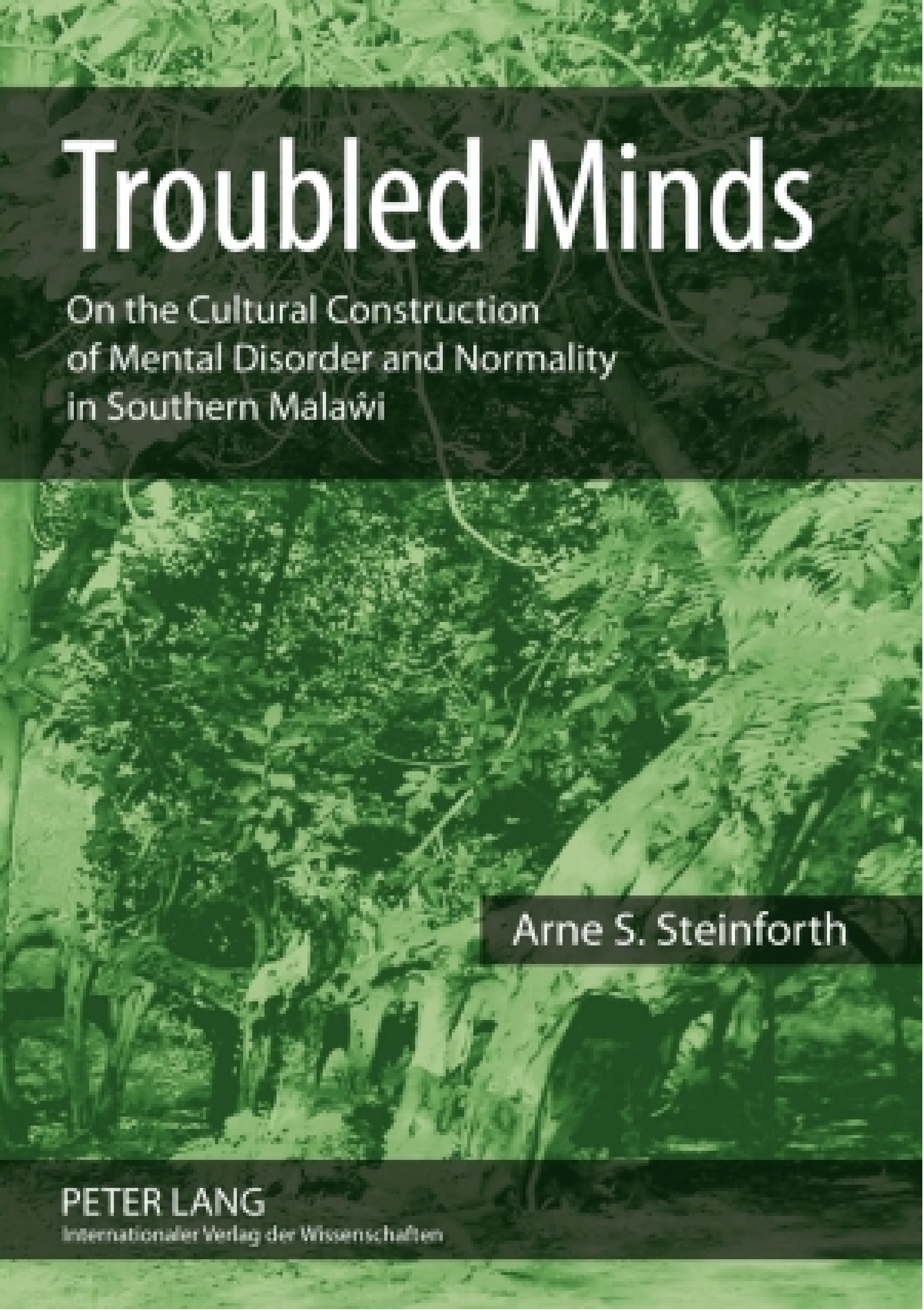

Troubled Minds

On the Cultural Construction of Mental Disorder and Normality in Southern Malaŵi

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I.

Introductory Considerations

According to recent estimates, an approximate 500 million persons worldwide are categorized as disabled. Arguably, these numbers are on the increase, independent from the economic wealth or the medical care system offered within a given country, and in every society the affected persons range among the socially disadvantaged (Barnes, Oliver & Barton 2002: 2). At the same time, the question that arises is whether people are actually born with a disability – or if, as a phenomenon, disability should rather be seen as a result of a complex process of classification on the basis of culturally defined normative representations (Stiker 1997: 158-160). Cultural processes of allocation establish a – frequently implicit – notion of the normal human condition, thus distinguishing the normal from the other, the deviant – or disabled. From any perspective, it is evidently crucial to recognize the importance of collective representations for the understanding of any cultural concept of disability as well as for the living conditions of the affected persons. And it is not helpful from the perspective of constructive social anthropology to consider cultural notions as mere impediments to the implementation of allegedly super-cultural, biomedical concepts of disability. Rather, it may be agreed that

> "The notion that cultural beliefs are only barriers to development is changing" (Devlieger 1995: 94).

