World ▮ Cultural ▮ Psychiatry ▮ Research ▮ Review
OFFICIAL JOURNAL OF
WORLD ASSOCIATION OF CULTURAL PSYCHIATRY

Original Paper

Lay concepts of psychosis in Busoga, Eastern Uganda: A pilot study

Catherine Abbo, Elialilia Okello, Solvig Ekblad,
Paul Waako, Seggane Musisi

Abstract. ***Introduction:*** *Biomedically based interventions are the officially accepted form of health care for psychosis in most African countries. However, many people who present psychotic symptoms use traditional healing services. Understanding how lay people view psychosis is important not only for epidemiological research but also for understanding health-seeking behaviour.* ***Objective:*** *To explore and describe lay concepts of psychosis among the Basoga.* ***Method:*** *A qualitative study using Focus Group Discussions and case vignette techniques. Four focus group discussions were held; two for traditional healers and two for the general community, totalling 31 participants.* ***Results:*** *The Basoga differentiated schizophrenia from mania and psychotic depression, giving names for each disorder and describing the symptomatology and natural course. Schizophrenia* (eddalu *or* ilalu*) was viewed as a more serious illness, with the possibility of not recovering, mania* (kazoole*), as less serious mental illness, with normality between episodes. Psychotic depression was seen as illness caused by too much thinking. Clan/family/cultural issues were mentioned as causing schizophrenia and psychotic depression, while physical causes and a failed relationship with God were mentioned for mania. Other causes were witchcraft, genetics and substance misuse. Choice of care depended on what was believed to be the cause of the psychotic symptoms.* ***Conclusion:*** *These findings provide insight into Basoga lay concepts of psychosis and will be used in the main study to modify the Western instruments, thereby making them more culturally sensitive, applying an emic and etic approach.*

Key words: Psychosis, lay concepts, case vignettes.

WCPRR Jul 2008: 132-145.

INTRODUCTION Research has indicated that core psychotic disturbance is universal (Murphy, 1976; Parshall & Priest, 1993) and most clinical work and research in psychiatry has therefore proceeded on the assumption that schizophrenia and affective psychoses are universally understood uniformly. It is argued that successful research into understanding psychoses requires that environmental factors, including culture, are combined with biomedical factors in research designs. Culture is a conceptually distinct and potentially powerful environmental factor, capable of exerting significant effects on the understanding of mental illnesses in different cultures (Edgerton & Cohen, 1994). In the clinical field, one way of helping patients in the context of multiple healing systems with different models is to be aware of some of the socio-cultural processes involved in the definition of serious mental disorders and in the traditional healing systems (Swartz, 1998).

While psychotic behaviour is recognized as deviant across cultures (Murphy, 1976), there is no universal conceptual category of mental disorder (Kleinman, 1988). Psychotic behaviour often prompts supernatural explanations (Kirmayer, 1989). A review of the literature from Africa indicates that

Correspondence to: Catherine Abbo, MD, PhD Student. Karolinska Institutet, Department of Clinical Neuroscience. Psychiatry-HS, SE-171 77 Stockholm, Sweden.

E-mail: cathyabbo@med.mak.ac.ug

Received February 25th, 2008. Accepted July 24th, 2008.

mental health problems are variously conceptualized (Orley, 1970; Patel, 1995), including physical conceptualizations (Edgerton, 1966). For example, drugs, alcohol and HIV are implicated in Ethiopia, East Africa and Zimbabwe (Edgerton, 1966; Kortmann, 1987; Patel, 1995). More recent studies in Uganda suggest that people attribute mental illness to physical trauma to the head, as well as to infectious disease, including HIV and malaria (Abbo, 2003; Okello *et al.*, 2005). Less evidence is available about the psychological models of serious mental illness. Some African communities directly attributed "madness" to psychosocial factors, including stress, grief or worry (Edgerton, 1966; Okello & Ekblad, 2006). Patel (1995) found that unemployment and marital problems were seen to cause mental health problems. Depression has been collectively described as 'illness of thoughts' (Okello & Ekblad, 2006; Patel *et al.*, 1995). However, when affective disorders, such as depression, progress to psychotic levels, other factors are involved (Okello & Musisi, 2006). In Uganda, Teuton *et al.* (2007) described the conceptualization of psychosis by indigenous and religious healers in Kampala, an urban area (Teuton, *et al.*, 2007). Another study demonstrated that psychotic depression is recognized and labeled as 'clan illness', translated as *ebyakika* illness, by the Baganda in central Uganda (Okello & Musisi, 2006). That study looked at depression only in central Uganda. Our exploratory study aimed to catch the understanding of serious mental disorders (psychoses) as defined by DSM-IV criteria (APA, 2000) and perceived by the Basoga in Eastern Uganda. In particular, the study aimed to investigate how the Basoga, including their traditional healers, conceptualize severe psychotic mental illnesses, i.e. schizophrenia, mania and psychotic depression, by differentiating them, their symptomatology, perceived causes and treatment. This would help in comparing their conceptualization and finding appropriate words for the main etic study. The Basoga were chosen as the community of study because of their unique geographical location, occupying an area between two dominant cultural groups: the Bantu to the south and west and the Luo to the north and east. The Basoga would accordingly present a dualistic cultural mix of these two major ethnic groups.

