THE AWARENESS AND MANAGEMENT OF MENTAL ILLNESS AMONG THE BABUKUSU OF BUNGOMA DISTRICT

BY
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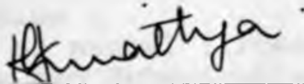

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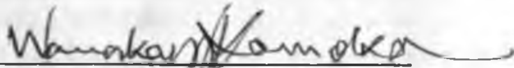

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TABLE OF CONTENTS PAGE

List of tables . . . . (iii)

Acknowledgements . . . . (v)

Abstract . . . . (vi)

CHAPTER 1: STATEMENT OF THE PROBLEM 1

1.1 Introduction 1
1.2 The Problem 4
1.3 The Study Objectives 7
1.4 Rationale of the Study 8
1.5 Significance of the Study 9

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK 11

2.1 Literature Review 11
2.1.1 Mental illness 11
2.1.2 Studies on mental illness: Strengths and deficiencies 12
2.1.3 Distribution of mental illness, Effects of Social Change and Urbanization process . . . 17
2.1.4 Culture and the Concept of mental illness . 22
2.1.5 Etiologies, Therapies and Therapists 26
2.1.5.1 Etiologies 26
2.1.5.2 Therapies 29
2.1.5.3 Therapists 32
2.1.6 Attitudes: The labeling concept 34
2.1.7 Summary of the literature review 38
2.2 Theoretical Framework 40
2.2.1 Disease theory system 40
2.2.2 Labeling theory 42
2.3 Research Hypothesis 46
2.4 Operational definitions of some concepts . . 47

CHAPTER 3: METHODOLOGY 53

3.1 Research Site 53
3.1.1 Economic Activities 54
3.1.2 Health facilities 55
3.2 Population 57
3.2.1 The Babukusu 58
3.3 Sampling 61
3.4 Data Collection 67

3.4.1 Documentary Materials - Secondary Data . . . 67
3.4.2 Health Centre Data 68
3.4.3 Random Sample interview schedule 68
General population 68
Modern Medical professionals and traditional healers 70
3.4.4 Unstructured interview. 70
3.4.5 Focused group discussion 71
3.4.6 Direct observation 72
3.4.7 Key informant interviews 73
3.5 Field Problems 74
3.6 Data Analysis Procedures 77

CHAPTER 4: CULTURAL PERCEPTIONS, ATTITUDES TOWARDS MENTAL ILLNESS AND THE MENTALLY ILL 80

4.1 Cultural Perceptions of Mental illness . . . 80
4.2 Attitudes Towards Mental Illness and the Mentally Ill. 95

CHAPTER 5: ETIOLOGIC CONCEPTS, THERAPEUTIC CHOICE AND THE PLACE OF TRADTIONAL HEALING 109

5.1 Etiologic Belief: A major factor in therapeutic choice 109
5.2 The Place of traditional healing 131
Pearson Correlational Analysis 150
Comparison of Means 156

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS . . . 167

6.1 Conclusions 167
6.2 Recommendations 176
Bibliography 180
Cited References 180
Other References 189
Appendices 191

LIST OF TABLES

Table	4.1.1	Knowledge of signs and symptoms of mental illness by sex.
"	4.1.2	Knowledge of signs and symptoms of mentall illness by education.
"	4.1.3	Knowledge of signs and symptoms of mental illness by age.
"	4.2.1	Knowledge of indicators of mentally ill persons with feelings towards the mentally ill person.
"	4.2.2	Feelings towards the mentally ill by education.
"	4.2.3	Attitudes towards the mentally ill by education.
"	4.2.4	Attitudes by severity of mental disturbance.
	5.1.1	Etiologic beliefs by age of respondents.
"	5.1.2	Etiologic beliefs by education of respondents.
"	5.1.3	Therapeutic choice by age of respondents.
"	5.1.4	Therapeutic choice by education of respondents.
"	5.2.1	Perceived ability to cure by age of respondents.
"	5.2.2	Perceived ability to cure by education of respondent.
"	5.2.3	Perceived efficacy of traditional healing of mental illness by age of respondent.
	5.2.4	Perceived efficacy of traditional healing of mental illness by education.

Table	5.2.5	Role of traditional healers by education of respondents.
"	5.2.6	Role of traditional healers by occupation of respondents.
"	5.2.7	Pearson correlational matrix
"	5.2.8	Description of behaviour of mentally ill persons
	5.2.9	Causes of mental illness
"	5.2.10	The age category considered likely to present psychiatric problems.
"	5.2.11	The sex category considered likely to present psychiatric problems.
"	5.2.12	Perception of traditional healing
	5.2.13	Perceived efficacy of traditional healing

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ABSTRACT

Anthropologists have turned in increasing numbers to carry out investigation on health care systems, etiologies and management of diseases and illnesses in societies of differing complexity. What is apparent from their works is that little has been done on mental illness with regard to etiological concepts, health seeking behaviour and role of traditional health care in the management of the problems particularly in the non-Western societies. This underscores the primacy of looking at these aspects in a given culture, thereby providing this study a major point for departure.

This study was undertaken among the Bukusu Community of Bungoma District. The study discusses mental illness with regard to causation, perception and resources employed in the management of the problem. It tries to investigate the extent to which Babukusu are aware of various signs and symptoms of psychiatric disorders and their attitudes towards the mentally ill and/or mental illness. The study also examines factors that may influence therapeutic choice, etiological concepts and perception of mental illness.

The study found that there are various definitions of mental illness and that physical appearance and behaviour are major factors in identifying signs and symptoms of mental illness. As a result, the study found, socioeconomic factors notwithstanding, conditions as sadness, hopelessness, restlessness are not considered by the majority to be in the domain of mental illness. This, it is concluded, is a consequence of cultural perception in which mental illness is mainly considered as the wildest insanity. As a result, it was found, attitudes towards mental illness are for the most part negative. There is, however, evidence to suggest that the severely afflicted mental patients are likely to face worse treatment than the less afflicted.

Further, the study found that etiologies of mental illness are multiple and so are therapies. Thus, it is concluded, no single etiologic model can be posited to explain the occurrence of mental illness. Also the study found that socioeconomic factors notwithstanding, a majority attribute the occurrence of mental illness to social etiological concepts. This, it is concluded, would have consequences for the sort of therapy chosen. The findings also show, and indeed it is one conclusion of this study, that

no single system of health care can adequately deal with the problem of mental illness. It is also observed that concurrent or serial use of different healing systems in search of cure seems to be common among the Bukusu society.

It is also one major finding of this study that among factors as socioeconomic status, past experience, social skill of therapists and satisfaction of the users, etiological concepts contribute substantially to therapeutic choice. A major conclusion here is that traditional healing system is perceived as providing effective health care services and to the satisfaction of those who utilize it. Support system, therefore, exists that guarantees its future.

CHAPTER 1

STATEMENT OF THE PROBLEM

1.1 Introduction

Mental illness, also known as psychiatric disorder, means simply that the person concerned does not fit well into the "order" or system of his time, place or culture (Masserman, 1976). It is visible when persons in the participant's group recognize his inability and reluctance to make proper responses in his network of interpersonal relations (Scheff, 1967). Mental illness affects the mind of an individual so that at its extreme (severe) the mind is completely deranged and the individual's behaviour changes and these are marked by a loss of touch with reality. Most symptoms of mental illness can be systematically classified as violations of culturally patterned normative network (Scheff, 1966) and that actions of the mentally ill deviate from what is expected in a defined social situation. The behaviour of such individuals is easily noticeable and culture of the group provides a vocabulary of terms for categorizing many norm violations and, crime, sin, drunkenness and bad manners are some of the examples (Scheff, 1967)

However, unlike many diseases such as malaria and diarrhoea which attract national and international

interest, most psychiatric disorders are not too easily seen or noticed. One good reason for the neglect of psychiatric disorders may be that the patients may not deviate from the normative expectations and may seem at least, to adequately perform their social roles. Also the isolation of power structure from the effects of psychiatric disorders may have contributed to this state of affair. For a long time mental illness did not raise the concern of the medical, political and socially vocal classes that ailments like Meningities and AIDS arouses. Nor is it considered as a major contributor of morbidity and mortality in our populations. It is only recently that problems of mental illness touched a sensitive part within the policy-making quarters. The few studies conducted in Kenya have shown that the problem is prevalent and its effects on social and economic life are equally disturbing (Ndetei and Muhangi, 1979; Acuda, 1983; Muya, 1991[1]). As a result mental health has become one of Kenya's national-health goals (Republic of Kenya 1989; Daily Nation, April 20, 1991).

Mental disorders cross-cut social borders although some groups are at a higher risk than others and the causes may vary. Pregnant mothers, adolescents, the elderly and the deprived are some of the high risk groups (Bennett, 1988:163). When young people suffer from psychiatric disturbances their education is adversely affected or even impaired due, partly, to school

absenteeism. When an adult member(s) of a family is afflicted productivity is lowered. Though there is no documented evidence, time is certainly lost either through repeated hospital visits where the problem may be vaguely presented as other physical illnesses such as bodyache, abdominal problems, headaches, and so on. Family relationships are strained endangering marriage stability that may result in divorce. Criminal activities are also concomitant with mental disturbances (Bennett, 1988). Thus the social cost to the community in terms of disrupted organizations and family life are irreparable. The loss of productivity and the amount of disability and unhappiness due to the problem is very great and on these counts alone there is a need for mental health services.

Manifestations of mental illness are varied and these depends on the severity of the problem. Individuals with such disorders may experience for example, lack of sleep, low spirits, extreme worry, fear/anxiety, continued sadness, loss of memory and violence. Results from some of the studies conducted show that upto between 30% and 40% of the out-patients in Kenya might have psychiatric disorders (Bennett, 1988); with schizophrenia and acute psychotic states being the commonest disorders in mental institutions while psychoneuroses such as anxiety and depression are more prevalent in the general population (Acuda, 1983).

1.2 The Problem

Most studies of mental disorders have dealt with urban population, industrialized societies and patients who have been hospitalized or who have sought treatment at a medical facility. Epidemiologically there is scarcity of community based data to determine the frequency, distribution and determinants of mental illness, particularly in the developing world, save for Ethiopia and Uganda (Mustafa, 1974; Bennett, 1988:157). Mustafa (1974:453), for example, notes: "reviewing the literature on mental disease in Kenya one is faced with scarcity of population based data". In fact mental disorders have for a long time been assumed to be a problem of the urbanized, industrialized society. There still lingers the assumption that mental illness is a price to be paid for rapid social and economic change. The argument advanced has been that modern complex societies impose severe limitation on the satisfaction of individual impulses which are subordinated to the social order.

This assumption may be well founded and that it is undeniable that for decades mental disorders have been a serious health problem in the industrialized societies. That notwithstanding ethnographic data have shown that not a single society is a stranger to psychiatric disorders and Bourguignon (1979:271) assertively confirms

this: "mental disorders are to be found everywhere in all societies and culture, among all races and in all geographic zones".

There are, however, variations in the form, frequency, distribution, causes and social implications of this behaviour. This is because the basic decision about illness is usually made by community members not professional personnel and this varies with culture. This is in turn determined by definitional process of illness in a given society so that some "very sick" persons go unattended while "moderately sick" persons receive treatment (Scheff, 1967:27). This determines who is to adopt a sick role and who is not (Logan and Hunt, 1978:247).

Thus, although most studies on disease and illness have been biomedical, many biomedical and social scientists are becoming increasingly aware that health and illness behaviour and beliefs are cognitively related to belief systems of a people; hence disease and illness whether physical or mental have in the course of human history acquired both biological and sociocultural variables. Social factors, therefore, are equally important in the study of any disease and illness. About this Foster and Anderson (1978:113) have the following to say: "disease involves pathology and at one level, it is obviously biological. Yet socio-psychological and

cultural factors often play roles in triggering disease". Thus culture plays an active role in the definition of etiological concepts of disease (whether mental or physical), methods of diagnosis and therapy (Bennett, 1988:47). The need therefore, is long overdue for a study to find out what a given people know about mental illness and its attendant problems.

This study, therefore, attempts to investigate what the lay Babukusu know about mental illness, that is, the beliefs held by Babukusu with regard to mental disorders - their definition, perceptions and explanation of the causes of psychiatric disorders and strategies employed in the management of such disorders. The study also investigates the Babukusu attitudes towards mental illness and the mentally ill. Thus the current study is, of necessity, exploratory in nature.

In Kenya, Acuda (1983) argues that a large number of patients with psychiatric disorders consult traditional healers. However, resort to traditional healing is not limited to mental illness alone (Koumare, 1983; Brian, 1986). Elsewhere it is noted that a large proportion of people in Kenya still depend on traditional healing for their cure (Republic of Kenya, 1989). In this study it is one major problem to investigate the prevalence and place of traditional healing in Bungoma District. Specifically, the study investigates the interface

between modern and traditional or other forms of indigenous healing in the management/treatment of mental illness. Also, the study seeks to understand the extent to which socioeconomic variables influence, if at all, the Babukusu knowledge of causation of mental illness, perception and utilization of both modern health facilities and traditional health care system or other forms of health care.

1.3 The Study Objectives

This study has several objectives:

To identify the Babukusu beliefs, knowledge on causation factors and symptoms of mental disorders.

Attempt to highlight some factors that influence knowledge on concepts of causation and perception of mental illness.

To identify the people's attitudes towards the illness and those who are mentally ill.

To identify cultural definitions (conceptions) of mental illness and the significance of such definitions for diagnosis, prevention and management of psychiatric disorders.

To assess the place of traditional healing or other forms of healing in the treatment and management of mental illness.

1.4 Rationale of the study

For a long time there has been assumption that mental disorders, particularly psychoneurosis such as anxiety and stress, are rare in the less industrialized societies (Foster and Anderson, 1978:93). However, historical evidence indicates that mental disturbances have been known in all societies regardless of their level of complexity (Hollingshead, 1966); hence no culture provides immunity to mental disorders. Consequently, mental illness has recently been recognized as one of the most serious unresolved health problem facing society today (Deshen and Deshen, 1989). There is consensus that mental illness is rapidly increasing throughout the world (Foster and Anderson, 1978; Bourguingnon, 1979); yet there is no consistent attack on the problem around the world.

Studies done show that there are mentally disturbed persons in the general public who never come to the attention of sources of help (Bourguignon, 1979). In fact, too often psychiatric disorders are ignored or missed by primary health providers (Dressler, 1987; Bennett, 1988:150; The Standard, Sept 5, 1990); yet

emphasis on community-based health care and preventive medicine remain crucial particularly in rural areas which are medically underserved (Koumare, 1983:25; Republic of Kenya, 1989). Furthermore community-based mental health care in Kenya is inadequate due, partly, to lack of baseline information and representative data on mental disorders. This is attested to by Bungoma District which, like elsewhere in developing countries, lacks figures to indicate the magnitude of the problem of mental illness (Republic of Kenya, 1989:93).

In spite of this, however, there are strong suggestions that mental disorders in the district are on the increase (Republic of Kenya, 1989), and throughout the republic psychiatric disorders are assumed to have reached proportions where management facilities have to be decentralized to involve the local people (The Standard, December 5, 1990; Daily Nation, April 20, 1991). The Government of Kenya has recognized mental illness and mental health as health areas requiring special and urgent attention. This calls for understanding of beliefs and practices, knowledge and attitudes of a given people that may yield information about the illness if it is to be adequately dealt with.

1.5 Significance of the study

This study should therefore be viewed in two

dimensions, as both academic/intellectual pursuit and practical work. Academically the study acts as a pioneer as well as exploratory study of Bungoma District where no studies have been conducted hitherto on mental disorders. It endeavours to make known explicitly what is otherwise taken for granted. In its practical sense, the study proceeds from the assumption that the social and economic cost to the family and community at large in terms of loss of productivity and the amount of disability and unhappiness due to mental illness is very great. These considerations render this study important in understanding the beliefs on the causation and management of mental illness from an anthropological view point/perspective. Thus the study provides a basis of which a plan can be developed for primary preventive and treatment interventions.

Footnote

1. Director of mental health, Ministry of Health, in Nation, February 19, 1991.

CHAPTER 2

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Literature Review

2.1.1. Mental Illness

The concept of illness, either physical or mental, implies deviation from some clearly defined norms (Mustafa, 1974:453; Szasz, 1967:245). Mental illness, therefore, means, in effect, simply that the person concerned does not fit well into the "order" or system of his time or culture (Masserman, 1976:2). Mental disorders can be classified into various categories. Swift and Asuni (1975) have proposed seven categories, viz: neurosis; psychological disorders and mild functional complaints; personality disorders which include psychopathic or anti-social behaviour such as sexual deviations, alcoholism and drug addiction; functional psychoses such as Schizophrenia and affective psychoses; organic brain disorders; epilepsies and mental subnormality (Bennett, 1988:158).

Mental disorders affect the individual's mind and at its extreme the mind is completely deranged and the individual's character changes and these are marked by a loss of touch with reality. The behaviour of such

individuals is easily noticeable. The affected individuals are not only social misfits but in many cases are economically depended. However, in its mild state mental disorder may go unnoticed because the patients may not deviate from the expected norms and may seem at least, to perform their roles as expected. Such patients are recurrent attendants of clinics, dispensaries and/or traditional healers (Bagshawe, 1983:1). The problems include anxiety and depression which are presented or masked in various disguises (Acuda, 1983).

Symptoms or manifestations of mental illness are varied and depend on the severity of the affliction. Individuals with such disorders may experience, for example, lack of sleep for a considerable period of time, low spirits/depression, hallucinations, withdrawals, extreme worry, fear/anxiety, continued sadness, loss of memory, and antisocial behaviours such as violence, suicides, sexual offenses and murder (Bennett, 1988).

2.1.2. Studies on mental illness: Strengths and Deficiencies

In spite of the difficulties in establishing the actual figures of those who suffer from mental disorders worldwide, it is estimated that about 250 million people in the world suffer from psychiatric disorders and about 25% of these suffer severe psychiatric illness (Daily

Nation, February 19, 1991).

However, the available literature on mental illness appear biased because a great deal of it is facility-based rather than community-based and the patients are self-selecting. In fact there is a scarcity of community based data to determine the incidences, distribution and determinants of psychiatric disorders particularly in Africa, Kenya included. Deshen and Deshen (1989) concur with this observation by arguing that incidences and prevalence of mental illness have only been conducted in industrialized societies. They further contend that where the studies have been conducted most of them have been centred on hospitalized patients, urban centres and street patients. Nonetheless a few population based studies with regard to mental disorders have been attempted (Nunually, 1960; Hollingshead, 1966; Scheff, 1967; Eaton and Well, 1967; Kiev, 1976; Dressler, 1987). In Africa, a few such studies can be found viz for Ethiopia, Uganda and to a lesser degree Kenya (Edgerton, 1966; Muhangi, 1970; Giel and Luijk, 1969). These studies are unanimous in the conviction that mental illness is one of the most serious unresolved health problems facing society today.

Evidence of frequencies of mental disorders in the Western societies show that the problem is actually chronic (Scheff, 1967; Dressler, 1987; Deshen and Deshen,

1989). However, evidence of frequencies of mental disorders in non-western societies has been impeded largely because there is no feasible method to obtain reliable data (Foster and Anderson, 1978). This problem has been and continues to be sustained by the long-standing assumption that mental disorders, particularly stress, are a problem of urbanized industrialized society. There still lingers the notion that mental illness is a price to be paid for rapid social and economic change. The argument has been that modern complex societies impose severe limitation on the satisfaction of individual impulses which are subordinated to the social order. Nevertheless, the few that have been done have shown a worrying trend.

In Kenya study on the prevalence of mental illness was first attempted by Carothers in the 1940's (Carothers, 1953). Carothers' study was done in various institutions in Kenya about the "insane persons" and he found that the prevalence of such persons in the country was 0.1 per 1000 persons at risk compared with 4 per 1000 in England and Wales at that time. Further investigation using data from DCs and Chiefs about insane persons living at home, raised the prevalence figure to 0.37 per 1000. On the basis of this study he concluded that incidences of insanity among Kenyan Africans were very much lower than in Europe and America. This study ignored a large number of patients who remained quiet and

non-violent and never came to the attention of the administration.

Studies that followed also tended to follow Carothers' approach. However, unlike Carothers' conclusions these studies have been able to show that incidences of mental disorders compare favourably with those obtained elsewhere in urbanized industrialized countries. A study done by Ndetei and Muhangi (1977) on some patients attending general clinic in Athi-River showed that 20% of the patients were suffering primarily from psychiatric disorders while 20.7% of the diagnosis was not immediately certain with 59% being physically disabled. Such figures are similar to those obtained elsewhere in Africa (Giel and Luijk, 1969). The most common afflictions were anxiety states and depression masked by somatic symptoms, often leading to unnecessary delays in diagnosis and management (Acuda, 1983, Bagshawe, 1983:1). About the same time, Ndetei and Muhangi made efforts to determine the prevalence of psychiatric morbidity among the school going students in a school in Machakos District. 12% of the students were found to be mentally ill while 3.9% were overtly psychotic requiring immediate treatment; anxiety and depression were the most common.

Studies conducted by the Department of Psychiatry during the same year in Kenyatta National Hospital showed

that 34% had depression, 13.8% anxiety and 9.8% acute psychotic episodes with hysteria and alcoholism 9% and 4.4% respectively (Acuda, 1983). A recent study in Kenyatta National Hospital on alcoholism showed that 31% were alcoholics who had developed medical, mental and/or social complications before admission yet they were not detected before questionnaire results. And a study conducted by Dhadphale and Ellison of psychiatric morbidity among out-patients in Nyanza Province showed alarming results. 32% of the patients attending Nyanza general hospital and 28.8% of those attending Kisii hospital were found to have conspicuous psychiatric morbidity, mainly psychoneuroses (Acuda, 1983).

In general Acuda (1985) argues that upto one-fourth of patients attending general out-patient clinics in Kenya have psychiatric symptoms, anxiety and depression being the most common. Bennett (1988) also submits that 30% to 40% of out-patients in Kenya might have mental disorders. And Muya (1991)[1] lends weight to the foregoing by noting that 20-25% of patients seeking medical help suffer primarily from treatable psychiatric disorders (See Daily Nation, February 19, 1991). Thus there is growing awareness that mental health problems are prevalent.

However, very little research has been done in the general public to confirm these observations (Acuda,

1983; Standard, September 5, 1990). Thus on the whole there is a serious lack of investigation of the population at large. Mustafa (1974:453) succinctly expresses this when he notes: "reviewing the literature on mental disease in Kenya one is faced with scarcity of population based data". Among the Babukusu who are the focus of the current study there is virtually no information on mental disorders a part from Wagner's (1949) ethnography which again did not deal with the question of mental illness per se. The data on Babukusu is mainly historical (Were, 1967; Wandibba, 1985; Nasimiyu, 1985; Makila, 1978). As such contemporary anthropological study on Babukusu and in particular with regard to mental disorders is scanty.

2.1.3. Distribution of Mental illness; Effects of Social change and urbanization process.

Distribution of mental disorders also remain largely unknown particularly in the developing World where, as noted earlier, studies on the frequencies and determinants of mental disorders have been impeded largely because of lack of feasible methods of obtaining reliable data (Foster and Anderson, 1978). There is a strong assumption that there are more mental disorders in industrially developed countries than there are in developing countries principally because of social and economic change. That notwithstanding, ethnographic data

have shown that not a single society is a stranger to mental disorder and Bourguignon (1979:271) assertively confirms this "mental disorders are to be found everywhere, in all societies and culture, among all races and in all geographic zones".