Accordingly, the subject of this thesis is explicitly not disability as defined within a Western framework. Rather, it focuses on African – or, more particularly, Malaŵian – concepts of 'problems of the mind', most of which would be labelled as disabilities according to present Western systems of classification (WHO 2001a). As a monograph in medical anthropology, this study depicts and analyses the cultural representation of mental disorders in an African society on different levels, thus creating a multi-layered, holistic outlook on the phenomenon not only in its medical, but also in a more complex cultural framework that, to mention the obvious, also incorporates factors such as religious and social perception, or economic activity. By that, this thesis means to outline the cultural embeddedness of the phenomenon as such and point out its culturally determining conditions which should not only contribute to the ethnographic understanding of cultural fact and process, but which shall also provide basic tools to alter the prospects of persons living with mental disorders in Southern Malaŵi.

1. Theoretical Overview

It has been justly pointed out that social anthropology so far does not give appropriate attention to questions of disability (Klotz 2003: 1; Shakespeare 1994: 283). Nonetheless, disability issues have been recognized and addressed within anthropological discourse over a considerable length of time. But in spite of these early efforts to fully include disability in the wider field of anthropological research – as undertaken by scholars like Ruth Benedict (Benedict 1934)[1] – this whole complex still leads a rather shadowy existence as expressing itself in the lack of anthropological monographs. Most of the research conducted in the context of disability and culture therefore still acts on the misleading assumption of a universal applicability of biomedical notions, giving little consideration to the cultural specificity of the phenomenon.[2] Arguably, the marginalization this whole phenomenon experiences within social and cultural sciences may be seen as reflecting its neglect within Western societies (Sagner 2001: 175-176).

In itself, the definition of the term *disability* is the basis for an ongoing scientific discourse that still does not seem to be satisfactorily concluded. As a technical term, it is closely connected to international health standards that try to establish it as a universal term. In 2001, a revised edition of the ICIDH was issued, published as the *International Classification of Functioning, Disability and Health* (ICF, formerly referred to as ICIDH-2).[3] As a classificatory system, the ICF follows a concept of functional health, defining its aims as *(a)* providing a basis for a better understanding of health conditions, their outcomes and determinants; *(b)* establishing a terminological framework in order to enhance communication; *(c)* facilitate comparability; *(d)* introducing a systematic coding scheme. In all of this, the WHO asserts claims to interdisciplinary, international,

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[1] These sources will find more consideration in a later section of this chapter (see *Chapter I.1.c*).

[2] Accordingly, Mike Oliver defines disability as independent from the body as such. On the contrary, he describes disability as "a consequence of the failure of social organisation to take account for the differing needs of disabled people and remove the barriers they encounter" (Oliver 1996: 42).

[3] Up to the late 1970s, no official system of classification was internationally recognized with respect to disabilities. The 1980 *International Classification of Impairments, Disabilities and Handicaps* (ICIDH) provided by the World Health Organization defined disability in functional terms – and in distinction from the categories impairment and handicap (WHO 1980).

and intercultural applicability (WHO 2001b: 5). In credit for the new ICF system, some critics attest that

> "It is important to appreciate that disability is not an intrinsic or defining feature of a subset of human beings (and as such is not analogous to other human differences such as gender and race), but is a universal condition of humanity itself" (Üstün et al. 2001: 5).

This new concept classifies disability according to its manifestation on a physical, personal, or social level, giving consideration to its essentially relational character. It also recognizes the fact that so-called ADM disorders – i.e. alcohol, drug, and mental disorders – cause a degree of limitations due to which its burden on society far surpasses conditions such as HIV/Aids or cancer (Üstün et al. 2001: 4-5; WHO 2001b). While this re-definition of disability terminology as formulated in the ICF constitutes a major improvement to former ICIDH standards by creating more space to include the social determination of disability phenomena, its applicability is still debateable within an anthropological discourse. Convincingly, the universal practicality of the term disability is denied by many medical anthropologists, arguing that a disability is strictly culture-specific and therefore defined according to emic concepts of faultiness, abnormality, or deviation – which may, e.g., include young age, illegitimate birth, excessive freckles, or small buttocks – that by far exceed even the most generous of Western definitions (Whyte & Ingstad 1995: 5-7). Disability is not an ontological category – but may, at best, serve to describe a process of cultural allocation that would more clearly be addressed as either social stigmatization or activity limitation. The current study, at the same time, does not examine social deviation as a general phenomenon – and therefore, an altogether different term needs to be introduced. Accordingly, the present thesis will only apply the term disability with reference to data reproduced from other sources, i.e. from indirect – from published material – or direct quotes from Anglophone interviews. In all other cases, the term mental disorder will be used as a substitute for the sake of a closer depiction of cultural representations.

