '*Businze*', the traditional salutation to a Kabaka. The subject himself speaks with a voice other than his own which is presumed to be that of the *lubaale*. As the ceremony continues other people may become possessed including the doctors themselves and the assistants, as well as other people who attend who are known to serve the *balubaale* at times. There may be as many as six people possessed at one time. The ceremony is continued for several nights to ensure that all the *balubaale* who are troubling the patient or his family have made their wishes known. It may be that the *balubaale* may not come at all on the first night and renewed and more intensive

efforts have to be made on the subsequent nights. If the *balubaale* fail to attend, this would either be due to the wrong diagnosis having been made or to the fact that the singers conducting the ceremony were too lazy and did not persist long enough in the songs to allow the *balubaale* time to come upon the subjects. It is not thought that one doctor is limited to settling only a few of the *balubaale.* It is expected that every *lubaale* troubling the sufferer will be settled at the one ceremony, and it is for this reason that it should go on for several nights. There are therefore no "cults" which are limited to a single *lubaale* (Note 22).

It is difficult to comment on the experience of the subject in these ceremonies since the subject denies all knowledge of what happens to him while possessed. At one ceremony that I attended a young man started by timidly whispering the name of the *lubaale* who had come upon him. This however would be greeted with great delight by all and he would be told how everyone was so pleased to meet him. As the days passed he became more bold, and on the last night the *lubaale* of thunder, Kiwanuka, came demanding a sheep. He was assured that one would be obtained, "No, two sheep" they were told "and a hammer", he added, and they had to agree. Slowly, as the ceremony continued, he had indeed become a god, although as he said a few weeks later, it was he himself who had to get two sheep for the ceremony to be held at his homestead. He had, however, the consolation of having been cured of his symptoms. The subject becomes completely identified with the spirit who comes upon him. Thus he acts out his psychodramatic part. A *lubaale* may order the subject to work as a doctor himself, and in this way new doctors are recruited. Others, however, although possessed by the *balubaale,* are not expected to divine the causes of illness and misfortune. Many are required to build a *ssabo* in their own homestead and obtain various small articles to put in it or to buy small ornaments to wear. When the various articles and animals that have been ordered by the *balubaale* have been obtained, a further ceremony will be held at the homestead of the subject, attended by the doctors who conducted the original ceremony, and these things will be offered to the *balubaale.*

Other spirits may attend the ceremonies. A *musambwa* in the form of a lion or python may come and cause the subject to behave like these animals. The family *mayembe* are recognisable because they talk through their nose and the subject kneels with

his head in his hands on the floor and his buttocks in the air. The buttocks move up and down in time with the music and because the *mayembe* does not like light, he is covered with a barkcloth. A *kitambo* spirit will cause the subject to stare at the ceiling without blinking despite lighted grass being held in front of his eyes. Some *mizimu* may also attend. Some of those *balubaale* attending may be able to perform superhuman feats. The *lubaal*e Mukasa of the lake is able to dance on glowing charcoal or lick hot knives from the fire. (Charcoal is very light and does not store heat, so that once the burning surface is extinguished by touching it or putting it in the mouth, it becomes quite cool). The *lubaale* Namalere, beats his head with a stick with resounding cracks (Note 23).

The atmosphere at such a gathering is rather like that of a party. Beer is usually drunk, and the spirits are treated like visitors and given a good welcome, an aspect also stressed by Mair (1934, p. 270). When the spirit goes the subject looks as if he has just woken up and denies any memory of the events. Certain mediums have their 'pieces' which the audience know, thus when the *kitambo* looks at the roof someone will be ready with a light to demonstrate that he does not blink. On one occasion when I was present a doctor was possessed by a spirit causing her to block the doorway and wield a knife, threatening people and demanding beer, calling out all the time *'Ndi mulalu'*, I am mad. This was greeted with laughter although all she asked for was given to her. The attitude toward licking a hot piece of metal or walking on coals is rather like that of a conjurer's audience, although they are impressed by the power of the spirit, not the daring or cleverness of the subject.

The *balubaale* do not only attend ceremonies at which it is hoped that they will be appeased and stop causing illnesses or misfortune. There are other occasions on which they may attend. If a close relative within a family which 'has' a *lubaale* dies then a ceremony will be held to 'wipe away its tears'. They may also be called upon to help settle a lawsuit and then if their help has been successful in this, or in, for instance, bringing children to a previously sterile woman, then there will be a ceremony to which they will come to be thanked. Some of these may be very informal, and if the subject does not practise as a doctor or for some other reason does not have a *ssabo,* the ceremony may be held in the front room of the house. The ceremony may be punctuated by

such remarks as "give me some beer, you don't expect the *lubaale* to come until I've had more to drink, do you?" On such occasions a *mayembe* may be teased about its nasal voice, and it may be told how sorry everyone is to hear it has a cold. The most frequent occasion for a *lubaale* to attend is to divine the cause of illness and a doctor may be possessed many times a day to do this, and Mair (1934, p. 266) gives an account of such a session conducted rather publicly, but often these sessions take place privately.

In these days the ceremonies are considered a little shameful and the *ssabo* is built some way from the house. The doctors do not readily admit to their profession, especially to Europeans. On one occasion I asked an informant to name things that combined the properties of both 'happiness' and 'foolishness'. The subject of conversation at that time had not been about the *balubaale*, but the two things that he named were sexual intercourse and the serving of *balubaale*. He thought that both these things would look stupid to an outsider. Roscoe (1911, p. 275) tells us that the occasion of the first possession was called 'being married to the god' (*kuwasa*). Young men may refer to their girl friends as *balubaale* and to having sexual relations with them as serving them (*okusamira*). At times the *balubaale* are thought of as male in character and in fact the subject at the settling of a *lubaale* should be accompanied by a younger sister (*lubuga*) and she is said to be there as a wife for the *lubaale* when it attends (Note 24). The doctor who conducts the ceremony when a *lubaale* comes is known as the father of that *lubaale* and Mair (1934, p. 239) says that he is also called the father of the initiate.

The *balubaale* seem particularly prone to affecting the eyes. A woman told me that while she was a schoolgirl she had had a sudden attack of partial blindness while receiving prizes at school. This lasted nine months and although it slowly improved over that time she was only completely cured in the week following the settling of a *lubaale*. I came across another case of a boy whose vision was so disturbed that he was unable to continue with his schooling. He started to improve as he began buying the necessary things for the settling of a *lubaale*. Ssekamwa (1967, pp. 33, 34) also reports two cases of eye trouble caused by *balubaale*. One had been a secondary schoolboy who was therefore unable to continue his studies and the other was about to board a plane to take up a scholarship to study in Britain when he was struck blind but unlike the former he never recovered his sight. Lest it sounds as it these

are illnesses that have come purely as a result of the stresses of western education it should be added that apparently in the old days the *balubaale* used to be very active in preventing men going to war or marrying. It might perhaps be truer to say that the illnesses they produce tend to come with the stresses of adolescence and early adulthood. Case histories obtained from those who had been cured by the settling of a *lubaale* do not always fit the pattern of psychiatric illness, and without much deeper investigation, it would be too facile to suggest that such people are hysterics whose powers of dissociation have been harnessed into a socially acceptable outlet.

The treatment of diseases caused by spirits other than the *balubaale*

The *mayembe aga kifalu* produce a much more sudden and disturbing illness, killing quickly, and never producing a prolonged illness like leprosy. The *muzimu* may also produce a sudden illness, especially if sent by someone. I saw a boy of about 20 some five days after such an illness had started. He had fallen ill with fever, became comatose and in fact died a few hours later. A *muzimu* of someone who had a chronic illness or who had killed himself, may visit others in the family bringing the condition upon them (Note 25). For this reason the bodies of such people are buried far away from the house because a *muzimu* is thought not to wander far from its body. Bennett (1963, p. 155) says that "*kifalu* (meaning a jeep or Land Rover that is powerful and emitting a lot of noise) is the descriptive term given to a variety of violent noisy states such as delirium in typhoid or the restlessness of meningitis. Many hysterical states and epilepsy fall into this pattern, and the term is used to cover the violence and agony of the caning of a pupil by a teacher!" The word *kifalu* is the Swahili for rhinoceros, and is used by extension in the above ways (Note 26). The words *mayembe ag'ekifalu* means therefore rhinoceros horns, a well known phallic symbol and supposed aphrodisiac. The great majority of the Baganda however do not know that *kifalu* means rhinoceros, nor have they ever seen one.

These *mayembe* can cause an epidemic of illness. An instance of this followed the death of a man of about 45. In the two days following his death the mourners arrived for the burial but on the day before the burial was due, a girl of eight fell down and had what looked like an epileptic fit (as described by a neighbour

whose wife has epilepsy). The mourners became apprehensive and some minutes later a boy became dizzy, and he vomited and defaecated into his trousers. The mourners all began to run away from the house and another girl was affected. A boy of 17 tried carrying away the girl who was first affected, from the house. He himself was overcome by dizziness and weakness. A traditional doctor was called who specialised in dealing with *mayembe* and for a fee of 250/- said that a hen and a goat needed sacrificing. He told the family that it was just as well that he had been called because had he not brought medicine, three people would have died in the night. The body of the man who had died was hastily buried that day instead of waiting until the next. Meanwhile at a homestead a few miles away some children who had been at the house of the deceased in the morning began to be attacked. The first got a fever at about the same time as the others had been attacked and it was after this that word came that *mayembe* had attacked the other household. During the evening four other children in this homestead also began to feel faint.

The traditional doctor who was called in for the above epidemic ran a successful clinic. The most usual complaint amongst his women patients is stomach pains (*ekigalanga*) brought by *mizimu* and a common complaint amongst his male patients is a feeling of worms crawling under the skin (*enjoka ndigirigi*). There are usually about three long-term cases there at any one time and these stay for about three months, although some may stay for as long as a year. The majority of his cases just stay overnight since much of his practice is performed at night. He would probably see about five new cases each day. Those who stay long will of course learn much of the art of this form of healing and this is a form of apprenticeship for those patients who return home to start a practice of their own.

The method of treatment for both *mayembe* and *mizimu* is to induce the spirit to speak through the victim and identify itself so that a medicine may be prepared or the person who sent it may be induced to remove it. I was called to see an elderly woman who had had severe stomach ache. She was surrounded by women neighbours who had covered her head with a cloth and were giving her inhalations of burning peppers in order to make things so unpleasant for the spirit that it would reveal itself. At the time of my arrival she was extremely agitated and was making a series of incoherent barking noises and did indeed seem possessed in

some way. From lack of time and out of consideration for her son who had taken me there I was obliged to interrupt the proceedings. Palpation of her stomach revealed that there was no gross illness. I therefore reassured her and those around that she was recovering and gave her the only medicine I had with me at the time, a tranquillizer tablet (chlorpromazine 100 mgm). She apparently made a quick and uneventful recovery with no recurrence. The interruption, however, had made some of the women neighbours angry because it had prevented the act being played out to the full. The true diagnosis therefore could not be made, since it was assumed that the spirit had been about to reveal itself. It is quite likely that her barking would have become coherent enough for some, possibly cryptic, information to have been gathered from it. This kind of an attack by a *muzimu* is known as *kigalanga.* Mair (Note 27) says that "the spirit is supposed to enter the stomach by the mouth and cause a kind of indigestion known as *kigalanga,* whose first symptom is said to be a very cold feeling. This is regarded as the manifestation *par excellence* of spirit possession . . . . . ." Indeed the word *empewo* is used for both a spirit and a cold wind. A *muzimu* can attack people of either sex seizing them by the throat and killing them instantly. In the case of *kigalanga* however time is available to treat the condition, and "the first thing to do on such an occasion is to 'make the spirit speak'." (Mair, ibid).

