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ATTRIBUTIONS FOR ADMISSION TO ZOMBA MENTAL HOSPITAL: IMPLICATIONS FOR THE DEVELOPMENT OF MENTAL HEALTH SERVICES IN MALAWI

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SUMMARY

Within Malawi, as in many other African countries, a variety of traditional and modern attributions exist regarding the cause of a person's mental disturbance, or their admission to a 'mental' hospital. It is argued that a good mental health service should consider the beliefs of the patients it seeks to serve. Consequently we studied 103 consecutive admissions to Zomba Mental Hospital in order to find out how patients explained their own admission to the hospital. Traditional attributions were the most common, followed by medical and then psychological attributions. Some patients explained their admission to the hospital by combining traditional, medical or psychological ideas. Content analysis of traditional attributions identified examples of "Tropical Tolerance" and the "Pull Down" phenomenon. The possible interactive nature of traditional, medical and psychological processes is discussed and it is suggested that traditional healers should be incorporated into 'modern' Malawian mental health services.

INTRODUCTION

Within the tropics mental disturbances are attributed to a variety of different causes and these different interpretations often reflect different cultural beliefs (Kiev, 1964). In Malawi it has been noted that both physical and mental disorders are often explained in terms of traditional beliefs (Wilkinson, 1992). Within this context illness may be understood to reflect problems between different members of the community. The treatment of a variety of 'illnesses' is therefore often directed towards restoring social harmony (Chilivumbo, 1976; Kalipeni, 1980). The possible value and efficacy of such social treatments has become increasingly recognised (Peltzer, 1993). Within Malawi the psychological characteristics of traditional beliefs have been studied in an attempt to specify their therapeutic aspects (Peltzer, 1987). Such aspects could be incorporated into the provision of contemporary health services.

The contemporary patient's understanding of their own disturbance is likely to influence the readiness with which they accept a particular form of treatment. Research on both physical and mental health in Malawi suggests that rather than 'illness' being understood in purely 'modern' medical terms or 'traditional' socio-spiritual terms, many people are able to integrate these apparently disparate approaches (MacLachlan & Carr, 1994). This is important because a good mental health service should also be able to take

into account the beliefs of those it is serving. We must therefore have knowledge of patients' beliefs about the causes of their problems and consider what implications such beliefs might have for service provision.

Zomba Mental Hospital is Malawi's only specialist inpatient facility (see Wilkinson, 1992) and has existed in its present form since 1953. Treatment is predominantly along 'modern' medical lines, usually involving electroconvulsive therapy and/or pharmacotherapy. To date there have been no published accounts of admissions to the hospital and no systematic investigation of the factors which patients see as being responsible for their own admission.

There is increasing support for the idea that the health services of developing countries may be sustained more effectively by integrating traditional and modern approaches to therapy (see for example, Ojamunga, 1981; Ezeji & Sarvela, 1992; MacLachlan, 1993a; Simukonda, 1994). The relatively poorly developed mental health service in Malawi offers a number of options for future developments including the integration of traditional and modern approaches to mental health care (MacLachlan, 1993b). The present study is an initial attempt to consider the perspective of Malawian psychiatric inpatients by investigating their own beliefs regarding the cause of their admission.

METHOD

Subjects

One hundred and three consecutive admissions to the two male and one female receiving wards of Zomba Mental Hospital were studied over a three month period. The 70 male and 33 female patients had a mean age of 29.48 years (SD = 11.18, range 15–75). There was no significant difference in the age of male and female patients.

Procedure

As part of their admission interview patients were asked to describe what had caused the problems which led them to be admitted to the hospital. Patients' explanations were written down verbatim and categorised as Traditional, Medical or Psychological, with combinations of these categories being allowed (for example, Traditional and Psychological). There was also an "Other" category which was subsequently broken down to, Denial, Other and Don't Know. These categorisations were subsequently either confirmed, or changed by mutual agreement, through a second rater who is a clinical psychologist with clinical experience of working in Malawi.

