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Introduction

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This study developed while I was working as psychiatrist to the Swaziland Government Health Services for five years between 1982 and 1987 sponsored by the Overseas Development Administration (British aid). It was a unique experience involving the development of a very different model of service provision, which required an expanded role for the psychiatrist and posed challenges of fundamental interest. In order to train manpower appropriately it was necessary to understand the profile of mental illness in a very different society and also to achieve a working knowledge of the culture and ethnography. This experience had a personal impact which gave interesting insights into both the problems and rewards of acculturation. It also generated ideas and working hypotheses, some of which are examined in the four studies presented here.

Service development

The post required clinical supervision of the 200-bed mental hospital with 500 admissions a year, staffed by one psychiatric nurse, six general trained nurses and 30 untrained orderlies (in 1982). Only 15 years previously, the mental patients had been moved out of the town gaol. Much had been done by a dedicated South African psychiatrist to create a hospital, establish a good record system, design a Mental Health Act and introduce fluphenazine to reduce chronicity. However, it remained a custodial hospital, alien, feared and inaccessible to the people, selecting only the most florid pathology. It was not, of course, the only service available. Cultural concepts of mental illness and its management in Swaziland are intimately related to traditional religion and are mediated by the healers whose ceremonies and rituals are undoubtedly effective in containing morbidity, especially of minor psychiatric disorders. Nevertheless there is huge unmet need requiring radical redesign of services.

The World Health Organization (WHO) has pioneered an alternative model which maximises scarce resources. This is the Primary Health Care (PHC) approach conceived at the 1978 Alma Ata World Health Assembly. It requires a move away from the vertical service and the centralised hospital, towards integration with general health services. It operates through a hierarchical infrastructure based upon progressive delegation from the expensively trained specialist at the top, through the various cadres of paramedical workers, to the minimally trained village health workers at the bottom. It requires successive levels of support and supervision with clear definition of roles and responsibilities at each level. It also involves mobilising community resources to facilitate community-based rehabilitation, detect untreated illness and even attempt primary prevention, especially in the control of alcohol availability.

When I arrived, a start had already been made. The one psychiatric nurse, an enterprising Swazi, had initiated a mobile psychiatric community clinic. The nursing College had negotiated an agreement with the Ministry of Health for a one-year post-basic course for training community psychiatric nurses (CPNs) locally. In our planning it was essential to adapt training of manpower to the needs of the service rather than follow Western models rigidly. The WHO has strongly advocated the task-orientated approach (Harding, 1978; German, 1980) rather than a Westernised theoretical training, for several reasons. Paramedicals in developing countries must take on more responsibility much earlier in their careers than their counterparts in the West. Moreover, their roles in the PHC hierarchy may have to combine key features of the multidisciplinary team rather than represent only one. For instance, the demanding, composite role of the CPN had to include the nursing skills of ward and clinic management, the diagnostic and prescribing skills of the doctor, the ability to do social and occupational assessments and to liaise with community leaders, and the teaching and supervision of paramedics further down the hierarchy. The diagnostic role was essential if accessibility to treatment was to be increased on a large scale. To facilitate this, protocols of the chief diagnostic criteria of common syndromes together with standardised schedules for medication had to be designed. Yet basic research was required to clarify these common syndromes both in hospital and community practice. The first priority was to move out of the confines of the hospital in order to train community-orientated nurses and to explore psychiatric morbidity before the selective effect of admission. Pioneering new community clinics was integrated with training and exploratory research in the active case-finding exercises described in Paper I.

After CPNs had completed training and had consolidated experience by a year at base they were posted out to district general hospitals to work with local PHC clinics. After five years, 33 nurses had been trained, and out-patient delivery points had increased from 15 to 50. Clinical supervision and coordination of this community mental health programme with ongoing in-service training was an important part of the job.