3

SPECIFIC BELIEFS ABOUT MENTAL ILLNESS

When people become mad they behave in a way quite out of keeping with their usual personality, as if they had become another person. Similarly, during an epileptic fit it seems as if the patient has become possessed by some outside force and is no longer able to control his actions. It would therefore seem quite reasonable to think of both conditions as being caused by spirits which take control of the patient's body, causing him to behave in a strange way. If people are asked what brought a strong illness the immediate answer is usually "they bewitched him", but this may well be modified if a further explanation is asked for. As has been noted, there are two principal types of spirits. The first include the *balubaale* and the family *mayembe*. These are very human in nature and their object is to encourage people to work for them in different ways. They would therefore never kill or produce a bad chronic illness unless the patient and his family had ignored their requests. This could be because of religious scruples or other beliefs opposed to the idea of appeasing spirits or simply because of laziness or lack of money. The second principal type of spirits include the *muzimu* and the *mayembe ag'ekifalu*. These come to kill and are likely to produce a rather violent or unpleasant illness. At first sight therefore, an epileptic fit would appear to be brought by these latter since it is a rather violent and horrifying episode. There is something rather inhuman about a fit and this accords with the idea that it is produced by *mayembe ag'ekifalu*, who cannot be conversed with like the *balubaale*. Those possessed by a *lubaale* or who have an illness caused by one, remain like human beings. On one occasion I was told that a madman, who was confused but not violent, was probably affected by a *lubaale* because it was 'treating him nicely'. In the case of epilepsy, however, it is recognised that no spirit would be so inept as to fail to kill the patient every time it came. When talking in general terms it may be said that epilepsy is brought by *mayembe*, but when actually confronted by a case in the family, relatives are much more uncertain about the cause.

There is a difference of opinion as to which of the spirits is

the most dangerous. The *mayembe* are sent to kill but their effects can be countered by medicine, even western medicine. The *balubaale* usually produce illnesses which are not susceptible to medicine but require the process of 'settling'. A visit to hospital will only bring temporary remission and on return home it will not be long before the illness recurs. Thus, although less violent, the illnesses the *balubaale* produce are more difficult to cure and consequently many say that they are the most dangerous (Note 28). It has been pointed out by others, and I would agree, that western doctors, when confronted with an illness supposedly brought by witchcraft, should not argue with the patient about the causation. It is usually quite acceptable that there may be a western medicine to cure him. This is not entirely unlike the attitudes of many western patients to medical treatment.

Madness

A madman, *omulalu*, is considered to possess superhuman strength. He is greatly feared because even if not aggressive he is thought very likely to become so. Mad men are feared much more than mad women because of their superior strength. They are very quickly seized and tied hand and foot. A mad woman is much more likely to be left free, and if she stands in the path, passers-by will not be afraid to go near her, whereas no one would dare pass near a mad man. When I asked if more men than women became mad, some replied that it only seemed so because mad men are more noticeable. This is because they tend to be more violent and the commotion caused by restraining them is more obvious. Others, however, thought that men suffer from madness more frequently than women because it is typically caused by witchcraft directed against an adulterous man by the husband of the woman. Ssekamwa (op. cit. pp. 35, 37) also notes that this was the reason given for a young man becoming mad, (and he gives an interesting account of how these *mayembe* were caught).

In the old days mad people were put into stocks until they got better or died, but in these days there can be few Baganda who have not heard of Butabika, the Mental Hospital at Kampala, even though it was only opened 10 years ago. It is now regarded as a natural replacement for the stocks of old. It is rare in these days to see patients shackled, although they are often tied with ropes. Of course, the Baganda live around Kampala and some of those Ugandans living farther afield may not have heard of Buta-

bika. Nowadays, in the rural areas of Buganda, one of the procedures for getting a patient to Butabika is to get a letter from the Village Chief and go to the Muluka Chief who in turn would give a letter with which to go to the Gombolola Chief. Although he has the power to make out a detention order, the Gombolola Chief does not usually do so but gives the relatives a note to the nearest Police Station. A Land Rover is then sent to bring the patient to the Station where he is put on a detention order (Urgency Order). Within a day or two he is taken to Butabika Hospital, the delay depending on the distance from Kampala and the availability of transport. These delays can be bypassed if the relatives take the patient to the police station themselves where an order is made out before taking him on to the hospital. If the patient has been at Butabika Hospital before or if for some other reason the relatives know of the out-patient Mental Health Clinic at Mulago Hospital, then the patient may be taken there instead of to a police station. Patients from the more distant parts of the country are usually admitted on a Reception Order made out by a Magistrate. These cases often have to wait in prison until there are sufficient numbers to warrant a lorry journey to Kampala.

A superficial glance at the admission register and annual reports of Butabika Hospital shows that, at least since 1960, the number of male admissions is double that of females. There would seem to be four possible reasons for the difference: (1) that women go mad less often than men; (2) that they go mad as often but their pattern of behaviour is less socially disruptive; (3) that they go mad as often as men but there is less tendency to take them to the police or hospital because they are not feared so much; or (4) that less trouble is taken over women in societies where the men are particularly dominant. All these factors probably play some part except possibly the first. A breakdown of admissions for the months of October 1967 and April 1968 shows that the difference in admission figures between males and females is most obvious in the cases coming from Police Stations under Urgency Orders (Note 29). The police are usually involved if the patient is violent although they occasionally pick up mentally disturbed vagrants. Thus it would seem that the principal difference lies in the number admitted because of violent behaviour. It is recognised that violent behaviour toward a person will usually bring forth a violent response, and since violent restraint is almost immediately forthcoming at the first signs of madness in men it is hardly surprising

that they exhibit a more violent pattern of behaviour than women.

The members of a patient's family usually seem to dislike discussion of the mad episode once the patient has recovered. (The embarrassment is also found in Europe). This attitude gives the patients little support or sympathy as they ponder the episode, especially if they remember much about it. It is in fact not uncommon to find people who were quite aware of what they were doing while "mad" and in fact felt quite justified in behaving the way they did (Note 30). Some admissions to Butabika are just "carried away" during a fight and in others this aspect can be seen as part of the circumstances leading up to admission.

> A Munyankole woman was married to a Muganda. Both drank heavily and when they became drunk they would argue. They had been married for 2 years and had a child of 6 months but the woman also had a daughter of 14 years of age by a previous marriage. This girl wished to marry and therefore needed to go to see her father, but the present husband of the woman had refused this, one reason being that the girl was useful about his own homestead. He had in fact insisted that the baby remain with him since it was his, and as it was breast-feeding, the mother could not therefore take her elder daughter to see her father. The situation became such that following a drinking bout, the husband eventually hit his wife with a plate of food — a particularly offensive thing to do. At this she refused to talk and became aggressive. She had had an episode of "madness" three years previously for which she had been in hospital, and so the husband and his relations decided that her baby should be taken away from her. She began arguing about having the baby taken away, but this just confirmed, in their minds, that she was becoming mad. At this stage she stalked around the homestead, hardly talking but doing some work. She would become aggressive if people approached her, and the husband's immediate demand was that she should go to Butabika Hospital. Fortunately her brother lived nearby and was able to talk to her and give her some medicine. The husband was quite obviously terrified of her. When I suggested that the situation be discussed quietly with her he reluctantly agreed, but as soon as he got near to her he attempted to seize her by force and she gave him a sharp hit with a hoe. Within a few days on medicine she was sufficiently recovered, in the eves of the family, to have her baby back, although it was difficult to persuade them to let her go on breastfeeding. (It is believed that if a child has not suckled for a few days, the milk in the breasts goes bad and will only harm the child). Within two weeks she was quite well, although still angry with her husband. She remembered the whole episode very well, except for hitting her husband

with the hoe, but despite the fact that she could give a lucid account of her problems and past events her husband insisted that I should not listen to her because she was ill! The neighbours, while admitting the husband's faults also agreed that she was ill and would have been pleased to see her taken to Butabika Hospital. A few months later she left her husband and was reported to be perfectly well; six months later she was admitted to Butabika Hospital having returned to her husband in the meanwhile! (Note 31).

Another case of the same sort was a lad of 20 who had epilepsy. The family were Bagisu but had been living amongst the Baganda for a long time. The lad's father drank heavily and when drunk would abuse him. Epileptics are treated badly and in this instance the abuse had increased because a baby in the family had had a febrile convulsion and it was thought the illness had been spread by the elder boy (epilepsy is thought to be infectious). This abuse eventually became too much for him and he seized a stick and chased everyone away, screaming at them and saying how badly he was treated. Again the immediate reaction was for all present to plead with me to take him to Butabika Hospital. It was, however, quite possible to talk to him and I persuaded him to accompany me to my house for the night. The next day he seemed quite calm and we returned to his home. As soon as the family and neighbours saw the car they surrounded it renewing their demands that he should go to Butabika Hospital. The lad could obviously hear all this and on arriving at the house he seized a stick and once more attempted to hit his father, who took to his heels, quite terrified. It was quite possible, however, to quieten the lad with words and a tranquillizer tablet and peace was eventually made between father and son. The father agreed to stop abusing his son and the son promised to refrain from behaving like a madman. The boy made his point and the father had learnt a lesson.

Neither of these patients were Baganda, and Robertson (1966), who also worked in a high immigrant area of Buganda reported a similar sort of case. This man was a Munyarwanda labourer whose employer had a troublesome dog which he wanted killed. The employer believed that a *lubaale* possessed the dog and so was reluctant to kill it himself (Note 32). He offered this labourer 10/- to do it for him but when the dog had been killed he refused to pay. The labourer began to get angry and eventually became literally mad. The villagers recognised that this was due to the *lubaale* from the dog. The subsequent madness lasted several weeks, but at one stage a traditional doctor was able to hold sensible conversations with the patient. He was eventually taken

to Butabika Hospital. Robertson felt that the labourer was, perhaps unconsciously, using the role of "madman" to express himself. Like the other two he was also an immigrant into the area. Although this may not be significant it may be that their position is such that they lack some of the family support necessary to help them through certain stressful situations. Their anger and frustration in these circumstances may thus lead them to appear "mad". This can only be one factor however and there seems to be no reason why similar cases should not occur amongst the Baganda themselves.

It has been said by those working in mental hospitals that depressive illness is very rare amongst Africans. Amongst the Baganda at least, it is only the excited patients who tend to be sent to mental hospital for treatment. A depressed patient, who is unduly slow and quiet, would not usually be taken there.

> This is well illustrated by a woman of about 50 who had had a manic-depressive illness for 12 years. In such an illness, periods of excitation alternate with periods of depression. Following childbirth she had become weak and had suffered from headaches. She was treated by traditional doctors for three months but this was no help. She returned home where she spent most of the time keeping quiet and doing practically no work for 6 years. She then spontaneously became well, but a year later relapsed. This time she began crying and talking nonsense. Her behaviour was now sufficiently disturbing for the family to take her to Butabika Hospital. She was discharged after a few months, and then followed a series of admissions, each lasting several months over the course of the next few years. She was taken to hospital whenever she became excited, abusive and aggressive. For the last three years, however, she has been quiet, doing very little work in the home and taking no care of her appearance. She talks a little at times and often cries quietly. Anti-depressant medication improved her to the extent that she began doing the cooking and put on a proper dress, but she did not progress beyond this and offers to take her to hospital for further treatment were never taken up by her or the family. In short, within a few days of becoming excited she would be taken to Butabika Hospital but she could remain at home for years on end while severely depressed.

This difference in attitude toward the manic and the depressed patient must have been at least partly responsible for the old observation that depressive illnesses are rare in Africans (Note 33).

Epilepsy

Amongst the Baganda, as in many other parts of Africa, there is a great fear of a triad of diseases. These are epilepsy (*ensimbu*), leprosy (*ebigenge*) and consumption (*akafuba,* usually translated tuberculosis). It was known that I was treating epilepsy and because these illnesses are closely associated in the minds of the Baganda, I was approached on several occasions for treatment for leprosy. The Baganda believe all three to be highly infectious. In epilepsy the froth from the mouth and the urine which may be passed during a fit are thought of as particular carriers of the disease, but the sufferers are also thought to be able to spread the illness at all times and not only during a fit. The diagnosis of epilepsy is usually correct when people have been said to have *ensimbu,* but any chronic cough or skin disease will be feared to be *akafuba* and *ebigenge* respectively. All three illnesses are associated with a terrible stigma but in the case of epilepsy it sometimes seems more tragic since the patient may only be incapacitated for a day or two each month and for the remainder of the time will be perfectly well. Nevertheless, because of the fear of contagion they will typically have their own plates, cups and wash basin, and their clothes are washed separately. They eat their food on their own and sleep in a room on their own and when old enough, they will live in a hut of their own, isolated from the others in the household.