In retrospect however, both anthropologists and psychiatricts of different persuasions agree that available evidence on mental illness is good with respect to the consequences of rapid socio-cultural and economic change: Such change is productive of high average incidences of mental illness (Foster and Anderson, 1978:95). Such changes were long felt in Western industrial societies, viz: America and Europe (Dressler, 1987; Deshen and Deshen, 1989). These changes have already taken root in the developing world. In Africa, for example, Bourguignon (1979:272) candidly notes that social, cultural and economic changes have resulted in increased mental problems. Among the reasons she cites is: "the fact that disruptions of traditional life patterns have produced stress leading to psychiatric illness in significant number of people". She further contends that traditional institutions that dealt with distressed persons have broken down, and the traditional resources for preventing disturbed behaviour have become less available.

Social change may be accompanied by loss of customary support systems and may undermine confidence in habitual ways, foster dependence on new situational and interpersonal stimuli and increase susceptibility to environmental influences (Kiev, 1976:38). During social change individuals find it hard to rely on previous patterns of adjustment or employ previous cultural responses. As a result the individual's sense of identity is challenged, his orientation disrupted and this produces cognitive dissonance (Kiev, 1976). This becomes a source of psychological conflicts with their concomitant new stresses. This partly explains why urbanization process has been associated with high incidences of mental disorders.

The foregoing argument is well supported by findings of Scheper-Hughes (quoted in Foster and Anderson, 1978) studies she conducted among the Irish people. In this community famine necessitated migration and this resulted in disruptions of family life, disintegration of traditional life, i.e, social life and institutions, limited social interaction and this led to anomie situation due to lack of norms appropriate to guide or hold the community together. This situation increased cases of alcoholism, high incidences of heavy drinking, sexual deviations and high incidences of mental disorders. These problems affected malesmost due to social and cultural expectations. And latah, although a

culture-specific disorder in Malaysia, is a hysteria brought about by social and economic changes as a result of contacts with colonialists. This problem affected old women most as they could not keep pace with the new behaviour. Similarly among the Okinawans, known for their relatively low incidences of mental illness on their home island, apparently found migration to Hawaii enormously stressful; in their new home they developed rates of psychoses significantly higher than any other major group in the island (Moloney, 1945:391-399; quoted in Foster and Anderson, 1978:95).

As already intimated it is widely held that urbanization contributes significantly to the etiology of mental disorders. Bagshawe (1983), for example, notes that if urbanization and social change are contributing to the etiology, there may be rising incidences. This observation concurs with Foster and Anderson's (1978) observation. They noted that urbanization process leads to increased incidences of psychiatric disorders. Opler (1959:1) makes the same point when he argues that mental illness toll may be linked with cultural disorganization and social decay. This is one aspect of urbanization. For example, Kiev (1976) argues, about Africans, that an African living in an organized related traditional bound group derives identity from multiple parent figures in childhood, extended family and from strong links to ancestral spirit. This support, he further argues, is

likely to fade fast in urban setting. Passive individuals in urban areas suffer because of lack of emotional and family support or social support for extended kin (Dressler, 1987).

Back in rural areas though people there are not subjected to stress of urban centres, they have their own problems. In Africa, for example, Hay and Stitcher (1984) argue that male outmigration from rural areas to urban areas in search of jobs and school participation by children have increased women's already heavy workload. Besides their domestic duties, they take care of the farms and animals. These have created new stresses to women; hence Oliech (1990)[1] observes that: "Socioeconomic changes in Kenya have resulted in social trends that cause psychosocial problems leading to increase in mental illness". It is, however, important to note that some individuals are at a higher risk than others in any society; they include pregnant mothers, adolescents, the old and the sick (Bennett, 1988). Also important to note is the fact that whether social, cultural, and economic changes in Africa have resulted in increased mental problems, particularly stress, than was the case before may be a matter of conjecture. What we know for sure is that while this may be true, a world peopled by vengeful deities and ghosts, witches and sorcerers, angry neighbours and envious relatives has never been less stressful (Foster and Anderson, 1978:93). Thus it is

imperative to note that even when recording increased incidences of mental disorders in populations that are undergoing rapid social, cultural and economic change we are not measuring from a zero baseline of no mental disorders whatsoever (Foster and Anderson, 1978)

2.1.4. Culture and the concept of Mental illness

Illness is a cultural concept. It is illness which causes people to seek treatment because illness leads to impairment of function (Foster and Anderson, 1978). Culture provides a set of shared beliefs, values and customs (Kiev, 1976:37). Every cultural group has therefore its own way of defining and categorizing illness and has its own models of what constitute health (Kimani, 1988; Ndeti, 1973:78; Foster and Anderson, 1978). Consequently symptoms that are accepted as evidence of illness in one society may be ignored in another (Foster and Anderson, 1978). With this has evolved the concept of the sick role (Kimani, 1988).

The World Health organization (1953) observes that socialcultural factors are closely related to mental disorders, and Ndetei (1985:3) makes the same point when he argues that culture plays an important role in shaping psychological phenomenologies and it cannot be dismissed in the study of psychiatric disorders. Opler (1959:7), when discussing the problem of culture and personality,

takes the same arguments further by submitting that culture form a fundamental basis for both studies of personality in society and of mental dysfunctions. He further notes that individuals who cannot resolve culturally created strains through the provided means are likely to experience mental disorders (Opler, 1959:141). About this Kiev (1976) submits that culture guards against psychological anxieties and affects the tolerance of stress and adaptability to new situations in the event of social change. Touching on culture, health and illness Micozzi (1988:320) observes that actual patterns of health and illness are cognitively related to the health and illness beliefs of a given people. Frank (1967:170) is also the same opinion when he argues that beliefs of members of a culture as to what constitutes illness and its treatment are formed and supported by generally held cultural values.

The foregoing discussion point clearly to the relevance of culture in the study of psychiatric disorders. Thus the definitional process of the illness in a given culture determines who is to adopt a sick role and who is not (Logan and Hunt, 1978:247). In some cultures, for example, the role of sickness is assigned to anyone who develops paranoid ideation and hallucinations although this is not always the case with neurotic depression. In places like Puerto Rico, hallucinations may be considered a symptom of a potential

spiritual healer (Kiev, 1976). This may also be the case among African societies as Gatere found among some Kenyan traditional healers (quoted in Acuda, 1983). In other societies adolescent rebellion that threatens the status quo may be considered as a pattern of mental disorder; and in some ceremonies in certain cultures like Haiti, possessed individuals are accepted in the context but when they remain possessed outside the context they may be classified as mentally ill, yet in others breaking a taboo is taken as sin and is associated with mental disorders (Foster and Anderson, 1978). And Ndetei and Muhangi (1979) conclude that in African cultures concepts like depression and anxiety do not have medical implication; hence on cultural level alone it is unlikely that a patient would complain of these states.

Mental illness is, therefore, considered as a social problem (Mustafa, 1974:453). This observation is in agreement with that of Szasz (1967:245). Szasz argues that the concept of illness, whether bodily or mental, implies deviation from some clearly defined norms and this social recognition has got moral, psychosocial and legal implications. This, of course, depends on the degree of disturbance some of which may go unnoticed because the patients may not deviate from their roles/norms. Thus, as noted earlier, manifestations of mental disorders are varied and depend on the severity of affliction (Bennett, 1988), hence the tolerance of

unusual behaviour will often depend on the context in which it occurs. In effect, Masserman (1976) notes that many of the amazingly diverse patterns of behaviour could be clinically labelled disturbed behaviour, yet they could also be considered adaptationally "normal" because they are a product of a unique experiences. At this point it is, perhaps, necessary to point out that explicit in many popular classifications of human behaviour is the idea of deviation from an acceptable norm and that the range of kinds of acceptable behaviour vary among cultures (Cancro, 1976:98). It would thus be misleading to assume that the index of mental illness is constant for all cultures; observations about a disorder must be interpreted and this task can only be performed through cognitive means imposed by a given culture. Thus beliefs of members of a culture as to what constitutes illness and treatment are formed and supported by generally held attitudes. In effects Szasz (1967:243) submits that mental illness is widely regarded and that popular conceptions of mental illness and views which are typically held by laymen concerning mental disorders are very informative in the study of mental disorders and the public.

The foregoing arguments make it clear that there are variations in the frequency, distribution, causes and social implications of psychiatric disorders. As such mental disorders vary both in quality and quantity

according to different social environments (Opler, 1959:9). This is because the basic decisions about illness are usually made by community members not professional personnel and these vary with culture; hence some "very sick" persons go unattended while "moderately sick" persons receive treatment (Scheff, 1967:27).

2.1.5. Etiologies, Therapies and Therapists

In the preceding part of this chapter it has been noted that different cultural/social groups not only have different rates of illness but to some extent different kinds of illness. Culture, therefore, defines etiological concepts of disease and illness, methods of diagnosis and therapy (Bennett, 1988:47).

2.1.5.1. Etiologies

Szasz (1967:243) argues that mental illness is widely regarded and the causes taken to be innumerable diverse happenings. Hollingshead (1969:9) also makes the same point by submitting that no single cause of "abnormal" behaviour can be identified nor can any single model of abnormal behaviour be posited. Hereditary, physiological and sociocultural factors all play roles in explaining mental illness (Foster and Anderson. 1978:100). However, the concept of disease causation among non-western societies differ in basic ways from

those that characterize Western societies. Foster and Anderson (1978) argue that many non-Western people do not make sharp distinction between physical and mental etiologies of illness. They, therefore, conclude that the need to articulate the dichotomy of physical and mental illness is more a reflection of western consensus than the orientation of societies rooted in naturalistic or personalistic belief systems. Both naturalistic and personalistic etiologic models have been advanced by Foster and Anderson to explain the presence of illness, including mental illness, among the non-Western societies. In personalistic etiologic model illness is believed to be caused by the active, purposeful intervention of sensate agent who may be a supernatural being such as deity or a god, non-human beings such as ghosts, ancestors, or evil spirit, or a human being such as a witch or sorcerer. On the other hand, in naturalistic etiologic model illness is explained in impersonal, systemic terms. This model conforms, above all to, an equilibrium model:

> health prevails when the insensate elements in the body, the heat, the cold, the humours or dosha, the yin and yang, are in balance appropriate to age and conditions of the individual in his natural, and social environment-when this equilibrium is disturbed illness results (Foster and Anderson, 1978:53).

Guided by this Foster and Anderson (1978) offer several causes of psychiatric disorders, among them, psychological tendencies, hereditary and psychocultural

factors. And Deshen and Deshen (1989) when dealing with the problem of homelessness and mental disorders found that causes are multiple and varied, perhaps requiring different therapies. Similarly, Dressler (1987) found causes of mental disorders among a Southern black community in U.S. to be numerable. Among the causes is inability to cope with economic problems.

According to Edgerton (1966:364) the Akamba attribute some of the causes of psychiatric disorders to personalistic agents, among them sorcerers and evil spirits while others are a result of organic illnesses. Ndeti (1972) and Kimani (1987) also found similar causative beliefs to be very popular. And the Ariaal Rendille attribute the occurrence of mental disorders to factors which fall in either naturalistic or personalistic causation models. Among the causes are witches, evil eye, and organic diseases (Fratkin, 1980). The Yoruba ascribe the cause of mental disorders to several factors, among them superhuman attacks, gods, spirits and ghosts, breaking taboos, failure to carry out ceremonies, witchcraft, physical trauma and cosmic forces (Foster and Anderson, 1978). While Fabrega (1974:243) notes that in Tenejapa Southern Mexico, the causes of psychiatric disorders are not judged as different from those of other illness. And on St. Lawrence island, Eskimo spirit possession is associated with shamanism, but not with major psychiatric disorder. Magic and

witchcraft are given as explanations, as are stress factors described as "too much worry", to "get afraid" and the like (Foster and Anderson, 1978:87). In Wagner's (1949) ethnography of Abaluhyia of Western Kenya, Babukusu attribute some mental illness to anti-social behaviour of some members of the community such as sorcerers and witches, while failure to perform certain ceremonies is equally an important cause.

The World Health Organization (1953) considers one of the etiological factors related to child maladjustment to be deprivation of the mother during the early years, with emotional trouble being the most common. Similarly, Ndetei and Muhangi (1979) found several causes of mental illness, among them social and organic diseases. And in their study of middle income Anglo-Americans, Chino and Vollweiler (1986) observe that alternate etiological beliefs are found in both developing and developed societies and that they are believed by members of different socio-economic stati . Thus causes of mental illness are varied and can safely be discussed in the realm of theories of disease causation.

2.1.5.2 Therapies

On healing and management of mental disorders Appel and Bartemeier (1961:28) submit that the treatment of mental disorders takes two approaches, viz, medical and

social, and both carry psychological implications. This implies that the management of mental disorders is varied. Depending on, among other factors, the perceived cause, knowledge and severity, different therapies and/or therapists may be engaged. They include modern medical psychiatrists, general medical practitioners, traditional healers and religious healers. In other cases treatment is never sought.

Among the Akamba, ritual healing for short lived mental disorders may be engaged while some other mental problems are taken to hospital (Edgerton, 1966; Ndeti, 1972; Kimani, 1987). Coppo (1983:35) calls the healing part, which involves dancing, musicotherapy. And among the Pokot, songs and clapping in the healing of some mental disorders are employed. Such healing, no doubt, stresses psychological efficacy other than physical. The foregoing observations concur with Foster and Anderson's (1978) submission that treatment of the mentally ill is varied particularly in most non-Western societies. The pair argue that the majority of the people who display abnormal behaviour if not violent, for example, more often than not are permitted freedom in their own communities; their needs are met by members of their families. The Yoruba, for instance, take care of their own disturbed persons in keeping with the idea of predestination and luck so that insane persons may be left to roam the countryside, working, begging or

stealing to stay alive. The mentally disturbed, if their behaviour involves violence, or threats of violence, require more formal modes of treatment of which, viewed within the context of the society in question, is thoroughly professional and sometimes more nearly partakes of the nature of "home remedy".

This is the case in many other non-Western societies. Various herbal treatments are used, animal sacrifices carried out and, where the psychotic patient lived with the healer, upon recovery, discharge ceremony may be held and symbolic cleansing of the patient of his illness also performed. Thus the public takes a significant part in the treatment of psychiatric disorders.

In some other cases, particularly where the patients are violent, they are put in total institutions such as mental hospitals and drugs administered (Acuda, 1982). In the U.S, for example, the mentally ill are institutionalized for proper management of their illness. In effect Frank (1967) concludes that all forms of psychotherapy, whatever their underlying theories and whatever techniques they employ, are tailored towards promotion of beneficial changes in the individual's behaviour.

2.1.5.3. Therapists

Just as psychiatric syndromes, etiologies and therapies are multiple and overlapping so are therapists. Medicinemen, religious healers, psychiatrists, or even laymen, may be engaged in one time or another in the treatment of mental disorders. For example, Haiti vodoo priests and priestess have elaborate systems of folklore and practice and are able to deal with a whole spectrum of psychiatric conditions through religious ceremonies which involve the entire community. Thus therapists are involved in major curing rites. This is not confined to Haitian vodoo only but also applies to many other societies who have elaborate ways of dealing with a range of disturbed behaviour. In Indonesia island shamans handle the indigenous psychiatric problems among the Balians who recognize two types of disorders, viz, culture-bound syndrome, which is a special field for shamans or Balian healer, and major global psychosis taken to doctors (Foster and Anderson, 1978).

Mbiti (1969) observes that modern medicine may deal with the physical side of disease or illness but not necessarily the religious or psychological aspects of suffering; hence traditional healers and religious healers may be consulted. That, however, depends on the perceived efficacy of a given practitioner to deal with a given health problem. Chino and Vollweiler (1986) concur

with the foregoing when they note that tendency to consult traditional healers is depended, partly, on their ability to cure illnesses. This, they further argue, may also be influenced by etiologic beliefs as well as socioeconomic status of the person in question. Brian (1986) makes similar observations on traditional healing in Malawi. Brian notes that on the basis of a particular practitioner and peoples faith that he or she can heal the illness, the practitioner would be consulted.

And in their study of psychiatric morbidity among out-patients in Nyanza province, Dhadphale and Ellison (quoted in Acuda, 1983) found that 5% of the patients with psychoneuroses (anxiety and depression) had consulted a traditional healer before coming to the hospital for the same illness. And another report by Gatere on traditional healers in Murang'a and Nairobi showed that seven of the eleven traditional healers became healers through a "revelation" following a sudden illness only to recover after treatment by a traditional healer (quoted in Acuda, 1983). Acuda (1983) sums it all by submitting that quite a large number of patients with psychiatric disorders consult traditional healers. The same is pointed out by the current Development Plan (1989-83) that a large proportion of people in Kenya still depend on traditional healing for their cure.

2.1.6. Attitudes: the labelling concept

Kimani (1988) argues that socioeconomic status has some influence on knowledge, attitudes and practices (KAP) in relation to illness in any given community. She further argues that the general level of health is largely determined by the socio-economic status and education. In their study of etiologic beliefs in a middle income Anglo-American Community, Chino and Vollweiler (1986) found that socioeconomic status has some impact on etiologic beliefs. In the same community Koes (1954, quoted in Chino and Vollweiler, 1986:247) found that the use of health resources differed with socioeconomic class. Specifically he found that members of the lower socioeconomic class were more likely than the middle class to seek therapeutic help from "non-medical personnel". They also adhere to traditional or non-medical systems and alternative belief systems. He singles out education, age, sex and marital status to be of cardinal importance. Similarly Scheff (1967) argues that socioeconomic status determine who is to seek treatment for mental disorder and who is not. And in their study on the prevalence of and clinical presentation of psychiatric illness in a rural setting in Kenya, Ndetei and Muhangi (1979:269) show that socioeconomic status such as age, sex, marital status and education are important in the study of mental illness. These, in their view, affect knowledge, prevalence, and

attitudes.

The foregoing, notwithstanding, studies on mental disorders and their attendant problems show that they vary culturally. For example, Hollingshead (1966) in discussing the attitudes of the public towards mental illness and the mentally ill, asserts that they are a product of a people's culture. And while pursuing a similar issue, Phillips (1967:63) points out that in many cases, the penalty that mentally ill persons pay "for being different" is often rejection by others in the community. Masserman (1976:73) succinctly confirms this when he asserts:

> to this day the society has not learned to respond rationally to the plight of the mentally ill; they are treated with fear, hostility, dread and suspicion, hence the mentally ill remain the society's lepers.

In a wider perspective Scheff (1967:4) argues that there are psychological processes such as stereotyping, stigmatizing, and social processes such as rejection and isolation. Thus, when an individual is labelled "mentally ill" it becomes a self-fulfilling prophecy to both the patient and his family and even relatives (Murphy, 1978:249). As a result Bennett (1988:158) notes that these conditions when severe arouse in many (if not all) rural people a feeling of harror or fear, and reactions of avoidance, denial, concealment or ostracism of these unfortunate patients. However, the foregoing argument appears to consider only severe mental disorders

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such as schizophrenia and psychotic states which are the most common in mental hospitals (Acuda, 1983:13). Social reactions are therefore related to differences in the way psychiatric persons are able to function both in and outside of institutions.

Perhaps it is helpful to note that most studies concerned with attitudes towards the mentally ill have focused on individual's behaviour as the sole determinant of community or public response towards the mentally disturbed. Other studies have considered the importance of help source such as psychiatric treatment or hospitalization in identifying the individuals who are mentally ill and subsequently determining behaviour towards them (Phillips, 1967:63; Scheff, 1966).

It is the case, however, that laymen may not be able to identify, categorize or recognize certain serious symptoms of mental disorders for they dismiss them as normal; the community members understanding may not be in accord with the views of professionals. This is probably so because some people limit the concept of mental illness to behaviours as those exhibited by psychotics who cannot be controlled or who are in rags and tatters, foraging for food and shelter and the like (Dean, 1976); hence some behaviours such as trouble-sleeping, alcoholism, hopelessness, and juvenile character disorder show public ignorance concerning the signs and symptoms

of disturbed behaviour (Scheff, 1967:27). As a result, such individuals are not treated any different from the normal members of a community. As such in many societies most psychiatric symptoms are denied in the community or general population and do not go on to become sustained mental disorders (Scheff 1967, Bennett, 1988).

This observation is attested to by Ndetei and Muhangi (1979:273) who argue that in African cultures concepts like sadness, or anxiety do not carry medical implications and so at the cultural level alone it is unlikely that patients would complain of these states. Such behaviours seem to tie well with the arguments of labelling theory whereby the label "mentally ill" is stigmatizing and puts one into an ascribed role, exit from which is extremely difficult; hence no one would like to be associated with such a label.

This points to discrepancies that often occur as to who is mentally ill so as to adopt a sick role and when such discrepancies arise, adequate solutions for resolving them are not always readily available. consequently, some victims of such conditions and illness may sometimes be denied the privileges of the sick role by the community (Kimani, 1988).

It is perhaps because of these differences that too often mental disorders are ignored or missed by the providers of primary health care within communities or the public (Bennett, 1988; Dressler, 1987:211; The Standard, September 5, 1990). Whatever the reason Bennett (1988) sums it all by noting that in general attitudes towards the mentally disturbed persons are negative.

2.1.7 Summary of the literature review

From the literature reviewed herein we gather that there is serious lack of community based studies with regard to mental illness as most of the studies conducted are facility-based and the patients are self-selecting. Such studies, particularly in non-Western societies, have not been able to capture the whole lot of mental disorders. This is mainly because they have been guided by the bio-medical model which has limited application outside such institutions.

We also gather that the distribution of mental disorders remains unknown, especially in non-Western societies, due to lack of feasible method for collecting reliable data on the incidences and determinants of mental disorders. This has been compounded by the assumption that mental illness is a problem of the industrial urbanized societies. Admittedly, however,

social change and urbanization have been associated with high incidences of mental disorders. If this be the case, then it is possible that there may be widespread or increased incidences of psychiatric disorders in the community in the developing societies.

That notwithstanding, mental illness has been, and is, endemic in every society. Though this is the case, however, mental illness is widely regarded and the causes taken to be multiple and varied, ranging from biological, psychological to sociocultural factors. In the same way syndromes and etiologies are multiple and overlapping, so are therapies and therapists. Thus no single cause of abnormal behaviour can be identified nor can any single model of abnormal behaviour be posited; consequently, there is no single medical model/system that adequately deals with such varied causes.

What may be considered mental illness in one culture may go undetected in another. Thus, culture plays a very important role in identifying and assigning sick role with regard to mental disorders. Also, it is evident from the literature that reactions towards the mentally ill are related to the way afflicted individuals are able to function both in and outside of institutions. As such mental illness is measured in terms of deviation from normative expectations. This implies that mental illness is still perceived and considered as wildest insanity.

Given this kind of understanding, it is possible that certain serious symptoms of mental illness are not able to be recognized by laymen and such patients are denied privileges of a sick role.

2.2 Theoretical Framework

In this study certain theories were utilized.

2.2.1. Disease theory system

This theory was propounded by Foster and Anderson (1978). The theory deals with classifications, cause and effect of disease and illness. Disease theory system embraces beliefs about the nature of health, causes of illness and remedies, and curing techniques. Explanations given by people to account for loss of health; explanations such as curse, breach of taboo, an upset in the hot-cold balance within the body, theft of soul, or the failure of human organism's immunological defences against pathogenic agents such as germs and virus are a major concern of the disease theory system.

The following ideas emerge prominently from the disease theory system.

(a). It provides a rationale for treatment. This is to say that the perceived causation provides the logic

for treatment.

(b). It explains "why", that is the theory is not only limited to providing a guide to therapy but also deals with the much wider question of what has happened to disturb the patients social relationship or what happened to make the patients ill.