MATERIALS AND METHODS

Design

The study used qualitative methods, which made it possible to use an emic perspective, i.e. a collection of meanings from the participant's cultural context. According to Glaser and Strauss (1967), qualitative research is preferable for inductive, hypothesis-generating investigation, as opposed to hypothesis testing (Glaser, 1967). Focus Group Discussion was chosen as a useful tool for exploring topics connected with group norms and the group meanings that underlie those norms (Bloor *et al.*, 2001; Ekblad & Baarnhielm, 2002). Focus groups generate alternative views on an issue and the intention is not to reach consensus. Focus group discussions do not require formal training for the moderators and the observers but the literature does recommend interpersonal skills (Owen & Milburn, 2001). The moderators (the first and second author) were skilled and experienced in guiding discussion and maintaining focus. An advantage of using focus group discussions to collect original data is their connection with oral traditions, which makes them preferable when participants have little or no educational background. Further, focus group discussion is relatively easy to arrange, inexpensive and flexible in terms of format, types of question and desired outcomes.

Study site and setting

This study was conducted in the Busoga region of Eastern Uganda. Busoga is a kingdom made up of the 11 principalities of the Basoga people; it is one of the largest of the five traditional kingdoms in present-day Uganda. The kingdom's capital is located in Bugembe, which is near Jinja, the second largest city in Uganda. Busoga Kingdom is composed of seven political districts: Kamuli, Iganga, Kaliro, Namutumba, Bugiri, Mayuge and Jinja, each headed by a democratically elected chairperson or Local Council V chief (L.C.5s), while the Municipality is headed by an elected mayor. The Resident

District Commissioner is the presidential representative in the district and therefore acts as the district's gatekeeper. Jinja is the industrial/economic hub of Busoga. Busoga is bounded on the north by the swampy Lake Kyoga, which separates it from Lango, on the west by the Victoria Nile, which separates it from Buganda, on the south by Lake Victoria, which separates it from Tanzania and Kenya, and on the east by the Mpologoma (Lion) River. Busoga Kingdom is a cultural realm that promotes popular participation and unity among the people of Busoga, through cultural and developmental programs for their improved livelihood. It strives for a united people of Busoga, who enjoy economic, social and cultural prosperity. It also continues to enhance, revamp and pave the way for an efficient institutional and managerial system for the Kyabazinga kingship. The three million Basoga (2002 Census) make up the second largest Ugandan ethnic group or tribe (after the Buganda), although they represent only about 11 percent of the population. The Basoga occupy a geographical location between two large ethnic groups: the Bantu to the South and West and the Luo to the North and East. This position presents a mixture of cultural influences from these two ethnic groups.

The Basoga are a peace-loving people who traditionally lived in small homesteads comprising the father, mother(s), children and relatives. They also subscribed to large communities with similar traditional norms, culture and origin. These large kinship families or communities are known as clans. As long as they shared these norms, their sense of freedom was complete.

Like any other African community, the Busoga have traditional healers, defined by the WHO as 'a person who is recognized by the community in which he/she lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on social, cultural and religious background as well on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well being and the causation of disease and disability' (WHO, 1978). The conceptualization presented by the healers in the healing systems is likely to influence the way in which a sufferer interprets his/her experiences and the nature of the experience itself.

Sampling

Two focus groups of lay Basoga and two groups of traditional Basoga healers were obtained as follows. A sub county, Bugembe, was chosen because it is on the highway to Iganga district and the local study population was selected from this sub county through the local council chairpersons. The latter were requested to provide the first author with 30 names of local adults (over 18 years of age), among whom the first author then randomly selected 20 names and gave each a written invitation to participate voluntarily in a group discussion. Sixteen of them (80%) turned up. The traditional healers were contacted through their district leader, who provided a list of registered traditional healers, among whom the first author again selected 20 names at random. Fifteen (75%) traditional healers turned up and were randomly distributed to two groups regardless of age and gender.

Study Procedures

Three case vignettes depicting chronic Schizophrenia, Mania and Psychotic depression, based on DSM IV criteria, as seen in a Ugandan setting were developed by the first author. Another practicing psychiatrist (the last author) reviewed the case vignettes to make sure they met these DSM IV diagnostic criteria (APA, 2000) and that the clinical symptoms represented common scenarios in the Ugandan setting. Three other psychiatrists were asked to make a diagnosis from the case vignettes and their comments were incorporated. Finally, a medical anthropologist (second author) with experience of case vignettes read them and submitted comments about lay people's understanding of mental illness. The case vignettes and the guiding questions that followed were translated into Lusoga, the local language in the study area, by a clinician who spoke Lusoga and back translated into English by an independent person. Data collection was in July and August 2007. Each group interview took 2½ hours. Discussions were held at intervals of two weeks to allow for coding and initial analysis of data. The first author gave a brief oral account of the research project and its aims and introduced the

principles of focus group discussion, encouraging the participants to discuss freely and allowing them to ask questions. The participants were then informed once more that participation was voluntary. The participants were then asked to introduce themselves.