In some families everyone has his own plate so that this is not a noticeable distinction, although the epileptic's plate may be washed separately. An epileptic may sleep in the kitchen, which is usually a separate hut away from the main house. Any youth, however, when he is old enough to begin having sexual relations will be expected to sleep under a different roof from his parents. Children with epilepsy will not be allowed to play with others and the parents of the others will warn their own children to keep away and not to play together with them. The result of these beliefs is that when an epileptic has a fit everyone runs away. If he should fall in the fire or into water it is quite likely that no one will pull him out and he will be left to burn or drown. A few informants said that they recognised that epilepsy was not infectious and others said that the isolation they were subjected to was not only due to its supposed infectious nature, but because of the unpleasant and rather frightening nature of the fits themselves. Epileptics also tend to be dirty although in many cases this is due to their isolation

and lack of the usual socialising influences. There may also be a certain amount of fear of the strange behaviour sometimes displayed by the patient on recovery from a fit.

Belief in the infectious nature of epilepsy is widespread in Africa south of the Sahara but unfortunately, there is little literature on it. Giel (1968) reports this belief in Ethiopia, Aall-Jilek (1965) in Tanzania and Leighton and Lambo (1963) in Nigeria. I myself have heard of it in many other areas that I have visited, and it seems that few people in this area do not have such a belief (Note 34). Some Baganda believe that it can only be spread to those in the same family. This suggests that the mechanism is similar to that of the attacks of *lubaale* and *mizimu,* which are similarly limited. Indeed a few say that there are two types of epilepsy. If it has been caught from another then it may be spread to another, but if it came without the patient ever having been near anyone else with epilepsy then it may be of another variety which is not infectious. It is very often thought to be due to a lizard in the head which may either be there at birth and slowly grow until it begins to disturb the brain, or it may be introduced in later years by witchcraft. As it runs round and round in the head it causes dizziness and then the epileptic fit. A method of treatment is to cup the head and so remove it, but even this is not the final answer since the patient will still be left with a good deal of illness even if he does not actually have fits, and he will probably die soon. Even the most optimistic acknowledge that a considerable amount of further medication is required after the cupping. The belief that epilepsy is caused by witchcraft or a lizard in the head can co-exist at one and the same time with the idea that it is infectious. The idea of contagion is very non-specific and none could describe a mechanism by which it could be spread. Similarly while leprosy is thought to be contagious there is no notion of how it is spread and *at the same time* it may be thought to be due to witchcraft or a butterfly which touched the patient's skin leaving a light patch of powder from its wings.

If a patient has been burnt from falling in a fire this is acknowledged as a sign that the patient cannot be cured, or, as some say, it is an excuse that some doctors use when they have failed. This is interesting in that it is generally acknowledged in western medicine that some forms of apparent epilepsy are in some way under the conscious control of the patient, and occur as a response to some stressful situation. They are known as

hysterical fits and it is these that would probably be most amenable to treatment by traditional healers. Since there is thought to be some degree of control exercised by the patient they are extremely unlikely to fall into a fire. In other words, those who fall into fires are almost certainly genuine epileptics.

> One case of mine had started having fits following his failure in examinations at the end of his fifth year at school. He was successfully treated by a traditional healer using inhalations of burning medicine and the illness was acknowledged to have been the underlying reason for his failure. Two years later he restarted in the same class, but again failed at the end of the year, and the fits began again. I explained that the fits were due to school work and that his failure at school was linked to this, so that he must not reattend school. This, coupled with an injection to add credibility to the idea that he had in fact had an illness which was being cured, again effected a complete cure.

Epilepsy is thought to lead to spoiling (*okwonooneka*) of the brain, the word *okwonooneka* being stronger than the English word "spoil" and more nearly approaching the idea of destroying. The nearest analogy that people could give to what they thought was happening was that it was like butter melting in the sun. A spoilt brain may be present in those who are merely foolish, but it is also thought to be the inevitable outcome of untreated madness and epilepsy. Epilepsy is not usually thought to lead to madness but may lead to the mild form (*eddalu ly'akazoole*). Drinking large amounts of alcohol and smoking hemp also spoil the brain. There is no doubt that the social isolation which epileptics are subjected to, especially in the case of children, can lead to failure in their social development, so that the brain certainly appears spoilt.

> A three year old girl was brought to me by her grandmother with whom she was living. She had a three month history of fits. Her grandmother said that her brain had already begun to 'spoil', as was shown in the way she appeared sullen and had become disobedient. Before the fits she had been sleeping in the same bed as her grandmother, but after the illness began she had to sleep on the other side of the room, and her friends were told not to play with her. Tablets were given to prevent the fits and the grandmother was told that the tablets prevented the disease from spreading, and the child was no longer to be separated. Her grandmother reported that she soon became her normal self again but unfortunately the old woman then died. The girl's father had died two years before, so after the grandmother's death the father's relations started

looking after the child and began again to keep her well apart from others. Not unnaturally, the little girl was greatly upset, by the death of the grandmother and this, coupled with an apparent indifference to her welfare on the part of the father's relatives, such that everyone in the household found some reason why they were unable to attend for further medication, soon led to a recurrence of her fits and bad behaviour. This was quickly attributed to her brain being spoilt. The adults could see no alternative but that she should go to Butabika Hospital, since they were antagonistic to the mother of the girl who was presumed to have caused the death of her husband. They were eventually persuaded to let the mother take care of the child, although by custom she belonged to the father's family. The mother was instructed in giving medicine and within a few weeks the girl was behaving like a normal child and was apparently quite obedient. Some of the bad behaviour may be due to the direct effect of the illness, but almost certainly treating a child of three in the ways mentioned above must have contributed a great deal to her misbehaviour.

A girl with epilepsy is unlikely to marry although she will probably have sexual relations and children. If she does marry it will be to a man who has been unable to obtain a wife by the conventional means. If already married when the illness begins she will usually be sent back to her parents by her husband. For a child it almost invariably means an end to schooling, the schoolmaster asking the child to leave. This is often anticipated by the parents, and they take the child away before the request is made. The reason for the withdrawal is that the child may spread the disease to other children, and since it is thought to make the child stupid it is considered that further education would only be wasted. One boy was asked to leave school "because his school work had deteriorated", despite the fact that he had come 7th in a class of 35. If the fits occur infrequently (for example, not more than twice a year) or if they occur only at night, then the patient is treated less harshly.

The position of such people was highlighted by study of a group of patients with leprosy. They complained that they had lost their second names. If anyone wanted to explain, for instance, which Kapere he was talking about, then instead of giving his other name he would just say *omugenge* (leper). The same is true for epileptics. Even after death the stigma remains and no one will inherit from him for fear of also inheriting the illness. The body is buried in the bush, as opposed to the normal custom

of burial near the homestead. The bush is "bad" and "hostile", whereas the homestead is "good" and "friendly". (Wild animals are known as those of the bush (*ensolo ez'ensiko*) and domestic ones are those of the homestead (*ensolo ez'amaka*)). If the patient owned his plot of land he might be buried at the edge of it rather than actually in the bush. Beside those suffering from one of the terrible triad of illnesses, other people buried in the bush are those who have killed themselves, and those with *entumbi* (translated as dropsy), which causes a swollen stomach. In the case of this illness the barkcloths, in which the body is wrapped, have holes cut in them so that a sharpened stake may be placed against the stomach, passing up through the holes in the barkcloths and sticking up above the ground. When the grave has been filled in and everyone has dispersed someone from another clan (ideally a sister's son) goes and drives the stake down into the abdomen.

Epilepsy is considered by many to be an illness restricted to Africans. It might have been thought to be restricted to Baganda if it were not that there are so many immigrants in the area. It was certainly suggested to me on many occasions that the illness did not affect Europeans, and one immigrant family noted that the illness had afflicted one of their number after moving into the area, so that perhaps it did originate amongst the Baganda. Madness is also thought of in this way by a few. It is the strong, Kiganda illnesses "that are sent" that tend to be thought of in this way.

Suicide

Suicide is considered to be a most terrible act, and it perhaps shows the extent to which people with epilepsy and leprosy suffer since they often actually admit that they have had thoughts of killing themselves. Chronic disease is an important reason for suicide, but Baganda also recognise that someone may kill himself after becoming angry as a result of a quarrel (Note 35). It is considered that some form of spirit must make a person kill himself. The act itself is thought to derive from the heart. I was told that someone may go to Butabika Hospital for examination of his brain and nothing may be found. On returning home he may kill himself since the condition had been affecting his heart, not his brain. (This is perhaps a very astute observation on the way that most patients are necessarily treated at this hospital. Because of pressure of work there is little or no time to get to the "heart" of things). The body of a suicide is feared, and in a sense suicide

is treated as contagious in that no one of the same clan should touch the body lest its ghost enter him and he should also be tempted to commit suicide.

Suicide occurs typically by hanging and the body should be cut down by a person from the clan that a sister married into (ideally a sister's son). The body may then be beaten, a custom said to have been introduced by the English police in the colonial era and to have stopped now that they have left. It is then taken and buried in the bush as opposed to the normal custom of burying near the homestead. The body will be buried in a shallow grave, perhaps only 3 feet deep, preferably on the day of death, and may be covered with dried leaves and burnt. All these are signs of disrespect and indicate the haste involved. The normal burial procedure is to wait at least one day for people to gather and to allow time for a deep grave to be dug. The tree the suicide hanged himself from will be burnt, or if he did it in a house, this will be burnt or dismantled. No one will inherit from him since that person will be tempted to commit suicide, but a banana tree is planted in front of the house, left there overnight and then taken the next day and thrown in the bush. This tree is then said to have inherited and the mourners cut their hair to show that the mourning is ended. Under normal circumstances the period of mourning is several months, not just a day. If a person who commits suicide has himself inherited from someone, then the ghost of the latter will be angry that its heir had done so. A ceremony is therefore held in which a second person is appointed heir in place of the one who had killed himself. In one case I investigated this had been done together with the ceremony of inheritance for another in the clan elsewhere. If it is held at the homestead of the one who killed himself, only a few people will attend and there will be no dancing on the night before, as there usually is, although the ceremony will otherwise be the same (Note 36).

Both epilepsy and madness exclude a man from ever inheriting from anyone or becoming a chief, even if cured, because the brain is considered spoilt and it would always mean that any mistake would immediately be attributed to the illness, and the judgement of the person could never be fully trusted (Note 37). In the case of madness, the danger of recurrence is clearly recognised, and with both illnesses there is sometimes shame felt by the relatives because it is recognised that in some way it might

also come out in any one of them or their children. This is seen in terms of a ghost or *lubaale* in the family rather than it being in the blood, or genetic. Such spirits, however, when not placated, tend to produce a rather chronic form of illness, whereas a violent episode of madness from which the patient fully recovers is more likely to be thought to be due to witchcraft which may be why it is considered less shameful.

The social consequences for sufferers from madness and epilepsy

The underlying feeling amongst the relatives if someone in the family has a disease of the brain is difficult to assess. If anything the shame surrounding epilepsy seems greater than that surrounding madness, and indeed, at times there is a surprising openness about someone in the family who had an episode of madness. Shame more often surrounds those in whom the illness takes a chronic course than those who have had one or two episodes of violent madness, in whom it may be considered as a bit of bad luck, like catching a cold or being run over. Madness at least is not considered infectious so that the mentally disturbed are not separated in the way that epileptics are.

As has been indicated, the immediate reaction to anyone who shows signs of what is thought to be unreasonable violence is to try to get them to Butabika Hospital, and while there is any sign that this behaviour might recur, the family are extremely reluctant to take the patient back home. They want the patient completely cured or not at all, and although this may be an advance on keeping him in stocks until he is cured or dies, it is hardly an attempt to face the problems such a person poses. Indeed there is seldom any discussion with the patient himself, who is dismissed as being unable to understand. Efforts on my part to delve into what the patient was trying to express were ridiculed and met with no co-operation from the family. It was thought, after all, that a 'doctor of the brains' of all people must surely know that such people do not understand anything. Even in cases where recovery seems complete, any minor piece of odd behaviour which may subsequently occur will be attributed to the brain being a little spoilt. In those cases where there is some residual sign of illness the patient is ignored, if not physically separated. The family of one man with epilepsy had insisted he was too ill to pay his poll tax, but he had fortunately retained enough self-respect

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to complain about this and all the other ways in which he was treated like an invalid. Many cases, especially those in which the illness started at a young age, accept this attitude and the patient tends to form the same view of himself as that expressed by the family and will often agree that his brain is spoilt. They are allowed, if not encouraged, to sit around doing nothing and they slowly become a parasite on the family which is exactly what is expected of them. In fact their position as such is well defined.