Clinical practice

Initial difficulties included adaptation to a very different style of practice – heavy clinical workloads, lack of facilities (laboratory and EEG), the need to work through interpreters, unfamiliarity with cultural norms and beliefs, and the baffling clinical profile. Hospital practice consisted almost entirely of florid psychosis, criteria for admission being violent and unmanageable behaviour at home. Many patients were highly disturbed and inaccessible on admission. Fortunately, families almost always accompanied them, which was essential for obtaining the history. Careful clinical observation and accurate history taking was as important as appropriate cultural interpretation of the mental state. For instance, the clouding of consciousness of organic confusion had to be distinguished from the trancelike dissociated consciousness of the transient reactive psychoses. Accurate history taking was the only means of distinguishing epilepsy, particularly temporal lobe epilepsy, from hysterical equivalents. The need to elicit the mental state through interpreters was a difficult but profitable exercise if turned to training advantage by using trainee CPNs as interpreters. For instance, discussions on how to differentiate pathological delusions from cultural beliefs and from overvalued cultural ideas taught the CPNs the basic distinctions and allowed the author valuable insights into cultural beliefs. Paranoid ideas had to be weighed against the widespread beliefs in bewitchment, which usually signalled dysphoric mood rather than psychosis. Delusions of control had to be set against beliefs in spirit possession. First-rank symptoms were much easier to elicit in educated patients than uneducated peasants, which was probably a matter of linguistic sophistication rather than any difference in phenomenology.

There appeared to be a low threshold for auditory hallucinations, which were revered as voices of the ancestors. One had to distinguish whether the patient meant vivid disturbing dreams or voices heard in the waking state. In order to elicit formal thought disorder, the CPNs had to translate verbatim, which helped them to identify this phenomenon. Accurate assessment of mood was the most difficult. Careful observation of affect was usually consistent with mental state examination in distinguishing the various states of psychomotor hyperarousal – for instance, the manic state with its euphoria and omnipotence, from the phase of excitement in catatonic schizophrenia, and from the terror which often accompanied the dissociated state. But depressed mood was much more difficult to elicit. Symptoms were couched in hypochondriacal or paranoid terms and accompanied by agitation or withdrawal. Even when coherent, patients would deny low mood or unhappiness, despite biological symptoms and miserable affect. It was more meaningful to elicit anhedonia and also to inquire for suicidal feelings provided this was worded carefully so as not to imply any intentions, on account of strong cultural taboos.

Much psychosis appeared to be atypical, either in terms of duration or admixture of symptom types – schizophrenic, affective or dissociative – or in the relative contribution of organic or psychogenic factors. It was difficult to classify neatly by Western nosology. Nevertheless, the major syndromes could be discerned. Severe process schizophrenia was in the classic form, characterised by stereotypies, catatonia, unequivocal delusions or severe word salad, or else by the typical defect state. Acute brain syndromes were fairly common, as one would expect, due to vitamin deficiencies, or complicating infections or parasitaemias, or due to the post-epileptic confusional state which was related to the high level of untreated epilepsy. Dementias were more often the end result of acute brain disorder than old age. Alcohol and cannabis contributed to a complex picture of acute and chronic psychosis which was part functional and part organic and posed difficult management problems in half the male annual admissions. Unipolar manic psychosis was evident in classical form, but there was a lack of unequivocal depression. Was the different cultural expression obscuring it, and if so, how? Was it excluded from admission by the criteria of salient disturbed behaviour? Yet many apparent schizophrenics had depressive features. Was this the depression integral to schizophrenia? Was it schizoaffective, i.e. actually affective psychosis? What was the nature of the highly aroused inaccessible state which precipitated much admission but could not be explained by toxic delirium? Did it represent neglected late pathology or occult cerebral factors? But many recovered very rapidly. Was it a form of help-seeking behaviour related to cultural concepts of mental illness? On recovery, some but not all showed a depressive picture.

The challenge of this psychopathology was fascinating. Were the differences due to the pathoplastic effect of culture or to the greater organic component

to psychiatry in an impoverished Third World environment? What would be the impact of the rapid social change so evident in Swazi society – with its increased adaptation demands, cultural distortion and destructive effect on family life?

Could these three components be combined in a single hypothesis: this was not so much the exotic picture of an alien culture as an earlier period of history. Had a similar bewildering plethora of psychosis confronted the 19th century psychiatrists - arising moreover from a comparable population with a high level of physical morbidity and poverty, uneducated and superstitious and in the throes of the rapid social change accompanying the Industrial Revolution? Research would involve not only clarification of common psychopathology but also identification of the criteria of change from the pre-existing culture.