While it is important to investigate the living conditions of persons with disabilities in their social environment, it is, from an anthropological perspective, equally central to develop an understanding for the cultural construction of the condition as such. The current thesis applies emic notions as recorded in the Southern Region of Malaŵi which shall be complemented by etic observations. Therefore, the material compiled here represents both intentional and functional data in order to achieve a high degree of validity.[4]

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[4] This distinction has first been introduced by Wilhelm Emil Mühlmann who, in short, defines intentional data as reflecting emic cultural conceptualization, thus shedding light on a cultural

1(a) Theoretic Framework

Even within the framework of cosmopolitan biomedicine – such as reflecting and reflected by current European or North American contexts –, the term disability is subject to repeated definition and re-definition (Jenkins 1998b: 225). In the field of disability studies, questions concerning an adequate linguistic approach to the phenomenon of disability are under constant discussion. According to common legal definitions, disability is distinguished from other health disorders by two general criteria, representing *(a)* limitations in the physical and/or the intellectual capacities of a person on the one hand, and *(b)* as implying a prolonged duration of the condition.[5] The classificatory standards of the World Health Organization form the basis for this legal situation (WHO 2001a; ibid. 1980). While recent definitions of disability recognize its close interconnection with social conditions, it is still up to cultural specification to determine the social embodiment of disability in its cultural surrounding.

The present study is not a primarily theoretical discussion. It is an ethnographic study that presents and analyses the findings of anthropological field research conducted to examine mental disorder within its larger cultural framework. If a more theoretical approach would have been followed, different standards and methods would have been applied during the field research proper – such as limiting it to a small scale case study, addressing a less broadly defined set of emic categories, or taking a more etic perspective on the phenomenon as a whole. Nonetheless, a number of theoretical considerations as well as on the wider discussion need to be outlined, and this section subsumes the theoretical approach and assumptions underlying the present study. The basic question that requires clarification in this study lies in the conflict between two complementary theoretical concepts which address the cultural construction of deviance from opposing perspectives.

Tracing the Stigma

Western biomedical concepts imply a basic assumption which – according to an idealistic notion of a human state of normality defined by complete physical and

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hierarchy of values. Functional data is, on the other hand, not meant to *understand* but to *explain* cultural phenomena, thus taking a clearly ‘etic’ and interpretative perspective towards them (Mühlmann 1938: 108-114).

[5] According to common medical reference, limitations of perception, cerebration, conversion, learning as well as behaviour are pointed out. The minimum duration of disability is usually a critical element of legal disability definitions due to its significant role in labour legislation. German law, e.g., recognizes a condition that inhibits full participation in a given work process for six or more months as disability (see § 3 of German Schwerbehindertengesetz; Pschyrembel [ed.] 1994: 171).

mental well-being – identifies disease as a 'lack of health' in a person.[6] Correspondingly, bio-medically defined concepts of disability – and its terminological siblings *handicap* and *impairment* (WHO 1980) – operate from the same, *quasi* negativist perspective on the person, defining difference as a lack of certain attributes which are rooted in a non-explicit, culturally defined notion of normal human capacity (Fougeyrollas 1987: 54). In response to this realization, Erving Goffman introduced the category of stigma into sociological discussion. According to his understanding, three types of stigma may be distinguished – those based on *(a)* criteria of physical deviance, *(b)* criteria of deviations of personal character, and *(c)* criteria of group affiliation. In case of disabilities, he sees stigmatization as a social reaction on the affected person's failed attempt to receive acceptance as a 'normal' member of society. His theoretic approach describes disability – as well as other forms of divergence from the cultural norm – as social deviation which leads to immediate stigmatization on the basis of external, ontological factors, most likely resulting in social marginalization. In the eye of society, a person with a disability is thus reduced from a complete, normal person to an incomplete, contaminated existence (Goffman 1967).[7]

It has been argued that Erving Goffman defines stigma as an essentially static concept – while recent field data from Malaŵi supports the notion that stigma as a category is subject to situational modification as well as processes of change on a personal and larger cultural level (Braathen 2005: 13, 58). In consideration of this recent addition to the definition of stigma, one element of this study's objective is to investigate to which extent societies in Malaŵi classify and stigmatize persons with mental disorders according to the above-mentioned criteria of physique, behaviour, and – less prominently here – social group affiliation, thus evaluating the relevance of the stigma approach in a particular cultural context.