As no formal system of psychiatric diagnosis (for example, the World Health Organisation's International Classification of Diseases, or the American Psychiatric Association's Diagnostic and Statistical Manual) is routinely employed to assess admissions, it was decided that the most reliable and valid way of classifying patients for the purposes of the present study, was into an 'exhibiting psychotic behaviour' group and a 'not exhibiting psychotic behaviour' group. Patients who presented with classic 'first rank' symptoms (delusions, hallucinations, thought disorder, etc; see Schneider, 1959) were classified as displaying psychotic behaviour. Those who did not present with these symptoms were classified as not displaying psychotic behaviour. This classification

Table 1
Attributions for admission by Classification and Sex

Attributions	Classification		Totals by sex	Total
	Psychotic	Non-Psychotic		
Traditional				
M.	21	6	27	32
F.	2	3	5	
Medical				
M.	11	5	16	21
F.	4	1	5	
Psychological				
M.	10	7	17	19
F.	0	2	2	
Trad/Medical				
M.	2	2	4	6
F.	0	2	2	
Psycho/Medical				
M.	3	1	4	4
F.	0	0	0	
Trad/Psycho				
M.	2	0	2	2
F.	0	0	0	
Denial				
M.	2	0	2	2
F.	0	0	0	
Other				
M.	4	1	5	5
F.	0	0	0	
Don't Know				
M.	8	3	11	12
F.	1	0	1	
Totals	88	15		103

is descriptive and makes no assumption about the cause of a patient's condition on admission. So for example, drug abuse which resulted in hallucinating behaviour was classified as displaying psychotic behaviour. The summary data form which was used to record salient aspects of the admission interview is shown in the Appendix. Admission interviews were usually conducted in Chichewa, but occasionally also in other Malawian languages with translation into Chichewa.

RESULTS

Quantitative Analysis

Of the 103 patients, 88 (63 males and 25 females) were classified as psychotic while 15 were classified as non-psychotic (7 males and 8 females).

Table 1 shows the number of patients giving Traditional, Psychological or Medical (or

combination of these) attributions for their admission to Zomba Mental Hospital. It can be seen that a pure Traditional attribution for admission was the most common (32 out of 103) with pure Psychological (19) and Medical (21) attributions being similarly common. In addition, 12 patients gave attributions which included elements of more than one of the Traditional, Psychological or Medical categories. Once again, Traditional attributions featured prominently with 8 of these patients giving attributions which included a traditional element. Only two patients denied having any reason for being admitted, while twelve patients said they did not know the reason for their admission.

To determine whether category of attribution was associated with patient's sex or their classification (psychotic versus non-psychotic), Chi-squared tests were computed. There was no association between what sex a patient was and whether they made a Traditional, Psychological or Medical attribution for their admission ($\chi^2 = 2.31$, df = 2, ns). Regarding the relationship between attribution and classification, the expected frequencies fell below 5 (invalidating the chi-square test) and so Psychological and Medical attributions were collapsed into a category of 'Modern' attributions, which produced expected frequencies greater than 5. However, this chi-square test showed that there was no association between a psychotic or non-psychotic classification on the one hand, and whether patients made Traditional or Modern attribution for their admission, on the other hand ($\chi^2 = 0.30$, df = 1, ns).

Ninety per cent of males were classified as psychotic whilst 75% of females were classified as psychotic ($\chi^2 = 3.66$, df = 1, $P < 0.056$). Thus there was a trend for males to be more likely to receive a psychotic classification than were females.

Qualitative analysis

Table 2 gives the English translations of examples of the attributions made in each of the three pure categories. We conducted a content analysis of the Traditional attributions and found some recurring themes in the 40 subjects who made such attributions for their admission to the hospital. These themes included bewitching (mentioned in 36 attributions), family or relatives (24 attributions) and achievement or jealousy of achievement (21 attributions). Of course, within one attribution several of these themes may occur. Attribution 1 in Table 2 combines all of the above themes, while attribution 2 combines the themes of bewitching and the family.

An example of a traditional attribution which does not involve witchcraft was given by one man who believed that the jealousy of others had led them to want to poison him. He said that the worry of this is what led him to being admitted to the hospital. This was rated as a traditional attribution because the theme of trying to harm someone who has done better than oneself is a long established theme in Chewa culture (Bowa & MacLachlan, 1994). For more than half of the traditional attributions the theme of achievement or jealousy was present. In other cases people believed they were bewitched but did not know why, or believed that their bewitchment was connected with them doing wrong to someone else.