(c). It plays a powerful role in sanctioning and supporting social and moral cultural norms particularly when illness is attributed to sin, taboo violation, and other forms of wrongdoing.

(d). It may also provide the rationale for conservation practices. This is particularly so in the preservation of ecology and sociocultural practices that may have some bearing on the health of a given people.

The disease theory system is applicable in this study for it helps in understanding people's behaviour and beliefs with respect to mental illness. It is possible, therefore, from the perspective of this theory to accept that a preferred mode of treatment stems logically from the perceived cause as the theory argues that causality systems are, in large part, rational and logical in that curing techniques are functions of, or stem from, a distinctive conceptual organization of ideas

about causes; and that they can be thought of as irrational only by people from other cultures (Foster and Anderson, 1978:37). The theory is thus a logical conceptual and intellectual construct which is part of the cognitive orientation of the members of the group in question.

Utilizing this theory, it is possible to understand why traditional disease causation concepts and treatment still persist even after western health care and other innovations have long become attractive.

2.2.2 Labelling Theory

Recently the labelling theory, otherwise known as societal reaction theory, has aroused strong interest among people concerned with mental illness. Labelling orientation represents a radical departure from the application of medical conceptual framework to the study of mental illness. The labelling theory emphasizes the social meanings imputed to deviant behaviour and focuses on the unfolding process of interaction whereby self-definition is influenced by others (Murphy 1978:250). Several authors have demonstrated well the relevance of labelling theory in the study of mental illness. Mustafa (1974) and Opler (1959), for example, have in their works on culture and mental illness argued that sociocultural factors are related to psychological disturbances which

directly may give rise to what may be considered as maladjustment behaviour in the individual. Scheff (1967) has provided the most systematic theoretical statement regarding labelling and mental illness. In his formulation,the primary deviations that are fed into interactional process to come out as mental illness are described as "amorphous", "unstructured" and "residual" violations of a society's norms.

The salient features of the behaviour patterns called mental illness from the perspective of labelling theory are well demonstrated by Murphy (1978:248). The following are among the features.

(a). These behaviours represent deviations from what is believed to be normal in a particular sociocultural group.

(b). The norms against which the deviations are identified are different in different groups.

(c). Like other forms of deviations they elicit societal reaction which convey disapproval and stigmatization.

(d). A label of mental illness applied to a person whose behaviour is deviant tends to become fixed.

(e). The person labelled as mentally ill is thereby encouraged to learn and accept a role identity which perpetuates the stigmatizing behaviour pattern.

The labelling theory contends that despite efforts to humanize treatment of mentally disturbed people, the attitudes of the public and even the professionals are characterized by fear, hostility, aloofness, suspicion, and dread; and that once the label of mental illness has been applied, the diagnosis acts on all of them, that is, the patient, family and relatives and this becomes a self-fulfilling prophecy. Eventually, the patient accepts the diagnosis, with all its surplus meanings and expectations and behaves accordingly (Murphy, 1978:249).

This theory further argues that social reactions are related to differences in the ways abnormal individuals are able to function both in and outside of institutions; and that labelling studies of mental illness have shown there are variations in the definition and tolerance of mental illness. Thus, labelling orientation adopts the cultural relativism approach in which the culture of a given group/people provides a vocabulary of terms for categorizing many norm violations (Scheff 1967). Further, Scheff contends that cultural stereotypes tend to produce uniformity of symptoms within a cultural group and enormous difference between societies.

Thus what may be mental illness in one culture may be considered normal in a different culture. Thus, the primary deviations of mental illness become, for the most part, insignificant, and societal reactions become the main etiological factor. There is consensus, however, that in almost all societies the label "mentally ill" is a stigmatizing and brutalizing assessment and it forces the individual into an ascribed role, exit from which is extremely difficult.

In the labelling approach popular conceptions of mental illness by the public and views which are typically held by laymen concerning mental disorders become very informative in definitional process by which persons within a community are adjudged "mentally ill". The approach is descriptive and affects attitudes of the public which are largely influenced by beliefs in causation of mental illness. In fact Thomas and Zuaniecki (1974) contend that attitudes can and actually are affected by our definitional process, where attitudes are seen as part of subjective behaviour. Definition and causation beliefs will largely determine the choice of therapy in a given culture. It is, however, observed that popular conceptions of mental illness as the wildest "insanity" (which still remain a significant component of public opinion) are often oversimplified to a point where it becomes difficult for any theoretical formulations. This means that methodology is very important in the

study of mental disturbances.

Although this study was basically exploratory and descriptive, certain hypotheses were advanced to be tested against the data collected.

2.3. Research Hypotheses

On the basis of the literature reviewed herein, the following research hypotheses were advanced to guide the study and be tested against the research data.

1. Cultural perceptious of mental illness determine the extent to which people reject various indicators of disturbed behaviour.

2. Attitudes towards those who are mentally ill are determined by the perceived severity of mental disorder.

3. Therapeutic choice is by and large a function of etiologic beliefs.

4. The future of traditional healing largely depends on its perceived effectiveness.

2.4. Operational Definitions of some concepts.

It is imperative that certain concepts applied in this study be defined clearly so as to be understood. These concepts are conceptualized within the context of the study. As such they may not be defined in accordance with those found in the standard dictionaries.

Attitudes: refers to mental view, reactions or feelings towards mental disorder or the mentally ill. These were elicited through the use of a scale questions read to the respondents and their responses recorded.

Perception: refers to cognition or intuitive recognition.

Etiology: refers to cause of an illness.

Etiology beliefs: refers to beliefs about causes of illness. In our case mental illness.

Therapy: is a treatment of a disorder.

Therapists: those who treat disorders. In our case mental disorder.

Therapeutic Choice: is a choice of treatment.

Cultural perceptions: are community's models, i.e., the way people view and understand or define mental illness. In our case it is the way Babakusu view and understand or define mental illness.

Future: refers to continuity or persistent of traditional healing.

Efficacy: is the ability of traditional healing, religious healing or other forms of healing to produce the desired effect.

Effectiveness: used to denote the ability of traditional healing to produce the desired results.

Management: refers to therapeutic atmosphere which involves decisions making, choice of treatment, demonstrations of support, love etc.

Mental illness/Mental disorder/ psychiatric disorder:

In the real sense this concept has no clearly

specified label. Babukusu who are the focus of this study defined it as disease of the head. This implies that the individual concerned does not fit well into the order or system of his time or culture. It becomes visible when persons in the participant's group recognise the individual's inability and reluctance to make proper responses in his network of interpersonal relations; or deviation from socially acceptable norms.

Occupation: is defined as the main activity a person/persons does/do, and is therefore different from employment.

Household: a group of persons who normally live and eat together, whether or not are consanguineals (related by blood) or affines (related by marriage) and who share a common source of food.

Family: a group of persons who reside or do not reside together but have consanguineal relationship .

Farmer: a person who works on or cultivates a piece/pieces of land; though not necessarily the legal owner.

Age: the length of time in years a person has lived and is categorized as young (18-35 yrs) middle aged (36-54 yrs) and old (55 and above).

Education: defined in terms of formal education. It directly refers to the level of schooling one has attained. It is recorded here in categories of "none", "primary" and "secondary".

Sub-location: an administrative unit under one government representative, the assistant chief.

Village: a unit of people living within one administrative sub-location. Is the smallest administrative unit and is headed by a headman. In my case the headman is referred to locally as omukasa.

Socioeconomic status: refers to the social and economic class an individual occupies whether ascribed or achieved. In our case it is measured by mainly age, education, occupation and sex.

Symptoms: Used to denote any noticeable changes in the behaviour or functioning of the mind of the individuals to indicate mental disorder. These included unacceptable behaviours which the people were able to identify.

Religion: used to refer to one's affiliation to a denomination or sect. Since the predominant religion was found to be christianity (at least among the sample- 94%) religious affiliation was not found to be a major factor in influencing perception and beliefs on the causation of mental disorders.

Reaction: used here mainly to refer to attitudes of the community towards the mentally ill and traditional healing.

Public: used here to refer to mainly the Babakusu.

Traditional healers: defined as a group of persons recognized by the community in which they live (Babukusu in our case) as being competent to provide health. Their methods are based on social, cultural and religious

backgrounds prevalent in the community and they treat physical, mental and social ills.

Healer shopping: used to refer to the use of a second healer without referral from the first for a single episode of illness.

Footnote:

1. Director of Medical Services, in the Daily Nation, April 20, 1991.

CHAPTER 3

METHODOLOGY

3.1 Research Site

Bungoma District is one of the four districts in Western Province of Kenya. It is located on the Southern slopes of Mt. Elgon and covers an area of 3074Km^2 (Republic of Kenya, 1989). To the northwest the District borders Uganda, to the North is Trans-Nzoia District, Kakamega District to the East, Southeast and Busia District to the West and Southwest. Bungoma District has seven divisions, twenty four locations and seventy three sublocations. The divisions are Webuye, Kanduyi, Kimilili, Sirisia, Tongaren, Kapsakwony and Cheptais. However, the data for this study were mainly collected from North Bukusu Location in Sirisia Division.

In general Bungoma District rises from 1,200m above sea level in the West to over 1,500m above sea level to the North, with Mr. Elgon as the most conspicuous feature which rises to 4,420 M above sea level (Republic of Kenya, 1989). There are inselbergs and ranges which stand above the general level, including Kabuchai and Luucho hills in North Bukusu Location. The mean annual temparatures in the southern parts away from the mountains are above 21.22^{0C} while in areas close to the

Mt. Elgon the mean annual temperatures range from 5°C to 10°C.

The climate, topography and geology work together to determine the soil structure and patterns of the district. The soils range from mountain soils to volcanic soils with cotton and clay soils being prevalent. Thus soil fertility varies from place to place. The district is productive with an average rainfall of about 1270 mm per annum (Nasimiyu, 1985). In general the district experiences two rainy seasons - long rains and short rains. The long rains are from March and continue to June or July with April and May receiving the heaviest. On the other hand the short rains are from August to October (Republic of Kenya, 1989). All parts of the district receive adequate rainfall.

3.1.1 Economic Activities

Agriculture is the main base of the economy, accounting for over 60% of the income earning activity in the district as a whole (C.B.S, 1984). Both food and cash crops as well as vegetables are grown. In North Bukusu, sunflower, sugarcane, bananas, and maize are commonly found. Other crops grown in the district include coffee, cotton, cabbage, citrus fruits, onions, tomatoes and potatoes (Republic of Kenya, 1989). Livestock farming is also practised, with both indigenous

and grade cattle kept in North Bukusu and the district as a whole. It is not uncommon to find people, particularly women and young girls, selling fruits such as bananas and pineapples on the road sides, for example, along the Bungoma-Bungoma-Bokoli-Kimilili road which passes through parts of North Bukusu location.

There are no industries located in the location in particular but the district has a number of industries. They include Pan African Paper Mills at Webuye, Nzoia Sugar Company, and the Cotton Ginnery and Tobacco Leaf Centre both at Malakisi. Transport in general is fairly good with the Bungoma-Bokoli-Kimilili road passing through parts of North Bukusu location. The Great-North Road also passes through the district . However, some areas lack means of communication. People riding bicycles to and from Bungoma town is a common feature.

3.1.2. Health Facilities

Bungoma District has four hospitals, one government hospital, two mission hospitals and one private hospital; ten health centres, twenty three dispensaries and four mobile government clinics (Republic of Kenya, 1989). Others are under construction. North Bukusu has Kabuchai Health Centre. Like elsewhere in Kenya health services are inadequate in terms of personnel, equipment, drugs and other facilities. Some health facilities are

inaccessible whereas in some cases are not available altogether. In 1988, hospital - population ratio stood at 1:250,057 while doctor-population ratio was 1:83,352 (Republic of Kenya, 1989:184). The psychiatric facilities in Bungoma District are far less than adequate with only a few psychiatric nurses, the majority (four) of whom are in Bungoma District Hospital. Official records show that Kabuchai Health Centre has a psychiatric nurse but at the time of the research there was none in the institution.

There are about 50[1] registered traditional healers but it is presumed that this is far less than actual figures of the traditional practitioners in the district. There are 312 trained Traditional Birth Attendants (TBAS), baloosi babebusia with many others without training. Religious healers are also found in the district but their actual numbers is not known.

Malaria infection represents the highest morbidity in the district with 167, 695 cases in 1987. In 1988 there were 167 in-patient mental cases while in 1989 there were 232 out-patient and 142 in-patient mental cases. In 1990 there was no significant change in the number of out-patient and in-patient mental cases as there were 207 and 168 cases respectively[2].

3.2. Population

The 1979 population census shows that there were 503,935 people in Bungoma District. From the same census North Bukusu Location had a population of 21,393. Between 1969 and 1979 annual growth rate was 3.85% and this increased to 4.2% per annum between 1979 and 1988. It was projected that the district will have a population of about 786,379 people by the year 1990 (Republic of Kenya 1989). This demographic trend is typical of a growing population at a high rate.

According to the 1979 population census, the main ethnic group residing in Bungoma district are the Abaluyia, 81.35% (the most predominant who are mainly the Babukusu), Kalenjin, 9.95% (mainly the Sabaot some of whom are found in North Bukusu) and Iteso 4.8%. Others include the Akikuyu, 1.52%, Luo 1.15% and nationals of other African countries, 0.77%. Others include Abagusii, Turkana, Asians, Europeans and Arabs (Republic of Kenya, op.cit). North Bukusu, from which data on the general population were collected, is predominantly inhabited by Babukusu but has a few Kalenjins. In the district as a whole there is no good reason to expect the 1979 population proportions to have changed significantly over the past years and are therefore considered to be quite close to the present reality.

3.2.1. The Babukusu

Abaluyia are not originally an homogenous group but rather have diverse historical roots and this has resulted in numerous variations in their dialects, customs and practices (Were, 1967). They are a collection of groups with Bantu and non-Bantu origins all of whom moved to Western Kenya at various times in the past. In spite of their diverse origins, they speak mutually-intelligible Luyia dialects and share many cultural characteristics (Were, 1967; 1985; Wandibba, 1985).

The Babukusu, who are the focus of this study, are one of the Abaluyia subtribes (Makila, 1978). They are believed to have common historical background with their neighbours the Kalenjin speaking group (Wandibba, 1985; Were, 1967). Like many Bantu in Kenya, Babukusu trace their origin to mythical ancestor they call Mubukusu (Were, 1967). They are patrilineal and therefore an individual becomes a member of his father's clan by birth (Wagner, 1949). Bukusu patrilineal clans comprise all persons who trace their descent in paternal line to a common ancestor. Each Bukusu clan has its own prohibitions which provide its code of conduct. Some of these include food prohibitions which have to be observed. For example, Batakhwe clan does not eat guinea fowl, ikhanga, for when members of this clan do they get

rashes all over the body; <u>Baemba</u> clan does not keep cows or bulls which have black and white stripped skin, <u>ekhafu eng'enda</u>.

Marriage is an important institution and traditionally serves to legitimize children (Wagner, 1949). Traditionally children are highly desired particularly male children. Because of this, there has been an emphasis on procreation by parents (Wagner, 1949; Nasimiyu, 1985). Exogamy is a core expectation of a nuclear family members. Exogamy may be on either of both sides, that is, mother's or father's, hence individuals have to marry outside certain designated groups to which they belong. Polygyny is not uncommon practice where by men have between one and six wives who are socially and legally recognized but this is reasonably correlated with the age of the husband and economic factors.

Extended family is widespread and this is probably due to its adaptive role, especially in providing the organizational basis for pooling productive resources particularly land and labour. However, each component nuclear family typically maintains a functionally separate household in terms of cooking arrangements, residence, and so on. Traditionally age and sex determine the division of labour. Women, assisted by young girls perform roles such as cooking, fetching water and firewood, taking care of the home and children and

attending the farms. Men and young boys performs such roles as looking after cattle, construction of houses and clearing the bush.

We must, however, note here that the traditional division of labour among the Babukusu has changed. The shift from economic self-sufficiency within the traditional family to dependence on the market economy has affected both the division of labour and the social cohesion. The continuous flux in search for employment by men has not only affected social cohesion as a result of separation in family lives, but has also increased women responsibilities besides their traditional ones. They now look after cattle and other livestock.

Babukusu have an age-grade system reminiscent of that of the Kalenjin marked by the institution of circumsion, while their war organization is similar to that of Maasai (Wesonga, 1985). Traditionally Babukusu are very resistant to invasion and are known to have resisted the British in the bloody, untimely abortive Chetambe war at the turn of the century (Wandibba, 1985).

Respect and authority among the Babukusu go with age, and so elders are highly respected (Wagner, 1949). Furthermore, old men are highly respected as potential troublesome spirits; their curse is feared too because it is efficacious. There are several rituals which are

supposed to be performed, failure of which may result in illness. Traditionally these rituals are performed in all stages of life as well as after death. Circumsion confers some status on the initiates just as marriage does on the individuals involved.

There are specialists, among them diviners, medicinemen, traditional birth attendants, religious healers and sacrificial priests, who must be without failures and blemish and wield a lot of mystical powers. They are often consulted by the people and help solve some of their health problems. Some of the illness which requires their attention include sudden and violent illness, repeated bad dreams in the course of which a patient suffers from appearance of the spirits of the dead, as well as hallucinations and many others (Wagner, 1949). A diviner would be consulted to know the cause and the appropriate treatment. In short the Bukusu belief system is similar to the belief system of many other societies in Africa and Kenya in particular.

3.3. Sampling

In this study there are three different samples. One sample is drawn from the general population. In this category the ideal sample unit is defined as the household. This sample includes households with mental cases. The other sample is drawn from the modern medical

professionals among them psychiatric nurses, and the third sample is selected from the traditional healers.

Before proceeding to the field, I anticipated to draw the sample for the general population from two locations in order to increase the chances of getting households with psychiatric cases as they are not concentrated in one locality. I also anticipated to carry out a household census survey of the two locations which would have comprised my sampling frame. I had worked out a recording schedule on household census survey which would have yielded the following information on the members: age, education, occupation, marital status, household structure and mental cases, that is, whether the household had a mental case.

However, realities in the field proved different. Given the limited time, personnel and financial resources, it was not feasible to take census of two locations. I opted to carry out the research in one location. I therefore chose North Bukusu location as my research area. Furthermore, records from the district hospital showed no evidence of regional variability in terms of mental illness prevalence throughout the district. North Bukusu location, however, was found to be ideal due to its accessibility as it was close to Bungoma town and that Bungoma-Bokoli-Kimilili road passes through the location. Means of transport was therefore

regular. The location also had a modern health facility, Kabuchai Health Centre, which gave people option of this type of medical care.

After identifying the location I set out to do a household survey of the entire location so as to compile a sampling frame from which to draw my sample. Again the same constraints viz, time, personnel and financial resources weighed heavily against me. I finally adopted a method of getting my sampling frame without counting each and every household in the location.

I set a sampling frame of 2,000 households. This figure was expected to be about one half of the number of the total households in the location (Note: the 1979 population census indicated that the number of households in the location was 4,755).

With the assistance of local adminstration, the Assistant Chiefs, two young men and the respective headmen of each village I carried out a census of each sub-location. After a period of about four weeks, I ended up with a sub-census of the households population of 1900. Each of the three sub-location was represented in the sub-census by at least 630 households with each single village in the location represented.

The required sample of the general population was estimated at about 150 households. I expected my sampling frame to include households with mentally disturbed persons. My sub-census had six households with mentally ill persons. These ones were conveniently isolated to be included in the sample. A list of the remaining households in each sub-location was compiled, and the households were assigned numbers. These numbers were used to randomly select 135 households; 45 from each of the three sublocations, West Nalondo, North Nalondo and South Nalondo. It was expected that this would create fairness in the sample because one principle of random sampling is that each individual or household had an equal and non-zero chance of being included in the sample.

Because of the nature of my study more households with mental cases were required so that if some refuse to cooperate there would be some left to provide the required information. I therefore and conveniently identified and selected more households with mental cases outside my sampling frame. Thus with the help of the two young men, village headmen and the Assistant Chiefs I selected 8 more households with mental cases. Thus from the general population I selected a sample of 149 household which included 14 households with mental cases. However, in the general population after all the refusals, using both purposive and random sampling

procedures, a sample of 104 households which included 6 households with mentally disturbed persons was finally employed. In every household, one member aged 18 years and above was randomly selected for questionaire administration and interview on concepts of causation, symptoms, treatment and prevention of mental illness. However, for households with mental cases the head of the household was prefered. Where possible discussions were held with cases which had been ill but recovered.

The second category of my sample in this study was drawn from medical professionals. To get the general overview of the problem of mental disorders in the district some modern medical professionals were interviewed. 24 modern medical professionals were sampled from 14 health institutions in the district. 6 were from the district hospital (government), 2 from each of the other three hospitals and the others were drawn from ten health centres in the district with at least 1 respondent from each health centre. Of the 24, were 4 psychiatric nurses who as key informants gave detailed information about mental illness in the district. The psychiatric nurses were conveniently included in the sample for detailed information. Information from medical professionals has also been used for comparison purposes.

The third category of the sample employed in this study was selected from traditional healers. With the assistance of the district culture office, a list of those registered in the district was obtained from the District Chairman of the local Association of Herbalists and Traditional Healers. There are about 50 registered traditional healers in the district. The reputable ones were identified with the help of the chairman to be included in the sample. Numbers were assigned to the names of the remaining traditional healers to randomly select the sample. Again after refusal by some of the traditional healers a sample of 24 traditional healers from various parts of the district was finally employed. The traditional healers were interviewed on the treatment, management of mental illness and their practice in general. They were also interviewed on the causation of mental illness. It was necessary to select some traditional healers to assess their role in the community and particularly in understanding and dealing with the problem of mental illness. Their information has also been used for comparison.

Thus employing both probability and non-probability sampling procedures a total of 152 respondents were selected. The sample could not be larger than the stated one because time, personnel and budgetary constraints heavily weighed on the researcher.

3.4. Data Collection

A number of techniques were employed to obtain both qualitative and quantitative kinds of data.

3.4.1. Documentary Materials - Secondary Data

Before embarking on the field study written materials about mental disorders and traditional healing were reviewed. Only pertinent issues were examined and it is from written materials that the research proposal for this study was developed. Though the study was anthropological, some medical books and journals were examined to acquaint the author with some medical terms. On the whole, the materials reviewed included books, journals, papers and articles. However, literature on mental illness in Kenya particularly the social and cultural aspects of mental illness is scarce. Enthrography of Babukusu was reviewed and written. Space could not allow to detail every aspect of Bukusu life hence what is presented in this piece of work is brief, and deals mainly with the social organization of the Babukusu.

The secondary data provided the framework within which to operationalize the study. A set of hypotheses to guide the field study was also formulated.

3.4.2. Health Centre Data

Medical records in some of the health institutions particularly Bungoma District Hospital and Kabuchai Health Centre, were examined for illness morbidity. However, these records were found to be inadequate as regards mental illness though they had some useful information on some illnesses known to have some bearing on mental disorders if not properly treated. For example, the 1987 statistics on disease morbidity/mortality show that over half of the reported illness episodes in the district were malaria cases. If left unchecked this may have serious implications on both the physical and mental health of the people.

3.4.3. Random Sample Interview Schedule

General population

Structured interview schedule in the form of questionnaires were administered to the respondents. The questionnaires had both open and closed ended questions. Most of the responses emerged from the respondents and apart from those questions coded beforehand, the questions were coded after the data collection process was over. Some of the questions coded beforehand were re-coded. Though the questionnaire were not written in Bukusu language they were translated by two research

assistants who were Bukusu. The questionnaires were administered by the principal researcher with the help of the research assistants. It was necessary to engage and train research assistants to be conversant with the form structure and contents of the questionnaires and also for communication purposes since the principal researcher was not a Bukusu, neither could he speak nor understand the language.