There were two moderators: the first author and a Lusoga-speaking clinician, and two observers: the second author (medical anthropologist) and a clinical psychologist. The first author read out the case vignette slowly, carefully and clearly to everyone, after which the Lusoga-speaking moderator repeated this in Lusoga. Anything that was not clear was clarified before the participation. All discussions were tape-recorded with the consent of the participants. The observers and moderators jotted down important points to be followed. The moderators used the focus group guide, which covered the following areas: identification and naming of the illnesses, discussing their understanding of the causes of the illness and finally their proposed/suggested treatment. After each focus group discussion session, the moderators and observers discussed the content of the discussion and the observed interaction process was recorded in a notebook. For example, the participants would be observed to have a lively and open interaction with each other, drawing examples from their own experiences.

The case vignettes

Case vignette I: Schizophrenia

Mr. Kirunda, 29 years old, male, single and unemployed, gave up a university education in Fine Arts 9 years ago.
He was taken to the traditional healer after he had painted everything in sight black and white, including his room, furniture, clothes and finally even himself.
He was responding to a persistent male voice that told him his behaviour would solve all his family problems and bring peace to his people. His relatives had consulted traditional healers at least five times previously during the past five years. Each consultation was due to worsening of his behaviour, characterized by voices commanding him, arguing amongst themselves about him, and a feeling that people were following him and would harm him. He had strange behaviours, like avoiding people, refusing to eat with others and putting off a change of clothes. His hygiene and self-care were poor.
Sometimes he became mute and practically devoid of spontaneity, but responded to some people's requests to him. He stayed in the same position for hours on end, his facial expression fixed and stony. He stayed awake most of the night and rarely spoke to any one outside his immediate family.
He was afraid to go outside during the day and preferred to eat by himself because he believed that strangers on the street were talking to each other about him and were able to direct his thoughts and actions. He also believed that thoughts and commands were transmitted to him via solar energy panels and that he was safer at night. He spoke uncoordinated words and people could not understand what he said.

What would you call this illness?
What is the cause?
How is this illness treated? How does this illness differ from the ones below?

Case vignette II: Psychotic Depression

A 45-year-old woman, Mrs Isabirye, a teacher by profession, presented with a 3-year history of persistent sad feelings and loss of interest in things she used to enjoy. Indeed, she resigned her job and just sat at home. She stayed awake most of the night and got up in the morning with no energy. She had thoughts of killing herself and heard voices telling her she was useless and urging her to jump into a river and die. Sometimes these would be voices of her dead ancestors/grandparents.

What would you call this illness?
What is the cause?
How is this illness managed? How does this illness different from those of Mr. Waiswa and Mr. Kirunda?

Case vignette III: Mania

A 34-year-old man, Mr. Waiswa, presented with extreme happiness, preaching, singing and dancing all over the Saturday market in Jinja. On the previous Friday, he was out preaching about Jesus even to passing Muslims, which made them very angry, so they chased him away. At the market, he got into trouble for making inappropriate seductive sexual talk to a 14-year-old girl who was selling pancakes. He fought people who wanted to stop him until the police were called in. He believed he would talk to God and that he had lots of money. He was apprehended, tied kandoya *(with ropes) and thrown into the back of a pickup on the way to remand. The next day, his wife pleaded with police to have him taken to the traditional healer, who had treated his sister for a similar condition. Unfortunately, his sister had fallen into a river and drowned two years ago.*

What would you call this illness?
What is the cause of this illness?
How is this illness managed? How does this illness differ from the other two?

Scientific rigor

We used the following measures to enhance our data's credibility.

1. Observer–moderator discussions were held at the end of every focus group discussion.
2. Notes about the central themes in the focus group discussions were made at the end of each group discussion.
3. Feedback was obtained from participants. Drafts of the interviews were presented orally to some of the participants, who gave comments. The participants agreed that the drafts represented what had transpired in the interviews.
4. Reliability was achieved by means of consistency checks between colleagues. The first and second authors continuously discussed the content and inductive coding of the focus group discussions. The authorship of this paper is multidisciplinary, comprising a medical anthropologist (second author), a clinical psychologist with transcultural psychology (third author), a pharmacologist from the study area with an interest in traditional medicine (fourth author), a psychiatrist with an interest in transcultural psychiatry (first author) and a psychiatrist from the central region (fifth author). In addition, a multidisciplinary research group (in transcultural psychiatry /psychology, supervised by the third author) reviewed the results twice and their comments were incorporated. These comments and discussions helped the authors to move beyond a descriptive level to an abstract level of analysis without becoming too far removed from the original data.

Data analysis

Interviews were transcribed and content analyzed in accordance with guidelines for handling qualitative data. The whole interview was translated literally from Lusoga to English from the cassette recorder and then written down verbatim by a bilingual speaker. These transcriptions were checked, evaluated and edited by another bilingual speaker. After transcription, the first author read through the transcript several times and grouped the content by themes with the help of an experienced medical anthropologist (second author). The content analysis was organized manually by comparing various themes within the same Focus Group and between the other Focus Groups.