In the rural areas there is no great haste to obtain medical attention for any illness. The family of an epileptic will probably delay a few days more than they would have done with a normal member of the family. This, coupled with the direct dangers of having fits, almost certainly leads to these people having a lower life expectancy than the general population.

The Baganda say that any misbehaviour by someone who is mad is excusable, but lay assessors who assist the judges in Uganda courts by giving advice about the customary law tend to be reluctant to accept the plea of "guilty but insane". This is particularly so when the illness has not taken the form of violent madness, with the patient running around in a state of confusion and talking nonsense in the typical form of *eddalu*. If a crime is committed by someone who seems to have some idea of what he is doing, then it is not excusable. Thus those with *akazoole* tend not to be excused easily. Robbery by recognizably mad people is excused, especially if the goods are recovered, but if property is destroyed feeling runs very high against the patient. Robbery by otherwise normal people and particularly robbery with violence is considered one of the gravest offences. Such robbers are known as *kondo* (pl. *bakondo*) from the word *akakondo* meaning "a lock on the door", which is broken by the robbers. A proposed law is before Parliament in Uganda to allow the death penalty for such offenders. It is not uncommon for the public to take the law into their own hands and kill such people when they catch them. I have heard many lurid stories of how bands of these robbers were attacked while in the act and speared or beaten to death or how they were found afterwards and killed. Unfortunately, a mentally disturbed person is occasionally taken for a robber, especially if he has wandered into an area where he is not known. I saw one madman who had wandered into a strange village. He had been hailed and had taken to his heels. This had led the villagers to think he was

a thief and he was chased and beaten quite badly before he was recognised as being mentally disturbed.

My impression is that the Baganda have an exceptional fear of violent people. The madman is obviously violent and an epileptic fit is seen as violent behaviour. This is not explicit, but it is often pointed out that the eyes turn red during a fit, typically a sign of anger. Group violence is, however, greatly enjoyed and there is no sign of fear in the faces of a crowd beating a thief. In fact, everyone joins in even though they may know the circumstances do not justify such action. This is, in a sense, comparable to the attitude towards sex, discussion of which in a quiet situation can produce confusion and shame; but at a dance, the more a performer simulates sexual intercourse, usually by what can only be termed gluteal gymnastics, the greater the approval of the audience. (In fact, the most enthusiastic reception I have ever seen was for a dancer who added to his act by placing his hand over the genital area and raising and lowering his finger as a representation of his penis.)

The attitudes discussed above towards those with epilepsy are shared by the neighbouring Basoga.

> A Musoga boy of 10 was recently in court for having killed his 18 year old brother who had epilepsy. Both boys were living with their grandmother, but the elder boy had a separate hut built for him because of his illness and all the children were instructed to avoid him and especially not to let him touch their food. He never played with them and his grandmother was the only one to have any contact with him when she brought him his food. The boy was never given matooke, (made from bananas), but only maize. The younger boy was frightened of his brother and was terrified every time he saw him having fits. One day, while they were eating, the elder boy came up to his brother and tried to take some of his matooke. The latter became annoyed and frightened. He seized a knife and stabbed his brother in the chest, killing him on the spot.

Although this work describes the situation in rural areas, the same attitudes and beliefs are present in the towns. In fact, in the more restricted atmosphere of Kampala, the situation is often aggravated.

> A girl of 12 years came to the attention of the Social Welfare Department having been found wandering by the Police. She had suffered from epilepsy since the age of 6 years and she and her sister had been living with their grandmother, her

parents having separated. On the death of the grandmother, the mother agreed to take the healthy daughter but she and her new husband refused to have the one with epilepsy and the father had to look after her. He was an alcoholic and worked as an electrician, but he could not find another woman to live with him, or even get anyone whom he could pay to look after the girl in the day, because they all feared her illness. All that he could do was to leave her locked up in the house all day with some bread, a flask of tea and some bottle tops to play with. It was from this that she one day managed to escape and was found by the Police. She was placed under care and protection by the court and it was arranged that she should attend a nursery school in the day and receive treatment for her epilepsy. This treatment almost always necessitates the patients taking tablets every day, often for life, and these prevent the fits appearing but they will recur as soon as the medicine is stopped.

The child responded well to medication and the mother was easily persuaded to take the child for short periods of time. The girl and her father moved to stay with his sister but soon afterwards he was admitted to hospital as a result of his alcoholism. The girl's father's sister continued to look after her but she had to sleep separately in a small kitchen in which she was also locked up for most of the day. She (not unnaturally) developed the habit of wandering away from home and would be picked up by men.

In the following months she developed venereal disease. Even though the father returned and she was allowed to live in a room with him, yet while he was away working in the day she would wander from home. If she did not take her medicine, then in a few days before having a fit she would become angry and might be easily provoked to violence. This did not occur if she was taking the medicine. When she wandered away from home she did not take her medicine with her and so the fits and angry outbursts could no longer be controlled. Her family were extremely reluctant to give her a small supply of medicine since they felt that by keeping it themselves they encouraged her to retain her links with home. At one stage she disappeared for two months only to be returned to her guardians, much to their surprise, by an ambulance from Butabika Hospital, where she had been all that time, having been taken there by the Police. Although the father always made an effort to get medicine for her, he would beat her severely for her wanderings. Her feelings about staying with the father's relatives are best expressed by the fact that when visited 6 months after discharge from Butabika Hospital, she hoped that we had come to take her back there or to the Remand Home. Almost certainly her wanderings

were a search for some kind of human relationship, although attributed by the relatives to her spoilt brain.

Their belief led them to abandon hope for her and they lost interest in her welfare, although my impression was that she was by no means unintelligent and was quite articulate. In Kampala there is very little for a child to do if not going to school, especially if isolated from other children or of a solitary disposition. At least in the villages there is always some work to occupy the children for large parts of the day.

There is a certain amount of fear at even mentioning the names of epilepsy or leprosy when talking to a sufferer or his family and once it is clear what is being talked about, then it is referred to as 'that illness'. One young man with epilepsy who approached me for treatment appeared so ashamed and used so much circumlocution that I thought at first that he was asking for treatment for gonorrhoea. Before getting the illness he had slept with a woman who had epilepsy and it was impossible to convince him that epilepsy was not contagious.

Shame, however, is not the only reason for not actually saying the name of the illness. There is also the feeling that the name of an illness itself has certain powers and if spoken may spread the disease. Thus if someone with backache is asked what he is suffering from the answer should not be *mugongo* (the back, with the implication of backache) but *muyini* (the handle of a hoe, implying stiffness). Similarly *makajja,* lumps in the muscles, is referred to as *mayinja* (stones). *Mulangira,* (a prince) is used for illness brought by *lubaale* Princes, and particularly for *lukusense,* which is measles or any rash resembling it.

Beliefs concerning the western treatment of epilepsy

The Baganda do not, as a rule, believe that there is a western medicine for treating epilepsy, because it is a Kiganda illness. Out of 83 cases of epilepsy whom I saw in the rural area, only eight had tried to obtain some help from western medicine. Out of these only two had understood the necessity for continuing the medicine indefinitely, but had been unable to afford to fetch it each month. Two others had obtained treatment from private practitioners and one from a chemist, but these had not understood that they needed to return for more. One had been in Butabika Hospital because of associated violent madness and another had attended the local dispensary and been asked to attend Mulago Hospital but had never gone there. The remaining case had got as far as attending

Mulago Hospital but says he was told there that the medicine for this illness "was not easily obtained" and so came away empty handed. Most cases in fact had never even thought of getting western medicine, while others were quite emphatic that, up to my coming, there had never been medicine available. I heard of a few instances in which there was a definite feeling against trying to get western medicine. It was difficult to trace such cases and the reasons for such an attitude can only be surmised. Shame and the possibility of ridicule at being turned away without treatment are more likely to be a reason than fear that such an action may anger any spirits causing the illness.

One family of a woman, who had had epilepsy for 15 years, had gone to the extent of beginning to take her to Mulago Hospital solely because of some violent behaviour which had developed. On reaching the nearest trading centre they were told that once it was seen that she had epilepsy they would be turned away immediately, and so they returned home without troubling themselves further.

There is, of course, a certain amount of truth in the idea that epilepsy was not being treated by western medicines if we accept that treating it involves more than just giving a few tablets. Treatment also requires careful explanations about the continuous nature of the treatment, and an effort to ensure that the patient is able to obtain medicine easily over a very long time. Insofar as treatment is not systematic in this way it is not treatment at all and it is only over the last few years that attempts have been made to start such treatment within the Government medical service (Note 38).

At least in the case of epilepsy the patient can see quite quickly that it has stopped working when the medicine is stopped. In the case of leprosy however it can be difficult to persuade a patient to continue with a medicine when the actual benefits are not seen quickly, or when the illness does not return for some time if the tablets are stopped. The fact that these are Kiganda illnesses leads to the gravest of doubts as to whether the medicine given is effective. Even long term patients at a leprosy treatment village said that they still really accepted the traditional belief that they would not be cured until they had lost all their fingers and toes.

This belief remains in these more intractable cases, despite more active public health measures taken over leprosy because of the agreed need to isolate them to a certain extent. Indeed more active

measures might have been taken in treating epileptics in the past had it really been an infectious disease. In this respect it is unfortunate that it is not so.

"Spoiling of the brain"

The same word *eddalu* (mad) is used for unruly children, but the Baganda are clear when they mean this and when they mean madness. If they wish to qualify the word to indicate unruly behaviour they add that he does not throw stones at people. Such behaviour they believe, may develop into madness, since the bad behaviour is associated with a spoiling of the heart and madness with a spoiling of the brain. A time may arise therefore when a child's misbehaviour begins to be such that an illness is suspected and the brain is then thought to be beginning to spoil.

This idea of 'spoiling of the brain' is also of great importance in understanding the attitudes towards people who have those illnesses already mentioned, since it is thought to develop from madness, epilepsy and unchecked unruly behaviour as well as being an illness in itself, (foolishness — *obusiru*) (Note 39). A child thought to be beyond control is thought of as 'ill' and little further attempt is made to control it. The relatives of the patient feel that medicine is the only method of treating them and that removal to a mental hospital is the best that can be done, especially if the child is not living with its real parents but only with uncles or aunts. It is customary, but by no means universal to send children to stay with relations after the age of three, for if parents love their children too much this leads to disobedience, just as there is the concept of the "spoilt child" in western thought. A child, however, may not only be sent away for its own good. It may be sent to stay with other members of the family as an expression of goodwill; or may be sent to grandparents as company for their old age. Grandparents, as in most parts of the world, are renowned for spoiling their grandchildren (Note 40). Whether this custom of sending away a child leads to much emotional disturbance or not, it is certain that an emotionally disturbed child needs a great deal of attention and a strong relationship with an adult, and this is often what is missing on such occasions.

Once a person is thought of as having a spoilt brain he is no longer counted responsible and little attempt is made to correct his deviant behaviour. This is no doubt an improvement on the

old European idea of locking them away, but in young people it does have bad effects. Those with epilepsy in particular are not expected to help with work and no exception is taken to what would otherwise be considered laziness. I have seen several young people with epilepsy, in whom fits occurred only once or twice a month, but who did practically no work. When questioned directly about this they would reply that their brain was spoilt. Further enquiry revealed that they meant that they felt a headache on the day after having a fit. This was considered to be sufficient reason for them to do no work at all.

> One lad of 16, an immigrant from Tanzania, had epileptic fits twice a month. He was not isolated and used to spend most of his day sitting, drinking, or in a rather unproductive form of fishing (a hazardous pastime for him in view of the possibility of falling into the water during a fit and drowning). As well as giving medicine, I gave some instructions about helping with the cultivating at home, but when the medicine finished he did not return and after some months I visited him. He admitted that the tablets had prevented fits but did not seem anxious for me to give him any more, even though the fits had recurred. The reasons for this attitude are probably multiple. My stress on the necessity to start work had probably upset him since he had become accustomed to living life exactly as he pleased. The illness seemed to have had little adverse effect on his social life, and he was staying with relatives who were not very concerned about his health. All these factors led to the situation in which he preferred his idle life as an epileptic, to that of a healthy "worker".
>
> Another boy of 12 years with epilepsy had established for himself a position as a singer and joker in a market area inhabited by down-and-outs. He also had a begging story about how his father refused to get treatment for him, but because someone took him seriously he found himself in the hands of the Social Welfare Department. He at first seemed pleased that he might be treated, but as it dawned on him that his whole way of life might have to change if he became normal, he began refusing medicine and insisting that he could not possibly be helped.