Sources of information

A picture of the culture and ethnography of Swaziland was built up gradually from clinical experience, multisectoral workshops, both at ministerial and community level, and from the sociological and anthropological studies of the University of Swaziland (Low, 1977; Ngubane, 1977; Prinz, 1980; Makhubu, 1982; Mbatha, 1983; Russell, 1989), and the Department of Transcultural Psychiatry at the University of Durban (Cheetham & Cheetham, 1976; Cheetham & Griffiths, 1980; Edwards, 1982; Wessels, 1984). Opportunities to become acquainted with traditional healing systems arose as community work opened up; healers' kraals were visited and occasionally patients treated jointly; community workshops were held with traditional healers. Discussions were very difficult because of the radically different conceptual constructs on which they operated. Most helpful were the insights of the Durban transcultural psychiatrists on the concepts and practices of Zulu healers (Zulus and Swazis are closely related in language and culture). They have worked clinically with healers and correlated their classifications of mental illness with Western categories.

Clinical discussions with CPNs were the richest source of information on the culture. For example, talking to depressed women gave insights into family structures, the inequalities of marriage and the overextended role of women. Seeking to understand the common adolescent syndrome, somaticised anxiety at school (brain fag syndrome), indicated the stresses imposed by education – the investment by the family in the student, the intense rivalry generated. It was noticed that students were admitted with transient psychosis at certain times of year related to the school calendar. This was an important clue in unravelling the psychopathology of brief reactive psychosis. The delusions expressed in this condition were more correctly termed intensely overvalued cultural ideas.

Tracking these ideas with the interpreters raised many questions. What was the impact of cultural beliefs on symptom formation? Conversely, to what extent did symptoms give insights into cultural beliefs? If these overvalued ideas were not delusional, did they indicate the thought patterns and coping strategies of the community which healthy people were usually reticent to express? They seemed to be intensifications of prevalent cultural defence mechanisms. For instance, beliefs in bewitchment were commonplace among patients – and even troubled hospital staff at times. They could be understood as an expression of dysphoria, fear or threat, an indication of bad relationships, especially jealousy, a form of projective defence. For example, a factory worker was admitted in a transient psychotic state related to a labour dispute with an unpopular foreman (see Case 17, paper II). His belief in bewitchment by the foreman had intensified to such an extent that he cut his own throat at the command of his vision. However, there were other strange ideas expressed in the overaroused state which indicated how fundamental were the concepts of bewitchment to the ways of thinking and world views of the people. Bewitchment provides an explanation for misfortune: disputes, crop failure or illness are attributed to malign influence rather than individual circumstances or natural causes. But it also maintains homeostasis within the social group by limiting the advancement of the individual. For example, a young mother in a distressed state insisted that she and her baby were to be killed and resurrected as ghost slaves. This was not delusional. It related to the beliefs underlying bewitchment. In the context of the conservatism and need for homeostasis in the peasant society a successful person is suspected of empowering himself by bewitchment rather than his own hard work. If his crops are conspicuously successful he must have killed someone and resurrected them as ghost slaves. Swazi anthropologist Makhubu (1982) has written on the sinister distortion of this belief since independence, related to the pressures of acculturation. The extrapolation of this belief implied that in order to succeed in business or politics, powerful sorcery using human body parts was required. This led to the practice of "muti murder" which is abhorrent to the Swazis and no part of traditional culture. Yet it indicates the powerful forces of cultural dissonance. How does a society with this world view cope with the demands of the individually orientated entrepreneurial Western culture? Do existing cultural defence mechanisms intensify during rapid social change and what effect

does this have upon psychopathology? Does cultural dissonance itself constitute an aetiological factor in mental illness?

Introduction to a culture through its mentally ill members would give a biased view, to say the least. An important counterbalance was the series of multisectoral workshops instigated by the WHO on the social dimensions of mental health. It was designed to promote service development; but it also provided an opportunity to meet leading Swazis, wise and discerning people who understood the complex changes occurring in their society. Civil servants from nine ministries presented papers on the contribution of their work to the mental welfare of society. Education, law and local government (the chief system) were prominent. Topics included the problems related to alcohol and cannabis, the loss of the customs governing their use and their current importance as a means of cash income; also the vexed question of women's lack of rights, particularly related to marriage and child custody; also the roles of the extended family, child-rearing practices, land tenure, educational philosophies, etc. There was opportunity to meet successful men from different walks of life who described how difficult it was for the individual to separate from the group and stand alone to initiate enterprise in Africa; and how great were the pressures on a successful individual from the extended family whose claims were paramount over and above those of the business or institution. In fact, successful individuals often preferred to live and work abroad for this reason. Many of this educated elite have studied in the West and have acquired the 'cultural distance' discussed below. They could 'see both sides of the fence', appreciate their own culture in the context of Westernisation, and understand the difficulties and, moreover, the valuable features of their culture which were being lost.