However, in spite of this limitation there was one advantage in the field, that most of the respondents could speak and understand Kiswahili and that made the communication easy, particularly in translating and explaining the questions to the respondents. The responses were recorded in the space provided for in the questionnaire. The questionnaires contained questions designed to elicit information on the causation beliefs, treatment and the role of traditional healers.

Interview schedule enabled the respondents identify in their own words the symptoms and behaviour of the mentally disturbed persons. Also included were questions designed to assess the feelings and attitudes of the respondents towards mentally ill/mental illness and their perception of mental disorders. A likert attitude scale using responses, some of which were re-coded after, was constructed. The alternatives were read out to the respondents and answers ticked.

Modern Medical Professionals and Traditional Healers

Besides the structured interview schedules with the general population, there were also structured questions in the form of questionnaire for modern medical professionals and traditional healers. There were two sets of questionnaires which were similar. Some of the questions, however, differed either in the sequence of the wording or the way they were asked. In spite of the differences they were intended to elicit similar information from the respondents. The information from the two sets of the questionnaire was used to compare the understanding of the causation and treatment/management of mental illness. The questionnaires contained both open and closed ended questions which were coded or re-coded after the data collection process was over.

3.4.4. Unstructured Interview

Unfocused in-depth random discussions were held with the informants in order to enrich my data. It was necessary to utilize this technique to obtain data in spontaneous and less controlled settings. Descriptions of some behaviours known to be exhibited by people with psychiatric problems were suggested to the respondents to assess the understanding and perception of mental illness. This information was recorded in a notebook to help in the interpretation and analysis of the data.

Proper rapport with the people had been initiated in the preliminary days of the field study. A Chief's "baraza" (meeting) was convened to introduce me to the general public. At the meeting, I made it abundantly known to the people in attendance the nature and objectives of the research and the means of acquiring relevant data.

The "baraza" turned to be the first major test of what to expect in the field. Questions were asked; how do we gain from the study? And will the respondents be remunerated? Why not look at the Malaria problem which is the most serious disease afflicting the people?--- and so on.

The questions put forward were meticulously answered so that by the end of it all, the audience was fully satisfied and ready to render any assistance needed from them. I took advantage of public gatherings and social meetings to engage a group of people or an individual in discussions. Such informal discussions were essential for providing qualitative data.

3.4.5. Focused Group Discussions

Discussions with groups of about five individuals were held. Caution was taken to ensure that age and sex did not interfere with a given group discussion. One

such group discussion was held with old men of between 50-65 years and they were in a social place (they were drinking Kamalwa). Another group consisted of relatively young women of ages ranging between 28-32 years. It was only one group discussion which had both young men and women of ages 24 to 26 years. With this group the discussion was very encouraging as the participants shared many things in common including their level of education. In all focused - group discussions the researcher raised questions regarding mental illness and the discussion went on unsystematically but with guiding questions - conclusions from the discussion were drawn and the salient features from the discussion noted in a notebook.

3.4.6 Direct observation

Simple observation technique was employed. Particularly the researcher was interested in establishing whether the community members do actually consult traditional healers. The researcher visited several traditional healers and almost all traditional healers visited had patients. In one such visit 10 patients were found waiting to be attended to. It was only one traditional healer who at the time he was visited had a patient with psychiatric problems and the patient had just been attended to and taken to a resting room for observation. Also religious healers were

visited to see whether they get clients and in one such visit in Bungoma Municipality a religious healer had clients who had health and non-health problems. A 38 years old mother who had economic problems had brought her son for prayers so that they can be able to get school fees. At the time of the visit they were in the process of prayer.

A lot was learned from direct observations and this helped in assessing the alternatives people have for solving their problems. Direct observation technique helps test ideas against observations. It is a very helpful way of collecting information particularly qualitative kinds of data; hence Bernard (1988:287) says of the direct observation: "it allows researcher to address important theoretical issues".

3.4.7. Key Informant Interviews

Key informants are those respondents with detailed information about a particular issue. These are the informants who are conveniently selected. Modern medical professionals were consulted. In this category the researcher was interested in psychiatrists. However, there was no psychiatric doctor even in the district hospital. Because of this situation it was felt reasonable to hold discussions with psychiatric nurses who were drawn from various health institutions in the

district. Psychiatric nurses helped the researcher to understand how the public perceive mental illness. It is also from such discussions that the researcher was able to get the general picture of the problem in the district, what the people consider to be the causes and some cultural practices that may have some bearing on some psychiatric problems in the area.

Traditional healers who were consulted on certain aspects of the disorder such as treatment and management provided useful information. In-depth discussion with care-givers, particularly families with mental cases also helped in the understanding of the management of the illness. Attitudes towards the psychiatric cases and causation beliefs of particular cases are best measured with the data from care givers.

It was expected that the methods described above would yield data on the problem of mental illness in Bungoma District, particularly cultural definitions, perception, attitudes, causation beliefs and management of mental illness.

3.5 Field Problems

Although the study was completed successfully a number of problems were encountered. Some of the problems were resolved in the field whereas others could

not be resolved. Medical records in both Bungoma District Hospital and Kabuchai Health Centre though enormous were inadequate.

Initially when the study began it was thought that the medical records could be used to trace the families with mental cases or even the patients but this proved misleading. This was because some people with psychiatric problems may not report to a health facility. Others with psychiatric problems may complain of other problems such as headache and in the absence of a trained psychiatric personnel their real problem may go undetected. Thus the necessary information in Kabuchai Health Centre was missing because at the time of the research there was no psychiatric personnel, although officially and on record there is supposed to be one. Furthermore, even where there were those records like in Bungoma District Hospital it was only figures which had no names of family, location or sub-location. In the absence of reliable records it was only reasonable to use the community leaders who include village elders <u>bakasa</u>, and members of the public to locate such families. That is why convenient sampling became very necessary. In some cases respondents were used to identify other respondents particularly families with mental cases. Thus the principle of snowball sampling technique was adopted which requires that a researcher uses a respondent to identify other respondents.

However, that had its limitations. People were reluctant to identify households with psychiatric cases. It is well known that mental illness is a socially stigmatized illness and so identification with it is likely to create social strains. One family with a mental case when asked whether they knew another family with the same problem in the same area the mother responded: "why are you asking the obvious and you know where you can get such people?". And in fact some households with mental patients would not give any information. I was aware of that fact as the research topic was sensitive. In the event of such a behaviour the respondents who refused to cooperate would be altogether abandoned and go to the next one in the sample. That explains why I settled at a sample of 152.

There was suspicion on the part of the respondents. One traditional healer when visited and after introduction responded: "you have been sent by the District Commissioner to investigate my work so that you can have me arrested?" It was however explained that the study was both an academic pursuit as well as data that may be used by policy makers to help understand traditional healing system as a whole.

There was at times communication problems as the researcher was not a Bukusu and did not speak the Bukusu language. This particular problem is the one which

actually prompted the engagement of research assistants who helped translate the questions. Visiting and tracing the respondents was not easy as besides inadequate means of transport, respondents in some of the sampled households were absent. Female respondents in some households would not give information in the absence of their husbands for fear of reprisals. This and the above problems constituted a major problem in terms of timing.

Initially the study had been allocated two months but as it turned out it took more than three months, that is, the field work commenced in the month of December and ended in March. As indicated earlier that was because of limitations in resources such as personnel and money which weighed heavily against the researcher. These were the major problems that were encountered in the field.

3.6. Data Analysis Procedures

In this study both qualitative and quantitative techniques are used for data analysis. Percentages, cross-tabulations, correlation and comparison of means in terms of the t-test are employed. Because of the very nature of the present study qualitative analysis is emphasized for better understanding of the results. Some of the data were worked out on a computer.

Data on etiologic models are categorized into

social/cultural, biological and combination of etiologies for purposes of analysis and have been expressed primarily as percentages. This information is, however, at best qualitative and helps to explain and understand various etiological concepts; hence Bernard (1988:322) notes about comments in qualitative data analysis: "..quotes that lead the researcher to understand quickly what it took one month to figure out". In the management of mental illness the data have been described using case studies for better understanding of the way Babukusu treat the mentally ill. Descriptive statistics are used in the analysis of etiological concepts and therapeutic choice. About the usefulness of descriptive statistics, Norcliffe (1977:19) notes: "it is designed to describe a given situation so as to yield qualitative information."

Inferential statistics which allow one to make probabilistic statements about relationship between variables and the population from which the sample is drawn have been applied. The Chi-square (X^2) measure has been applied to test the statistical significance of relationship between some variables in the analysis. Contingency coefficient has also been used to determine the strength of the association between certain variables. Pearson correlational analysis between certain variables has been applied. Therapeutic choice and etiologic concepts from modern therapists and traditional healers have been selected and comparison of

means of the two groups done to find out whether there is any significant difference.

Footnote

[1]. Information from the Chairman of the local Association of Herbalists and Traditional Healers. Also from the District Documentation Centre.

[2] Bungoma District Hospital Medical Records.

CHAPTER 4

CULTURAL PERCEPTIONS AND ATTITUDES TOWARDS MENTAL ILLNESS AND THE MENTALLY ILL

4.1. Cultural perceptions of mental illness

It has already been indicated that laymen may not be able to identify or recognize certain serious symptoms of psychiatric disorders for they dismiss them as normal (Ndetei and Muhangi, 1979). This is so partly due to the fact that a large number of people limit the concept of mental illness to the behaviour exhibited by schizophrenics and those in acute psychotic states which are in fact the common disorders in mental institutions, while psychoneuroses such as anxiety and depression go unlabelled yet such conditions are more prevalent in the general population (Acuda, 1983). And Logan and Hunt (1978) argue that a phenomenon labelled "mental illness" in one culture may go unlabelled elsewhere. That is to say that culture provides a set of shared beliefs, values and customs (Kiev, 1976). Psychiatric disorders are thus culturally defined. Psychiatric disorder means, in effect, simply that the person concerned does not fit well into the "order" or system of his time, place or culture (Masserman, 1976).

In the same way the concept of psychiatric disorder is culturally varied so is the concept of normal. Socially normal simply refers to the ability of individuals to engage in a proper and acceptable behaviour (Masserman, 1976). This has, as it will be seen later in this chapter serious implication for the way members of the public react towards the mentally ill. It was hypothesised that cultural perception of mental illness determines the extent to which people reject various indicators of disturbed behaviour.

In attempting to understand the Bukusu definition or perception of mental illness, the respondents were asked to define what they considered to be mental illness and the following results were obtained: 37.5% defined mental illness as a disease of the head, 35.6% of the respondents said it is abnormal behaviour while 26.9% gave a combination of answers. Such definitions include loss of senses, traditional illness and unstable head. From these findings it can be deduced that the Babukusu use the concept head to refer to mind. Thus findings imply that the Babukusu have a knowledge of what mental illness is but they have a wide range of definitions. Among the behaviours said to be abnormal are laughing alone, eating dirt, going naked or in tattered clothes, wandering, and so on. Disease of the head was described as the individual's head being affected so that the

victim loses touch with reality hence behaviours such as hearing voices (hallucinations), shouting, anti-social behaviours such as violence, insulting other people for no apparent reason and even raping.

Clearly the foregoing descriptions point to the divergent views held by Babukusu about mental illness; such views tend to conform with the observations of Szasz (1967) that mental illness is widely regarded even within a community. We also note from the responses that the descriptions seem to point to the severe psychiatric disorders.

About the indicators of mental illness the responses below were obtained. 14% of the respondents mentioned physical appearance as the major indicator of psychiatric illness while 34% cited unusual behaviour and 52% said that indicators of psychiatric illness are a combination of factors including both physical appearance and unusual behaviours. Only 1% could not tell the indicators of psychiatric illness. None of the respondents mentioned alcoholism, insomnia, anxiety, hopelessness, sadness and restlessness as some of the experiences that may have a bearing on psychiatric disorders. Such findings seem to concur with Ndetei and Muhangi (1979) that in many societies particularly in Africa, concepts like anxiety, trouble-sleeping, sadness do not carry medical implications.

It must, however, be pointed out that although people in these cultures may not place such experience in the domain of mental illness they nevertheless complain about the experiences mentioned above and it is not uncommon for them to seek help from traditional healers and/or herbalists. Scheff (1976) is of the same opinion when he observes that hopelessness, trouble-sleeping and juvenile character disorder show public ignorance concerning signs and symptoms of mental illness although people do complain about those experiences and seek treatment. This is probably so because mental illness is stigmatized and that once the label "mentally ill" is applied on an individual it becomes a self-fulfilling prophecy for both the individuals and the family members (Murphy, 1978:249). Also it is plausible to argue that there is lack of knowledge on the part of the community that such experiences tend to be manifestations of psychiatric disturbance.

Thus, from the foregoing argument it can safely be argued that the respondents were only able to identify and associate mental illness with those overt behaviours and where individuals do not behave according to the normative expectations. These are physical appearances which may embarrass the audience as, for example, when one walks naked or in tattered clothings, unusual behaviour such as laughing alone, shouting and abusing

people for no apparent reason. These behaviours reflect extreme or severe mentally deranged personalities. The implication here is that the beliefs of members of a culture as to what constitute illness and its treatment are formed and supported by generally held cultural attitudes (Frank, 1967:170).

The foregoing argument falls well within the purview of labelling approach which emphasises the social meanings imputed to deviant behaviour and focuses on the unfolding process of interaction whereby self-definition is influenced by others (Murphy, 1978). It is also evident that popular conceptions of mental illness as the wildest insanity still remain a very popular concept among the Babukusu in identifying signs and symptoms of the mentally ill. Thus the label "mentally ill" as already indicated is very stigmatizing and it forces individuals into an ascribed role, exit from which is extremely difficult. This may partly explain the reason why the respondents did not think those individuals with psychological and emotional problems which include lack of sleep for a considerable period of time, anxiety and alcoholics are to be labelled "mentally ill". Thus mentally ill persons must seem to be successfully violating the social norms and so become deviant and the label is successfully applied (Scheff, 1967; Masserman. 1976).

However, not all norms which cause the violator to be labelled "mentally ill" and therefore entering the sick role. Some may earn the violator the title of being ill-mannered, ignorant or sinful or even criminal. For example, among the Babukusu, when an individual commits incest taboo kumusilo he may not be considered as mentally ill although his behaviour will be considered sinful and earn him rebuke and demand that be cleansed. However, while the act of incest may not enable people to successfully apply the label "mentally ill" on the individuals, the consequences of such behaviour may and actually subject one to stress from supernatural world as a result of haunting or even punishment from the ancestral spirits.

When the respondents were asked whether they knew individuals who repeatedly create disturbance without any good reason about 60% said that they knew and " they engage into that kind of behaviour when they are drunk". Three of the individuals cited were said to be drug addicts. Asked whether they categorized them as possible mental cases a majority of the respondents, 58% said that they did not consider them possible cases particularly those who do so under the influence of alcohol. One respondent said Kamalwa (traditional brew) does not make one mad .... their behaviour is because they are drunk ... they are normal when not drunk". Thus alcoholism in Bukusu just like in many other societies is not

associated with mental disorders.

However, the respondents were quick to add that such persons may be normal but their behaviour sometimes may be described as that of mentally disturbed persons hence such persons may be referred to as omusiy ingwa but not omukwamalalu (note that it is the behaviour of the individual which is referred to and not the individual per se hence the distinction between the abnormal behaviour and the disease of the head). Omukwamalalu is a mad person who was described as chaotic, violent, talks to himself and may stay away from home.

The argument in this work is thus far consistent with the arguments of the proponents of the determinants model. In this model Shuval (1981) put forward variables he considers important for the individual's entry into the sick role: perceived seriousness and potential consequences of symptoms, the threshold of their visibility, the availability of information and the assumption concerning the causation. Thus a member would be considered for example, alcoholic only if a society recognizes the existence of such and sanctions treatment for that. In our case alcoholism, bunywi was not associated with major health problems and thus no treatment would be sought. These findings can also be seen in the light of the role of alcohol in African cultures. Alcohol is part of a people's culture and is

brewed for social reasons. Each society has its own local brew. Traditionally only the elder became alcoholic, he was tolerated in the community as his alcoholism did not affect many people, either emotionally or economically (Bennett, 1988:47). Thus rural communities tolerate such minor changes (Scheff, 1967) and such behaviours are not necessarily perceived as mental disorders in many African societies (masserman, 1976).

Evidence is abundant that some of the amazingly abnormal behaviours in one culture may be considered adaptationally normal in another culture (Foster and Anderson, 1978; Bourguignon, 1979). For example, some holymen and shaman are psychotics who have been rewarded for their psychotic behaviour by being made incumbent of highly regarded and useful roles. In the view of the audience these personalities play a very important social role and as such they are not perceived as possible psychiatric cases. Among the Babukusu victims of kumusambwa (pl. kimisambwa) are not perceived as mental cases per se although their behaviour when is not any different from that of mentally disturbed persons. When healed from kimisambwa many end up becoming traditional healers and so become highly regarded. To this Bourguignon (1979:276) notes that beliefs influence behaviours or actions and to understand whether actions are bizarre, people must know how they are related to

local beliefs. Thus, in the case of the victims of kimisambwa there is a social opinion and beliefs also shared by the victims that they are not mentally ill but are punished as a result of their refusal to obey certain instructions from the ancestors.

It will be remembered that it was one objective of this study to investigate how the Babukusu perceive mental illness. The foregoing discussion has shown that the beliefs of mental illness as wildest insanity is still very popular. The behaviours of such individuals as we have seen, tend to violate the normative expectations. Indicators of such behaviours are also easily noticeable. I now turn to examine Bukusu perceptions of experience, some of which have already been mentioned, known by professionals to imply psychiatric disturbance. Subjects were asked whether psychiatric disturbance can make one feel restless, sleepless, hopeless or any other unusual feelings. The responses were categorized according to sex and cross-classified as shown in table 4.1.1.

TABLE 4.1.1 Knowledge of signs and symptoms of Mentall illness by sex

	Sex		
	Female	Male	Total
Knowledge			
Yes	58.8(n=38)	41.5(n=27)	62.2(n=65)
No	51.3(n=20)	48.7(n=19)	37.5(n=39)
Total	55.8(n=58)	44.2(n=46)	100(n=104)

Df=1 X^2=.3492, PL=0.05, $P<0.05$ contigency coeff.0698

The above table (4.1.1.) shows that a majority of the respondents (62.5%) agree that experiences such as insomnia, hopelessness, restlessness and other similar experiences may be associated with psychiatric disturbances. Females present a slightly higher figure (58.8%) than the males (41.5%). Asked what they think could be the causes of such experiences, the respondents cited too much responsibility, economic problems and domestic problems. Such experiences are indicators of inability to cope with socioeconomic problems. It has been argued that the majority of the rural population are women. It has also been argued that the majority of the rural population are poor. Further there is evidence to show that rural women have too many responsibilities which include farming, taking care of the home, looking after cattle, domestic duties such as fetching water, firewood, cooking, and so on (Hay and Stitcher, 1984). Such problems and responsibilities tend to lead to stress on the part of women; women may be more familiar with such experiences hence the slightly higher

representation.

Education has bearing on knowledge of signs and symptoms of mental illness. The data on these two variables are displayed in the table below.

TABLE 4.1.2. Knowledge of signs and symptoms of mental illness by education

	Education			
	None	Primary	Secondary	Total
Knowledge				
Yes	29.2(n=19)	33.8(n=22)	36.9(n=24)	62.5(n=65)
No	43.6(n=17)	41.0(n=16)	15.4(n=6)	37.5(n=39)
Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n=104)

Df=2, X^2=5.995, PL=0.05, P>.05, Contingency Coef..22824

X^2 was computed to find if education influences knowledge of signs and symptoms of mental illness and it was found that the relationship is significant. Those with education are likely to have knowledge on the implications of the experiences aforesaid. However, although this may be the position it is not invariably the case that the educated would present problems such as insomnia, restless and hopeless for psychiatric examination. This tends to agree with the observation of Ndetei and Muhangi (1979) that in African cultures concepts like depression and anxiety do not have medical implication; hence on the cultural level alone it is unlikely that patients would complain of these states.

Experiences like insomnia, restlessness and hopelessness are manifestations of the aforementioned states.

The foregoing explains why the variation in the responses in table 4.1.2 is not high as those with relatively more education presented 36.9% while those without education presented 29.2% and is also reflected in moderate contingent coefficient of .22824. However, the educated as we have already seen, tend to be more knowledgeable with regard to signs and symptoms of mental illness. This is likely to influence their perception of mental illness as formal education is one of the severest exposures to Western culture; thus it is safe to conclude that these findings are supportive of our hypothesis.

It is plausible to argue that young people have attained a relatively high level of education as compared to the old people. Education, we have already seem has bearing on knowledge of signs and symptoms of mental illness. We now examine the relationship between age and knowledge of signs and symptoms of mental illness. Table 4.1.3. presents knowledge or perception of signs and symptoms of mental illness by age.

TABLE 4.1.3. Knowledge of signs and symptoms of Mental illness by age

Knowledge	Age: Young	Middle	Old	Total
Yes	53.8(n=38)	35.4(n=33)	10.8(n=7)	62.5(n=65)
No	41.0(n=16)	23.1(n=9)	35.9(n=14)	37.5(n=39)
Total	49.0(n=51)	30.8(n=32)	20.2(n=21)	100.0(n=104)

Df=2, X^2=9.639, PL=0.05, P>.05, Contingency Coef.29124.

The calculated X^2 shows that there is a greater than chance relationship between age and knowledge of signs and symptoms of mental illness. The degree to which they are associated is indicated by the contingency coefficient of .29124. Hence the above statistical values lend substantiation to the hypothesis. Young respondents represent 53.8 percent as compared to only 10.8 percent of the old respondents.

It is safe to argue that young people are faced with a lot of socio-economic problems such as unemployment, marriage problems as they are the ones with young families, and even anti-social practices. In African cultures it is widely held that young people have the obligation to take care of the old members of their families (Mbiti, 1969). Parents invest in their children, for example, through education so that children

can in turn help them not only in old age but also when they are not able to meet their basic needs, particularly economic needs. If one has been educated and fails to secure employment, for example, this is not only disappointing but also puts one in a very difficult situation as the cultural expectations are high. This has adverse psychological effects in that the young people may have no peace of mind. Most young respondents interviewed mentioned unemployment as one of their major problem. Thus socio-economic problems are associated with psychiatric disturbance in that social problems can lead to psychiatric disorders.

Young people, it has already been indicated, are likely to have attained high level of education a factor crucial in changing individual's beliefs, attitudes and perceptions of mental illness. This is well reflected in table 4.1.3. in which a high number (53.8%) of the young respondents agreed that insomnia, hopelessness, and restlessness are symptoms of psychiatric disorders as compared to only 10.8 percent of the old respondents who agree that the above experiences are associated with mental illness.

However, in general when the respondents were asked in which category they would place the experiences discussed above a majority of the respondents (58%) said they are normal, 17.3 per cent of the respondents said

those symptoms could indicate slight mental disturbance while only 2.9 per cent of them said they are indicators of psychiatric disorders. 22.1 per cent said they did not know. As I indicated earlier in this chapter Babukusu consider mental illness as a "disease of the head" and thus psychological problems (resulting from social problems) are not equated with the "disease of the head".