Once the brain is thought to be spoilt, any sort of even mildly eccentric behaviour by the patient, or disobedience in the case of a child, is immediately attributed to this, whereas it would have been overlooked in others. This then reinforces the idea that the brain is indeed spoilt. The same is true, not only for those with epilepsy, but also for mentally retarded people and cases of madness, particularly in its more mild but chronic form.

A man of 29 who was mentally deficient, possibly as a result of a severe febrile illness at 6 months of age, was living with his grandparents and being cared for by them. Since he had a 'spoilt brain' he was not expected to help in the work at home. I gave him some tablets which could not possibly have helped him by their pharmacological action, but I also suggested ways in which he could begin helping at home. The tablets were sufficient to raise the expectations of the family and he did in fact begin doing a little more work. Such cases, unfortunately, need much encouragement over a period of years rather than months and so it is unlikely that my treatment will be of any lasting benefit in this case.

The extended family relationships found in many parts of Africa have often been mentioned as an ideal way of sharing out the burden of looking after the disabled. This may be so amongst old people whose work potential is low, and who remain sufficiently mentally alert to be socially active. The indifference shown towards the mentally ill may be an improvement on the habit of locking them away, but in these days drugs are available which can often help, and it is known that a very large number of cases can become much more active in society by means of education and rehabilitation. What in fact happens to many mentally disturbed people is that they wander from relative to relative and no one bothers to take any interest in them, apart from giving them food. This is so, not only with adolescents and adults, but also with children.

A boy of 12 years reported to the police that he had nowhere to go. He was referred to the Social Welfare Department and was brought before the court as being in need of care and protection. The boy's father was an alcoholic who had no fixed home and the boy had been in the habit of staying at various homesteads, seldom for more than a week or two. At times his father would remove him, at others the boy would wander away on his own. As the relatives admitted, he was always considered a guest at each homestead and no one took the responsibility of caring for him — no one would be in the least concerned if he left, since it was presumed that he had gone on to stay with someone else. Although at the moment the boy is well, the potential hazards in leading such a life are great and make one realise that the extended family system need not always be an advantage to its members. Within two weeks of his return from the Remand Home he had already gone off to stay with other relatives and although some effort was spent going round asking for him, no one was quite sure with whom he was staying and in fact he could not be traced. Within a month he was back in the Remand Home.

4

IMPLICATIONS OF THE STUDY

The implications of this study are more than merely academic and extend beyond the special field of interest of anthropologists. In this section an attempt will be made to draw conclusions relevant to both medical practitioners (especially in the fields of mental illness and epilepsy) and also to medical planners concerned with the development of services appropriate to the African scene. These conclusions can be summarised under four main headings.

1. Problems of "understanding the patient". This applies particularly to individual doctors, caseworkers and others operating at the personal level.
2. Problems of therapy (particularly social) and rehabilitation.
3. Problems of administration and medical service planning.
4. Problems for future research programmes.

Problems of "understanding the patient"

In dealing with individual cases one cannot overstress the necessity of being able to empathise with and understand the patient, but of equal importance is the need for the patient to understand the caseworker. Patients often present a series of complaints about aches and pains which in many cases reflects the difficulty that the patient has in expressing himself (and possibly his desire to express his illness in what he thinks are terms acceptable to western medicine). For this reason he uses the language of body illness. "Fever", for instance is a very loosely used word amongst the Baganda, often indicating no more than weakness and irritability (Note 41).

There used to be a myth current in Europe that there were no mental illnesses amongst Africans, but it has become obvious in medical circles that there are, in fact, plenty of "mad" people in Africa, so the myth has been changed to suggest that there is no neurosis amongst African subjects. Sir Harry Johnston (1902, vol.

2, p. 646) states "nor apparently do they (the Baganda) suffer from nervous diseases. Epilepsy is rare and insanity still more uncommon." One need not go back over 60 years to find such ideas (Note 42).

This fitted in with the Rousseauesque concept of the "noble savage" living his life of primitive bliss, free from all the strains of civilization. In fact, of course, life in a rural community in an underdeveloped country is fraught with danger, with grief because of high infant mortality (unless one cares to believe another myth that African mothers do not grieve over the death of their children as much as European mothers) and with worries over the possibility of crop failures. There are also many fears resulting from traditional beliefs, such as the very great possibility, if one is successful in some venture, of being bewitched by others who are motivated by jealousy; or the fear of the coincidental, such events being thought to have been planned in some way. Large numbers of people in the rural as well as urban areas complain of persistent, diffuse symptoms which in Europe would be regarded as of neurotic origin. In an area where the prevalence of some form of parasitic infestation and anaemia is so high it is, of course, easy to treat such patients for something physical; having failed to experience a cure, the patient is unlikely to return to the out-patient clinic, but will continue with his round of private doctors if he has enough money to pay for the coveted injection. Neurotic conditions are hardly likely to be diagnosed by a doctor who has to see a hundred patients in a morning, as they file past in a line, many receiving aspirins and a purge, particularly when the doctor may have had no training whatsoever in psychiatry. Many symptoms are much more worrying to the patient than the doctor often realises, and attempts should be made to reassure patients about them. There is the fear that dizziness may lead to epilepsy, that a mild skin disease may turn into leprosy, that a persistent cough is tuberculosis or that a persistent headache is spoiling the brain. The consequent anxiety may aggravate the symptoms further so leading to severe neurotic disorder of a hypochondriacal nature.

The doctor should also be in a position to understand what has been happening to the patient before he sees him. People with epilepsy may delay many years before coming for attention because it is widely held that there is no "western" treatment for this condition. Similarly, cases of mental depression may drag on for a

long time before being brought to a Government clinic. In fact it may be more important to ask why they have come at a particular time than to ask why they have delayed, since it may give some idea of precipitating changes that are taking place in the family or in the patient's condition. Similarly, it is rare for parents to say that their children have epilepsy, if there is the least excuse for thinking it is another illness. Thus when a father brought his daughter to a clinic, insisting that she had epilepsy, when in fact she was having fits of a kind that lacked several of the features that the Baganda think typical, then I was alerted to the possibility of a deeper disorder in the relationship between father and daughter.

Doctors must also be aware of the expectations that patients have about treatment. As Giel (1968) has also remarked, in Ethiopia, the villagers expect a once and for all *cure* for epilepsy by their own traditional methods of treatment, and are disappointed to find that the illness is not cured by one all-powerful injection. In cases of recent onset, the search for traditional cures will continue and it is disheartening to see hundreds of shillings being spent on traditional healers just because "western" medicine requires to be taken indefinitely. If however the patient or his family can be encouraged to try treatment for a period of time sufficient to see whether or not it works, then they can learn by trial and error which treatment is the more effective.

In one case studied, the parents of a girl whom I had started to treat for epilepsy became anxious to take her to traditional doctors in order to obtain a complete cure. They cited two instances of cases having been cured outright. I traced one of them, only to find that she was in fact being treated by myself!

If one has some idea of the beliefs about an illness it is possible at times to modify them somewhat and to create new beliefs that may be more beneficial to the patient. This is obviously a complex matter and only suggestions can be given. *Akawango,* a persistent headache, may be thought by the patient to be spoiling his brain and the anxiety resulting from such a belief can make things even worse. The name of the illness however is derived from *ekiwanga,* meaning "the skull", and it is possible, while also giving medication, to explain to the patient that the illness is in the bone of the head only, and not in the brain. Similarly, emotional disorders can be attributed to the heart and the brain absolved. Such

beliefs rely on the fact that all Baganda nowadays seem to accept the primacy of the brain and are relieved to hear that it is not being spoilt.

A more dubious procedure, which I have used successfully in cases of epilepsy, is to tell the relatives of a patient that the tablets prevent the illness spreading to others, and so the patient need no longer be isolated. When it is seen that the tablets do in fact prevent fits as forecast, then the assumption is that the statement about the illness being no longer infectious is also true. This particular approach may be thought to be of doubtful value, since it does seem to indicate that epilepsy is sometimes infectious, but in the present situation some such compromise with the truth might well reduce the incidence of disastrous practices such as enforced isolation of the epileptic.

Problems of therapy and rehabilitation

It is important to bear in mind two very strong but pernicious beliefs entertained by the Baganda which it is necessary to counter. The first is that all violent individuals or those liable to violence, must be locked away in a custodial environment. The second is that in many conditions the patient's brain is "spoilt" and therefore the patient is not susceptible to control or cure and consequently is not worth bothering about; many think that these patients should also be locked away. A doctor or police officer must therefore be on his guard against giving way too easily to demands that a patient "must go to mental hospital". At the moment, when the alternative is that the patient will receive no treatment at all, it is not so important perhaps to deter these admissions, but as the psychiatric service develops it will become possible to keep more of these patients in the community and this is when conflicts will begin to arise.

Since violence is, in fact, the main symptom at present leading to hospital admission, once this symptom has been controlled the pressure is much reduced. Fortunately, this very symptom is one most susceptible to control by the use of certain tranquillizers (the phenothiazines). These usually produce drowsiness at the start of the therapy, but families do not seem to mind this, therefore it would seem preferable to give large doses and initially oversedate the patient, rather than to err on the side of too little medication with the patient remaining unacceptably violent.

One part of this study involved interviewing families who had brought a relative for treatment to the out-patient department of the mental hospital. I came across an old woman whose children had brought her because she was excited. She had been given an injection of a phenothiazine tranquillizer before being sent on to the mental hospital. By the time I saw her she had already become calm and the relatives wanted to take her home since they were fortunate in having a car. There seemed no good reason for forbidding this, since the medication could easily have been continued in tablet form, except that because of pressure of work the doctor had not had time to discuss this point with them!

It is distressing to come across people for whom relatives have given up all hope and where case workers are struggling with the enormous problem of persuading the family to accept back someone whom they consider to have a "spoilt" brain. As I have indicated, this is a label that is all too often applied. In many cases the efforts required to change such attitudes and the supervision needed to maintain better ones (especially when hostility has developed between the patient and his relatives), are too much to expect from an overworked social service. An alternative might be to find other relatives living elsewhere who might be prepared to start afresh with the patient without prejudging the issue. It must be emphasised that relatives must be found who really will make an effort in helping. In many cases this change from one part of the family to another occurs without any intervention from the case worker, but it may be necessary for the worker to try to persuade one part of the family to think of themselves as particularly responsible.

The next task is to get relatives to help in encouraging the patient to take part in work about the home. In addition, someone in the family should be encouraged to discuss possible reasons for deviant behaviour when it occurs, something which villagers always seem to try to avoid. The aim should be not only to improve the image that the relatives have of the patient, but also to improve the image that the patient has of himself. All too often patients seem quite demoralised and become resigned to their lot of having a "spoilt brain". With children in particular the family need to realise that they should encourage progress and openly express appreciation for help given.

With occupational rehabilitation, many Western standards

have to be modified. In the fertile parts of Uganda, a man working only two hours per day is quite capable of supporting himself. A woman might have to work a little more but could probably get help from others. A person working this amount is not considered lazy by others. Problems of rehabilitating a patient to this occupational level do not seem to be formidable and should be quite easily achieved.

Problems of administration and medical service planning

In "Medical Care in Developing Countries", edited by Maurice King (1966), chapters 2 and 12 emphasise the need for decentralisation of medical services since it is recognised that patients will not usually be able to travel long distances for hospital attention. This is of particular importance to mental patients, not only because early treatment is important (as in other forms of illness), but also because mental illness, if not always a result of poor family relationships, usually has a serious effect upon them once it occurs.

Many of these serious effects can be prevented if the relatives can have close contact with the doctor, and if patients can maintain close links with home. It is difficult to retain these links if the catchment population is more than thirty miles away from the treatment service. Bearing in mind also that many mental illnesses and epilepsies require medication over very long periods of time, then it is impossible to provide proper maintenance treatment if the patient has to travel even as little as 30 miles every month to fetch medication. For a patient and one relative such a return journey would cost at least 12/- by bus, and in the case of an epileptic on treatment with phenobarbitone (admittedly ridiculously cheap), this would be to fetch less than a shilling's worth of medicine, even when on a high dose. It therefore becomes necessary to give such patients a relatively large quantity of drugs to ensure that they begin to see benefit from treatment and become motivated to return for more.