The following account of the culture and ethnography of Swaziland does not accrue from empirical study but represents essential background information for clinical work and service development. The account indicates how suitable Swaziland is for a study on the patterns of mental illness in the early stages of urbanisation, because the issues are relatively simple and there have been no other major social forces such as civil war, ideological oppression or foreign occupation.

Ethnography and culture

Economy and politics

Swaziland is a tiny country of 700 000 population of a single tribe and language, bordered by Mozambique and the Republic of South Africa. For the past 100 years, the Swazis have developed in relative political isolation free from the trials besetting their neighbours. Having become a British Protectorate during the Zulu Wars they were not included in the Union of South Africa and so avoided the problems of apartheid. They have enjoyed political stability since Independence in 1972, perhaps because of the absence of tribal conflict but also due to the long patriarchal reign for 82 years of the late King Sobhuza who promoted cohesion and embodied cultural values. The Swazis were traditionally a pastoral people who relied upon cattle and maize for subsistence.

The country is situated just south of the tropics at the edge of the escarpment of the high central plateau of Southern Africa. This divides it into three climatic zones – the high veldt, mountainous, cool and wet favouring timber; the middle veldt, fertile arable land; and the hot dry low veldt where irrigated commercial sugar plantations have recently developed. Nevertheless, foreign settlement is not extensive and a good proportion of available arable land is designated Swazi National Land. Allocation by the local chief, not by purchase, ensures access to land by any married male Swazi. It also slows the development of the class of landless urban poor; 80% of the population is still rural-based. They live on smallholdings of a few acres, in thatched wattle and daub rondavels. A prosperous homestead may number 50 family members but usually much less. Many are depleted of their menfolk by migrant labour. This is reflected in the distribution of agricultural labour – 37% by women, 35% by children and 28% by men (Low, 1977). A mixed subsistence cash economy is becoming increasingly essential (Prinz, 1978) due to population density and land erosion common throughout Africa. Nevertheless, economic proximity to South Africa has led to relative prosperity. Industries for processing primary products have developed – timber, paper and sugar mills, fruit canning and asbestos mining. Thus, most migrant labour is domestic within the country; only 12% of the labour force goes to the South African mines.

The need for a cash income is a key factor in social transition. For many reasons, the whole family does not migrate to the work place – such is the cultural importance of land, the need for cattle and crops, and the obligation to support dependent relatives. Thus the family is split between town and farm with rural depopulation by the able-bodied and accumulation in the rural areas of the less able, the elderly, the very young and the handicapped.

Traditional culture

Let us consider the traditional culture and then look at what is changing.

There is a harmonious relationship between the original culture and the demands of the self-supporting agricultural way of life. The social conventions and taboos, belief systems, and family structures provide coping strategies and safeguards against the hardships and disasters of the subsistence environment. The extended family is of obvious survival value; the non-viability of a nuclear family attempting to survive in the bush could be observed clinically sometimes. In this context, many customs make good sense – such as the patriarchal male dominance, the subservience of women, and the customs of polygamy and bride-price where women are both child bearers and agricultural labourers. Another survival factor is the obligation of mutual support between family members.

Belief systems provide coping strategies for the close aquaintance with illness and death (the high infant mortality and short life expectancy of adults). There are few old people and they are revered as 'almost spirits' who can remember the dead the longest and therefore prolong their existence as spirits. The 'cult of the living dead', or reverence of ancestors, is fundamental to African traditional religion. Dead family members are consulted and placated, as some forms of misfortune are attributed to their continued anger (relevance to Western family therapy?). Funerals are obligatory and are major family occasions. They provide therapeutic mourning customs in the form of ritual weeping, rehearsal of the deceased's last illness, and extolling of his merits. Fear and reverence of the dead binds the living together and enforces the obligations of mutual support – or 'extended family discipline' as the Swazis call it. The traditional healer plays a key role in this, indeed multiple roles. He can divine the will of the ancestors, or diagnose the source of bewitchment. He is priest, healer, adjudicator, and counsellor. Ceremonies and rituals symbolise expulsion of the evil, e.g. vomiting, purging, sneezing, scarification. These serve to reinforce defence mechanisms such as projective defence, denial and magical thinking. They have the effect of promoting release from the sick role and reinstating the patient into his family. Nearly all mental patients consulted the healer before or after admission.