Psychological attributions generally concerned stressful experiences leading to a 'breakdown'. Medical attributions frequently included the theme of drug abuse (7 patients had been abusing Chamba), and at other times referred to a physical illness, such as heart problems or T.B., as preceding the admission, and by inference, 'causing it'.

Table 2
Examples of Traditional, Psychological and Medical Attributions for admission to Zomba Mental Hospital

Traditional
(1) He was bewitched by his workmates, or relatives, because he works hard and is married to a beautiful woman.
(2) He has been bewitched by his wife because he attempted to marry another wife.
(3) He is bewitched by his stepbrother of his father, because in his own family they are all educated.
(4) Her uncle has bewitched her. This is evidenced by the KW 20 he gave her.
(5) People are jealous of him because he owns the sun and all the stars ... people have therefore put a spell on him in order to make him ill.

Psychological
(1) She is worried her husband is intending to marry another wife because she is infertile.
(2) People at home don't like her and they wish she was dead – "someone actually poisoned me".
(3) His wife is having sex with other men and he sees men who want to 'have' her.
(4) Her children are dying without proper cause, however one died from malaria and another because of the divorce her husband is planning.
(5) Thinking too much following the death of his child. It was a sudden death.

Medical
(1) He is mentally sick due to chamba (marijuana) abuse.
(2) He suffered from tuberculosis and then broke-down mentally.
(3) He has twice suffered from acute cerebral malaria and has had his eye operated on twice because of a sight problem.
(4) She is sick because of the effects of labour in childbirth.
(5) He is sick because he is asthmatic and so most of the time he is very irritable.

As indicated in Table 1 there were also attributions for admission which included more than one of the Traditional, Medical or Psychological categories. For instance one woman believed that "thieves who stole her clothes in 1985 had bewitched her through her clothes. She had never suffered any illness before this ... and her heart problem probably also has something to do with it she claimed". While this example includes Traditional and Medical attributions, the following one combines Traditional and Psychological attributions: "She believes the cause is that her husband always leaves her alone ... he works in Blantyre and goes around with other women ... also her sister has bewitched her [by making her husband do this] because she is jealous". Finally an example of one attribution which included all three categories was as follows: "I was working very hard and getting quite tired ... I had dizzy spells and my heart would jump and beat very fast ... because of the success I had achieved, other people were jealous and put a spell on me."

DISCUSSION

The great majority of patients admitted to Zomba Mental Hospital were displaying psychotic behaviour at the time of their admission. Two thirds of admissions during the study period were male and there was a tendency for males to be more likely to receive a classification of 'displaying psychotic behaviour', than were females.

Most commonly patients attributed their admission to factors representing traditional beliefs, and this was not influenced by their classification as psychotic or non-psychotic.

One interpretation of this is that traditional attributions – which often included ideas of 'persecution' – are not related to delusions, which are often used to diagnose schizophrenia, or psychotic behaviour. Yet the idea of being bewitched and falling 'ill' because of this, is one which would be labelled delusional in other cultures. For purposes of identifying those people who have lost a sense of reality, this poses an important question. Should ideas regarding witchcraft be classified as "delusional explanations", or "subculturally influenced delusions", or "overvalued ideas", or what? If they do not discriminate between psychotic and non psychotic behaviour, should they be given any diagnostic significance at all? Peltzer (1989) argued that in Malawi, although it is frequently believed that mental disturbance arises from witchcraft, witchcraft is not seen as a social aberration but as a normal part of everyday life.

Whether the clinician wishes to treat a schizophrenic illness (see Johnston, 1993) or a false belief (see Bentall, 1993) s/he still needs to be able to identify when a delusion is a delusion. However, the matrix woven by cultural beliefs and psychiatric phenomenology may leave little room for any confidence in clinical demarcation. As such, developing a system for understanding when a clinical interpretation is warranted, is a prerequisite for the development of effective mental health services in Malawi, and elsewhere. Such an understanding is, however, only likely to be achieved by the integration of traditional and modern approaches to mental health care.

A number of patients explained their admission to hospital by referring to traditional beliefs and at the same time mentioning medical or psychological factors. Thus a medical belief, say in having a heart problem, and a traditional belief in being bewitched, could be presented by a patient as dual causes. This reflects a tolerance for what 'western' minds might see as incompatible explanations: "If it's medical then it can't also be traditional." This ability to entertain competing explanations of illness, has been described as 'Tropical Tolerance'. Similar observations have been made in several African countries (see for example, Jahoda, 1970; Barbichon, 1968; Ezeji & Sarvela, 1992) although the co-existence of different belief systems has often been viewed as a difficulty rather than as a possible resource.