The findings of this study are in accord with the argument of Ndetei and Muhangi (1979), Deshen and Deshen (1989), and Scheff (1967). These scholars argue that laymen are not able to recognize serious symptoms of mental illness and that conditions such as anxiety and depression do not carry medical implications. Babukusu, just as many other Kenyan societies, do not perceive such conditions as having any relation with mental illness. This reflects the perception of mental illness as the wildest insanity marked by gross deviation from normative behavioral expectations.

In this piece of research attempts have been made to understand the Bukusu perception of mental illness. It has been found that the belief of mental illness as the wildest insanity is still common. This is inferred from the definitions given that mental illness is a "disease of the head" or "abnormal behaviour". Both these descriptions reflect severe mental disorders. As a

result some of the behaviours considered in the western culture as being in the realm of mental illness (for example, alcoholism) were not thought to be the case in the present study. Also some of the symptoms associated with mental illness in Western culture (for example, sleeplessness, hopelessness and restlessness) were on the whole not categorized as psychiatric disorder although people complain of these conditions and seek treatment. This is probably so because those who suffer these conditions may be seen to perform their roles and obligations as expected. It is therefore concluded that evidence from our findings thus far is supportive of the hypothesis.

4.2. Attitudes towards mental illness and the mentally ill.

In the preceding part of this chapter we have seen how the Bukusu define mental illness, their perceived indicators and categorization of signs and symptoms of psychiatric disorders among other factors. This is expected to have serious implications on the way the Bukusu react towards those who are mentally ill.

Reaction refers to the way members of the Bukusu community respond to the mental patients. These reactions or responses are the ones referred to here as attitudes. Attitudes are mental view or individual

dispositions. They include feelings, rights, obligations and even emotions as manifested in the individual's behaviour. We have seen in the preceding section of this chapter that as in many other societies, conception of mental illness as the wildest insanity is still a widely held belief among the Babukusu. Such perception or conception will certainly have implications on their attitudes towards the mentally ill. In discussing the attitudes towards the mentally ill, Hollingshead (1966) asserts that they are a product of a peoples cultural heritage. In other words attitudes towards the mentally ill largely depend on the way members of a given culture perceive to be mental illness. And in pursuing a similar issue Phillips (1967) argues that in many cases, the penalty that mentally disturbed persons pay for "being different" is often rejection by others in the community.

There are psyhological processes such as stereotyping, stigmatizing, and social processes such as rejection and isolation. This is likely to depend on the ability of laymen to recognize various symptoms or indicators of psychiatric disorders. It was therefore hypothesised that attitudes towards those who are mentally ill are determined by the perceived severity of mental disorder. Table 4.2.1. crosstabulates knowledge of indicators of mentally ill persons with feelings towards the mentally ill persons.

TABLE 4.2.1. **Knowledge of indicators of mentally ill persons with feelings towards the mentally ill person**

	Indicators of a Mentally ill person				
	Physical appearance	Unusual behaviour	Combination of factors	Don't know	Total
Feelings					
Sympathy	-	31.6(n=6)	63.2(n=6)	5.3(n=1)	18.3(n=19)
Fear	15.9(n=13)	35.4(n=29)	48.8(n=40)	-	78.8(n=82)
Both	33.3(n=1)	-	66.7(n=2)	-	2.9(n=3)
Total	13.5(n=14)	33.7(n=35)	51.9(n=54)	1.0(n=1)	100.0(n=104)

Df=6 X^2=10.1087, PL=0.05, P>.05, Contigency Coeff.29764

The above table shows that the majority of the respondents (79%) treat the mentally ill with fear. A much smaller percentage (18.3%) would show sympathy towards the mentally deranged. It is safe to argue that the data seem to point to the severe cases of psychiatric disorders whose physical appearance which may include unkempt hair, tattered clothing, nudity, and behaviours such as eating garbage, laughing and/or talking alone, violence and shouting are very overt and tend towards inability to fulfil one's obligations as well as violation of the cultural norms.

Scheff (1967:158) in his discussion of attitudes towards the mentally ill, argues that conditions such as madness, fits (epilepsy) all arouse feelings of fear, horror, avoidance, denial, ostracism and concealment. Murphy (1978:249) is of the same opinion when he notes that attitudes of the public and even the professionals are characterized by fear, hostility, aloofness and

suspicion towards the mentally ill. Edgerton (1966) also submits that among the Akamba the Sebei, and the Hehe, the mentally ill are treated with fear and hostility. He, however, adds that this depends on the degree of the disturbance. Muya' too notes that the mentally ill are feared and socially rejected. He singles out epilepsy as one of the mental illness of which its victims are inhumanly treated as the victims are said to be cursed or bewitched. Thus society has not changed its attitudes towards those with mental disturbances and this is so probably because of the antisocial behaviours they are associated with. The antisocial behaviours include rape, violence, and destruction of property.

On whether education has any influence on the attitudes towards the mentally disturbed, the following results in table 4.2.2 were obtained.

TABLE 4.2.2 Feelings towards the mentally ill by education

	Education			
	None	Primary	Secondary	Total
Feelings				
Sympathy	21.1(n=4)	42.1(n=8)	36.8(n=7)	18.3(n=19)
Fear	34.1(n=28)	34.1(n=28)	28.0(n=23)	78.8(n=82)
Both	33.3(n=1)	66.7(n=2)	-	2.9(n=3)
Total	34.6(n=36)	36.5(N=38)	28.8(n=30)	100.0(n=104)

Df=4, X^2=3.591, PL=0.05, P<.05, Contigency Coeff.1827

From table 4.2.2 we get the impression that education has seemingly negligible effect on the feelings towards the mentally ill. When asked about his experience the way the professionals and the educated treat the mentally ill, one psychiatric nurse responded that "the professionals (i.e., general practitioners) are not any better because a lot of times they do not understand these people (mentally sick) and they treat them for general or physical illnesses". He further said that the professionals also stigmatize the mentally ill and also fear them. The foregoing observation is well reflected in table 4.2.3. which has to do with attitudes towards the mentally ill as reflected by willingness to help.

TABLE 4.2.3: Attitudes towards the mentally ill by education

	Education			
	None	Primary	Secondary	Total
Attitudes				
Willing to help	42.9(n=6)	28.6(n=4)	28.6(n=4)	13.5(n=14)
Not willing to help	28.9(n=13)	42.2(n=19)	28.9(n=13)	43.3(n=45)
Other	37.8(n=17)	33.3(n=15)	28.9(n=13)	43.3(n=45)
Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n=104)

Df=4, χ=1.5990, PL=0.05, $P < .05$, Contingency Coef - 12306.

The relationship not significant at 0.05 probability level and thus education, it can be concluded, does not influence the way individuals react towards the mentally

ill. From table 4.2.3. we find that 43 percent of the respondents were not willing to help the mentally disturbed persons. Forty three percent of the sample said that their behaviour towards the mentally ill (i.e., to help or not to help) depends on the severity of the mental disturbance. Thus if the affliction is less severe the people may be willing to help the victim. When the affliction is severe they distance themselves and treat the victim with fear.

To enable us grasp the insights of the community's attitudes and the management of the mentally ill, three examples are discussed below. An interview with the wife of a 58 year old man indicated that the man became mentally ill in January 1974. He started beating people, burning houses, and chasing the family members away. Two of his brothers cornered him, tied him with a rope and put him in a vacant room (with a bed only). The following day the family members consulted a religious healer, Omusali, who came to pray for him but there was no help. They consulted a diviner who diagnosed the problem to be a result of "bad things" planted by somebody in the homestead. Those "bad things" were uprooted but also no help. Another traditional healer, omufumu, was consulted and diagnosed the problem as a result of witchcraft, bulosi, but said that it could not be cured.

The third traditional healer said that his ancestors, Bakuka, needed a goat and the sacrifice was made and other rituals performed but no improvement occurred. They gave up although they never took the patient to hospital. His problem is such that it becomes severe in the months of July and August when he starts destroying property and chasing members of the family away. During this time they have to put him in a room, tie him and lock it. Also during this time they live in fear particularly at night. No one, even the wife, likes going near him or even taking food to him. Only his first son takes food to him and that is done through the window.

When the affliction become less severe, the man is allowed to mix with the other members freely, share talks with them and also participate in other household activities. The wife said that people, and especially women and children, do not like visiting the home in the months he is severely afflicted. At the time of my visit to the home, the man was looking after cattle while other family members were working in the "shamba".

The above case shows how family members and also the community react to severe psychiatric behaviour by trying to control the patient's movements for fear that he might cause harm to the people or destroy property. When the behaviour is mild (not violent) or non-aggressive the

family members treat the patient with sympathy and allow him to participate freely in household activities. Thus the behaviour of the family members towards the patient is to a considerable degree determined by the psychiatric behaviour.

In another case a 25 year old young man who had mental problems was found locked in a single mad-plastered but iron sheet roofed house. The man was standing by the window staring at one place without talking. The rest of the family members had gone to work in their "shamba". The reasons given for such treatment were that if the patient is left to move around he would destroy property or even burn houses. He may also embarrass family members by walking naked. The patient's elder brother added that such a treatment also enables them avoid disruption of the household routine work. He said they feed him, cloth him and sometimes force him to bath. This is, however, done by the elder brother as other family members fear him as he does not cope with them. When the affliction is mild he is allowed out of the small room and he interacts with other members freely.

Similarly, a mother of a 36 year old divorcee who according to one psychiatric nurse is a confirmed schizophrenic expressed similar experiences with both the family and members of the community. The mother noted

that when her daughter is less afflicted they live together peacefully but when the affliction is severe she asks her husband who is polygynous to live with them. At times the community mistreats her when she has gone to roam in the villages. The mother says she takes care of her especially when the behaviour is non-violent. However, it becomes a problem when the affliction is severe as the daughter becomes not only aggressive but also does things that are unacceptable like, for example, wasting water, food and shouting at people. When the psychiatric behaviour is mild the patient helps her mother with domestic duties. Also during this time the mother lives with her without much fear.

The foregoing discussion is in line with the treatment and attitudes towards the mentally ill in many cultures. Among the Yoruba and Eskimo, for example, insane people are restrained in violent phase, followed around and forced to return home if they run away. Others are put in a house which has door and window bars through which food can be passed. Yet others may be forcibly bathed and put new clothes (Foster and Anderson, 1978; Logan and Hunt, 1978). And among the peasant Americans, the severely disturbed are institutionalized yet when they become calm they are free to participate in daily life as best as they can (Logan and Hunt, 1978).

In villages people know or at least recognize one another and the confused or sick can roam with greater impurity than in cities. Thus treatment and/or attitudes towards the mentally ill vary with the psychiatric behaviour they exhibit. When a 32 year old man was asked if he would be willing to help a madman with, for example, a glass of water he responded "it will depend on his behaviour if he is violent then it may not be possible but if calm then I will certainly help him". Another respondent, a woman primary school teacher, said a "madman can rape you so how do you allow him get near you". Yet a 40 year old businessman said that he at times gives mad people "something" when they pass by his shop.

The above views represent the diverse views and attitudes the public has regarding those who have mental disorders. While Murphy (1978) argues that the public including the educated and the professionals treat the mentally with fear and aloofness, he also agrees that with regard to informal behaviour towards the mentally ill it is difficult to draw conclusions, because there is evidence of a wide range of behaviours that can be conceptualized as audience reactions. In this regard Logan and Hunt (1978) observe that compassion and rejection are sometimes engaged at the same time.

However, it has already been argued that once the label "mentally ill" has been applied successfully it tends to stick and is stigmatizing regardless of the degree of affliction and that makes people's reactions very negative (Murphy, 1978:249). Both the patient and his family conditions become self-fulfilling prophecy. Thus once one is said to be mentally ill, the degree of disturbance may only be a factor but otherwise the peoples attitudes are already formed (Thomas and Zuaniecki, 1974); hence exit from is extremely difficult. Table 4.2.4 lends credence to the foregoing argument.

TABLE 4.2.4: Attitudes by Severity of Mental disturbance

	Severity of Mental disturbance		
Attitudes	Disturbed and Extremely disturbed	Slightly disturbed	Total
Willing to help	5.7.1(n=8)	42.9(n=6)	13.5.(n=14)
Not willing to help	51.1(n=23)	48.9(n=22)	43.3(n=45)
Other	46.7(n=21)	53.3(n=24)	43.3(n=45)
Total	50.0(n=52)	53.3(n=52)	100.0(n=014)

Df=2, X^2= •76347, P< =0.05, P<.05, Contigency Coeff. 0853

Attitudes, we have already seen, are mental view, opinion or individual judgement. Attitudes are to a considerable degree depended upon what people term or define as illness and what is not and that provides rationale for action which includes treatment and reaction towards the individuals with psychiatric disorders. Definition of illness also provides rationale

for choice of therapy (Kroeger, 1983:150).

Elsewhere in this work it has been intimated that laymen may not be able to recognize certain serious symptoms of mental illness. The laymen may also not be able to distinguish between less disturbed and severely disturbed psychiatric persons because their behaviours may be similar.

From table 4.2.4. it is evident that regardless of the severity of the mental disturbances, the respondents in general have negative attitudes towards the mentally ill patients. Both those with severe (51.1%) and less severe, that is, mild (48.9%) affliction seem to face the same treatment. This, as discussed earlier, may be understood in the light of the labelling model which argues that social reactions are related to differences in the way individuals with psychiatric problems are able to function within or outside institutions such as family and marriage.

Thus whether the affliction is severe or less severe, if the individuals do not function well they certainly will receive negative treatment from the public as the conditions becomes permanently self-fulfilling prophecy. Thus, it can safely be concluded, there are other factors apart from the perceived severity of mental disorder that determine attitudes towards the mentally

ill.

The discussion contained herein has shown that Babukusu, like many other societies in Kenya, have different definitions of what they consider to be mental illness. It has also been shown that once the label "mentally ill", is applied successfully to an individual suffering from mental illness disorder it tends to be permanent. Individuals have, as a result of such permanency, negative attitudes towards those who are mentally ill regardless of their level of education.

There are, however, some suggestions in our findings that education is likely to help change people's attitudes towards the mentally ill; and that those who exhibit extreme behaviour of affliction are likely to face worse treatment more than those who are less afflicted. However, we have found that on the whole when the label "mentally ill" is successfully applied whether the affliction is severe or less severe the reaction of the community is for the most part negative.

The findings of this study thus far show that although both compassion and rejection may be applied at the same time, society in general has not learned to respond well to the plight of the mentally ill; and that those who are likely to be labelled "mentally ill" are those who exhibit anti-social psychiatric behaviours.

Evidence from our findings thus far indicates that severity of a mental disorder is only one factor in determining attitudes towards the mentally ill.

Footnote

1. Director of mental health, Ministry of Health in Nation, February 19, 1991.

CHAPTER 5

ETIOLOGIC CONCEPTS, THERAPEUTIC CHOICE AND THE PLACE OF TRADITIONAL HEALING

5.1 Etiologic Belief: A major factor in Therapeutic choice

Etiologic beliefs, that is, concepts or models of disease causation, are numerous and vary from society to society. This is not only in non-Western societies but also in the West where there are multiple etiological models as well. Among non-western peoples however, there are cognitive frameworks to explain the presence of disease (Foster and Anderson, 1978). Two major frameworks have been found to be sufficient to distinguish the principal explanatory models. Foster and Anderson (1978) have suggested that these two categories be called personalistic and naturalistic. The two further argue that although these terms refer specifically to causality concepts, they can be used to refer to all the associated behaviour that stem from the two views. However, these models of disease causation and with reference to mental illness tend to overlap. It is also fitting to note here that no society has just one causal framework. By extension, the accepted model or etiologic concepts will have implications for treatment.

Therapy concerns treatment and rehabilitation. Scheff (1967) argues that therapeutic approach to mental illness is somewhat broader and includes not only description of psychiatric treatment and rehabilitation but also reaction of members of the community to mental illness. This part of the chapter examines etiologic beliefs of mental illness, some factors in etiologic beliefs and how these are related to therapeutic choice. It was therefore postulated that therapeutic choice is by and large a function of etiologic beliefs.

Traditionally etiologic concepts of mental illness of the Babukusu are numerous. They include failure to offer sacrifices to the ancestors, Bakuka, broken taboos, kimisilo, witchcraft, bulosi, inheritance, kimisambwa, drug abuse, curse, khuchuba, ghosts, attacks, from bimakombe, attacks from bisieno (evil spirits), diseases such as malaria and syphilis. These etiologic concepts appear to fall in the purview of the two major frameworks identified above. There are, however, factors that influence the models people have.

Silverstein (1968) has argued that there is apparent relationship between socioeconomic status and etiologic concepts, and treatment or non-treatment for a mental disorder. He further contends that this can only be accepted with systematic examinations of the influence socioeconomic status has on etiologic beliefs and

therapeutic choice. Among the indicators of socioeconomic status he lists are age, sex, religion, education, occupation and marital status. Table 5.1.1 crosstabulates etiologic beliefs of mental illness by age.

Table 5.1.1 Etiologic beliefs by age of respondents

	Age			
Etiology	Young	Middle	Old	Total
Social/cultural	36.1(n=13)	22.2(n=8)	41.7(n=15)	34.6(n=36)
Biological	55.6(n=5)	44.4(n=4)	-	8.7(n=9)
Combination of etiologies	55.9(n=33)	33.9(n=20)	10.2(n=6)	56.7(n=59)
Total	49.0(n=51)	30.8(n=32)	20.2(n=21)	100.0(n=104)

Df=4, $X^2=16.440$, $P \leq 0.05$, $P>.05$, Contigency Coeff. 3694

From the table above it is clear that respondents gave various causes of mental illness. Most of the respondents (56.7%) say mental disorders are caused by a combination of factors and they include both social and biological etiologies. Sociocultural causes include curse, broken taboos, witchcraft, evil spirits, ancestral spirits, deity and gods. Biological causes include organic illnesses and here malaria was highly rated, accidents, drug abuse, environmental problems and chemical imbalance in the brain. Thus from table 5.1.1. it is evident that etiologies of mental illness are multiple.

There is, however, variation in the way age influence etiologic beliefs. A comparatively significant percentage (41.7%) of the old respondents consider social and cultural etiologies as an important explanatory model in the occurrence of mental illness. Usually old members of a community are slow in discarding most of their traditional beliefs (Kroeger, 1983:148). Among these are religious and medical beliefs. They also have a wealth of experience as regards, for example, disease causation and treatment. Thus they tend to attribute the causes of mental illness to social etiologies. However, a sizeable number (36.1%) of the young respondents attribute mental illness to social factors. This shows how culture shapes belief systems of individual members. Although that is the case, however, a majority of the young respondents (56%) attribute mental disorders not to a single factor but to a combination of factors. It is safe to argue that young people have been exposed to formal education which has given them wide knowledge on the causation of mental disorders. Among those etiologies are diseases such as malaria and syphilis, chemical imbalance in the brain and environmental factors. At the same time they belong to a certain culture (Bukusu) and will have, through institutions of socialization and experience, learned that certain behaviours may also cause mental illness. They include breaking of taboos, curse and witchcraft, among others. Thus they believe that no one causal framework can be isolated as the only cause of

mental illness.

On the whole 56.7% of the sample see mental illness resulting from a combination of factors. Of these, spirit attack, broken taboos, witchcraft and diseases were frequently mentioned as the major causes of mental disorders. They explained that both personalistic and naturalistic concepts contribute to the occurrence of mental disorders. 34.6% of the respondents thought mental disorders can be explained by social factors while 8.7% of the respondents thought mental disorders can for the most part be explained by biological factors.

Our findings thus far concur with the observations of Scheff (1967) who notes that causes of mental illness are numerous. And Chilivumbo (1973) found that among the Malawians illness, be it mental or physical, is said to be a result of a myriad of factors. For example, sexuality outside wedlock is a taboo and is associated with a cluster of illness. Thus illness is linked with social relationships. It is interesting to note from table 5.1.1. that few of the respondents in the middle age (22%) considered personal predisposing factors as having any relations with psychiatric disorders. Such factors include family size and interaction with the social network and beer drinking. For example, when asked whether there is any relation between too much beer drinking and psychiatric disorders, a 45 year old man

responded "we have taken kamalwa (traditional brew) for a long time and nothing has happened to us so how can you link beer with such bizzare behaviour". On the whole 82% of the respondents did not think too much beer drinking can lead to psychiatric disorders, 6% said there is a possibility while 12% of the respondents could not tell the implications of too much beer drinking.

Clearly the foregoing discussion reveals multiple etiologic concepts and, as intimated earlier, the accepted model of etiologic concepts will have implications for treatment. Thus it can be submitted here that just as etiologic concepts are multiple so are therapies. Logically, it can be argued that our findings thus far lend credence to the hypothesis.

It has already been shown that there is apparent relationship between socioeconomic status and etiologic beliefs (Silverstein, 1968:32). Among the measures of socioeconomic status, he says is, education. And Bennett (1988:41) identifies education as the single most useful indicator of socioeconomic status. He notes that education certainly produces many changes as reflected in knowledge, attitudes and practises. Kimani (1988:41) also shares the same opinion by suggesting that education correlates positively with health practices such as beliefs, attitudes and utilization of health facilities. We sought to examine whether there is any relationship

between education and etiologic concepts of mental illness. Table 5.1.2 crosstabulates etiologic concepts with education.

TABLE 5.1.2: Etiologic beliefs by education of respondent

	Education			
	None	Primary	Secondary	TOTAL
Etiology				
Social/cultural	52.8(n=9)	30.6(n=11)	16.7(n=6)	34.6(n=36)
Biological	22.2(n=2)	33.3(n=3)	44.4(n=4)	8.7(n=9)
Combination of Etiologies	25.4(n=15)	40.7(n=24)	33.9(n=20)	56.7(n=59)
Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n=104)

Df=4, X^2=9.557, PL=0.05, P>.05, Contigency Coeff.2830

The calculated X^2 shows that there is a considerable association between education and etiologic beliefs. About 53% (more than half of the respondents in this category) of the respondents without education believe in the social causation of mental illness as compared to only 16.7% of the educated respondents. Educated respondents (44.4%) consider biological factors as the major etiologies of mental disorders. A significant number of the respondents in both categories with some and more education believe in the multiple causation of mental disorder. These findings are in agreement with the findings in table 5.1.1. Logically, it is true to say that respondents without education are also the respondents in the old category. Lack of education may be a factor of the conservative beliefs of the old members of a community (Kroeger, 1983).

However, as we have already seen no single factor or category explains the occurrence of psychiatric disorders. Thus the respondents in the three categories cite several causes of psychiatric disorders which fall under more than one category. These include violation of incest taboo, failure to carry out ceremonies such as chinyinja, a cleansing ceremony before burial or before marriage, witchcraft, ghosts, spirit attacks, as those related to kimisambwa (a group of illnesses associated with curses, and passed down in families and clans), organic illness such as malaria, accidents, environmental problems and chemical imbalance in the brain.

Occupation of the respondents was found to have no relationship with etiologic belief as a majority of the respondents in the sample (73%) were found to be engaged in small scale farming. This was interpreted to mean that most of the respondents had not been exposed to factors that may influence their beliefs. Almost all respondents (96%) claimed to be Christians with only 3.8% who considered themselves non-Christian. However, the different categories of Christianity were found to have no implication for etiologic beliefs of the people.

The foregoing discussion has shown that the Bukusu, like many other societies, regard causes of mental illness to be numerous and that no single etiology can adequately explain the occurrence of psychiatric

disorders; hence treatment would also be diverse.