Changing culture

What is the dislocating effect of urbanisation on this integrated human ecosystem? In the urban context with its different roles, demands and circumstances one would expect many customs to lose their adaptive significance. Thus polygamy and bride price become a source of dissent. The capacity of the extended family to absorb the handicapped and dependent is a vital factor in community mental health for there are no welfare benefits or social services in Swaziland. However, in the urban context it is much less feasible than in the labour-intensive rural homestead where essential commodities, food, fuel, and housing do not cost money but can be procured from the environment. Support of dependants can become a great burden to the few who succeed in life.

There is loss of valuable child-rearing practices. The group parenting of the large family unit provided many adult role models and compensated for sick or disturbed parents. The problem of child care for the urban working mother is a new one. An older child may be employed as baby minder or the small child may be sent to the rural homestead. The latter can work well, but it can also result in elderly women being overburdened with the care of too many young grandchildren.

Another loss concerns adolescence. The customs which structured and formalised the adolescent tasks of development – such as the rites of passage and the special training given by specific family members – have been lost in favour of schooling. These provided guidelines in sexual behaviour and the duties of adulthood. In contrast are the influences of alien value systems, and the feelings of 'relative deprivation' perceived by glimpses of the affluent West. Another problem is the disparity between the contemporary roles of men and women. This can be understood in the light of the earlier strictures of survival when the roles of hunter and warrior were vital. Nowadays men have lost these earlier roles but women have lost none of theirs. They must still produce food (i.e. they are regarded as breadwinners), as well as bear and rear the children, in addition to their modern roles in employment. Women appear to carry disproportionate burdens in the changing society. Could this be related to observed trends towards alcohol disorders in men and depression in women?

Marriage

Sociological studies on marriage customs, kinship patterns and child custody (Mbatha, 1983; Russell, 1989) indicate an ambiguity in traditional marriage. The various contractural ceremonies may be spaced out over many years, often related to difficulties obtaining bride price; in some cases marriage may be

ratified only late in life after the reproductive years. Marriage seems to be more binding on women than on men. Yet the dual concepts of polygamy and early reproduction (to prove fertility) mean that it is common for a woman to have a few children before marriage and for men to continue to have extramarital children. Swazi family structure is essentially patrilineal and patriarchal with the man's family having undisputed right of custody of the children. Illegitimacy carries no particular stigma but it may well carry social disadvantage. Extramarital children are reared by the man's wives or parents. Boys are at risk of becoming cattle herds, and the girls, household drudges. If a woman does rear her premarital children they are excluded from her household when she marries and must be taken on by her family. There is an increasing trend towards the matriarchal family structure seen in West Africa and the Caribbean, with families consisting of mother, grandmother and children with the fathers as visitors. It is not clear whether this fluidity of kinship patterns is a direct result of the disruptions of urbanisation, such as migrant labour, or whether the traditional marriage customs functioned well in the previous geographical isolation of tribal societies but were vulnerable to social change.

Education

Education in traditional Swazi society had been a task carefully structured within the extended family, preparing children for their appropriate roles. It can still be observed in the impressive way in which families train their disabled children to the ceiling of their ability. Formal Western education has largely superseded this and has become a major agent of change. Census statistics show that a large proportion of the population is still the first generation to be educated. In the 1976 census 55% of the 35–55 year-old age group had had no formal schooling compared with 31% in the 20–35 age bracket. In 1986 the figures were 43% and 25% respectively. Education is neither universal nor free, yet it is the key to employment. Enthusiasm and determination for education offset the difficulties in obtaining it, and both opportunities and expectations are high. A peasant's son can rise to professional status by educational achievement alone; there are no class barriers. Extended families make financial sacrifices to obtain education for some if not all of their children in the hope of acquiring a member who can earn well. What is the effect upon the student of this investment and over-expectation?