The presence of Tropical Tolerance in Malawi has been noted in a range of physical illnesses including malaria, schistosomiasis, and epilepsy, and also for mental health problems (see MacLachlan & Carr, 1994). Furthermore, Elliot *et al.* (1992) also reported that Zimbabwean nurses understood suicide through a mixture of traditional and modern beliefs. However, what is noteworthy in the present study, is that the majority of patients gave attributions for their admission in terms of purely Traditional, Psychological or Medical causes, rather than combinations of these. This may of course be influenced by our methodology of giving three labelled categories for interviewers to 'code' patients' attribution. Such an approach could have encouraged interviewers to simplify patients' explanations in order to make them 'fit' the categories. Nonetheless, the plurality of views that may co-exist, either within one patient or across many patients, should also be reflected in the mental health services of developing countries. To some extent this is the case in Malawi. Staff at Zomba Mental Hospital do grant permission for patients to attend traditional healers, but only if the patient's guardian requests it. However, such a 'referral' takes a rather circuitous route as it is made "against medical advice". The point here is that they refer the patient *outside* of the

hospital and 'modern' health service system. With the number of Traditional attributions being made for admission, surely a case can be made for inviting some traditional healers *into* the 'modern' mental health service system. Presently 'the system' is run along medical psychiatric lines.

The content analysis of Traditional attributions revealed common themes of bewitchment (predictably), family and relatives (again predictably, because people exist within the social fabric of the extended family) and also achievement, or jealousy of achievement. That achievement, or jealousy of achievement, should be a common theme of Traditional attributions for admission to mental hospital, is perhaps less obvious. However, it has been suggested elsewhere that many people in Malawi have a propensity, especially in work settings, to impede the progress of others. This has been termed the 'Pull Down' motive (Carr & MacLachlan, 1993). There is much anecdotal evidence to support the notion that people who do not have any mental problems experience jealousy, or are the targets of other people's jealousy, when one person has 'outperformed' others, or has achieved more than others (Bowa & MacLachlan, 1994). In Malawi Marwick (1965) interpreted accusations of witchcraft as a reflection of tense social relationships and jealousy is often an important motivation for bewitchment (Mwale, 1977).

This then poses an intriguing interface between the Psychological and Traditional causes of mental health problems. If one has achieved more than one's peers (or elders), then the knowledge that they are jealous of you and wishing you ill can no doubt be stressful. Thus the belief that someone has put a spell on you, or has bewitched you, could be supported by your own stress related malaise, which may in turn be attributed to the spell working its effects. Thus there is clearly scope for a mutually reinforcing spiral between psychological and traditional elements. In time, these may also incorporate physical ailments, through the well documented effects of stress on the physical systems of the body (see for example, Fontana, 1989).

CONCLUSION

The present study shows that a variety of Traditional, Psychological and Medical attributions are made for admission to mental hospital in Malawi. Sometimes these attributions may combine the above dimensions and reflect 'Tropical Tolerance'. Often Traditional attributions will reflect a general cultural concern with the consequences of achievement. It is clear that a 'western' or purely 'modern' model of mental health care cannot incorporate these phenomena. Rather, mental health services in Malawi must develop by creating a framework in which Traditional beliefs can be seen as part of the mental life of the people, and at the same time be 'interpreted' when they reflect mental distress and disorder. To achieve this, the Malawian mental health service must access its heritage of traditional mental health healers.

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APPENDIX

Summary data sheet for admissions research
Zomba Mental Hospital

Part 1

1. Patient's Number: Date:
2. Age: Sex: Marital Status:
3. Occupation:
4. Home District:
5. Diagnosis: 1) PSYCHOTIC
   2) NOT OBVIOUSLY PSYCHOTIC
   3) OTHER

Part 2

1. PRESENTING SYMPTOMS/COMPLAINTS ON ADMISSION:

2. PATIENT'S OWN EXPLANATIONS FOR ADMISSION:

A) TRADITIONAL:

B) PSYCHOLOGICAL:

C) MEDICAL:

D) OTHER:

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