A look at the therapeutic choice was considered useful in trying to verify our foregoing discussion. Table 5.1.3 below cross-classifies therapeutic choice of mental illness and age

TABLE 5.1.3. Therapeutic Choice by Age of Respondents

	Age			
	Young	Middle	Old	Total
Therapy				
Hospital	60.9(n=14)	30.4(n=7)	8.7(n=2)	22.1(n=23)
Traditional	43.8(n=21)	31.3(n=15)	25.0(n=12)	46.2(n=48)
Other	48.5(n=16)	30.3(n=10)	21.2(n=7)	31.7(n=33)
Total	49.0(n=51)	30.8(n=32)	20.2(n=21)	100.0(n=104)

Df=4, X^2 3.0116, PL=0.05, P<.05, Contigency Coeff.1677

Relationship was found to be not significant at .05 probability level. Thus age does not influence the choice of therapy.

From table 5.1.3, it is evident that nearly half of the respondents (46.2%) would prefer to take their patients with psychiatric disorders to a traditional healer, omufumu. Several factors may lead to that behaviour. Bungoma District has no adequate facilities for the treatment of psychiatric disorders. In terms of

personnel, there are only psychiatric nurses found in a few of the district health centres. This implies that many of the psychiatric illnesses that may have physical manifestations like, for example, headache and sleeplessness, go unattended or undiagnosed. These experiences may be a result of social problems that require understanding if the individual's problems are to be adequately dealt with. Traditional healers may be better placed in this regard because in many cases they (traditional healers and patients) share similar world view and values. Traditional healers also try to understand the social background and environment of their patients. Thus experience with traditional healers and their ability to deal with many of the psychosocial problems make them a better choice. Evidence thus far seems to suggest that the etiologic concept is only one but a major factor in therapeutic choice.

Acuda (1983:1) argues that most of non-western societies rely on traditional healing for their cure. He notes: "quite a large number of patients with psychiatric disorders consult traditional healers". This, as we have already noted, may be a result of people's experience with traditional healers, their availability and social skills and/or etiologic factors in mental illness. Whether such treatment is real or not it has psychological implications and as such it may restore the patient's health after assurance that those factors that

led to his/her affliction have been prevented. Mbithi (1969) calls traditional healers "great psychiatrists".

Appel and Bartemeier (1961) have noted that treatment of mental illness takes two approaches namely medical or physical and social. It is because of the physical aspects of psychiatric disorders that a significant number of the respondents (22.1%) would prefer hospital for the treatment of mental disorders. 31.7% of the respondents felt they would seek therapy from other sources of health care such as the faith or religious healers, basali, and home therapy or even take no measures towards treatment depending on the individual's or family perception on whether mental illness is treatable or not. It is interesting to note here that even those who claim to be religious healers, basali use methods of treatment and approach to mental illness which do not fundamentally differ from those employed by traditional healers bafumu. Thus in this vein, vodoo priests and priestesses have an elaborate system of folklore and practice and are able to deal with a whole spectrum of psychiatric conditions through ceremonies which involve the entire community (Kiev, 1976).

I had an opportunity to talk to a 20 year old girl who had suffered a strange illness later diagnosed as mental disorder by one religious healer in Chebukwa

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market. According to the girl (and her mother also) the religious healer whom they call "prophet" or "nabii" belongs to and is the founder of what he called Africa Kenya Sapcrnnsk of Soi (I had a chance to chat with him but I was not able to verify what it is). The healer used a bible, a rod with a cross at the top to diagnose the cause of the girl's illness and also treatment. He found it was spiritual attacks from the ancestral spirits which required that two red cocks and a he goat be slaughtered so that they feast with other family members.

The cocks and the he goat were slaughtered in the presence of the healer, drinks (sodas) bought and alittle beer prepared. The healing ceremony involved also neighbours and it took two days. After the second day and to the amazement of the participants, the girl was able to behave in a normal way. The girl had tried hospital and traditional healing but without success. Thus if cure is not forthcoming from one source of therapy another would be tried (Kroeger, 1983:150). Sometimes the cure may be achieved in one source of treatment but that may only involve physical aspects of the illness, leaving psychological aspects an unattended. That may necessitate the utilization of more than one source of help in search of complete cure. The foregoing is consistent with the findings of Frankenberg and Leeson (1976) in urban Zambia in which they found several therapies would be tried, either alternatively or

simultaneously, in search of complete cure.

A significant number of the modern medical personnel, particularly the psychiatric nurses, said that a majority of the patients, particularly those with psychiatric disorders, prefer to consult other sources of treatment, especially traditional healers, before going to hospital. In fact they said a significant number of the patients go to hospital as a last resort. That, according to the professionals, is attested to by the charms they find round their wrists and/or neck and incisions on their bodies.

Various scholars support these findings. Brian (1986), for example, observes that Malawians would visit a traditional healer after being treated in a modern health facility and choice of the healer depends on his/her reputation. Luijk (1974:63) also notes that people look for therapists and not medical systems.

Back in table 5.1.3, it is, however, evident there is variation in the way age influences therapeutic choice of mental disorder. 61% of the young respondents prefer hospital in the treatment of mental disorders. That is probably so because of the influence of education (as will be seen later)on the causation concepts and treatment. Only 8.7% of the old respondents would prefer hospital to other sources of therapy. About 44% of the

young respondents would first seek treatment with a traditional healer as compared to 31% and 25% of the middle age and old respondents respectively. This finding is unique. The expectation would have been that old people are more readily inclined towards the utilization of traditional medicine than do the young ones. This argument is based on the previous findings where a majority of the old respondents gave causes of psychiatric disorders that are best handled by traditional healing. This change of attitudes and behaviour towards traditional healers by old members of the Bukusu community may partly be explained by change of personality of traditional healers, as one 59 year old man said of them: "these people (traditional healers) have greatly changed their role ... they used to prophecy about the future, rains and calamities but today they do not; even some now wear clothes similar to those of doctors yet their role in society is different; others use stethoscope, a doctor's instrument, others have moved to practise in town ... they must be cheating their patients out of their money".

Thus the fact that the traditional healer, omufumu no longer appears all knowing and all powerful by way of his dressing, language, and facilities he now uses as was the case in the past may have contributed to the loss of confidence by old people in his treatment of illnesses. On the other hand, his changing role (to that of

counsellor), his appearance as genuine doctor (by way of dressing and use of modern instruments such as stethoscope, injections), and the fact that he is easily available in open places which is partly in keeping with the changing society may actually attract young people and win their confidence. Thus, as earlier observed, availability of source of therapy, reputation of traditional healers, efficacy of the healing system and personality of traditional healers may be equally important as etiologic beliefs in therapeutic choice.

In discussing the issue of therapeutic choice further, it was found necessary to examine the effect education has on the same. That was due to the simple reason that education is said to have effects on knowledge , beliefs and attitudes (Kimani, 1988). Table 5.1.4 below crosstabulates therapeutic choice of mental illness by education.

TABLE 5.1.4: Therapeutic choice by education of respondents

		Education			
		None	Primary	Secondary	Total
Therapy					
Hospital		8.7(n=2)	43.5(n=10)	47.1(n=11)	22.1(n=23)
Traditional		43.8(n=21)	35.4(n=17)	20.8(n=10)	46.2(n=48)
Other		39.8(n=13)	33.3(n=11)	27.3(n=9)	31.7(n=33)
	Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n104)

Df=4, X^2=10.220, PL=0.05, P>.05, Contingency coeff.2991.

At 0.05 probability level comparison of the calculated X^2 value to the tabled value shows that education has influence on choice of therapy. The degree to which they are associated is indicated by the contingency coefficient of .2991. This is a greater than chance degree of association. It is evident from table 5.1.4 that a relatively significant number (47.1%) of the respondents considered to be educated prefer hospital as compared to only 8.7% of the respondents without education that preferred hospital. There is no significant difference between the responses of the more educated (Secondary) and the less educated (Primary). 43.8% of those without education would prefer traditional healing to others while 40% of them would prefer other sources of therapy as compared to smaller percent (27%) respondents with education in this category. Several factors may be put forward to explain this. Those with more education, it is safe to assume, have taken a longer period of time in school and that is expected to have influenced their beliefs and attitudes towards therapeutic choice. It is also safe to infer that they consider most cases of psychiatric disorders as a result of biological factors such as organic illnesses for example, malaria, syphilis, and chemical imbalance in the brain which they know can be handled effectively in hospital.

The impression we get from the findings above is that with proper education on the causes and treatment of psychiatric disorders Babukusu may take their psychiatric patients to hospital, something that would probably minimize chances of the handful (but significant in terms of social and economics cost) of mentally disturbed persons seen in the community. However, that may not necessarily be good given the lack of trained personnel and the rate effectiveness of traditional healers. That notwithstanding, the findings are in agreement with the argument of Silverstein (1968), Bennett (1988) and Kimani (1988) in which education is seen to produce positive changes in knowledge, attitudes and practices. On the whole, however, there is overwhelming evidence so far to suggest that therapeutic choice is a function of multiplicity of factors.

Muya argues that epilepsy and other psychiatric disorders are taken to be a result of witchcraft practices or curse and that, he says, places the family members into a very difficult situation of avoidance, shame , and other social problems. To the victim it may result in fear, ostracising, neglect, and other social evils such as lack of life partner. It would, however, be misleading to assume that different etiologic concepts would reduce the stigma of psychiatric illness. Suffice it to say that two models may explain the behaviour of the public towards the mentally ill. One, disease theory

systems which provide explanations and etiologies of mental disorders (Foster and Anderson, 1978), and two, labelling approach which provides for the reactions of the people towards the mentally disturbed. Masserman (1976), for example, argues that society has not learned to respond rationally to the plight of the mentally ill as they are treated with fear, hostility, dread and suspicion. Muya sees a remedy in educating people about etiologies and treatment of psychiatric disorders.

Back to table 5.1.4 it is noticed that a comparatively large number (46%) would prefer traditional treatment and this, as indicated above, can be seen in the light of education level whereby over half (74%) of the respondents had either none or little (primary education) which was not sufficient to influence, among other factors, causation concepts of individuals. Health campaigns at the community level may help understand the problem and help alleviate it. This can only, however, be raised as a proposition in the study subject to test and verification in a more elaborate study. As intimated earlier therapy of mental illness is multiple and that is probably why almost in every category there is a significant number of respondents who prefer a particular therapy. There seemingly was no great variability between the respondents in the category "other". This category has both traditional and modern health facilities and also religious or faith healers, depending

on the outcome of the specialist engaged previously. A case interview with a 29 year old professional nurse in Bungoma municipality would throw more light on the foregoing discussion.

A 3 year old daughter started convulsing in January 1990. She fell from a chair, and was rushed to the District Hospital where she was diagnosed as malaria case and subsequently treated for that. This did not help. Her neighbours advised her to seek traditional treatment for they strongly believed it was witchcraft, _bulosi_. They believed that _bikumba_, bones had been "cast" into the child. She informed her husband who is a trained clinical officer working in Kakamega. They took their daughter to a traditional healer _owebikumba_, an expert in removing bones. The healer removed some sharp pointed bottle-like pieces by making incisions on the body and applied some herbal powder. The healer cautioned them to keep secret lest the treatment will not work. That they observed but the condition worsened. The child was biting people as if possessed. Several other traditional healers were consulted but without help. Elders thought it was _kimisambwa_ and so spiritualists were consulted. The parents were asked to perform certain rituals, that is, slaughter 2 chicks, one white and the other red. This was in accordance with what each ancestor liked when he or she was alive. The paternal grandfather of the child took one chick in his right hand and implored his

deceased mother to come and dwell in the house. Similarly the maternal grandfather did the same. Charms were put round the neck, legs and wrists. This ritual also failed to work. Another diviner was consulted and divined that the ancestors needed a she goat for sacrifice. This also failed. A third diviner consulted said the illness was chronic and could not be cured. The parents and other family members did not lose hope, however.

They lastly consulted a faith (religious) healer at Cheptais who used bible to also divine. According to the mother of the child he is good at divining people's problems. He had another group of faithfuls. They sang songs and read verses from the bible. They belong to the Church of God. Eventually he told them all that they had done (therapies they had sought) and advised them to confess and have faith in God and the child will heal. They all said prayers and the child's parents left, leaving the child with her aunt.

The child and her aunt stayed for three months with the healer (in the church compound) The child used to be dipped in cold water three times a day- at 6.00 a.m, 3.00 p.m. and 9.00 p.m. During the dipping hours the aunt would kneel down pray with the healer and sing hymns with selected verses. The healer asked God to guide them and heal the child. The healer said the child had a lot

of stubborn demons which required praying, and casting the said demons. That continued until the child regained consciousness. She could now eat food and do sober things. When asked why they prayed three times a day the aunt's girl said that according to the healer Jesus prayed three times a day (corresponding with the hours above). At the time of research the girl was not completely cured, but she was much better and slowly getting healed. The parents believed she would be cured completely. Occasionally the mother either takes the daughter to the healers or the healers visit her and pray.

The above case makes one point very clear, that although the child's mother had education (and also training in medicine) that did not prevent her from seeking therapy where appropriate. In the above case all available sources of therapy were tried until they found one which was able to cure the child's illness.

In his study of professionalization of traditional medicine in Zambia, Twumasi (1984) found that all types of patients regardless of their status visited spiritualists. And most of them will do that as a result of failure to receive appropriate treatment from a modern health facility while others feel that allopathic medical treatment would not be useful in treating their ills. A majority of the cases would be psychiatric cases

(ibid). And Muya (1991) observes that a lot of health seeking behaviour in Kenyan society is such that people just visit a traditional healer before visiting a modern trained medical professionals. Sickness has both physical and mental or psychological aspects. Faith (religious) healers are experts in this realm just as are traditional healers. If both specialists find the problem is better settled in psychological sphere, they will use the psychological approach such as counselling and advice.

Several conclusions can be drawn from the findings cited above. One, that not a single etiological belief can explain the occurrence of psychiatric disorder. In other words, mental illness is a result of multiple etiologies. In the same way etiologies are multiple so are therapies of mental illness. And that several factors such as education and age have consequences for etiologic beliefs. Similarly, education, age, etiologic models, perceived effectiveness, expected benefits and consumer satisfaction, among other factors, will have consequences for therapeutic choice. Above all culture, which entails the belief system, is very crucial in making sense of mental illness. Several help sources (therapies) may be visited as people try to seek the appropriate treatment. The foregoing discussion is therefore supportive of our hypothesis in the light of the fact that etiologic belief contributes substantially

to therapeutic choice. That notwithstanding, evidence from the study suggests that it would be misleading to hold that etiologic belief is the only cardinal factor in choice of treatment of mental illness. In view of the foregoing, it is concluded that therapeutic choice is a function of a multiplicity of factors and that people's concept of disease etiology contribute substantially to the choice of health services.

5.2. The place of traditional healing

Traditional healing is underpinned by the belief system of a people. Its artistic experience is understood and appreciated by the people. It guarantees the norm and values on which societal arrangements rest (Twumasi, 1984:8). If one has a query about traditional medicine, such a query must be directed towards the norms and axioms of the society in question (ibid). It was the objective of this study to examine Bukusu perceptions of traditional medicine so as to be able to make propositions about the systems future. It was hypothesised that the future of traditional healing largely depends on its perceived effectiveness. Table 5.2.1 crosstabulates age and the perceived ability of traditional healers to cure.

Table 5.2.1 Perceived ability to cure by age of respondent

	Age			
	Young	Middle	Old	Total
Perception				
Effective	47.6(n=39)	32.9(n=27)	19.6(n=16)	78.8(n=82)
Not effective	54.5(n=12)	22.7(n=5)	22.7(n=5)	21.2(n=22)
Total	49.0(n=51)	30.8(n=32)	20.2(n=21)	100.0(n=104)

Df=2, $X^2=.8478$, PL=0.05, $P<.05$

The calculated X^2 with two degrees of freedom at probability level 0.05 is insignificant, and thus age does not influence the way people perceive traditional healers in terms of their ability to cure illness. This is indicated by the contingency coefficient of .08992 which is very low.

Clearly table 5.2.1 shows that a majority of the respondents (78.8%) perceive traditional healers as being able to cure illnesses. Only 21.2% respondents did not think traditional healers cure illnesses. This suggests that traditional healers are seen by Babukusu as playing an important role in health care and in particular to their satisfaction. Wagner (1949), in his ethnography of the Bantu of Western Kenya, shows how various Bukusu specialists are able to deal with health problems in both preventive and curative medicine.

We note from table 5.2.1 that 47.6% of the young respondents said that traditional healers cure many

illnesses as compared to 19.6% of the old respondents who said that traditional healers cure most illnesses. The expectation would have been that more older respondents would know of the ability of traditional healers to cure illnesses. This is because older members of a community are the custodians of a people's culture and as such are expected to have discarded fewer of their indigenous beliefs and attitudes as well as values. These findings as indicated earlier may be a result of the changing roles of traditional healers in a changing society. Thus, unlike young and some of the middle aged people, old people have the ability to asses the present and the past performance of traditional healers. One 60 year old man when asked about traditional healers responded: "these people (traditional healers) are not as reliable as they used to be ... they do not follow traditions and some have even taken their work to town ... they are out to make money". This may be explained by unchanging attitudes and values of the old people.

However, old respondents presented one of the lowest categories of those who regarded traditional healers as unable to cure. It is probably the case that the traditional healers changing role and personality measure upto the expectations of the young people; for instance in dressing, operating clinics in towns, urban or market centres or even treating some of the illnesses that are common in young people such as sexually transmitted

diseases without being subjected to embarrassment when one is told one can only be treated if they come with their partners.

It is also possible, and indeed the case, that many of the mental disorders such as those caused by family demands, inability to cope with socio economic problems, such as unemployment and too much responsibility, affect mostly young and middle aged people. They manifest themselves in physical illnesses and these may not be solved unless the psychological aspects are dealt with and traditional healers may be better placed to deal with such aspects. When asked about their ability to cure a 25 year old mother of 2 children said that "traditional healers cure illnesses and besides, they do their work in the open these days as they are licensed". Twumasi (1984) in his study of professionalization of traditional medicine in Zambia found that traditional healers have changed their roles and structures of the institution of healing as they become professionals, thereby attracting a large number of patients particularly young ones. This suggests that traditional healing is still going to persist given that it is a viable system and young people consider it an effective system of health care; hence the findings lend weight to the hypothesis.

Mbiti (1969) supports the foregoing discussion when he argues that so long as modern medicine remains unable

to deal effectively with psychological problems, and so long as traditional healers have psychological appeal in their approach, the practice will continue to persist and thrive.

Concerning influence of education and the perception of the ability of traditional healers to cure, the data are tabulated in table 5.2.2

Table 5.2.2. Perceived ability to cure by education of respondents

	Education			
	None	Primary	Secondary	Total
Perception				
Effective	36.6(n=30)	35.4(n=20)	28.0(n=23)	78.8(n=82
Not Effective	27.3(n=6)	40.9(n=9)	31.8(n=7)	21.2(n=22)
Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n=104)

Df=2, X^2=.6695, PL=0.05, P<.05 contingency coeff. 07976

The X^2 computed to find if education has any influence on the perception of traditional healers to cure was found to be insignificant. Thus the relationship is insignificant as indicated by contingency coefficient of .07976 which is very low.

The expectation would have been that the educated have changed their belief and values in re ation to traditional healing. Regardless of their evel of

education the respondents said that traditional healers cure. There is a chance variability between the education levels and thus not possible to make a probabilistic statement.

All that we can say is that education does not make one divorced from commonly held beliefs, values and attitudes. In fact beliefs are aspects of culture which are underskin and so hard to drop. At times education may reinforce certain beliefs.

Religion was found to have no consequence as almost all the respondents (6.2%) claimed to be Christians and of these 95% expressed confidence in the ability of traditional healers to cure while 21.2% did not think they cure. They instead thought faith (religious) healing, clergymen and hospitals were better placed to do so. Only 4.9% of the respondents claimed they were not Christians and all of them said traditional healers cure. These findings concur with Munguti's (1986) findings. In her study of Kalaazar in Kitui, she found that religion did not prevent people from consulting traditional healers and they believed in their ability to cure many illnesses.

It was one objective of this study to investigate the perception of Babukusu on the efficacy of traditional healing of mental illness. The following responses in

table 5.2.3 with respect to age were obtained.

TABLE 5.2.3. **Perceived efficacy of traditional healing of mental illness by age**

	Age			
	Young	Middle	Old	Total
Perceived Efficacy				
Agree and strongly agree	44.7(n=34)	31.6(n=24)	23.7(n=18)	73.1(n=76)
Disagree & strongly disagree	60.7(n=17)	28.6(n=8)	10.7(n=3)	26.9(n=28)
Total	49.0(n=51)	30.8(n=32)	20.2(n=21)	100.0(n=104)

Df=2 X^2=2.829, PL=0.05, P<.05 contingency coeff..1627.

The obtained chi-square value of 2.829 with 2 degrees of freedom at a probability level of .05 shows that the relationship is insignificant. That is to say, age does not influence the perception on the efficacy of traditional healing of mental illness.

However, although there is no significant relationship statistically between age and perception on efficacy of traditional healing of mental illness, there is variability in the way different categories perceive its effectiveness. As indicated earlier, a majority of the respondents attributed the occurrence of mental disorders to social or cultural factors. These include witchcraft, spirit attacks, curse, breach of taboos, and failure to offer sacrifices as required by ancestral spirits. These have psychological implications. It is

safe to argue that young people are the targets of most social malpractices in any given community or society. They are the category threatened by witchcraft, people vulnerable to breach of taboos, are the people with young families which are prone to marital problems, and they are the very category in the society faced with economic problems such as unemployment. All these may create untold damage to their psychological stability, a problem that may lead to psychiatric disorders. Faced with such problems they are likely to consult traditional healers who are in fact good "psychiatrists". That may be one plausible explanation of their perceived effectiveness of traditional healing of mental illness.

The fact that a traditional healer, omufumu, performs certain rituals in the cause of treatment and assures his or her patient that he or she would get employment or no more witchcraft can be directed to them is enough to offer the patient peace of mind with some hope, hence their treatment is seen as effective. The foregoing argument is in accord with observations of various scholars. Mbiti (1969), for example, argues that traditional healers deal effectively with psychological aspects of illness while Foster and Anderson (1978) observe that traditional healers are good "psychiatrists". Thus, it can be submitted here that young and middle aged people find help from traditional healers and that is probably the reason why they consider

traditional healers effective in healing mental illness.

Back in table 5.2.3, it is, however, interesting to note that in the distribution of responses, only 28% of the old respondents said that traditional healers are effective in treating mental illness. This does not seem to reflect well the findings in table 5.1.1 in which old respondents attribute most of mental disorders to social and cultural factors something expected to determine their therapeutic choice hence perceived efficacy. They, however, react with caution to questions that tend to portray traditional healers as inefficacious in treating mental illness. They represent only 10% as compared to 61% of young respondents.

In spite of such variability, a majority of the respondents (73%) we have already seen, perceive traditional healing as efficacious in treating mental illness. When questions were put about the illnesses traditional healers are experts in treating, mental illness and gynaecological problems were frequently cited. Others were barrenness, bodyache and impotence, <u>kimisambwa</u> and spirit attacks. Twumasi (1984:62) found among the Malawians a number of illnesses said to be treated well by traditional healers. These include epilepsy and other mental disorders, marital problems, unemployment problems, spirit attacks and women bleeding. Thus findings already discussed are supportive of our

hypothesis.

In further examination of the perception of efficacy of traditional healing of mental disorders, it was found necessary to examine the influence of education on the above. Table 5.2.4 below crosstabulates perceived efficacy of traditional healing by education.