Even the initial bus journey is impracticable if there is a danger of a fit occurring during it, since the shame it would bring is too great for most relatives to risk. In new cases, living in outlying areas, the cost of private transport is usually prohibitive. Severely disturbed patients may be transported to hospital by the police (at the tax-payer's expense), but if police transport is not

immediately available, the unfortunate patient may be locked up in a cell for a week or more. If relatives will not involve the police, the only alternative is to hire a car, at enormous expense, because a "mad man" just cannot go by public transport. Involving the police in the care of mental patients is not necessarily bad, for although it may tend to stigmatise mental patients, it can also help towards the police being seen as a type of social worker (which is after all what they are).

Work is already in progress in Uganda aimed at developing psychiatric facilities (staffed by a psychiatrist) in up-country general hospitals and this is a welcome step in decentralisation. The majority of patients could be accommodated as self-care patients (King, op. cit. chapter 9) since quite often hospital admission is not necessary.

Self-care accommodation can be very cheap. This is well illustrated by Aro Village in Nigeria where patients, accompanied by a relative, rent rooms and attend a day hospital situated in the village (King, op. cit. chapter 20). The presence of the relatives is emphasised since it is they who will be responsible for the continuation at home of the work started at Aro. Aro however lacks adequate follow-up facilities because its patients tend to be drawn from a very wide area. This need could be met by having larger numbers of smaller units spread throughout the country.

Apart from their medical or professional paramedical staff such units need to include what might be best described as a Community Nurse or Public Mental Health Nurse (a term derived from King, op. cit. chapter 3). There is a shortage of all cadres of trained social workers in developing countries, and it is being unrealistically optimistic to hope for a fully fledged social work service. Uganda at the moment has about 60 probation officers, some unfortunately with virtually no training. But they constitute a form of social service which is spread over the country and is already in existence and efforts must be made to ensure that the decentralised psychiatric service is integrated with the probation service.

At the moment there is a training school for Health Visitors in Uganda, and it is hoped that in the future a few nurses with mental hospital experience will pass through this school every year, and these will then be in a position to act as Public Mental Health Nurses.

These proposed auxiliaries would have many functions. They would be able to investigate the home background of cases and to supervise the patient on his return home. In cases where medication needs to be continued over long periods, they can ensure that the relatives understand the importance of this, and that they do not allow the medicine to run out. It has been found that many families can tolerate a mentally disturbed member, provided that they can call on a trained person for help, and can feel that they are being supported by someone who understands their difficulties. When friction occurs between patient and family, this can often be settled as it arises, and the family can benefit from the social worker's instruction, using the particular situation as an object lesson. In this way families can learn that persuasion and gentle words can often be just as effective as any amount of medication, and certainly more effective than violence or rejection. Such workers would be sufficiently mobile for this kind of work given a small motorcycle.

The job of mental health education is always hard. For every one success story told there may be several failures evident to all; added to which there are always plenty of lurid myths and rumours to dispel.

Apart from dealing with those patients who have a known family background, there are also many chronic cases in mental hospital and vagrant psychotics in the towns. A substantial number of these have lost all contact with their families. They may, for instance, derive from groups of migrant labourers from other countries who have fallen ill and have no relatives to return to. Others may have deteriorated so much in their home that it is felt that they need to be removed.

In developing, predominantly agricultural, countries, it is considered an exceptional achievement to get a training, let alone a job, in some technical occupation, and so it is hardly realistic to think in terms of extensive industrial rehabilitation. Farming however is ideally suited to rehabilitation, and if an area is chosen which is more than usually fertile, even the smallest efforts can bring some reward — an important principle in rehabilitative techniques. The choice is between having a new village built to house patients working on a special farm or for the patients to be settled in already existing villages and farms (or both, with the first as a half-way step to the second). Aro Village for instance

has arranged with neighbouring farms to employ such people as labourers (King, op. cit. chapter 20:5).

At the moment some regional rehabilitation centres are in operation in Uganda and many more are planned. The rehabilitation takes place in the context of agricultural instruction and work. Sewing, leather-work and village crafts are also taught as well as citizenship. The plan is to have rehabilitation officers at the local level throughout Uganda who would be responsible for supporting and supervising the patients on their return home or during the initial stages of resettlement. Their main work at present is in helping the physically handicapped but as psychiatric services also become available near these centres, they will also be able to take some of the mentally disabled. For children, various specialised institutions such as schools for the mentally backward, the blind and the deaf, as well as approved schools are needed, but the development of these must await the development of enough ordinary schools for the general population since their need is equally great if not greater.

Governments are always under pressure from voters to provide prestige hospitals instead of more scattered systems of health centres, which may, however, serve a country better. It needs a strong government to resist such pressures, although such decentralised rehabilitation schemes and psychiatric services are not very expensive projects.

Some mention should be made of the interesting problems involved in making use of traditional healers in psychiatric practice. There certainly seems no need to oppose these practices unless they seem to be interfering markedly with the patient's health, but in view of the fact that they may take much of the patient's money it is as well to have some idea of how to advise them. Some of the enthusiasm for advocating this practice derives from an extension of the "noble savage" myth. Having discovered that, after all, both psychoses and neuroses exist in primitive society, psychiatrists who still wish to see traditional African life as some sort of ideal, are only left with the possibility that "primitive" methods may contain the secret of treating these conditions.

To assess the efficacy of these methods is extremely difficult because it is known that a large proportion of people are 'placebo responders' — that is, they feel better after being given any

medicine, even quite inert preparations. People attending ceremonies have paid a lot of money, and many have collected a lot of relatives together to attend, and although it may be considered that this will encourage a realignment within the family, so removing possible aggravating relationships, it also means that the patient is under considerable obligation to indicate that all the effort has achieved something and to say that he feels better. Although in many cases such healers are very much part of the local culture and can therefore help people accordingly, it should nevertheless be remembered that it is by no means uncommon in Africa for traditional doctors to be called in from other tribes. Most traditional doctors for their part think nothing of working outside their own culture. In this way also, western doctors are accepted, not as anything peculiar, but just as another of these doctors from 'outside'. There is no sense of these being opposed systems of medicine, it is just a matter of trying different medicines until one is effective.

There is certainly a need to investigate some of these traditional practices, and in particular perhaps, the use of possession states in treating those with various hysterical manifestations. Until such work is done it might be better for the psychiatrist to remain strictly neutral. A visit to traditional shrines may have little more value for the patient than visiting health spas in Europe.

Where these practices however are seen to impose a heavy financial burden on the participants or involve obvious cruelty some may not feel able to stand idly by. It seems fashionable in some quarters in these days to talk of incorporating traditional healers into psychiatric practice. It is necessary to distinguish clearly between on the one hand an activity which is a useful psycho-therapeutic outlet within a culture and on the other, psychiatric practice. Thus in Europe the psychotherapeutic benefits derived from church attendance, or visits to the local pub, bar or cafe are well recognised. No attempts are made however, to integrate these activities into psychiatric practice, nor to recognise the priest, publican or patron as a psychiatric colleague.

Research

Any attempt at research in the social psychiatric field must be accompanied by a good knowledge of the cultural background of the population to be studied. It is no good basing claims for the absence of a particular illness in a population on the fact that

this illness is not found in hospital. As has been pointed out, it tends to be the excited patient who goes to mental hospital, but the quiet, depressed ones are more likely to stay sitting at home. Similarly, while epilepsy is considered to be a local illness for which no western medicine is available, one can hardly assess its prevalence on the basis of hospital attendance figures. In attempting to calculate suicide rates, one has to know the extent to which such a death will be hidden or called accidental because of shame. It is for example, far easier to claim death from other causes in cases where poison has been used than in cases where the person concerned has hanged himself. Prevalence rates will also be lowered for instance in epilepsy, because death may occur at an early age as a result of isolation and neglect. Even if field studies are carried out on the prevalence of epilepsy, it is not enough to go around asking who has *"ensimbu"*, since often it is given another name because the symptoms are slightly atypical.

Symptom patterns are very interesting and although this has been hardly dealt with in the text, they will provide a good deal of material for future research. It is only after looking beyond hospital populations that one can begin to see whether certain illnesses or symptoms are present or absent in a community. The most striking feature to emerge at present is the general similarity of symptom patterns to those found amongst Europeans. There are interesting exceptions — for instance, in Uganda, it would seem that guilt feelings rarely accompany a depressive illness and that obsessional neuroses are very rare. The relationship between these two observations, if any, and that between other symptom patterns should be investigated within a community and also cross culturally. The problem of the phenomenology of the mentally disturbed outside Europe has hardly been tackled and awaits investigation.

I ought perhaps to close with a reminder that the Baganda can hardly be regarded as a 'primitive tribe'. There has been over 80 years of contact with western teaching and culture. The literacy rate is high and the majority of the population has some schooling. This work describes principally the Baganda, with only occasional reference to neighbouring peoples. Some of the information may be applicable to other areas of Africa, if not the whole of Africa. It is hoped that this work will at least stimulate research efforts amongst other peoples to see to what extent the situation is comparable.

NOTES

Note 1 — My 16 month stay in Uganda was financed by the Nuffield Foundation, London, to whom I am indebted. I would also like to express my thanks to Professor G. A. German for his great help in the preparation of this paper and to Mrs. L. Coelho of the Department of Psychiatry, Makerere University College for her untiring assistance with the typing.

Note 2 — For those unaccustomed to the Bantu languages it should be pointed out that the root — ganda is used for things pertaining to the Baganda. Thus the land is Buganda, the language Luganda, a thing is Kiganda and the people are Baganda. One person is a Muganda.

Note 3 — Since the publication of Edgerton's paper there have been a few more works of note. There is in particular Fortes and Mayer (1966) from West Africa and papers by Aall-Jilek (1965) and Jilek and Aall-Jilek (1967) from East Africa. The latter paper contains a few comments on ideas of causation amongst the Wapogoro, but they ". . . do not possess a concept of mental disease. They have, however, a fairly clear notion of what constitutes a deviation from culturally accepted patterns". (*ibid.* p. 208). They also give six illustrative case histories and some Rorschah responses.

Note 4 — The noun *ensaalwa* from *okusaalirwa* is given in the dictionary as envy or jealousy, but I have only come across its use as grief.

Note 5 — I have tried in an appendix to give a very rough guide to one of the western medical classifications of these disorders. I have throughout used "western" to refer to the European tradition of medical practice and "traditional" for the African tradition. I shall use the word "patient" in most instances to refer to the subjects described in this paper, rather than the word "client" used by social workers.

Note 6 — The actual word, *okulwala,* like the English, "to be ill", is seldom used to describe a particular part of the body directly. A person is said to be ill, followed by the name of the part affected e.g. *alwadde amaaso*, he is ill, eyes; rather than his eyes are ill.

Note 7 — This seems to be what Carothers (1953, p. 156) has called "frenzied anxiety". Fortes (1966) has described the symptom of running away into the bush as one that is particularly noted by the Tallensi. Lambo (1965) has also noted that anxiety seems to be a particularly marked symptom in many cases of "schizophrenia" in Nigeria.

Note 8 — A depressive illness with a nihilistic delusion centered on the *emmeme*.

Note 9 — Roscoe (1911, p. 102) says that *amakiro*, affecting children, either of whose parents had committed adultery during pregnancy or nursing, was thought to bring nausea and general debility until the guilty had confessed. He does not mention that it affects the mother, but elsewhere (p. 262), although he does not mention the name *amakiro*, he states that adultery by a woman in pregnancy caused either her death or that of the child at the time of the birth; or "she would have a tendency to devour her child, and would have to be guarded, lest she should kill it". Bennett (1963) classes *amakiro* and *ebigere* as two separate puerperal illnesses, the latter being milder. It is perhaps that the euphemism is used for a milder form of illness.

The idea of confession producing a cure, and that when failure results this is due to the withholding of information, closely parallels an explanation sometimes given by psychoanalysts for failure, when they state that they have not got down to the real (but in this case, unconscious) reason for the symptom.