Locating Competence

It is, at the same time, only legitimate to assume that the global multitude of cultural models provide more than one possible perspective on mental difference. The deterministic approach that defines disability as a form of damage or

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[6] More exactly, it is seen as a dysfunction of vital processes leading to subjectively experienced or objectively identifiable alterations of a person's physical, intellectual, and/or mental condition (Greifeld 1995: 20; Pschyrembel [ed.] 1994: 824).

[7] In cultural anthropology, Goffman's stigma thesis has been received and applied in a number of studies. Accordingly, Joyce Dreezens-Fuhrke contrasts traditional and modern ways of dealing with deviation in a Javanese setting while Deliane Burck accounts for the stigmatization of children labelled as mentally retarded in Zimbabwe (Dreezens-Fuhrke 1996; Burck 1989).

impairment imposed on a given person – who is then stigmatized due to ontological criteria – may constitute a fundamental cultural representation in European and North American societies, but it may not claim universal super-cultural validity.[8] Subsequently, Robert Edgerton applies the concept of competence as a complementary approach to the social construction of deviance (Edgerton 1993; ibid. 1967), and in recent studies, Richard Jenkins has expanded this notion, subsuming that

> "'Competence' is the capacity or potential for adequate functioning-in-context as a socialised human" (Jenkins 1998a: 1).

Taking a more contextual stance on the labelling of social difference, it may thus be argued that no singular model determining the perception of mental disorder can be identified across cultures. Otherness may not necessarily be stigmatized, and may be a question of cultural models of classification as well as of contextual negotiation in which way and to which degree stigma and/or competence are attributed to a person. The notion of competence thus contrasts the deterministic idea of *quasi*-universal stigmatization of difference with the more inclusive approach that cultures define competence – and, therefore, potential for integration and participation – on the basis of social functionality. Susan Reynolds Whyte supports this approach with respect to her East African data, and according to her,

> "The term competence refers to ability, skill or fitness. It encourages us to ask: for what? Competence and its inverse point towards tasks and actions, the application of abilities. Intellectual competence may be measurable by tests, but mental competence and its lack can only be studied in the context of human life (Whyte 1998b: 153).

Competence is therefore closely related to social networks – an observation that is backed up by evidence within a wider African context.[9] The socially stigmatizing effects of lacking competence are therefore perceived as the inability to perform culturally defined obligations in the social sphere, making incompetence a question of interpersonal relations rather than an essentialist category.[10] While a certain degree of difference or other-ness may thus be

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[8] As one explanatory approach, Henri-Jacques Stiker traces the origins of Western ideas of impairment back to the historical impact of World War One experience (Stiker 1997: 123).

[9] Therefore, it has been assumed that, throughout sub-Saharan Africa, "Scattered, informal reports suggest that, while cases of neglect and abuse certainly do occur, other small-scale communities may have successfully integrated persons with mental retardation within the framework of their indigenous cultural practices" (Serpell, Mariga & Harvey 1993: 33).

[10] Comparing North American to African societies, Patrick Devlieger therefore explains that, among the latter, "having a disability of any kind does not directly mean that incompetence is necessarily implied. It is in the way that disability is associated with either a lack of social

culturally recognized, stigmatization is not inevitably its social consequence. In an ideal scenario, this concept counteracts the stigmatization of persons with disabilities within their respective social environments on the basis of their productivity, their accomplishments for the communal well-being – thus compensating for their other-ness. Considering the notion of capacity as an axiomatic presumption ascribed to the person on a social and cultural basis, it represents a local variant which, therefore, gives leverage for further anthropological examination. Therefore, this study will also assess the degree and character of competence allocated to persons with mental disorders in Malaŵi, thus giving a full picture of the social factors determining the social positioning of the affected person.

Contextualizing Medicine

The conflicting models of a social allocation of stigma as opposed to competence are a central objective of the current study. Assuming that both mechanisms do occur on some level within the cultural contexts in question, the inquiry obviously aims to identify those emic criteria at the bottom of these cultural processes.

A number of more precise aspects are of central concern here. At first, it is elementary to locate the social positioning of the other (as defined in the context of this study). Here, it must be clarified *(a)* whether the phenomenon and the persons affected by it exist only on the margin of cultural life – or whether conditions such as disability are located not on the fringes but, as Patrick Devlieger suggests, within the creases of society (Devlieger 1999: 299). Although this distinction may appear negligible at first sight, it reveals a substantial difference upon closer analysis: it addresses not only the degree of cultural recognition and awareness of other-ness, but it also identifies if the respective persons are considered as on the outside of the social system – or just in between its classificatory categories. Moreover, the negotiation between stigma and competence also raises the question *(b)* how normality – in the sense of normal, i.e. non-pathological mental performance – is defined in cultural terms. In essence, it is this identification of an *ab-normal* condition that underlies processes of stigmatization, and it is the reflection of a person's 'normal' characteristics that allows society to attribute competence to him or her (Sagner 2001: 199). This question directly leads to the fundamental problem of *(c)* how the human condition of other-ness correlates with cultural notions of personhood. As the utmost consequence of marginalization, depersonalization as a potential