The following three themes will be explored in the results:

I) Identification/classifying/naming of the illnesses,
II) Perception of causation of the illnesses, and
III) Suggested treatment of the illnesses.

RESULTS The presentation of the results begins with a description of the participants' socio-demographic characteristics, followed by a general summary of the results and, finally, a detailed description of the three themes.

Socio-demographic characteristics of the participants: Four Focus Group Discussions were carried out: two for community members and two for traditional healers. The socio-demographic details are presented in table 1.

Table 1- Socio-demographic characteristics of the participants

Type of group	Number of participants	Age range	Mean	SD
Community members	Women-9	22-53	38.7	6.2
	Men-7	30-70	46.9	6.8
Traditional healers	Women-7	25-57	40.3	6.3
	Men-8	29-73	48.6	6.9

Summary of results

All the participants agreed that they had seen or dealt with individuals like those in the three case vignettes. They differentiated the severe mental illnesses by giving them different names. Schizophrenia was called *eddalu* or *ilalu* (madness), which they regarded as more serious than mania. They called Mania *kazoole*, describing it as an illness with intervals of normality, and Psychotic depression as an illness of "thinking too much," relating it to social adversity. *Kalogojjo* was the name given to Minor forms of mania. The traditional healers were reluctant to give names to the illnesses, emphasizing that their interest is not in the naming of the illness but in making the patient better. Regarding causation and treatment, schizophrenia and psychotic depression were generally said to be caused by family/clan issues, including ancestral spirits and witchcraft, which called for the performance of rituals. Physical complaints, e.g. HIV and malaria, were mentioned as the cause of mania and referral to hospital was then mentioned as part of the treatment in addition to the traditional healer's herbal treatment.

A few participants thought that the patient with mania was not ill but was exhibiting God's power or backsliding; faith healing was therefore mentioned as the appropriate treatment. Substance misuse came up as causes of the above illnesses, with a tone of condemnation. This is summarized in table 2 below.

Table 2- Summary of the findings

Case vignettes	Schizophrenia	Mania	Psychotic depression
Naming	*Eddalu* (or *ilalu*)	*kazoole*	Illness of thoughts
Causation	Witchcraft **Clan/family issues** Substance misuse	**Physical illness, e.g. HIV, malaria** Backsliding Substance misuse	**Clan/family issues, social adversity** Substance misuse
Treatment	Perform necessary rituals, herbs	Herbs, faith healing, refer to hospital	Perform necessary rituals

i) Identifying/classifying/naming the illnesses

(Question: What do you call this illness?)

The participants identified, classified and named the illnesses in terms of different names, symptoms, severity and/or chronicity. They identified the case vignettes by giving them local names (identification by means of established groups/categories).

> *"We have names for such a sickness as Kirunda (schizophrenia) is suffering from – Eddalu (Naming) Mr Waiswa (Mania) is suffering from Kazoole not madness."*

The community members went on and classified this illness *Kazoole* in terms of its severity, e.g. *Kalogojjo* (increased talkativeness) as in hypomania and *Kazoole* for full mania. They distinguished these from *eddalu* (Schizophrenia). One community participant said:

> *"One suffering from Kazoole is periodically mentally disturbed and somebody suffering from Eddalu ("psyhotic madness") is also mentally disturbed. But this latter 'madness' is more serious than kazoole and is incurable. This illness disturbs the brain permanently. Mr Kirunda has eddalu."*

The participants mentioned that the patient with psychotic depression was thinking too much, leading to lack of sleep, loss of appetite, loss of interest in sexual activity and eventually causing madness and committing suicide. One of the participants said:

> *"If an individual has got a problem, he starts thinking too much, has no peace, cannot eat food, cannot sleep and for us men, even if your wife asks you for love, you tell her to leave you alone. It becomes an illness which might lead to committing suicide."*

All the traditional healers and community members spontaneously agreed that they had seen or dealt with persons like those in the three case vignettes.
All the traditional healers said that these cases represented abnormality but a few community members said that Mr. Waiswa (mania) was not ill but had experiences which demonstrated God's power over people:

> *"I don't think that this is abnormal but I think it is God's power, which is making him behave the way he does so that the people around can get this vision. Ago Amanyi ga Katonda" (That's God's power).*

For Mrs Isabirye (psychotic depression), some community members viewed her as possessed by the ancestral spirits of her late grandparents, who wanted her to follow them to the grave. Psychotic depression was conceived as a family/clan illness, which calls for collective responsibility in its treatment.
The traditional healers seemed to say that their focus was not on naming the illness but on the making the patient better. One traditional healer said:

> *"When patients come to us … we treat and they improve without giving the name of the sickness. We find out the cause and give treatment."*

Finally, the traditional healers agreed that sometimes it was difficult to make a clear distinction between these illnesses. Thus they would sometimes lump all mental illnesses together because they found it difficult to name them individually.