Note 10 — Bennett (1963, p. 155) states that this is a symptom of another related illness called *kigalanga* when it occurs in children. Some of my informants agreed that it could be brought by a ghost (*muzimu*) which is the agency bringing *kigalanga*, but the great majority thought it was a typical symptom of *eyabwe*.

Note 11 — Bennett (1963, p. 157) also noted this. Roscoe (1911, p. 101) says that *nyonyi* was a swelling in the side of an infant caused by the mother eating forbidden food during pregnancy. He almost certainly confused the name with that of another illness. Aall-Jilek (1965) says that the Wapogoro believe certain birds should not be killed, especially the fish eagle, because it circles and then drops to the earth like an epileptic in an attack.

Note 12 — In some cases of epilepsy the fit is preceded by symptoms which are usually referred to as an "aura" in English.

Not infrequently these symptoms involve the stomach. If the sensations follow a definite pattern each time, they may be indicative of temporal lobe epilepsy.

Note 13 — Bennett (1963, p. 151) suggests that *omutezi* (*sic*) usually affects one side only and is probably migraine, but I only found one case in which this was even a possibility.

Note 14 — It is of interest to compare the situation amongst the Baganda with that reported from elsewhere. Carstairs reports in "Twice Born" (1957) that amongst the Indians the semen is thought of as particularly potent and a man will therefore become strong spiritually as well as physically if he refrains from intercourse. Nocturnal emisions of the semen are worrying for Indians, and represent a loss of strength. Le Vine (in Whiting 1963, p. 66) describes frequency of intercourse as being a measure of potency amongst the Gusii of Kenya, at least on the first night of marriage. Margetts (1960, pp. 105-8) reports the unusual observation that amongst the Samburu of Kenya five informants stated that the subincision of the urethra practised amongst the men was done in order to make them ejaculate more quickly during sexual intercourse. The men of the Tembu of South Africa (Laubscher 1937, p. 77) are concerned to attain orgasm as quickly as possible during coitus.

Amongst the Baganda the sexual need of women is well recognised by men. The 29 men mentioned at the beginning of the paper were asked if it would be right to excuse their wives if they slept with other men if they themselves had to go to prison for a year. Of the 29 only 3 said that it was not right.

Note 15 — Southwold (1959, p. 45) also found this. He says that although one reads of such illnesses in the literature, "I never heard of a specific case of anyone with the disease, and when I approached it from the other end, by asking what would happen if anyone did break the taboo, people were pretty sceptical whether anything would." He says also (p. 46) "People will tell you that *buko* is an illness that people get through committing incest, but when you ask what happens to a man who commits incest and is not prosecuted they will say "nothing"."

Note 16 — Mair (1934, p. 269) implicitly confirms this division of the *balubaale* in quoting a 'prophet' who called upon them "all of you, all of you *lubaale*, everyone, of the lake and the dry land, of

Bunyoro and Kiziba and Ankole, all of you come and see our friend, this stranger".

Note 17 — Kagwa (1934, p. 126) mentions some of the greatest 'horns' which were nationally respected. The rather vague distinction between *balubaale* and *mayembe* is reflected by Kagwa's remark at one point (1952, p. 44) that Juma inherited the *mayembe* from his father, Tebandeke, whereas elsewhere he refers to *balubaale* in this context. Bennett (1963, p. 155) says that the *mayembe* are invisible magic horns sent to attack people. He agrees however, that this should not read like that and in fact people are quite explicit about the distinction between the material and visible container and the invisible spirit which usually resides in it but may leave it at times.

Note 18 — Welbourn (1962) has suggested that the *misambwa* were suppressed in order to emphasise the position of the Kabaka viz-a-viz the clan heads. I think this same process tended to emphasise the godlike position of the Kabakas which has been accepted by the early commentators centred at the court, so that the difference between the *balubaale* from the lake and the Princes is not emphasised. It is unlikely that this view of the Kabaka was universally held at village level and several informants told me that the Princes were inferior and were merely ghosts. This probably explains why the literature is full of contradictions over this point.

Note 19 — The stories surrounding such people, who are still generally believed in (and for all I know they may really exist) are just as lurid in these days as they were at the turn of the century, as reported by Sir Harry Johnston (1902, Vol. 2, p. 692-3). The whole question of whether a person is responsible for his actions when being influenced by a spirit poses difficult theological problems. Laubscher (1937, p. 27) notes that the Tembu elders maintain that certain spirits which indulge in a sexual relationship with women ". . . will only go to women if there is some desire for them in their hearts . . ."

Note 20 — Mair (op. cit. p. 238-240) states that some informants thought that there was a period of instruction for doctors, but "Many people firmly believe that the prophets required no human instruction whatever, but simply prescribed on each occasion as commanded by the *lubaale*".

Note 21 — Nsimbi (1956, p. 120) states that one of the names for mediums is *abakongozzi*. This is the name of a servant who carries

his master or mistress on his shoulders, particularly one of the Kabakas, Princes and Princesses. It therefore conveys the notion of the medium being a servant of the *lubaale*. Verbs ending in *-ira* as in *okusamira* tend to be used for doing something for someone.

Note 22 — Such cults have been described in neighbouring Ankole. If satisfaction is not obtained after initiation into one cult then another will be tried (Bamunoba and Welbourne, 1965). Similarly Beattie (1961) has described cults amongst the Banyoro, in which the members maintain close association with each other. This type of organization is not found amongst the Baganda.

Note 23 — I myself have observed Namalere's strange habit but it is also mentioned by Roscoe (1911, p. 317) Kagwa (1934, p.122) and Nsimbi (1956, p. 142). Roscoe (1911, p. 341) mentions the connection between fire and Mukasa only in relation to ordeals. "Another less popular test was to use a heated piece of iron or the blade of a hoe, this was termed Mukasa's test. Sometimes the priest would make the disputants sit down, and would pass the hot iron down each man's leg, from the knee to the foot; then the man who was burnt was considered guilty". Kagwa (1952, p. 46) mentions that Kabaka Tebandeke, who was possessed by Mukasa, practised the habit of licking red hot metal. Ndaula said "I have only inherited the kingship and not the *lubaale*. Bring Juma and let him inherit the old hoes upon which his father Tebandeke used to burn himself". (This passage is not in the translation). The word *ensimu* is used, meaning worn out of hoes of the old pattern which are heated in the fire and then licked. The diminutive *akasimu* is applied to a kind of knife used in the same way.)

Note 24 — Roscoe (op. cit. p. 54) "The afterbirth was called the second child and was believed to have a spirit, which became at once a ghost". I did not find this to be explicit belief today, but on direct questioning most people supposed it must be so because the *lubuga* was required to inherit from it at the ceremony of inheritance (*okwabya olumbe*). Roscoe mentions the *lubuga* but I have never seen reference in the literature to her connection with the afterbirth. She is usually said to represent the wife of the heir even in cases where the heir is a woman, and Roscoe refers to her as the "queen" during the ceremony of accession of the Kabaka, but states that she was the sister of the King (op. cit p. 187).

Note 25 — Roscoe (1911, p. 100) states that "Pthisis" (presumably Roscoe means *akafuba*) "was always said to be caused by the ghost of some ancestor who had died of the complaint, and unless the ghost could be propitiated, it would kill the patient". Ghosts (*mizimu*) tend to be limited to their own family relations who are closer than the clan as a whole.

Note 26 — One of the Nyoro *mbandwa* spirits is called Kifaru, referring in particular to the extended meaning of a military tank. Beattie (1967, p. 30) ". . . Kifaru is not the ghost or manifestation of any particular tank, but rather the essence of all tanks, 'tankness', with all the formidability and power that this implies". This particular spirit, however, appears to have no connection with magical horns (*mahembe*).

Note 27 — Mair (1934, p. 226). An account of the capturing of *mizimu* by causing the patient to vomit them into a gourd is given by Kagwa (1934, p. 126). Ssekamwa (1967, p. 37) also describes a case of the capture of *mayembe*.

The involuntary shivering which comes with fever may be interpreted as *empewo* which means a cold wind and so by extension a ghost. Dr. J. Bennett tells me that the word is also used occasionally for cases of kwashiorkor in infants. The Baganda recognise that this comes following the weaning of the child. The body swells and because of this the skin feels cold so that it is thought that the illness is due to the child getting cold at night now that it is separated from the mother. The word *empewo* in this context merely means that the child gets cold and does not refer to the extended meaning of a ghost. The illness is properly known as *obwosi* and also as *omusana*, the sun, because the stretched pale skin shines like the sun.

Note 28 — It must be emphasised that ideas of causation are vague and it is impossible to draw up an ordered system. Ssekamwa (1967, p. 35) gives an account of a man who was affected by *mayembe ag'ekifalu* who went mad. He got better in a few days in Butabika Hospital but relapsed on discharge.

Note 29 — Admissions to Butabika Hospital for the year:

1965/66	Male 1402	Female 712
1966/67	Male 1552	Female 762

Types of admission	*October 1967*		*April 1968*	
	Males	*Females*	*Males*	*Females*
Under Urgency Order from Police	75	20	71	30
Mulago Hospital & Out-patients	22	21	24	29
Under Detention Orders by Magistrates	21	9	4	3
Voluntary	7	6	8	7
Under Urgency Order from hospitals	19	7	5	1
Brought by relatives	1	2	0	4
Total	145	65	112	74

Note 30 — These people would probably be best described as having psychogenic psychoses.

Note 31 — The woman had a long history of frequent headaches and irritability. It was thought that she might have had a chronic organic illness, but all investigations while in hospital proved negative. She was discharged with the frequently used diagnosis of "Acute psychotic episode — possibly organic in origin". I am very hesitant in drawing conclusions from one case but it can be noted that on the occasion when I treated her at home she was better in two weeks, whereas she remained in the mental hospital for six weeks. I discuss later the desirability of not removing patients from their homes.

Note 32 — I have never heard of a case of a *lubaale* possessing an animal. It was probably used loosely here to mean *musambwa* since at another place in talking about this episode "I was assured that the transmigration of the *Muzimu*, the restless spirit, into a person was unusual, that usually they lodged in animals, trees or stones". This is further indication of the loose way these names for spirits are used (e.g. Note 17). I would think that had Robertson asked directly if they "really" meant *musambwa* they would have agreed.

Note 33 — Yap (1965, p. 96) has made a similar suggestion regarding the observation of a relatively high frequency of mania amongst Chinese.

Note 34 — On a brief visit to Eastern Uganda, I was told that the Karamojong did not believe epilepsy to be contagious. It should be remembered that it is *ensimbu*, the *grand mal* form of epilepsy, that is considered contagious by the Baganda. It is not surprising that Billington (1968, p. 565) found that a patient with *petit mal* was not stigmatised. He had not got *ensimbu.*

Note 35 — Bohannan (1963) reports on four tribes in Uganda, including the Basoga and Banyoro who are neighbours of the Baganda. Both share the abhorrence for suicide with the Baganda and treat it in similar ways. In Busoga out of 100 cases 20% were said to be due to chronic illness, excluding insanity and impotence, and the number is even greater amongst the Gisu. Amongst the Basoga there were 10% who committed suicide after killing a spouse and another 3% had attacked a spouse without killing. Amongst the Banyoro 3 out of 36 men who committed suicide had first killed their wife.

Note 36 — Of the 29 men who answered the questionnaire, 24 said that no one should inherit from someone who had committed suicide. No one would normally inherit from a man or woman before they had married unless the dead person had already inherited from someone. Mair (1934, p. 210) says an unmarried man might have an heir if he owned a plot. It would in fact be rare for an unmarried man to own a plot without having inherited it.

Note 37 — There is a Luganda proverb quoted in Snoxall's 1967 dictionary under *Kweyagaalula. "Weeyagaagula ng'ow'ensimbu atabaala.* You risk yourself like an epileptic who goes to war (because if he were to fall into a fit during battle he would be at the mercy of an enemy)." The 29 men mentioned earlier were asked some questions relating to epilepsy. All 29 men said that it was good to keep epileptics well separated. 18 said that no one should inherit from someone who had had epilepsy.

Note 38 — It is worth noting that the actual cost of the medicine may be very low. The safest and most effective medicine used in this illness is phenobarbitone which costs the Government about 5/- or less for a year's supply for one patient.

Note 39 — Jiggers in the feet, if not removed, are thought to lead to foolishness by weakening the blood. The connection no doubt exists, but jiggers occur due to neglect.