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embeddedness, or a lack of overcoming the difficulties that are associated with impairment, that one can speak of incompetence" (Devlieger 1998: 60).

threat has been addressed before (Nicolaisen 1995: 38-55). The fundamentally relational character of personhood in Malaŵi (Morris 2000: 49) in contrast to the likewise relational character of African concepts of disability (Devlieger 1995: 104) suggests a direct relationship between personhood and normality – and the conceptual proximity of cultural concepts of deviance and non-personhood.

In a Western discourse, the apparently easy definition of medicine as the science dedicated to the restoration and maintenance of human health by diagnostic and therapeutic means masks more fundamental questions. While health disorders and their treatment are indisputably universal features of human culture, the intercultural application of the term medicine may conceal the more extensive semantic dimensions attributed to a single phenomenon which must, therefore, be considered as more than just medical. In Malaŵi, this terminological pitfall becomes apparent in contexts such as the role of *asing'anga* or traditional healers (see below). While their activities are generally identified as medicinal, closer observation – of activities such as magic services in the field of love, property protection, or professional success – reveals that either this is not their only field of professional expertise or that the Western notion of medicine requires some extension.

This issue is by no means trivial. In contrary, it has been argued that the medicalization of phenomena such as spirit possession reflects a biomedical bias disregarding its full ritual character (Olivier de Sardan 1994: 7-8). Thus, the reconciliatory rituals in the context of spirit vocation (see *Chapter IV.2.d*) may be interpreted as bearing more religious than therapeutic meaning – while conceding that both are, actually, closely intertwined. This reflects the more general problem of applying Western notions – such as medicine – in a non-Western context, hence blurring the semantic complexity of cultural phenomena in favour of primarily functional criteria. For the sake of this thesis, no alternative term for medicine will be introduced, and it will be applied to Malaŵian phenomena on the general basis of a Western understanding. It is, nonetheless, important to bear in mind that medicine in its local context cannot be fully separated from other spheres of society, and that the term medicine follows strictly analytical purposes, denoting a function that is, in most instances, not the only semantic level of a given phenomenon. Spirit rituals in Malaŵi, e.g., hence are vehicles of complex cultural meaning, parts of which may be interpreted in terms of the restoration of cosmological or social equilibrium while other aspects qualify as medical activities from a Western perspective. As a basic theoretic prerequisite, this thesis argues on the assumption that the application of purely biomedical terminology would be misleading in the description, analysis, and overall understanding of those Malaŵian health conditions under investigation here. Especially in the context of mental health issues – and in recognition of their large degree of autonomy from biomedical categorization –, this study regards Malaŵian concepts of mental disorder as culture-specific or, in other words, culture-bound – an argument that will later be substantiated by more circumstantial analysis of emic mental disorder categories.

Being introduced into medical anthropology by the Chinese psychiatrist Pow Meng Yap in the 1960s (Yap 1969; ibid. 1965), the concept of culture-bound syndromes supports the idea that many predominantly mental health disorders are to a high degree determined by cultural factors (Kleinman 1980: 163-166). While the categories presented in this study do not necessarily qualify as culture-bound syndromes according to more strict definitions,[11] numerous articles have already stressed the implicitness of the term as such – arguing that every disorder is specific for its cultural context, and that no syndrome is fully independent from cultural bonds (Lux 2003: 158; Hahn 1995). Therefore, this study will, in fairly liberal terms, adopt an explicitly culture-specific position towards Malaŵian notions of mental disorder in the sense of acknowledging the general cultural determination of conditions of distress (Carr & Vitaliano 1985: 244-266).

Identifying Levels of Disorder

In medical anthropology, a specific perspective on human suffering has been established in order to give more consideration to the personal experience as well as the complex social embedding of the phenomenon. Therefore, Arthur Kleinman distinguishes the categories of disease, illness, and sickness – denoting the condensed cultural knowledge of a given condition, the subjective experience of a person, and the social agreement between both, respectively. More precisely, he argues that

> "A key axiom in medical anthropology is the dichotomy between two aspects of sickness: disease and illness. Disease refers to a malfunctioning of biological and/or psychological processes, while the term illness refers to the psychosocial experience and meaning of perceived disease. Illness includes secondary personal and social responses to a primary malfunctioning (disease) in the individual's physiological or psychological status (or both). Illness involves processes of attention, perception, affective response, cognition, and valuation directed at the disease and its manifestations (i.e., symptoms, role impairment, etc.). […] Viewed from this perspective, illness is the shaping of disease into behavior and experience" (Kleinman 1980: 72).