> "*We have to research on what these illnesses are actually called; but they are generally called madness. Compare this to prisoners. You find people charged for different offences but once in prison they are all called prisoners. Compare also to theft; once one is charged for theft, it is theft regardless of what one stole … (laughter).*"

Linking the different types of psychosis to prognosis and chronicity, the participants acknowledged that Kirunda's illness could be chronic. The traditional healers and the community members observed that the cases of psychotic illnesses were linked to prognosis. Madness *(Mr. Kirunda)* was linked to poor prognosis, *kazoole (Mr. Waiswa)* to good prognosis. They also said that a delay in seeking treatment could contribute to the poor prognosis of Mr. Kirunda's illness, *eddalu (ilalu)*. One of the traditional healers said:

> *"A delay in seeking treatment means one cannot recover from eddalu (ilalu). That is Kirunda's problem. Kirunda's problem was ignored and it went bad. So what is done, such a person has to be kept somewhere or be left to wander off provided he is not harmful. You always see these people as you move around. If one overstays with the disease, little can be done. There is no dustbin for human beings so one is left to loiter. For example, there are those who loiter, eat from dustbin, put on rags, you know. Those ones cannot be treated. When the relatives decide to take him to the musawo (the traditional healer), it is often too late."*

The participants described *kazoole* as an illness that 'has normal periods in between having symptoms'. However, the length of the interval between being normal and having symptoms was not elaborated. In addition, it was mentioned that *kazoole* is a temporary illness, while madness persists for a long time. For psychotic depression, the participants said that the symptoms will last as long as the clan issues are not handled.

ii) Perception of causation of illness

(*Question: what is the cause of these illnesses?)*

The participants mentioned a range of spiritual, physical and emotional explanations to account for the mental experiences. The most common cause they mentioned for these severe mental illnesses was a relationship with supernatural powers in terms of different forms of spirits. Two sub-themes emerged here: one was family/ancestral spirits (*Ebyakika*) as good spirits that wanted to convey a message to the family through the patient because what they (the spirits) want may not have been done. Psychotic depression and schizophrenia were mentioned as being caused by family spirits. They elaborated that the symptoms were due to the commands of the spirits. The other sub-theme was evil/bad spirits (*Muzimu*) that were usually sent by others, generally involving witchcraft. These may cause symptoms similar to those caused by family spirits.

> *"… Those people may be having spirits that disturb their brain. Those spirits disturb him so that they no longer understand what they are doing, their thoughts are not at ease, they are actually not aware of what is happening. These are sometimes due to family spirits or clan issues (ebyakika). Thus in the case of Mrs Isabirye, her illness caused her to think and think till she could not eat or sleep, she lost weight and energy and couldn't even work. The "too much thinking confused her brain" and she wanted to kill herself. The voices of her ancestors called on her to jump into the river."*

Two participants mentioned a conflict between traditional issues and religious spirits with regard to mania. As one participant said:

> "*He got saved and backslid. He was full of God's word and yet he has left it.*"

Blood inheritance (genetics) was also mentioned, with no particular reference to any of the above psychoses.
Other causes of abnormal behaviour that the participants mentioned included HIV/AIDS, malaria, hypertension, measles and substance abuse, especially marijuana and alcohol, hence invoking physical causes for some of these psychoses. These would be sent to modern western hospitals for treatment. One of the traditional healers said:

> *"Now we have problems, a patient can be brought in and you fail to know whether he was just beaten because he is drunk. When he actually smells of alcohol? In most cases some people use substances which are not good for them, e.g. opium, some people resort to smoking opium to the extent of disturbing their brains, they start presenting with odd behavior, eventually becoming mad. This is also called madness; but it is because they have weak brains, which cannot tolerate opium (Njaye). You try this and that, yet it is just njaye (Opium). So in researching about this problem we keep blaming spirits/ghosts, yet sometimes it is opium."*

Social problems, poverty, accidents and polygamy came up as other causes.
Generally, there did not seem to be a marked difference in the concepts of causation of psychosis between the community members and the traditional healers.

iii) Suggested treatment for the illnesses

(*Question: How are the illnesses treated?)*

The community members were more general in discussing the treatment of the patients depicted in the case vignettes. For case vignette 1 (schizophrenia), they said the patient would be taken to the traditional healer. For mania they would take the patient to church for prayers if they are believers or to the healers; if the patient did not improve, they would then proceed to a Western hospital. As to psychotic depression, '*it can be cured after performing the cultural ceremonies'.*

The traditional healers' responses to this question were connected more specifically to the different case vignettes: For schizophrenia and psychotic depression, the traditional healers said they call upon supernatural powers who examine the patient and make a diagnosis. One of them said:

> "*While in the shrine, the Jjajjas (i.e. the ancestors) magnify and isolate the main cause of the problem. Jajjas direct me about which medicine to use. After the Jjajjas have left, I remain useless as I have no memory of what was going on. The Jjajjas direct me to go out under their guidance to collect the medicine to use. When I light my pipe and call them, they immediately come and possess me."*

The traditional healers also highlighted the significance of healing rituals and the role of ancestors in the treatment process. For mania they seemed to say that they use herbs and then refer to hospital if the patient does not improve and also if they have identified a physical problem. One of the traditional healers said the following:

> "*Now mental illness is also caused by HIV/AIDS and mental illness caused by HIV/AIDS doesn't respond to our treatment. We can treat the rest of mental illness but not that one. Once you identify that the patient has underlying HIV/AIDS we refer to the hospital.*"

The general consensus seemed to indicate that the traditional healers perceive an individual as a whole, akin to biopsychosocial management in western medicine, and use a variety of treatment modes. For example, in addition to prescribing medication, they mentioned that they calm patients down by talking to them empathetically.
The routes they mentioned for the administration of herbs included smoking pipes, steaming and bathing for schizophrenia and psychotic depression, while the oral route was mentioned for mania.
As with causation, treatment concepts did not seem to differ between the community members and the traditional healers. However, the traditional healers, being the providers of the services, were more elaborate than the community members.

DISCUSSION This pilot study gave an idea of lay concepts of psychosis in a community in the Busoga region in Uganda. However, these are preliminary results of an investigation of the profiles and outcome of traditional healing practices in two districts in Uganda. The rationale of this preliminary study was to explore whether the community and traditional healers in the Busoga region recognized the different types of psychoses, i.e. schizophrenia, mania and psychotic depression, and, if so, what they called them, what they viewed as the causes and how they would be managed. The results of this study would then be used to modify and validate the instruments to be used in the main study.

Views about naming, classification and identification
Classification in science, including medicine, can be defined as the process of constructing groups or categories and assigning entities to these categories on the basis of their shared attributes or relations (Millon, 1991). Identification is the act of assigning a particular object to one of the categories. According to Feinstein (1972), medical classifications perform three principal functions: a) denomination (assigning a common name to a group of phenomena), b) qualification (enriching the information content of a category by adding relevant descriptive features, such as typical symptoms, age at onset, or severity), and c) prediction (a statement about the expected course and outcome, as well as the likely response to treatment). The findings in this pilot study about the respondents' classification and identification of the illnesses seemed to represent all three functions. For example, the community and the traditional healers identified schizophrenia, naming it *eddalu* or *ilalu*, qualified it by stating some of its symptoms, and predicted its outcome. Psychiatrists use diagnostic categories simply as concepts, which are justified by whether or not they provide a useful framework for organizing and explaining the complexity of clinical experience in order to derive predictions about outcome and guide decisions about treatment (Millon, 1991). Traditional healers and community members, on the other hand, may not be aware of the above but their conceptualization of psychosis seemed to guide decisions about treatment.
For a century or so, most clinical work and research in psychiatry has proceeded under the assumption that schizophrenia and bipolar disorders are distinct entities with separate underlying disease processes and treatments. However, many individuals with severe mental illness have both prominent mood and psychotic symptoms, suggesting the possibility of a continuum. Indeed, the likelihood that there is no neat biological distinction between schizophrenia and bipolar illnesses was very evident in the traditional healers' views. Even the Western authors of nomenclatures like the DSM-IV and ICD-10 concur with this (APA, 2000; WHO, 1992). These authors were careful to point out that 'there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries, dividing it from the other mental disorders or from no mental disorder' (APA, 2000; Craddock & Owens, 2005). This view is not dissimilar from the finding that the Basoga traditional

healers were hesitant about drawing a sharp dividing line between the psychotic affective disorders and schizophrenia.

On the other hand, the traditional healers underscored that their concern was not labelling; re-integrating the patient in society was their collective responsibility. Their reluctance to label the illnesses may indicate that the traditional healers were aware of negative effects of labelling. The tendency to avoid labelling individuals, combined with a community's tolerance of enthusiastic religious expression and the cultural tendency to label behaviours or states rather than personalities, relieves sufferers of disabling social stigma and allows them to maintain a view of themselves as not different from the others. This could contribute to the relatively favorable outcome of psychotic disorders that has been reported in developing countries (Edgerton & Cohen, 1994) and to re-inclusion in society.

The community and the traditional healers recognized the case vignettes of severe mental illness. However, a few felt that the descriptions did not necessarily reflect abnormality but God's power and possession. In a study of knowledge and practice of help-seeking for treatment of mental disorders in Pemba Island, Zanzibar, Mirza *et al.* (2006) reported that 0.4% of the respondents attributed mental health problems to God's power (Mirza *et al.*, 2006). The concepts of normality and abnormality from a behavioural perspective are relative, not absolute (Rhi, 1995). This kind of conceptual fluctuation of normality and abnormality demonstrates different ways of seeing the same thing. Even if social functioning was impaired, as in the case vignettes above, and the community realized that something was wrong, the notion that an illness was involved did not necessarily follow. Even when the condition was recognized as an illness, it need not necessarily be a mental illness (Kirmayer, 1989).