There is a steady drop-out from the 80% of the school-age population who register at Primary 1 to the 56% who complete Primary 7, from the 48% who enter secondary school to the 15% who finally take the Cambridge Overseas Certificate ('O' level). Farming commitments and lack of school fees, which may delay entry, or interrupt or terminate schooling, contribute to this drop-out, but there is also the rigorous educational selection. After the first grades, instruction is in English. There is no automatic progression to the next class: pupils must pass each grade before moving on. Each repeat incurs an extra year's school fees which is a burden on the family. There are few resources for special needs, and children with learning difficulties can spend years in the lower grades. There is therefore a very wide range in African schools. These factors could contribute to the widespread anxiety at school. One question might be: are families selecting children for education regardless of ability? Furthermore, what is the effect of educational philosophies and teaching styles? There is strong emphasis on academic examinations right from the start of primary school. This is by popular demand, as certificates are vital for employment. Non-academic options are disdained. Teaching style is didactic, with much rote learning and corporal discipline to reinforce learning (e.g. the cane for spelling mistakes). This is consistent with child-rearing practice and is expected by parents. Classroom management is strict and teacher orientated. Behaviour is typically excellent; but does the rather punitive style generate anxiety?

The issues of bewitchment, as outlined above, are very important at school. For instance, students fear that their books will be stolen and spells planted in the pages to enter their eyes as they read; mothers refuse to send food to school with their children lest it be bewitched; the normal anxiety at exam times is heightened by fear of charms, and 'muti' obtained to make the bearer pass and others fail; teachers attribute the episodes of epidemic hysteria to bewitchment. This cultural factor must therefore be estimated in any study of psychiatric morbidity associated with education.

Adaptation

What were the advantages and disadvantages of an 'outsider' investigating the psychiatric disorders of another culture? Disadvantages clearly included the extensive adaptation required. But much of this would apply to any Western-trained psychiatrist whatever his/her own culture – as is clear from the above descriptions of clinical practice. For this reason the WHO has advocated the training of national professionals within their own countries.

I was the sole psychiatrist for much of the five-year period, which is not unusual in the developing world where there may be only one psychiatrist per one to four million population. Fortunately there was a 15-month period of overlap with the preceding psychiatrist, which allowed valuable time for adjustment. Regular consultancy visits from the WHO to advise on service development were supportive. I was not new to Africa, having had a colonial childhood in West Africa and later worked in general medicine for ten years in a rural mission hospital in Uganda during the time of Idi Amin.

This gave a medical perspective. It was reasonable to suppose that psychiatry in Africa might be rather different from Britain since general medicine was different. It was the medicine of poverty, of low standards of living and preventable disease – with, of course, the geographical component of tropical illness – but reminiscent of an earlier era in Europe (e.g. tuberculosis, syphilis, grand-multiparity, the complications of the streptococcus, etc.). Clearly the cultural component would be of key importance in psychiatry, but there would be other factors shaping the picture.

A component of this adaptation is the inevitable 'culture shock' which is experienced by all expatriates and immigrants (but is not always recognised). It involves the complex adjustments to working and living with people who have a different set of social rules, coping styles and priorities. For the psychiatrist it is intensified by the demands of the job, since it is important to be able to empathise with one's patients. It is worth looking objectively at this culture shock. It is essentially an experience in intensive adaptation. Every action requires attention and effort. Nothing is automatic. There are no familiar routines. It is very tiring and this can be expressed as irritation, impatience and intolerance of the host society. Indeed, one begins to understand how psychiatric illness can be exacerbated by migration. However, if the expatriate can acknowledge this experience and the projective defence it generates, he can avoid making the various complaints of inefficiency, antagonism or racialism in his hosts, and even understand and make allowances for these when they do occur. One benefit from this experience is the 'cultural distance', or perspective, that results. This allows one to see one's own culture in the light of another, to realise that one's own culture is not the 'norm' but a variety of human experience. One can draw parallels and evaluate differences.

It is very difficult from an ego-ethno-centric stance to perceive the impact of one's own native religious/ideological beliefs on the social behaviours and world views of one's own society. One is a product of, and is formed by, these beliefs, and so cannot easily distance oneself and view them objectively. Having to strive to understand, and to practise psychiatry in a foreign culture gives an opportunity to perceive this impact as an observer rather than a participant. This raises some fascinating questions of relevance to psychiatry. For instance, does religious or ideological belief select, or shape, mental defence mechanisms from the human repertoire so that a certain culture has a predominant pattern of defences and coping strategies? The foregoing account has shown how concepts of bewitchment in African culture provide a means of defence and serve to regulate society but also shape world views and possibly make acculturation to Western styles difficult. One asks how did the religious beliefs of Judaeo–Christian civilisation shape Western world views? Did the emphasis on sin reinforce individual responsibility? What is sin in psychological terms? It is not simply overt behaviour but internal desires and motivations, even maladaptive defences. Now that concepts of sin and religious beliefs have waned in the West, what has replaced them as cultural strategies for internalising control? Has this change had an effect upon psychopathology?