Note 40 — A paediatrician who has worked amongst the Baganda

has said that the Baganda exchange children in the way that the English exchange Christmas cards.

Note 41 — The relatively high frequency of physical symptoms and hypochondriasis amongst the psychiatrically ill in many parts of Africa and Asia has been noted by many authors.

Note 42 — On the other hand Margetts (1965) a psychiatrist who has worked in Africa, tends to emphasise the constitutional and genetic aspects and the essential similarities between Europe and Africa.

APPENDIX 'A'

Western Medical Diagnostic Categories of Epilepsy

Epilepsy is an illness that occurs in all parts of the world. There are several types of epilepsy known and all are associated with certain changes in the electrical activity within the brain. This is accompanied by disorders in behaviour and sometimes in sensation. The disordered behaviour is known as a fit or seizure and in any one patient usually follows a very similar pattern each time it occurs. Between fits the patient is usually normal.

The principal varieties of epilepsy are known as:

1. *Grand mal* seizures
2. Focal seizures e.g. Jacksonian seizures and Temporal lobe seizures.
3. *Petit mal* seizures.

The disturbed electrical activity may spread from a small part of the brain that has become damaged. Although electrical recordings from the head can indicate that there is disordered activity, in most cases it is not known why it has arisen. In a few cases it comes as a result of a small scar following infection of the brain or trauma to the head.

Grand mal. This is the most common form of epilepsy. When the seizure occurs the patient falls to the ground unconscious with little or no warning. After a short interval his arms and legs start shaking. He may urinate, froth at the mouth and bite his tongue so that blood is seen mixed with the froth. The shaking may last just a minute or two or may continue for a quarter of an hour or more. Following this fit the patient usually sleeps heavily for up to half an hour and on waking may have a headache which will last for a day or so. In the hour or two following the fit the patient may behave strangely.

Jacksonian seizures. These usually begin with a twitching of the hand, foot or side of the face. The patient remains conscious.

The twitching may slowly spread to involve other parts of the body and may eventually spread to the whole body. The patient may then become unconscious so that the fit is now indistinguishable from a *grand mal* seizure.

Temporal Lobe Epilepsy. This form of epilepsy is characterised by recurrent sensations, hallucinations, or forms of behaviour more complicated than that in Jacksonian seizures, but which nevertheless follow a similar pattern each time they occur. In this way they differ from other forms of mental disturbance. In some cases, as with Jacksonian seizures, it may proceed to a *grand mal* fit. This type of seizure should not be confused with the behaviour disturbance that occurs after an epileptic fit. It is however, very difficult to be certain of the diagnosis of temporal lobe epilepsy without the use of expensive equipment.

The seizures in these three types mentioned may occur as often as several times a day or as seldom as a few times a year. Sometimes several may occur within a day or two and then none for a period of weeks or months. When the fits take place once or twice a month, their occurrence is often said to relate to the phases of the moon. It is usually only seizures of the *grand mal* type that are given the name which is translated 'epilepsy' in less sophisticated circles. The other two types mentioned will usually only be called this if they sometimes do proceed to a *grand mal* seizure.

Petit mal. This appears to be quite different from the other forms. The patient has periodic absences lasting from a few seconds up to a minute or more. These may occur many times a day and during them the patient does not fall down but may stare ahead, often with eyelids flickering. They are not followed by any mental disturbance.

Status epilepticus. Very rarely a patient with epilepsy may begin to have fits so frequently that he never recovers consciousness between them and may shake his body almost continuously. This is a dangerous state of affairs and may be confused with the later stages of tetanus or meningitis, in which the patient's body becomes stiff, with the head arched back. In these latter, however, there will have been no history of epilepsy.

Heredity. There is a chance of about one in forty of a child having epilepsy if one parent has it. This increases to one in seven

if both parents have it. There is therefore no reason for a person with epilepsy not to have children, but it is inadvisable for two people with the disease to marry.

Febrile convulsions. During high fevers in young children, a fit may occur which is indistinguishable from a *grand mal* seizure. In most cases these are isolated and never recur, but occasionally it is followed by recurrent fits and it is presumed that the child was predisposed to epilepsy and the fever caused the disease to manifest itself. Infections of the brain (e.g. meningitis or encephalitis) may cause a prolonged high fever lasting a week or two or even longer. The subsequent brain damage may cause epilepsy and it is sometimes difficult to distinguish this from epilepsy which merely first manifests itself during a fever.

Hysterical fits. A patient sometimes presents with a story of episodes that at first sound as if they are epileptic fits. They do not however have the typical electrical disturbances in the brain nor do they usually respond to the medication used in treating epilepsy. Such people do not become unconscious and therefore rarely hurt themselves, nor are they likely to urinate during a fit. They are very unlikely to get burnt by falling in a fire as so often happens to true epileptics in village communities. It is said that such people are unconsciously motivated to have fits for some psychological gain. These fits may be extremely difficult to distinguish from temporal lobe epilepsy.

What to do for someone having a fit

The most important thing is to prevent the patient hurting himself by rolling into a fire or hitting hard objects. He should therefore be lightly restrained. It is sometimes said that something should be placed between the teeth to prevent the tongue being bitten. Biting of the tongue does little harm and the dangers involved in trying to force something into the mouth outweigh any advantages for anyone but the experienced in attempting it. Do not be afraid to touch the patient. Epilepsy is not infectious and there is no danger if the saliva or any other secretion gets onto or into another person.

Treatment

Epileptic fits can usually be prevented by taking tablets every day. There is no once-and-for-all cure. Even in those cases in

whom the tablets have prevented fits for several years the fits will recur if the medicine is stopped. It has not been found possible to remove that part of the brain in which the abnormal electrical activity is initiated.

There is no reason why someone with epilepsy cannot lead a normal life (except that he should avoid places in which a fit would be dangerous to himself and others) and this is so even if the patient is not under treatment. Providing that the fits do not occur very frequently or continue for long periods then mental impairment will not occur, but there is sometimes a tendency for the patient to become angered easily.

For those few cases in whom epilepsy was brought by severe brain damage, then this damage may have also caused some intellectual impairment.

APPENDIX 'B'

Western Diagnostic Categories of "Madness"

The excited, often violent patient whom the Baganda would call *eddalu* may fall into one of four categories.

1. **Confusional states.** These are associated with some physical illness such as pneumonia or malaria, or with the ingestion of some toxic substance such as Indian hemp or alcohol. This category may include those whose condition is associated with epilepsy. Once the physical illness is cured or the toxic substance is removed from the body, then the patient quite quickly becomes his normal self again.

2. **Mania.** This is sometimes part of a manic-depressive illness in which at times the patient is overactive, excited, talking excessively and sometimes unduly generous (manic), whilst at other times he may be slowed down, dull and despondent (depressed). Once the mania has passed the patient may be perfectly well but there is always the strong possibility of recurrence. On the other hand there may be a swing from excitement to depression.

3. **Schizophrenia.** These patients may get excited at times, but even when not excited they tend to behave strangely and seem unable to communicate with others normally. The symptoms usually respond well to medication but in the absence of treatment the patient's condition may slowly deteriorate.

4. **Psychogenic Psychoses.** In such an illness the patient tends to react to situations in the environment by behaving madly. It differs from schizophrenia in that the behaviour tends to be coloured by the causative stress and the symptomatology does not take a typical form. The patient becomes quite well again when the stresses are removed or enough time has elapsed to allow the patient to adapt to the situation. Some of these cases are essentially hysterical in origin. The diagnosis is not altogether satisfactory since precipitating events may be found in schizophrenia or mania.

Psychiatrists working in Africa have noted that in comparison with Europe there is a higher incidence of acute psychotic episodes

(excited madness) between which the patient is quite normal. This would not be expected in schizophrenia. It has been suggested therefore that these might really be confusional states or psychogenic psychoses. Others have talked of this being an "African" schizophrenia different in form from that in Europe because of the different upbringing of children, the different social situation or different constitutional factors.

Just as mania may occur without depression, so depression may occur by itself. Sometimes this may be seen as an obvious reaction to a particular situation or event whilst at others no reason for it can be seen. The characteristic symptoms are weakness and lethargy, sadness, feelings of emptiness and thoughts of the futility of life. Such patients may be tempted to commit suicide.

APPENDIX 'C'

A Guide for Investigation of Beliefs About Epilepsy

My enquiries into beliefs about epilepsy amongst other people in Africa besides the Baganda, has prompted me to suggest an outline which further investigations could follow.

1. Explain the general nature of epilepsy to informants and obtain as many names as possible for the condition. There may also be euphemisms. Some of the names may be descriptive, e.g. "falling into fire" or they may be the names of spirits thought to bring the illness.

2. Enquire carefully into the symptoms and signs that characterise the illnesses named, and particularly those signs if any, that differentiate the various types distinguished by name.

Distinguish between signs that may be considered to be *normally* present and those that are *necessarily* present, such that their absence would exclude that name being used for the illness; e.g. different names may be used if the fits occur daily rather than monthly. Urination during the fit may be considered usual or it may be that if it does not occur then the illness may be given a name different from that given if it does occur.

3. Is the frequency of fits considered to be related to the moon's phases?

4. Is the illness considered to be related to a particular part of the body? If so, for what reason?

5. Are any conditions or diseases thought to be liable to develop into epilepsy? Note particularly infantile febrile convulsions and dizziness in this context.

6. Are there any measures taken to prevent these latter from developing into epilepsy or to prevent them occurring at all?

7. Is the illness thought to be infectious? If so—

(a) Can all those afflicted spread it or only some?

(b) Can all catch it, or only those people in some particular relationship with the patient?

(c) Are the actual infectious agents specified?
Are particular body products implicated?
e.g. urine, froth from the mouth or flatus?

(d) Can it only be caught during a fit or is the patient capable of spreading it all the time?

8. Are the patients separated? If so, is this only because the illness is thought to be contagious? (On several occasions in different parts of Africa I have been told it is bad manners to separate a person in an obvious way and in these cases the separation may take a more subtle form).

Separation within the household.

(a) Do they have their own room or hut?

(b) Do they have their own eating utensils?
Are these washed separately?

(c) Do they eat in a separate place?

(d) Do they have their own wash basin?

(e) Are their clothes washed separately?

Separation in wider social activity.

(a) May a child play with others?

(b) May an adult drink with others?

(c) May a child go to school?

(d) Are patients expected to work much?

(e) Can they marry?

(f) Can they become a leader, priest, etc.?

(g) Can they inherit from others?

9. If a patient is cured, do some of these social limitations still apply, and if so for what reason?

10. After death, is the patient buried differently? e.g. with all his belongings, in a separate place, with different ceremonies from normal?

11. Would anyone inherit from a dead epileptic?

12. Is it thought of as an illness peculiar to the people themselves? (Is it thought that Europeans may suffer from it?).

13. Are sufferers thought (a) to become stupid?

(b) to become mad?

(c) to die within a few years of onset?

14. Amongst the various agents thought to cause illnesses (a) are some thought particularly likely to cause epilepsy? (b) are some definitely not implicated in the causation of epilepsy?

(Causes may include witchcraft, spirits, infection, natural agents e.g. birds. It is not unusual for several ideas of causation to co-exist).

15. Is epilepsy thought to be curable? What forms do cures take? If the patient is burnt because of falling into a fire during a fit is a cure thought more difficult to achieve? Is it considered that epilepsy can be treated by western medicine? (It is useful here to try to determine actual numbers of patients who have attempted to obtain western treatment and for what reason. The reason may not be directly related to epilepsy).

Is there a fear of treatment because it is thought that if one person is cured then another will catch it?

16. What other people are grouped with those with epilepsy — e.g.

(a) Separated in the same way.

(b) Thought to have illnesses peculiar to the people.

(c) Buried in a similar way.

(d) Thought to be incurable or difficult to cure.

These questions are of course not exhaustive. The questions would be most useful in those societies like the Baganda, in which the patient is stigmatised but remains within the family. It could be of course that the patient is totally rejected by the family and becomes a total outcast, or it could be that the whole family is stigmatised and not the patient alone.

In carrying out such research it cannot be overemphasised that the outline must also be used in conjunction with actual case histories and observations made at the homes of patients. It is as well to remember the dictum that there may be three sets of conflicting data.

(a) that which the subjects believe ought to occur (their ideal)

(b) that which the subjects believe actually occurs

(c) that which the investigator himself observes to occur.

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