Views about causation, diagnosis and treatment

The participants' views about what causes mental illness were used as a basis for putting the findings of our study in context. This is because views about causation are strongly associated with health-seeking . The list of possible causes of psychosis was headed by a belief in different kinds of spirits. Such a view has important implications for seeking medical care by the persons affected. A supernatural view of the origin of mental illness may imply that orthodox medical care would be futile and that help would more likely be obtained from spiritualists and traditional healers. Indeed, previous studies in this area have suggested that care for psychosis is most often sought from the traditional healers (Okello & Musisi, 2006). This study confirms the view that supernatural causes of mental illness are perceived by many people in an African community. This may affect the propensity to seek Western medical treatment and could also contribute to the traditional healers' non-referral or delayed referral of psychotic patients for psychiatric attention (Maling, 2007).

The participants adhered to traditional beliefs about mental illness, which is consistent with other studies from Africa (Okello & Musisi, 2006; Patel, 1998). This is evidence that irrespective of the pace of 'globalisation', traditional beliefs about illness and misfortune are unlikely to be replaced by biomedical beliefs. Instead, new health concepts, such as HIV/AIDS, modern stress etc, are likely to be incorporated into the matrix of traditional concepts, resulting in a coherent whole rather than two distinct models (Patel, 1998; Teuton *et al.*, 2007). Thus the participants also mentioned other 'biological' or 'brain disease' causation for psychoses, e.g. HIVAIDS.

The belief that drug abuse can cause psychosis may be regarded as advantageous in that it may restrain the use of illicit or psychoactive substances. However, this would apply to just a limited number of mental disorders. There is still a widely-held public view that misuse of substances is a moral failing and this belief may translate into notions of psychosis being self-inflicted in some situations. Such a view is likely to elicit condemnation rather than understanding or sympathy (Gureje *et al.*, 2005). Apart from alcohol, the most commonly used psychoactive substance in Uganda is cannabis. It is not uncommon for people in Uganda to assume that anyone using cannabis will develop a psychosis or that anyone with psychosis has used cannabis.

Limitations and strengths

The study was limited on account of the small sample and finite data triangulation, as well as the lack of methodological triangulation. Another possible limitation is that the community participants and traditional healers in our interviews may have had a prior interest in the subject, since participation was voluntary. The background of the moderators and observers as Western-trained mental health workers could also have affected the results. For instance, some participants may have been more careful in expressing their traditional beliefs about mental illness. On the other hand, the fact that half of the moderators were from the region and spoke the same language may have encouraged them to speak out. Finally, the lack of a patient perspective in this article is a major limitation.

Some of the methodological strengths of the study are that the interviews were conducted in a field context with a multidisciplinary team and high level of interactivity in the focus group interviews.

In interpreting the results, it should be noted that the study was carried out among the people of Busoga in Eastern Uganda. Consequently, the views expressed may not necessarily reflect the views of other ethnic groups in the country. Uganda has diverse cultural groups who speak over thirty different languages. However, the few studies that have been conducted among other ethnic groups, especially in central Uganda, suggest that our findings may not be peculiar to the Basoga (Okello & Musisi, 2006; Teuton *et al.*, 2007). Note also that we have focused only on psychoses, the severe form of mental illnesses. Minor mental illnesses were deliberately not included.

CONCLUSIONS AND IMPLICATIONS

In the Basoga's conceptualization of psychosis, identification, causation and treatment are related phenomena. The Basoga were able to differentiate schizophrenia from mania and psychotic depressions by naming them as well as through their symptomatology and natural course. The Basoga called Schizophrenia *eddalu* interchangeably with *ilalu*, a more serious illness with a possibility of not recovering, while they named mania *Kazoole*. Psychotic depression was seen as an illness from too much thinking, which would eventually confuse the head. Both mania and psychotic depression were seen as less serious illnesses, with intervals of normality.

The Busoga community had shared concepts of causation and treatment. However, the traditional healers were reluctant to label or name the different psychotic illnesses. This may indicate that the traditional healers and the community do not hold the same views about naming the illnesses but it may also indicate that the traditional healers are aware of the consequences of labelling psychotic illness.

Implications

The findings from this pilot study provide an initial step in the forthcoming investigation into the profiles and outcome of traditional healing practices in the same community, using research instruments based on DSM-IV diagnosis. Comprehending the local understanding of the studied illnesses provides information for the validation of these instruments as well as an appropriate vocabulary that is familiar to the community. Methods can then be used that are sensitive to and valid for the local culture and result in data which are comparable across cultures.

Simply recognizing and respecting diversity is likely to improve the relationship between practitioner and patient. The local understanding of psychotic illness could be incorporated in the training curriculum of health workers, thereby bridging the gap to Western training and offering clinically relevant mental health care for people with severe mental illness.

ACKNOWLEDGEMENTS

This work is part of the project entitled "Psychotic disorders in the Northwestern crescent region of the Lake Victoria basin (Uganda)". A collaborative research project is in progress between the Department of Psychiatry at Makerere University (Uganda) and the

Department of Clinical Neuroscience, Psychiatry-HS, at Karolinska Institutet (Sweden). We thank the Swedish government for funding the project through Sida/SAREC. We wish to thank all the participants for taking part in this study and Patrick Hort for great help in transforming the text into readable and comprehensible English.
The study was approved by the local research ethics committee at Makerere University, the National Council of Science and Technology (HS 323) and the Research Committee, Ethical Council, at the Karolinska Institutet (Dnr 05/07).