TABLE 5.2.4. **Perceived efficacy of traditional healing of mental illness by education**

	Education			
	None	Primary	Secondary	Total
Perceived Efficacy				
Agree and strongly agree	36.8(n=28)	35.5(n=27)	27.6(n=21)	73.1(n=76)
Disagree & Strongly disagree	28.6(n=8)	39.3(n=11)	32.1(n=9)	26.9(n=28)
Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n=104)

Df=2, X^2= .6278, PL=0.05, P<.05

The X^2 computed to find if education had influence on perception of efficacy of traditional healing of mental illness was found to be insignificant. In otherwords education has no effect on perception of efficacy of traditional healing of mental illness.

Findings in the above table are in consonance with Fanon's (1967) observations based on his experience. As a psychiatric specialist working in a French colony, Algeria, in the 1950's he found that educated "natives",

some of whom were his colleagues, would treat psychiatric disorders but when they had their own psychiatric problems, they would go back to the villages and consult traditional healers. Thus education did not change their cultural beliefs, attitudes and values. However, this is not to say that the psychiatrists (Fanon's colleagues) never used other therapies. That notwithstanding, Fanon's colleagues must have found traditional healers efficacious and the outcome of their treatment satisfactory. And Mbiti (1969) argues that a great number of African politicians and even university students are known to consult traditional healers for success in their pursuits. Thus when it comes to matters of belief, it can be argued, education tends to play a very minimal role. Indeed a majority of the respondents, 73%, said that traditional healers are effective in healing mental disturbances, including psychosocial problems. The variability between the three categories, viz, none, primary, and secondary, is very small and can be said to be a chance variability.

On the question of whether traditional healers have any role to play in the contemporary Bukusu Society the data displayed in the table 5.2.5 below were generated.

Table 5.2.5. **Role of traditional healers by education of respondents**

	Education			
	None	Primary	Secondary	Total
Role				
Have	34.4(n=31)	35.6.(n=32)	30.0(n=27)	86.5(n=90)
Don't have	35.7(n=5)	42.9(n=6)	21.4(n=3)	13.5(n=14)
Total	34.6(n=36)	36.5(n=38)	28.8(n=30)	100.0(n=104)

Df=2, X^2=.4909, P∠ =0.05, P< .05, Contigency Coeff.·0685

It is clear from the table above that quite a large percentage of the sample (86.5%) agree that traditional healers have a role to play. Only 13.5% of the respondents said that traditional healers do not have any role to play among the contemporary Babukusu. Elsewhere it has been argued that traditional healing is an objectification of people's belief system. Traditional healing tends to deal effectively with illnesses thought to have ultimate cause besides the natural one (Twumasi, 1984). Ndeti (1972) shares the same view when he observes that among the Akamba illness and other misfortunes may be considered to have ultimate cause besides the natural one hence a traditional healer is, of necessity, consulted. The solution to such a problem has psychological implications. About this, Ndeti (1972.166) notes that mundumue, a traditional healer, knows he cannot cure some diseases and therefore the treatment is

directed to the psyche and soul.

Among many non-western peoples disease, misfortunes and treatment may take a religious form (Bourguignon, 1979). And Mbiti (1969:69) also contends that in Africa, some diseases and misfortunes are a religious experience and thus they require a religious approach; that is probably why some of the practitioners'activities are psychological rather than physical. To dismiss them as mere "superstition" is to miss the point, for they play an important role in healing the sick. There is, for example, a wide spread belief that breaching of certain taboos such as incest may provoke the anger of gods and spirits and that may result in illness. The solution to such a problem will most likely be sought from a traditional specialist who has to perform a ritual in a cleansing ceremony to ask for forgiveness from the gods. Once the gods accept the appeasement, the victims are forgiven and health restored. When asked whether there are taboos that may cause mental disorders if broken, 89.4% of the respondents said there are. They mentioned marrying or having sexual relations with relatives, failure to perform certain rituals, and shaking hands with ones *omukhwe* (in-law). This is said to create social misunderstanding as well as misfortunes. Cleansing may be necessary to clean those involved of contamination. When the respondents were asked which was the best treatment for a broken taboo, 71.2% mentioned

the traditional healer with only 13.5% of them citing hospital as a solution to a broken taboo while 15.4% mentioned others who include religious healers.

In a different context but with similar implications Nyamwaya (1987) argues that among the Pokot belief that social conflict can evoke bitterness and subsequent anti-social practices is very profound. And among the Akamba repeated failure to get good crop yields while one's neighbours do may be linked to anti-social practices of a jealous or some unfriendly neighbour. A traditional specialist will most likely be consulted and in such circumstances people will be interested in solving the "why" question (Ndeti, 1972). And Mbiti (1969) argues that some leading African politicians consult traditional healers to help them win elections. Thus, so long as traditional healing is seen by people, regardless of their social status, as performing an important social function effectively, it will continue to thrive.

The foregoing discussion is in accord with many other anthropological studies. Evans Pritchard (1956), for example, in a study of Azande witchcraft in Africa provided data to throw light on the place of traditional healing. In his account the healer did two main jobs, viz, holding public ceremonies at which he divined causes of illness and other misfortunes, and also treated illness in full public view. He concludes that

traditional healing would not fade away in Azande society so long as the support system existed. And Turner (1957) analyzed the place of divination in Ndembu society. According to Turner, traditional healers performed important social functions. Traditional healers divined and in the process they got into trance and this is understood and supported by the sick and their relatives. And among the Bukusu society this was found to be the case. A case in point would explain this.

I visited and interviewed a 32 year old man suffering from kimisambwa and whom people knew as a traditional healer. At the time I arrived at his home he was away but six people (2 middle aged men, 2 women and one boy and a girl) were waiting for him. After a while he came and I introduced myself; after which he invited me into his house. His other visitors also came in. He called his young brother to participate in the conversation. He clothed himself in a white gown, sat behind a table covered with a white piece of cloth, placed a bible on the table, opened it and placed a rod in between the pages. On the left side of the bible he placed a buffalo tail.

We started our discussion by praying. He stood and held his fingers by the face, closed his eyes and began to pray. In the process he got possessed, got into trance, and prayed in a language none of those present

could understand. After discussion (about his practice), I bade him goodbye and walked out. One man followed me out accompanied by the healer's young brother. When I asked them why the healer had to pray they told me that he was seeking to establish whether I had malicious intentions and also to know the problems of each one who was there. After prayers he was ready to solve the problems. Later on I came to learn from my research assistant that the man I talked to (as I was leaving) was a primary school teacher.

The foregoing discussion supports the arguments of Evans Pritchard and those of Turner. The support system existed; those present understood and supported the behaviour of both the clients and the healer. The very fact that there were people who had gone to consult the healer, and the fact that they understood and supported his behaviour in the process of trying to understand their problems is enough evidence to suggest that they (Babukusu) perceive traditional healing as an effective system of health care; hence we conclude that these findings bear support for our hypothesis.

In further attempts to examine whether traditional medicine has any role to play responses were crosstabulated by occupation. From table 5.2.6 we see that the majority of the farmers (74.4%) have a favourable opinion towards the role of traditional

healers as compared to only 11.1% of the salaried respondents. These farmers are small-scale farmers who depend on land, hence their income by implication is very low. It is not unlikely that given the circumstances they are unable to afford the now high cost of modern medical services. Those with salaried employment were either teachers, medical personnel or working in local industries such as Nzoia Sugar Company.

Table 5.2.6: Role of traditional healers by occupation of respondents

	Occupation				
Role	Farmer	Salaried Employed	Unemployed	Other	Total
Have	74.4(n=67)	11.1(n=10)	3.3(n=3)	11.1(n=10)	86.5(n=90)
Don't have	64.4(n=9)	14.2(n=2)	7.1(n=1)	14.3(n=2)	13.5(n=14)
Total	73.1(n=76)	11.5(n=12)	3.8(n=4)	11.5(n=12)	100.0(n=104)

Df=3, X^2=.8398, P$\angle$ =0.05, $P < .05$, Contigency Coeff.·0895

When asked whether they knew people in the area who consult traditional healers a large number of the sample (81.7%) said they knew. Only 18.3% said they do not know. When the respondents were asked to name illnesses and/or problems commonly dealt with by traditional healers, infertility, asthma, spirit attacks, <u>kimisambwa</u>, witchcraft, employment problems, mental illness, women bleeding, traditional illnesses, epilepsy, sexually transmitted diseases, heart disease and diabetes were

frequently mentioned. The same illnesses have been found to be common objects among traditional healers of Malawi (Twumasi, 1984:89).

Acuda (1983) has observed that a large number of patients with mental disorders consult traditional healers. Elsewhere it has also been noted that a large proportion of Kenyans depend on traditional healing for their cure (Republic of Kenya, 1989). And Koumare (1983) makes the same point when he submits that the majority of rural populations have to depend on traditional medicine to solve their health problems. This probably explains why the majority of the farmers in the sample (farming is a low income occupation) consider traditional healers as playing a very important role in their locality. That is, of course, not to suggest that employing a traditional healer will "cost" less rather than seeking modern therapy but rather their (traditional healers) availability, accessibility and social skills.

Mbiti (1969) submits that traditional healers are within easy reach, serving as pastors, psychiatrists and doctors; and it is therefore unjust to discredit them. Ndeti (1972) is of the same opinion when he argues that modern medicine has become aware that it is not just enough to know the biological basis of illness but also psychological aspects whose treatment plays an important role in all societies where mental illness is a chronic

problem. And Twumasi (1984) lends credence to the foregoing argument when he argues that traditional medicine is functioning in this day and age because it is still performing an important social function.

Practitioners of traditional medicine offer their services in areas of spirit possession, in giving love medicine, and advice on employment related matters, and in cases of psychological illnesses. They treat people in situations where the people are dissatisfied with modern medical treatment or where there is lack of modern health facilities. The common illnesses are alcoholism, mental illness, witchcraft, disordered personality structures, barrenness, impotence, love medicine, unemployment, solve social problems and many others (Twumasi, 1984). The medicineman symbolizes the hope of society, protection, and security from evil sources, prosperity, and good fortune (Mbiti, 1969). People go to see the traditional healers not only because they share a similar world view and values but also because of their past experience with them; they perceive them as effective in solving their health problems. Thus, from our findings it can safely be concluded that traditional medicine is still functional and is likely to continue to function in the future because it has roots among the Bukusu people.

Pearson Correlational Analysis

TABLE 5.2.7: Pearson Correlational Matrix

	V67	V68	V70	V72	V80	V81	V82	V84	V92	V93	V94	V99	V100	V101	V102	V103	V104
V67																	
V68	.0762																
V70	-.0943	-.0516															
V72	-.0571	.2309	-.1304														
V80	.1568	.1029	-.1883	-.1682													
V81	.3732	.2252	.0813	.0000	.7414												
V82	-.3380	-.2535	.1258	-.0585	-.0960	-.1333											
V84	.0152	-.4914	.3247	-.4699	.0280	.0897	-.0787										
V92	.3678	-.5334	-.2191	.0471	-.0502	-.2406	.5329	.0535									
V93	-.3603	.5858	-.1161	-.0423	.0451	-.1080	.4980	.1688	.9683								
V94	.0322	-.4528	.1968	-.2605	.3410	.3809	.1764	.3608	.3447	.5389							
V99	-.1554	-.3040	-.0055	-.1908	.2479	.1531	.2178	-.0691	.3165	.4360	.5470						
V100	-.2598	.0702	.0083	-.1464	.1653	.0602	.3524	-.0866	.2676	.3294	.4732	.4694					
V101	-.2689	-.2881	-.0514	.2719	.1512	-.1325	.5444	-.0398	.5821	.5288	.1445	.0199	.1710				
V102	-.0465	-.3130	.0433	-.3363	.0581	.0459	.2944	.1328	.6458	.7265	.5565	.4123	.3636	.2213			
V103	-.3755	.0230	.0417	-.0904	-.1531	-.1258	.2192	.0795	.3165	.2917	-.1085	.0065	-.0234	.1782	.4075		
V104	-.0176	-.4492	.0552	-.4172	.4235	.1998	.0745	.1901	.4189	.5243	.5466	.5660	.2339	.1245	.6514	.2179	

Variable description

V67	-Causes of mental illness
V68	-Behaviour of mentally disturbed persons
V70	-Causes of the common mental disorder
V72	-Who are likely to present psychiatric disorders
V80	-Whether people consult traditional healers often
V81	-Reasons for consulting them (traditional healers)
V82	-Ability of traditional healers to cure
V84	-Ways of alleviating mental illness problem
V92	-Description of behaviour of a mentally disturbed person
V93	-Whether the traditional healer has treated a mental patient
V94	-Causes of the mental disorder treated
V99	-Age likely to present psychiatric disorders
V100	-Sex likely to present psychiatric disorders
V101	-Causes of mental illness
V102	-Ways of alleviating the problem of mental illness
V103	-How often patients consult the traditional healer for any illness
V104	-What can the healer say about the future of his/her practice

In the preceding parts of this study analysis and discussion of the results have been based on the general population. We now deal with specialists, that is, modern medical professionals among them psychiatric nurses, and traditional practitioners. In the present study some of the measurements of the variables were nominal. In order to do a Pearson correlational analysis the nominal variables were transformed into dummy variables. A set of dummy variables is created by treating each category of a nominal variable as a separate variable and assigning arbitrary scores for all cases depending upon their presence or absence in each of the categories (Nie, et.al, 1970). Pearson correlation was computed and the coefficients constitute the correlational matrix in table 5.2.7 above.

The correlation matrix is on etiologies of mental illness, therapies and future of traditional healing as shown in the data of both allopathic therapists and traditional practitioners. As evidenced in table 5.2.7 there is a high correlation between etiologies of mental illness and therapeutic choice. We have, in the preceding chapters, shown that causes of mental illness are multiple, ranging from social to physical. We have also seen that just as etiologies of mental illness are multiple so are therapies. This seems to be upheld by both modern medical professionals and traditional healers who agree that a patient may try several therapies until

he or she finds a cure. This behaviour is to some extent a function of etiologic concepts. For example both modern medical professionals and traditional healers attribute some mental disorders to social problems such as witchcraft. A patient may not be aware and this may result in delayed treatment. In search of therapy a patient may go to hospital. If cure is not forthcoming it is unlikely that the patient or their relatives will sit back and watch the patient suffer. Rather, they will try alternative therapies and among the alternatives may be traditional healing.

However, what is considered by traditional healers to be major causes of mental illness seem to be of little importance to modern medical professionals particularly psychiatric nurses. For example whereas traditional healers consider witchcraft as a major cause of mental illness, modern medical professionals attach less importance to it. It is not unreasonable to argue here that such findings are partly a result of the fact that modern medical professionals are guided by medical model which attach too much importance to biological or physical factors rather than social factors. Thus there is a negative association as indicated by the coefficient of -.5334. On the basis of these findings, it is thus safe to conclude that though both groups attribute the occurrence of mental illness to a multiplicity of factors, each of the two does not attach the same

importance to the various causes of mental illness.

It can also be inferred from table 5.2.7 that both modern medical professionals and traditional healers consider traditional healing as a system that offers alternative therapy, particularly in societies rooted in personalistic and naturalistic etiologic models. Most medical professionals noted that a large number of the people consult traditional healers and that a great deal of their treatment has a psychological effect rather than physical and that in this aspect traditional healers have proved effective. On the other hand, the traditional healers argue that since patients have always consulted them as one of the alternatives of treatment, then their treatment must not only have corrected psychological aspects of illnesses but also have produced physical results. Thus, although the traditional healing system is perceived as efficacious by both groups, modern medical professionals tend to consider its treatment to be more psychological than physical while traditional healers feel they treat both psychological and physical ailments. Consequently there is high but negative correlation of -.7413 between modern medical professionals and traditional healers on perception of the traditional healing system. This implies that modern medical professionals do not attach much importance to the healing system as much as traditional healers do.

What comes out clearly from the current study is that mental illness is considered to be a disease of the mind and that it frequently results in anti-social behaviours. The causes are multiple hence no single cause of abnormal behaviour can be identified nor can any single model of abnormal behaviour be posited. Since syndromes and etiologies are multiple and overlapping so are therapies and therapists. However, depending on cultural inclinations, certain etiologies would be considered major while others minor. Evidence is incontestable that medical professionals have wide exposure to other cultures through formal education and training and this may explain why they consider biological or physical factors most important in the causation of psychiatric disorders. Effect of education on knowledge and etiologic concepts is well demonstrated by Kroeger (1983:150). On the other hand, traditional healers have had no formal training, are less exposed to other cultures and so are to some extent, less informed. Due to lack of formal training and exposure to other cultures, traditional healers may not be able to place some of the behaviours, signs or experiences in the domain of mental illness.

Admittedly, however, traditional healers are well informed about social relations that obtain in their communities. These social relations when interfered with may create social strains and anti-social behaviours may

follow. The anti-social behaviours may have far reaching effects; among them illnesses and/or misfortunes. Therefore, traditional healers consider social etiologies as major causes of mental illness. It is thus in order to argue here that different etiologies may produce different types of mental disorders and by implication different behaviours.

Further, it is clear from the present study that the traditional healing system as an alternative therapy is perceived as effective by both modern medical professionals and traditional healers. As we have already noted, allopathic therapists consider the traditional health care system to be effective psychologically whereas traditional healers consider the system as equally effective (just as the allopathic medical system) on both levels, that is, psychological and physical. Both traditional healers and modern medical professionals, particularly psychiatric nurses, were in agreement that some traditional healers cure some mental disorders. Elsewhere in the thesis it has been indicated that a large number of the people in rural areas consult traditional healers for various illnesses, including mental disorders. This implies that people have confidence in the system. They also consider it, it can be argued, as playing a complementary role to that of modern medical facilities. On the basis of the findings contained herein it can be concluded that traditional

healing is still perceived as efficacious, a major factor in determining its continuity; hence the findings are supportive of the hypothesis.

From the present analysis it is safe, therefore, to assume that there is a causal relationship between some dependent variables and their predictors. We thus find that failure to associate some behaviours with mental illness is causally related to perception and description of the behaviour of the mentally disturbed persons and in particular the behaviour of the patients traditional healers claim to have handled. On the other hand, etiologic concepts appear causally related to the reasons given as to why traditional healers are consulted and also the tendency to visit traditional healers by the community members. It is also safe to conclude, and indeed evidence from table 5.2.7 supports the observation, that the frequency with which the local people consult traditional healers is by and large causally related to reasons that prompt the health seekers to consult or visit traditional healers. Among the reasons is the fact that traditional healing is perceived as an effective health care system.

Comparison of Means

In the preceding part of this chapter Pearson correlational analysis has been used to show the

correlation of modern medical professionals on etiologies, therapies and perception of mental disorders, on the one hand, and of traditional healers on etiologic concepts, therapies and perception of mental disorders, on the other hand.

The t-test which now follows will be used to compare the means of the two groups of specialists namely, modern medical professionals and traditional healers. In the t-test, two types of tests may be performed: independent samples in which cases are classified into two groups and a test of mean differences is performed for specified variables; and paired samples which is for paired observations arranged casewise, a test of treatment effects is performed (Nie et al, 1970). In the present study the paired sample test has been used.

The views of the two groups, there is enough reason to believe, differ significantly toward mental illness and this difference, it is safe to argue, has got consequences for the management of psychiatric disorders. In this last part of the analysis I intend to find out the extent to which modern medical professionals and the traditional healers are similar or different in their causation concepts, perception and handling of the mentally disturbed persons. The goal of the analysis is to establish whether or not a difference between to samples is significant. Significant here does not mean

important but is used here to mean indicative or signifying a true difference between the two population (Nie, et al, 1975)

It is the case, and indeed it was demonstrated earlier in the study that a mentally ill person has got certain behaviours which can be described. Comparison of the behaviours described by modern medical professionals about a mentally disturbed person and those described by traditional healers was made to find out if they were similar or different. The results are displayed in table 5.2.8.

Table 5.2.8 Description of behaviour of mentally ill persons

	$\bar{X}$	s	$\bar{\pi}$
Modern Medical Professionals	4.7391	.689	.144
Traditional healers	18.2609	17.623	3.675

$\bar{X}$ difference = -13.5217, df=4 P>0.05

At .05 probability level the t-test shows that modern medical professionals differ significantly from traditional healers in describing the behaviour of mentally ill persons.

In the preceding parts of this thesis we have seen that laymen are not able to recognize some serious symptoms and signs of disturbed behaviours. That is to say, there is serious lack of knowledge pertaining to known behaviours of mentally ill persons. That, to some

extent, explains why people although they may complain of such experiences as lack of sleep and restlessness, and consult both traditional healers and modern medical professionals, they do not place such conditions in the domain of mental illness. Similarly, traditional healers deal with many of such disturbances but sometimes without knowledge.

It is not unreasonable to argue that traditional healers lack the knowledge of certain well known symptoms and signs of psychiatric disorder as compared to modern medical professionals. They include conditions as sleeping, anxiety, alcoholism and restlessness. Traditional healers may consider these as a result of other problems and not manifestations of mental disturbance per se. This is probably so because these traditional healers come from and belong to cultures that do not perceive such experiences as belonging to the domain of mental disorders.

On the other hand modern medical professionals and in particular psychiatric nurses who get specialised training are able to place such conditions. Thus, some behaviours described as normal and going undetected by traditional healers will be placed in the domain of mental illness by modern medical professionals. Consequently, behaviours as alcoholism, insomnia, anxiety, and hopelessness are described by modern medical

professionals as having psychiatric implications. Traditional healers may consider these conditions to be a result of social problems such as witchcraft. Thus the foregoing argument lends credence to the hypothesis that cultural perceptions of mental illness determine the extent to which people reject various descriptions of disturbed behaviour.

It is, however, interesting to note that the two groups seem not to differ significantly in the causation concepts. The results on causation concepts are presented in table 5.2.9.

TABLE 5.2.9: Causes of Mental illness

	$\bar{x}$	s	$\bar{\pi}$
Modern Medical Professionals	3.0435	2.225	.464
Traditional healers	3.9130	1.952	.407

$\bar{X}$ difference = .8696, df=4 P<0.05

At 0.05 probability level, the difference between the two groups is insignificant. These results reflect the general knowledge in the population about causes of mental illness. Both traditional healers and modern medical professionals mentioned several causes of mental illness, ranging from social and physical to psychological causes. Among these categories are social problems such as witchcraft, organic illnesses, and accidents. However, as already intimated, the degree in

which both traditional healers and modern medical professionals described behaviours of the mentally ill persons differed significantly because of different perceptions and also to some extent limited knowledge and precision on the part of traditional healers in describing behaviours and symptoms of the mentally ill.

In comparing the two groups on the category that presents or is likely to present psychiatric problems in terms of age and sex, it was found that the difference between modern medical professionals and the traditional healers is significant. Data on comparison of the two groups on age are displayed in table 5.2.10 below.

Table 5.2.10: The age category considered likely to present psychiatric problems.

	$\bar{x}$	s	$\bar{\chi}$
Modern Medical professionals	12.8696	.920	.192
Traditional healers	3.8696	3.209	.669

$\bar{X}$ difference = 9.0000, df=4, P> 0.05

Comparison on age produced a value of 12.32 and this is significant at 0.05 probability level. The modern medical professionals said that it is the young and middle aged who mainly present psychiatric problems. They argued that the two categories are faced with social and economic problems with the attendant psychological problems that may lead to psychiatric disorders. In fact it is, they argued, the two categories which frequent

institutions of health services most. This must, however, be treated with a measure of caution as their visits may be a result of other disorders. The t-test performed on sex produced results in table 5.2.11.