In the West there has been a polarisation, or divorce, between religious thought and psychiatry. This was doubtless necessary, at least initially, to facilitate empirical scientific approaches to mental illness in the context of fear and stigma. But the strong feelings generated have prevented a readjustment of this polarisation. The perspectives gained from another culture suggest a close relationship between mental welfare and cultural beliefs. For instance, in Africa not only are traditional healing strategies closely linked to religious beliefs but these beliefs provide the driving force which maintains protective social customs. One hypothesis would be that as beliefs wane, social conventions lose their disciplinary effect and mental welfare is impaired. This can be observed fairly obviously in the alcohol-related disorders of transitional societies. But could it also be relevant to the post-industrial societies of the West? What has been the effect of loss of religious beliefs and the customs which these enforced? What underlying implicit beliefs drive Western societies now? Materialism, individual ambition? Could these be related to anorexia nervosa, which is regarded as a Western culture-bound syndrome?

This discussion indicates that in spite of the constraints of practising psychiatry across a language and culture barrier, the very necessity of having

to strive to understand the culture produces an objectivity and perspective which is an advantage.

Formulation of hypotheses

The study started with the premise: "it cannot be assumed that psychiatric syndromes and their component symptoms are the same in a developing pre-industrial society as in a developed post-industrial society". The null hypothesis that there is no difference needs to be tested. Moreover, in a pioneer area of psychiatry one needs to start by exploring clinical manifestation, and build hypotheses on the primary findings. The move out of the confines of the hospital made it possible to explore psychiatric morbidity in the community and to link this with the hospital profile, particularly in terms of the known frequency of depression in the community and its apparent rarity in hospital.

Paper I of the study is a qualitative exploration of predominant syndromes, presenting symptoms, and help-seeking behaviours in a selected population group – adolescents and young adults at school or within a year of school leaving. This choice was suggested partly by feasibility, since school populations are accessible to epidemiological study, and also because of the unexplained morbidity in this group, their neurotic presentation to clinics, and the observed pattern of incidence of transient psychosis to hospital. Furthermore, adolescents and young adults are by their very nature at the forefront of change, and might be vulnerable to the effects of rapid social transition. Paper I is not an exhaustive study; it can give no indication of incidence or prevalence of different types of disorder. It is a case collection representing predominant psychopathology and forms of presentation, outlining common psychosocial adversities. The findings generated hypotheses which were tested out in papers II, III and IV.

Paper II is a hospital-based prospective study with limited follow-up of 361 cases, of all ages, of functional psychosis. It examines several hypotheses: "depression can present with transient psychosis as a form of help seeking behaviour"; "this can lead to distortion of phenomena and a greater proportion of atypical psychosis than is seen in societies where depression *per se* is more presentable"; "there is an association between atypical psychosis and the indices of rapid social change (education and employment)". Predictive risk factors for transient psychosis ultimately becoming schizophrenia were examined. This exploratory case collection also generated further hypotheses.

Papers II and IV are more structured epidemiological studies which allowed limited quantitative measures of the selected group.

Paper III examines distribution of psychiatric morbidity in terms of symptom prevalence in different types of schools: rural, urban and elite. It also tests hypotheses concerning presenting symptoms: "predominant symptoms of affective expression are somatic, cognitive and 'spiritual' (derived from cultural beliefs)"; "factors influencing symptom formation include age, response set and cultural constructs".

Paper IV examines the hypothesis "factors identified in industrialised countries as related to adolescent psychiatric disorder would also obtain in Africa, such as family adversity, but there would in addition be factors specifically related to a society passing through rapid social transition". The specific factors which were relevant to the students were identified in the case studies in Paper I. They included the difficulty in obtaining school fees which represented the change from subsistence to cash economy, the effects on the family of urbanisation such as migrant labour, rural depopulation and population pressure (i.e. huge sibships), and the intensification of cultural beliefs in terms of fears of bewitchment and envy at school, and parental overexpectations of education.

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For references see pp. 69–72.