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[11] I.e. according to a number of closely defined forms or taxons. Here, classical models distinguish categories such as *(a)* the startle matching taxon, *(b)* the sleep paralysis taxon, *(c)* the genital retraction taxon, *(d)* the sudden mass assault taxon, *(e)* the running taxon, *(f)* the fight illness taxon, and *(g)* the cannibal compulsion taxon (Simons & Hughes [eds.] 1985).

Sickness, moreover, acts as a mediating category that reflects the understanding of a given health disorder within a given cultural context. Together, this distinction provides an elementary tool for specifying the social contextualization and meaning of health disorder. The relevance of this fundamental dichotomy cannot be overemphasized.

In the context of this study, all three levels are relevant. The personal 'ill'-experience will be reflected in numerous accounts of (former) persons with mental disorders; the disease category is represented in the troublesome relationship between emic nosological categories and biomedical pathology, and sickness resembles the broad cultural negotiation between the potential explanatory models belonging to different spheres of cultural discourse. In this line of argument, the objective of this study has a strong focus on the level of sickness – in terms of the cultural negotiation, interpretation, and construction of mental disorder. However, the present study does not base its approach on a strict differentiation of this terminological trilogy. In part, this reflects the idea that these categories are only distinct as long as a specific, structural difference can be discerned between the pseudo-objective notion of disease and the more culturally defined concept of sickness (Greifeld 1995: 17-18).[12] It may be argued that, on every level, the cultural conception of health disorder represents a social agreement, and data from a Malaŵian background also supports that no structural difference between the diagnoses provided by a biomedical health institution and the next door neighbour is culturally recognized. Therefore, while acknowledging the importance of this terminological distinction, this thesis generally addresses health disorders in terms of sickness, thus referring to categorization as recognized within the cultural context of Malaŵi – unless biomedical categories, i.e. diseases, are explicitly indicated.[13]

1(b) Question Formulation

It is not uncommon for an anthropological field research to produce unexpected results which, in turn, demand modifications, re-specification and/or amplifications in the research objective (Gregory & Altman 1989: 44). In case of the present study, the insights gained at an early point of the field research period required some redefinition which augmented the scope of the research significantly, and the research objective finally applied therefore reflects the cultural concepts identified in the field. Primary research outlines had meant to

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[12] Further critic evaluation of Kleinman's model of disease and illness is, e.g., provided by Thomas Lux (Lux 2003: 160-169).

[13] Accordingly, the Chicheŵa expression *matenda* – or, more rarely, *nthenda* – is translated as sickness.

address Malaŵian notions of disability with a particular focus on those cases connected to mental limitations.

Field research in Malaŵi commenced in February 2004, and the Southern Region of the country was selected as the wider research setting. Here, preliminary field results – obtained in interviews with representatives of organizations for persons with disabilities, traditional healers, and other specialists from different districts and ethnic groups throughout the Southern Region – indicated early on that local classifications do not differentiate between what would in biomedical terms be regarded as disabilities and mental illness. The social conception of the phenomenon as such is locally interpreted and categorized in a particular terminological context, thus making it artificial and futile to forcefully introduce biomedical categories for the study of non-biomedical concepts.[14]

In recognition of these emic systems of categorization, a modification and extension of the initial research objective became necessary in order to fully reflect the Malaŵian cultural framework. By collecting data on local nosological categories applied with reference to primarily mental health disorders – i.e. those that were associated with human processes such as cognition, reasoning, behaviour, or social interaction –, it was possible to demarcate a reasonably consistent field of research which shall be addressed here under the generic, blanket term *mental disorder* which will be defined more thoroughly later on. The focus of research as presented here therefore includes not only more strictly defined cases of disability, but it deals with all forms of conditions which are locally recognized as affecting a person's mental capacities.

The process of defining a research objective which retains its validity even outside of a biomedical model was one of the first conceptual difficulties in the research presented here. For lack of a direct semantic equivalent for the concept of disability and in order to approximate the indigenous notions presented in Southern Malaŵi, research questions were therefore focusing on problems affecting a person's mind or brain – *mavuto okhudza nzeru kapena ubongo wa munthu* in Chicheŵa. The information obtained on this complex proves hard to subsume under a general term that makes sense within a Western context. As a fairly broad yet tangible surrogate term, the term *mental disorder* will be employed here. In the United Kingdom, a 2007 Mental Health Bill defines mental disorder as denoting 'any disorder or disability of the mind.'[15] While it

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[14] On the basis of rich intercultural evidence, Richard Jenkins likewise concludes that "The distinction between 'mental retardation' or 'learning difficulties' and 'mental health problems' or 'psychiatric illness', that is so familiar in Europe and North America, is another example of gross categorisation. It is not always locally applicable or sensible" (Jenkins 1998b: 224).