Table 5.2.11 The sex category considered likely to present psychiatric problems

	$\bar{x}$	S	$\bar{\pi}$
Modern Medical professionals	12.8696	.920	.192
Traditional healers	4.6087	3.434	.716

$\bar{x}$ difference = 8.2609, Df=4, P>0.05

At 0.05 probability level a value of 10.76 is found to be significant. Thus there is a significant difference between allopathic therapists and traditional healers with regard to the sex likely to present psychiatric problems. Allopathic therapists argued that women, particularly young and pregnant mothers, are at a higher risk of developing mental disorders, an argument in accord with that of Bennett(1988). On the other hand, traditional healers argued that all ages and sexes consult and are treated by traditional healers not only for psychiatric disorders but also many other illnesses. The foregoing implies that traditional healers perceive mental illness as equally afflicting both males and females. Some were, however, categorical and felt that it is the young people who are mostly targets of anti-social practices of some members in a community.

It will be recalled here that one objective of the current study was to examine the role of traditional healers in the research population. It has already been found that they play a very important role and that it can, on the basis of the findings of this study be submitted that traditional healing is perceived as an effective system of health care. In this analysis attempts have been made to compare the perception of traditional healing by both modern medical professionals and traditional healers themselves. The results are displayed in table 5.2.12 below.

Table 5.2.12 **Perception of traditional healing**

	$\bar{x}$	S	$\bar{\pi}$
Modern medical professional	1.4348	1.674	.349
Traditional healers	3.8696	3.494	.729

$\bar{X}$ difference = .2.4348, Df=4 P>0.05

The t-tests computed gave a value of -2.85 and this implies that there is a significant difference between modern medical professionals and traditional therapists in respect of perception of traditional healing.

It has already been indicated that a large number of people in rural areas consult traditional healers. This implies that people have confidence in the traditional system of health care. Medical professionals felt that consultation with traditional therapists is widespread and that many people consult traditional healers. In

fact all the psychiatric nurses argued that the majority of the psychiatric patients go to traditional healers first and only after they fail to get cured do they go to a modern health institution. However, traditional healers felt that people do not consult them as often as they used to. This, according to them, is a result of improved health services. Also they argued that it might be a result of licensing many traditional healers to practise. These findings were contrary to the expectations that traditional healers continue to receive more patients in the wake of the government's policy to recognize and promote useful indigenous healing, that is, traditional healing and herbalism.

In spite of this, however, both traditional healers and modern medical professionals agree that traditional healers provide an effective alternative system of therapy. This is attested to by the results shown in table 5.2.13 below.

TABLE 5.2.13 Perceived efficacy of traditional healing

	$\bar{x}$	s	$\bar{\pi}$
Modern medical professionals	3.0000	1.758	.367
Traditional healers	2.9565	2.977	.621

$\bar{x}$ difference = 0.435, Df=4, P<0.05

Thus at 0.05 probability level the difference between traditional healers and modern medical professionals is found to be insignificant. Traditional

healers argued that they provide treatment as much as modern health facilities do and this was in conformity with the argument by modern medical professionals. They agreed that some traditional healers are able to deal with a wide range of psychiatric disorders. They (modern medical professionals) noted that some mentally disturbed persons go to traditional healers and not until their problems are not solved do they go to a modern health facility. A good number of the patients, they noted, have body incisions when they go to hospital. As noted above modern medical professionals admitted that traditional healers have a large following and that they are perceived as effective and in fact deal effectively with some psychiatric disorders. These findings seem to support Fanon's (1969) argument that even the trained psychiatrists have a lot of faith in their indigenous healers and they actually consult them for the treatment of various ailments.

There is abundant evidence from the findings in this study to show that traditional healing is perceived as efficacious and that it plays an important role. It is also concluded that it is highly regarded. On the basis findings, it is concluded that there is enough evidence to support the hypothesis that perception on the efficacy of traditional healing has consequences for the future of the traditional health care system.

Footnote

[1]. Director of mental health, Ministry of Health in a press conference, February 19, 1991.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The main problem of the present study was to examine the awareness and management of mental illness in the Bukusu community of Bungoma District.

Interests in the study emanated from the fact that hitherto no studies have been conducted in Bungoma District to explore etiological concepts of mental illness, health seeking behaviour and the role of traditional health care. Furthermore, the few studies conducted elsewhere have had medical orientation yet mental illness is, in a sense, no more a medical problem than it is social and economic problem.

This study, therefore, constitutes a pioneer in Bungoma District with an anthropological orientation. To achieve the objectives of the study baseline data were collected. There were three categories of subjects, the general population, the allopathic therapists and traditional practitioners. A sample of 152 was employed, that is, 104 from the general population, and 48 from both allopathic therapists and traditional practitioners.

The anthropological approach was adopted and a lot of emphasis put on observed events. Due to the very nature of this study efforts have been made to integrate narratives of some of these observed events and a number of cases put and described in the analysis. Quantification has also been employed to validate some contentions made here. Admittedly, however, the study is limited in that it did not engage services of a psychiatric doctor to screen the respondents sampled so as to be able to determine the prevalence of mental disorders in the research population. But, that notwithstanding, psychiatric nurses employed in the sample helped understand some of the technical concepts. Furthermore, the study was anthropologically designed to investigate the people's awareness, etiological models and management of mental illness. And in this connection, the study was satisfactorily conducted, hence conclusions are drawn along the themes investigated.

The study found that definitions of mental illness are multiple, ranging from disease of the head through abnormal behaviour to traditional illness. Physical appearance and unusual behaviour were found to be popular concepts in identifying signs and symptoms of mental illness. Thus, a majority (52%) of the respondents considered indicators of mental illness to be a multiplicity of factors such as wearing tattered and/or

dirty clothes, walking naked or half-naked, antisocial behaviours as violence, rape, homicides, suicides, shouting alone for no apparent reason, and talking or laughing alone.

There were strong suggestions that conditions such as insomnia, depression or sadness, hopelessness and restlessness, among others, are not considered to be in the domain of mental disorders. This, of course, is not to say that people do not complain of these conditions and seek treatment, rather they do but not as psychiatric disorders per se. These findings are consistent with the arguments of Ndetei and Muhangi (1979) that in many cultures the aforementioned conditions do not carry medical implications. The conclusion drawn here is that the belief of mental illness as the wildest insanity is still popular and that for the label "mentally ill" to be applied successfully one must violate the social norms. However, not all social norms cause the violator to be labelled "mentally ill" and thus enter a sick role. Thus, for an individual to enter a sick role factors as perceived seriousness and potential consequences of symptoms or behaviour, visibility and available information concerning causation are very important.

Quite clearly the implication of this study is that culture defines who is to enter a sick role and who is not, and that in our case individuals suffering from the

conditions already mentioned would be denied privileges of a sick role. In the event that patients seek health services for these conditions, they will do so as a manifestation of physical illnesses and not psychiatric disorders as treatment is not sanctioned for cases not considered a health problem.

The study, however, found that factors such as education and age have bearing on the knowledge of signs and symptoms of mental disorders. Those with formal education, it has already been noted, are likely to be also young. Education, the study has shown, is one of the severest exposures to Western culture. The educated have more knowledge of the signs and symptoms of psychiatric disorders as is reflected in table 4.1.2. That notwithstanding, a majority (60%) of respondents would consider insomnia, hopelessness, depression and restlessness as normal conditions. Both general population and traditional healers are understandably constrained by having limited knowledge of signs and symptoms of psychiatric disorders as opposed to medical professionals who have detailed and wide knowledge of these conditions and thus place the aforementioned in the domain of mental illness.

This finding concurs with the contentions of Scheff (1967) that laymen are not able to recognise serious symptoms of psychiatric disorders and that hopelessness,

trouble-sleeping and depression show public ignorance concerning signs and symptoms of mental illness. This implies that it is unlikely that people would present these conditions for any psychiatric examination.

There is an apparent link between cultural perceptions and atitudes towards the mentally ill. It was found that conception of mental illness as the wildest insanity is still popular. As a consequence, the majority (79%), it was found, would treat the mentally ill with fear. That notwithstanding, there is evidence to suggest that attitudes towards the mentally ill are for the most part determined by the psychiatric behaviour exhibited by a patient. This implies that those with severe mental affliction are likely to suffer worse treatment as compared to those whose affliction is perceived to be less severe. For example, it was found that severely disturbed persons are isolated while the mildly disturbed persons are allowed freedom to mix with other members of the family or community.

On the whole, and as we have already seen, once the label "mentally ill" is successfully applied, it is stigmatizing and individuals are put into a state exit from which is extremely difficult. This state becomes a self-fulfilling prophecy. Consequently, both the patient and the family members are treated differently from other members of the society and by extension rejected as they

are perceived to be different. This has both social and psychological implications in that the victims and their relatives may be denied their rights of association and life partners as they are feared and avoided. In order to avoid ostracism the families with mentally ill persons will always tend to conceal their identity. Implicit in this would be delayed treatment and management of psychiatrically disabled persons in that patients are either not taken for treatment as relatives do not want to associate with them or they (patients) are taken to incompetent therapists who compound the problem. Similar observations have been made by various authorities. Among them are Edgerton (1966) who found the same among the Akamba, Foster and Anderson (1978) among the Yoruba, Murphy (1978), Ndetei and Muhangi (1979) and Muya (1991)[1].

One theme which runs through this thesis is that etiologic concepts have definite implications for therapeutic choice. It has variously been argued that no single causal framework can be posted to explain the occurrence of psychiatric disorders. Findings of this study reveal that etiological concepts of mental illness are multiple, ranging from social to physical. They include, among others, witchcraft, broken taboos, failure to offer sacrifices, accidents, organic illnesses such as malaria and chemical imbalance in the brain. In addition, age and education were found to have consequences for etiological concepts. Elderly members

of the community tend to attribute mental illness to social explanatory models. In the same vein, the less educated (53%) tend to limit their concepts of causation to social factors.

Conversely, the young ones consider physical explanatory models as equally important as social etiological concepts. Similarly, education has effects on etiological concepts. Elsewhere in the thesis it has been shown that formal education is one of the severest exposures to western cultures. As such the more educated have wider knowledge of etiological concepts of mental illness. Thus the educated tend to attribute the occurrence of mental illness more to physical factors. However, social etiologies also feature prominently. On the whole, however, a majority (56%) consider social etiologic concepts as important in explaining the occurrence of psychiatric disorders. This has got consequences for choice of health services.

There is an apparent link between etiologies of mental illness and therapies sought. Indeed, evidence from this study has shown that etiology contributes substantially to the health service utilized. Just as the etiologies are multiple so are therapies. It was found that in general about 46 percent of the respondents prefer to take their patients to a traditional healers while 22 percent of the respondents would take their

patients to allopathic therapists. This, it has already been argued, is based on past experience and the expected benefits. The implication is that traditional practitioners treat mental illness to the satisfaction of those who consult them.

Findings in several other studies are in consonant with these conclusions. In rural India, for example, people with mental illness resorted to traditional healers (Kapur, 1979). In Taiwan Kleinman (1980) found that most people preferred traditional healers in the treatment of mental illness. And in Kenya the Abagusii choice of health services was found to be dependent to a greater degree on their respective etiological concepts; while in Tanzania people with folk disease preferred to resort to traditional healers while others preferred modern health services (Kroeger, 1983).

The implication from the foregoing, is that etiology plays a very important role in health seeking behaviour. This is attested to by the present study in which the majority would prefer to resort to traditional healers, a behaviour which is seemingly derived from social explanatory model. The foregoing notwithstanding, age and education were found to have effect on therapeutic choice. Old people tend to prefer the traditional healer while the young prefer hospital to other kinds of health services. Frankenberg and Leeson (1976) had similar

findings. They found that in Lusaka, Zambia, most frequently the elderly consult traditional healers. Earlier it was noted that education has influence over people's attitudes, beliefs and practises. This study found that education influenced the pattern of utilization of health services, as evidenced in table 5.1.4 in which the educated (47%) would use hospital as compared to 8.7% of the less educated. 44% of the less educated would prefer to consult traditional healers. Several other scholars have found similar results. In Tunisia, Benyoussef and Wessen (1974) found that formal education turned villagers away from traditional healing. In Taiwan, Kleinman (1980) had similar results.

In general, however, all ages and all levels of education would be treated without selection and traditional healing is highly preferred. In fact, a majority (73%) say traditional healers are able to cure mental illness while an overwhelming majority (79%) perceive it as a generally effective system of health care. Another overwhelming majority (80%) consider traditional healers as playing a very important role. This is also supported by allopathic practitioners who agree that traditional practitioners play an important role in alleviating the health problems of people particularly in the rural areas.

Several conclusions can be made of the findings

contained here. One, that in healer shopping choices are not mutually exclusive but rather concurrent and/or serial. Indeed, a few cases described earlier in this study attest to this. Two, that engagement of different healing systems in search of cure seems to be common among the Babukusu. And that there is a strong social support system of traditional healing and, therefore, it is likely that it will persist and thrive in the future. Various scholars, notably Evans Pritchard (1956), Turner (1957), Mbiti (1969) and Twumasi (1984), arrived at similar conclusions. This implies that traditional healing in medical pluralism should not be seen as a second alternative but a system of health care people turn to among several choices.

6.2. Recommendations

In view of the findings in this study the following recommendations are proposed.

1. There is need to conduct a detailed study to determine the prevalence of mental illness in the study district and factors that contribute to the most prevalent mental disorders. Indeed, a countrywide study should be carried out to compare results from different regions. Such a study should adopt an interdisciplinary approach involving specialists like psychiatrists, social workers and

anthropologists. Only in this way can the problem of mental illness be fully understood and appropriate measures taken to alleviate the now potentially worrying trend.

2. Bungoma District is wanting in terms of psychiatric services. In my observation social psychiatry should be integrated into the health institutions and, indeed, all parts of the country where traditional healers who are good social psychiatrists are readily available. Towards this, training programmes for traditional healers on health practices and hygiene should be intensified. Currently Traditional Birth Attendants (TBAS) are given such courses. Bungoma has a large number of Traditional Birth Attendants but only a handful are trained. It may be necessary to establish institutions for traditional healers (where their knowledge and skills can be tapped easily) or, as already suggested, have them work on a fulltime basis with modern trained medical therapists as is the case in South Korea and India. There is abundant evidence to show that modern medicine has not always dealt successfully with some chronic illnesses such as diabetes, hypertension, AIDS and mental disorders. There is growing evidence to suggest that the traditional system of health care may at least help alleviate some of these problems.

3. The government and the researchers should develop a realistic approach to traditional medicine to ensure that it acts not only as a compliment to modern medicine but also functionally integrate it into the larger system of health care. My observations and, indeed, findings of other studies are that a significant number of rural populations depend on traditional healing for their cure of physical and/or mental disorders. The proposal above may be facilitated if laws are promulgated to regulate traditional healing to protect community members from malpractices that may arise. This would also give traditional medical practitioners a legal status that would also protect them from fear, suspicion hostility and slander.

4. Finally, systematic research into the fundamental principles on which the traditional medical beliefs and practices are based should be carried out or intensified. This would make for a better understanding of some of the principles and practices that appear mysterious to many members of the community and society at large. This approach should lead to fruition in clarifying the principles and methods of diagnosis and treatment; covering mechanism of disease causation, prevention and cure.

Footnote

1. **Director of Mental health, Ministry of Health in a Press Conference, February 19, 1991.**

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APPENDICES

Appendix 1: Questionnaire 1 - General Population.

1. Sub-location___________ Village ___________
   Household
   No.___________

2. Sex of the respondent:

   Female ___________

   Male ___________

3. Age of the respondent (Years) ___________

4. Actual years of schooling ___________

5. Occupation ___________

6. Religious affiliation ___________

7. Marital Status:

   Single ___________

   Married ___________

   Separated/Divorced ___________

   widowed ___________

8. Number of children ___________

9. If male number of wives ___________

10. Are there any people in this home who are not able to do their normal work because of frequent illness?

    Yes ________ No ________

11. Are there any people in this home who seem to be unhappy all the time?

    Yes ________ No ________

13. Do you think psychological problems can make one to feel restless, sleepless, hopeless or any other unusual feeling?

    No ________ Yes ________

14. If yes what do you think may be the causes?

    Domestic problems

    ____

Too much work ____________________

Too much responsibility such as family clothing, school fees, etc. ____________________

School work ____________________

Bewitching ____________________

Spirit attacks ____________________

Beer drinking ____________________

Illness ____________________

Other (specify)

15. Have you ever had feelings similar to those in question +13? Yes ______ No______

16. If yes, for how long? Short time _____on and off _____

Always __________ Can't tell__________

17. What do you think were the causes?
____
____

18 In which category would you place such experiences?

Normal ____________________

Slight disturbance ____________________

Disturbed ____________________

Severely disturbed ____________________

Can't tell ____________________

19. How did you solve such problems
____
____

20. Large families contribute to socioeconomic problems such as unemployment, lack of school fees etc do you agree? Somehow agree
____

____

Agree______________ slightly agree_________________

Disagree ______________ Don'tknow________________

21. Do you think socioeconomic problems can lead to disturbed behaviour?

Yes ______________________________ No _______________

22. If yes, in what ways

____

____

23. What do you think about large families

____

24. Do you think extended families have any role to play in the prevention and management of disturbed behaviour? Yes ________________

No ____________

25. Explain

____

____

26. Are there any people in this home who previously had a mental disturbance?

____

27. Do you know any person(s) in this area who behave in an unusual manner, say causing disturbance without good reason, abusive language, picking fights with others for no apparent reason etc?

____

____

28. If yes, what do you think are the causes?

When she/he is annoyed_________________________

consumes substances such as bhang_________________

Alcohol/liquor ________________________________

mentally disturbed_________________________________

other (specify)

____

29. Where would you place such a person?

    Normal ___________________________

    Slightly disturbed ____________________

    Disturbed ______________________________

    Severely disturbed ____________________

    Other (specify) ____________________

30. Name substances consumed here which you think influence the consumer's behaviour negatively?

    ____

    ____

31. Who consumes them?

    Sex: Male ____________________

    Female ________________________

    Age: Young _____________ Middle aged __________

    old ____________________

32. TO what extent are they consumed?

    Less consumed

    ____

    Highly consumed

    ____

    Can't tell

    ____

33. Are there things if not done would cause misfortunes?

    ____

34. Name the misfortunes

    ____

    ____

35. Name taboos if broken would cause misfortunes or illness

    ____

    ____

36. Name the misfortunes and/or illnesses

____

____

37. How are such problems solved? By consulting

Hospital ______________________________

Traditional healers ______________________

Religious healer ________________________

Ritual performances ______________________

Other (specify)

____

38. Are there taboos if broken would cause mental illness

____

39. If yes, name them

____

40. Explain what you consider to be mental illness

____

41. Describe the behaviour of mentally disturbed person(s)

____

42. What do you think causes mental illness?

____

____

43. Do you know any people here who visit traditional healers

Yes ____________________ No ____________________

44. If yes, for what reasons do they visit them?

____

45. Some people say traditional healers cure many diseases and illnesses, others say not, what is your opinion?

____

____

46. Some people say traditional healers cure mental illness, do you agree?

Somehow ______________________________

Agree______________________________________

Strongly agree

____

Disagree

____

Don't know ________________________________

47. Do you know any mentally disturbed person who has been cured by a traditional healer?

Yes ________________ No____________________

48. Describe their behaviour at the time they were ill.

____

49. What kind of treatment did the healer administer

____

____

50. Some people with mental disturbances may consult traditional healers, what is your feeling towards them?

Sympathize ______________________________

Fear them _______________________________

Avoid them ______________________________

Willing to help__________________________

Other (specify) __________________________

51. Mention illnesses you think are best dealt with by traditional healers

____

____

52. Do you think traditional healers have any role to play today?

Yes ___________________ No ____________________

53. If yes explain

____

____

____

54. Do you know people here who consult religious healers?

Yes ______________________ No______________________

55. If yes, for what reasons
____

56. Are there religious healers here who heal mental illness?

Yes______________ No ________________________

57. Do you know any one in this area who has been to a mental clinic?
____

58. If yes, describe his/her behaviour
____

____

59. What is your attitude towards him/her

Sympathize ____________________________

Fear ____________________________________

Avoid ___________________________________

Willing to help _________________________

Other (specify) __________________________

60. If you discover that someone is mentally ill, what is your attitude towards him/her

Sympathize ______________________________

Fear_____________________________________

Avoid ________________________________

Willing to help
____

Other
(specify)___________________________

61. How do you recognize an individual is mentally disturbed
____

____

62. What do you think about mental illness

____

____

63. Where do you think is the appropriate place to take a mentally disturbed person for treatment ?

Hospital ______________________________

Traditional healer ______________________________

Religious healer ______________________________

Home ______________________________

None ______________________________

Other (specify) ______________________________

Thank you.

Appendix 2: Questionnaire 2 - Modern medical professionals.

1. Professional training

____

2. Some sources suggest that mental disorders are on the increase, what is your opinion

____

____

3. Do you think mental disorders are both health and social problem in this district that require attention?

____

____

4. Explain______________________________________

____

____

5. Describe the behaviour of a mentally disturbed person

____

____

6. Specifically what are the causes of mental illness in this district:

____

____

7. Generally what are the causes of mental illness?

____

____

8. About what number of the out patients do you consider to be psychiatric cases?

____

____

9. Who are likely to present psychiatric problems:?

   Sex: Male __________ Female ______________

   Age: Young ________ Middle aged ________

   Old ________________

10. Explain/Reasons

____

____

11. How do people (Bukusu in particular)in this district perceive mental illness

____

____

12. Do you think there are cultural practices which you may associate with mental disturbances?

Yes _____________ No ____________________

13. If yes explain

____

____

14. Do you think there are mentally disturbed persons in the community who never, go to modern health institutions for help?

Yes _____________ No ______________________

15. If yes, what are the reasons

____

____

16. Some people with psychiatric problems consult traditional healers what is your comment?

____

____

____

17. Do you think this is common in this district?

Yes _____________________ No _________________

18. Give reasons

____

____

____

19. Some traditional healers claim to heal not only mental related problems but many other illness, what is your comment?

____

20. What comment can you make about traditional healing?

21. Some psychiatrically disturbed persons do actually consult religious healers can you comment?

22. Suggest ways of alleviating the problem of mental disorders in this district

Thank you.

Appendix 3: Questionnaire 3 - Traditional healers

1. Sex of the healer:

    Male ____________________

    Female __________________

2. Age of the healer (yrs) ________________

3. How did you become a traditional healer?

    ____

    ____

4. What are your reasons for healing?

    ____

    ____

5. Explain what you consider to be mental illness

    ____

    ____

    ____

6. Describe the behaviour of mentally disturbed person

    ____

    ____

7. Do you think mental disorder are both health and social problems in this district that require attention?

    Yes ________________ No_____________

8. Explain

    ____

    ____

    ____

9. Have you handled patient(s) with mental disturbance?

    Yes ___________________ No ______________________

10. What was the cause?

    ____

    ____

11. How did you diagnose them?

    ____

___

12. What treatment did you administer?

___

___

13. Explain whether the treatment was successful or not

___

___

___

14. Specifically what are the causes of mental illness in this district?

___

___

15. Generally what are the causes of mental illness?

___

___

___

16. Who are likely to present mental disturbance?

Sex: Male ___ Female ___

Age: Young ___ Middle aged ___

Old ___

17. How often do patients visit you for any illness?

Daily ___

Weekly ___

Fortnightly ___

Monthly ___

Other (specify) ___

18. In recent years what can you say about your clients/patients

Increasing ___ The same ___

Decreasing ___ Other ___

19. Can you comment on your profession?

___

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21. Suggest ways of alleviating the problem of mental illness in the district

Thank you.