REFERENCES

Abbo C. *Management of Mental Health Problems by Traditional Healers in Kampala district.* Unpublished Master of Medicine in Psychiatry, Makerere University, Kampala, 2003

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders-Text Revision* (4th Ed). Arlington, American Psychiatric Association, 2000

Rhi B-Y. Normality and Abnormality in behavioural Aspect. *Acta Neurochirurgica (Wien),* 132: 164-168, 1995

Bloor M, Frankland J, Thomas M, Robinson K. *Focus group research in Social Research.* London, Sage, 2001

Craddock N, Owens MJ. The beginning of the end for the Kraepelinian dichotomy. *British Journal of Psychiatry*, 186: 364-366, 2005

Edgerton RB, Cohen A. Culture and schizophrenia: the DOSMD challenge. *British Journal of Psychiatry,* 164: 222-231, 1994

Edgerton RB. Conceptualization of psychosis in four Eastern African societies. *American Anthropologies,* 68: 408-425, 1966

Ekblad S, Baarnhielm S. Focus Group Interview Research in Transcultural Psychiatry: Reflection on Research Experiences. *Transcultural Psychiatry*, 39: 484-500, 2002

Feinstein A R. Clinical Biostatistics XIII: On homogeneity, taxonomy and nosography. *Clinical Pharmacology and Therapeutics,* 13:181-193, 1972

Glaser B. Constant comparative methods of qualitative analysis. In: Glaser B, Strauss A (Eds). *The Discovery for Grounded Theory: Strategy for qualitative Research*. Chicago, Aldine, 1967

Glaser B, Strauss A (Eds). *The Discovery for Grounded Theory: Strategy for qualitative Research*. Chicago, Aldine, 1967

Gureje O, Lasebikan VO, Ephraim-Oluwanuga O, Olley BO, Kola L. Community study of knowledge of and attitude to mental illness in Nigeria *British Journal of Psychiatry*, 186: 436-441, 2005

Kirmayer LJ. Cultural variations in response to psychiatric disorders and emotional distress. *Social Science and Medicine,* 29: 327-339, 1989

Kleinman A. *Rethinking Psychiatry*. New York, Free Press, 1988

Kortmann F. Popular, traditional and professional mental health care in Ethiopia. *Transcultural Psychiatric Research Review,* 24: 255-274, 1987

Maling S. Duration of untreated psychoses and pathways to specialized Psychiatric care in south-western Uganda. *Regional World Psychiatric Association meeting, Nairobi, Kenya*, 19th -24th March 2007

Millon T. Classification in Psychopathology: rationale, alternatives and standards. *Journal of Abnormal Psychology,* 100: 245-261, 1991

Mirza I, Michel OM, Jenkins R. Knowledge and practice of mental disorders in Pemba Island, Zanzibar. *Tropical Doctor,* 36: 140-144, 2006

Murphy JM. Psychiatric labelling in cross-cultural perspective. *Science,* 191: 1019-1028, 1976

Okello E, Ekblad S. Lay concepts of Depression among the Baganda of Uganda: A pilot study. *Transcultural Psychiatry,* 43: 287-313, 2006

Okello E, Musisi S. Depression as a clan illness (eByekika): An Indigenous Model of Psychotic Depression Among the Baganda of Uganda. *Journal World Cultural Psychiatry Research Review*, 1: 60-73, 2006

Okello E, Musisi S, Abbo C, Tusaba C. *Incorporation of Traditional Practitioners in Decentralized Mental Health Care*. Kampala: Makerere University, 2005

Orley, J. *Culture and mental illness: A study from Uganda*. Nairobi, East Africa Publishing House, 1970

Owen S, Milburn C. Implementing research findings into practice: improving and developing services for women with serious and enduring mental health problems. *Journal of Psychiatric and Mental Health Nursing,* 8: 221-231, 2001

Parshall A, Priest R. Nosology, taxonomy and the classification conundrum of the functional psychoses. *British Journal of Psychiatry,* 162: 227-236, 1993

Patel V. Explanatory models of mental illness in Sub-Saharan Africa. *Social Science and Medicine,* 40: 1291-1298, 1995

Patel V. *Culture and Common Mental Disorders in Sub Saharan Africa*. East Sussex: Psychology Press on behalf of Maudsley, 1998

Patel V, Simunyu E, Gwanzura F. "Kufungisisa" (thinking too much): A Shona idiom for non-psychotic mental illness. *Central African Journal of Medicine,* 41: 209-215, 1995

Swartz L. *Culture and Mental Health. A Southern African View*. Cape Town, Oxford University Press, 1998

Teuton J, Bentall R, Dowrick C. Conceptualizing Psychosis in Uganda: The Perspective of Indigenous and Religious Healers. *Transcultural Psychiatry*, 44: 79-114, 2007

WHO. *The Promotion and Development of Traditional Medicine* (Technical representative series). Geneva, 1978

WHO. *International Classification of Disease, 10th Revision (ICD-10)*, 1992