[15] This bill represents an amendment to the Mental Health Act of 1983. The 1983 definition thus

may be argued that the term lacks a clear definition within the biomedical discourse, could be replied that this circumstance actually promotes its use in the interdisciplinary context of this study, along with the fact that it is, by and large, also not connected to strong implicit connotations. Its applicability may further be supported by its two components and their interpretation. In agreement with Susan Reynolds Whyte, the term 'mental' is favoured here over similar terms – such as cognitive, emotional, behavioural, or intellectual – in order to describe the health disorders investigated here, arguing that, while

> "Intellect is generally defined as the ability to reason, perceive or understand relations or differences […], mental capacity refers to abilities of mind, a broader term that includes will, intention and feelings, as well as intellect" (Whyte 1998b: 153).

While thus apparently implying a differentiation of the research topic from other i.e. physical disorders, it should be emphasized that the definition of 'mental' as applied here follows a combination of emic and etic representations. It is, therefore, not a strictly analytic category meant to advocate a medicine based on a constructed body-mind-dualism; neither does it contradict Western endeavours addressing the psychosomatic and/or psychosocial character of diseases.

The selection of the term 'disorder' reflects a very basic rendition of the emic Malaŵian perception of the phenomenon as such – i.e. a human condition that is outside of the orderly or normal, a confusion or irregularity. As a term, *dis-order* therefore expresses a deep connection to concepts of the normal human person, appropriate social interaction, and cultural order which, as the following chapters will substantiate, underlies the ethnically and socially distinct levels of discourse in Southern Malaŵi. In the context of the present study, mental disorder shall therefore denote all forms of health disorders which lead to, or correspond with, impediments concerning the mental behavioural disposition of the person as acknowledged within the multifaceted cultural contexts of Southern Malaŵi, and mental disorder describes a condition that is perceived as pathological from an emic perspective, and which, by definition, is outside of the realm of the culturally accepted norm.

Due to the modifications in the research objective and further results obtained during the subsequent in-depth field research, a number of interconnected questions were formulated. While the overall research topic of this study – i.e. the cultural construction of mental disorder in Southern Malaŵi – is indicated by

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replaced saw mental disorder as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind" (Great Britain 1983: Section 1). It also provided closer specifications of some subcategories such as severe mental impairment, mental impairment, psychopathic disorder, and mental illness.

its title, this very general query can be broken down into a number of more specific questions. The first one would be *(1)* how mental disorder is culturally represented and incorporated. Not all cultural phenomena are expressed with the same density in a given society. The amount of references a cultural system makes to a phenomenon such as mental disorder – but also the exact contexts in which it is included – create a basic picture of its social contextualization and, in essence, its cultural construction. After that, further inquiries need to address *(2)* how the system of classification is structured. In order to develop a deeper understanding of the cultural conception of the phenomenon, it is a prerequisite to assess and semantically analyse the terminological arsenal applied to categorize mental disorder and present viable definitions for its various culturally recognized forms. By this, a basic ethnographic landscape of the various concepts of mental disorder in Malaŵi can be provided. At the same time, the results of this inquiry directly question *(3)* how this definition is reflected in cultural notions of normality and, more specifically, of normal mental competence. This aspect is crucially relevant in a number of respects. It localizes mental disorder within a wider framework of personhood, makes a connection to the context of age-related disorders, and it provides additional delimitation to the embodiment of minor cognitive problems such as learning impediments. By asserting an emic definition of normal competence, the differences perceived in states of mental disorder can be outlined more precisely, and the social criteria underlying mechanisms of allocation may be analysed.

The results of previous queries directly lead to the question of *(4)* what the causative factors recognized for mental disorder are. Here, cultural concepts such as magic and spirit possession – which by themselves constitute wide fields for anthropological research already – have to be considered within the limits of their connection to the greater context of mental disorder. Along with them, other models of explanation require further attention – such as divine intervention or a seemingly near-scientific notion of 'natural' causation. In order to clarify prevalence and cultural meaning of each of these categories, it is necessary to assess *(5)* what therapeutic services are locally available and how they are perceived. Closer knowledge of the various health services in the country are helpful to develop a bigger picture of the pluralistic medical framework in which the social phenomenon as such is embedded. On the basis of the data obtained in the context of this and the previous question, another vital issue needs developing, asking *(6)* how local notions of curability are defined and how they correspond with mental disorder. This question responds to the specific interconnection between cases which would, by biomedical standards, be addressed as disability and mental illness, respectively. The lack of differentiation leads to the question of specific cultural notions of curability. In the light of all this information obtained, it is finally crucial to investigate *(7)* how this cultural construction of mental disorder develops with regard to recent and future processes of transformation. This issue will give an outlook on the historical dimension of mental disorder in Malaŵi, at the same time providing a valid hypothesis on future developments. While any such prognosis is necessarily impaired by its speculative character, it may nonetheless be viable to formulate some theses that go beyond the present *status quo*.

1(c) Current State of Research

The current state of research on the cultural construction of mental disorder in Malaŵi is pieced together from a number of separate scholarly lines. First, the field of medical anthropology provides some important information on the overall research question, including issues of disability within its wider research objective. To a limited degree, studies on mental health and transcultural psychiatry are also of some interest here, giving consideration to the fact that disability and psychiatric phenomena are part of the same cultural discourse in Malaŵi. Finally and most particularly, social anthropology has produced a small but remarkable school of publications on the anthropology of disability itself. These studies can be seen as part of the wider, interdisciplinary field of disability studies which therefore merits particular attention. The data available from a specifically Malaŵian context will be described as well, restricting the outlook to contributions focussing on the explicitly medical question of this study.[16] While it is certainly impossible to give appropriate credit to all publications which are relevant in the line of the current research, the following evaluation will only point out a small selection of works referred to in the context of this study.

Over the last decades, the field of medical anthropology has received increasing scholarly attention that expresses itself in a large number of publications focussing on the culture of health and disease. For some time, early medical anthropology struggled to emancipate itself from the biomedical paradigm of interpreting health and disease. The works of Erwin Ackerknecht may be mentioned as early recognitions of foreign, non-Western medical systems as cultural configurations that must be analysed within their specific cultural context. Thus anticipating the emic/etic distinction of analytical perspective, he also questioned the universality of normality, describing 'normal'

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[16] In the area of more general ethnographic data, another number of authors should be acknowledged. As a particularly important researcher, J. Matthew Schoffeleers should be pointed out whose extensive work on the anthropology of religion in Malaŵi provides most vital data (Schoffeleers 1997; ibid. 1992; ibid. 1991; ibid. 1979; ibid. 1968a; ibid. 1968b; ibid. 1966; ibid. [ed.] 1979; ibid. & Roscoe 1985).

and ‘pathological’ not as absolute ontological categories but as cultural variants (Ackerknecht 1971).[17] In recent years, scholars such as Arthur Kleinman had a considerable impact on the current debate, giving new direction to medical anthropology.[18] Owing to his background in both psychiatry and medical anthropology, Kleinman has conducted significant research in a Chinese setting. In his work, he also focuses on culture-specific disorders (also known as culture-bound syndromes), reaching a better understanding of the phenomenon in both anthropology and medicine (Kleinman 1980). Later on, Arthur Kleinman and Byron Good edited an anthology on *Culture and Depression* which, even more so than Kleinman’s 1980 monograph, transcends the borders between medical anthropology and transcultural psychiatry (see below).

With respect to medical anthropology in Malaŵi, a number of studies merit special attention. Over the years, Brian Morris has published invaluable material gained from extended field research conducted in different areas of the country. His extensive study on *Cheŵa Medical Botany* (Morris 1996) provides crucial anthropological data on Malaŵian medical models, and a number of other articles contribute immensely to the scholarly understanding of the anthropology of medicine (Morris 1989; ibid. 1986; ibid. 1985). Other contributors have likewise expanded the debate of medical anthropology in Malaŵi, and here, Joseph Chakanza must be pointed out for his significant research on religious healing (Chakanza 2000b; ibid. 1998).[19]

Some references tackle questions of mental health and transcultural psychiatry which, due to the particular structure of the research topic as redefined according to emic categorization, plays a part in the context of this study.[20] At the same time, questions of transcultural psychiatry constitute a late

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[17] Earlier contributors to the discussion on the character and perspective of anthropological research data have offered a distinction between ‘intentional’ and ‘functional’ data (Vajda 1964; Mühlmann 1938).

[18] Likewise, Arthur Kleinman questions Ackerknecht’s systematic approach, criticizing him for advancing “a misleading dichotomy between »primitive« and »modern« medicine […]. Ackerknecht, who has had an enormous impact on studies in this field, viewed non-Western cultures from an ethnocentric perspective based on the organizational structure professional medicine had evolved in the West” (Kleinman 1980: 29).

[19] Other anthropological studies follow special questions. Thus, Anne Drake explores Malaŵian categories of sickness and provides a deeper understanding of cultural models of causation, giving particular attention to phenomena such as *mdulo* (Drake 1976). This notion is later elaborated by Joseph DeGabriele (DeGabriele 1999) and will be explained below. Arnold Wendroff examines the techniques of traditional medicine with a special focus on healer-patient interaction (Wendroff 1985) while Jerome Msonthi focuses on the traditional institutionalization of traditional medicine in Malaŵi (Msonthi 1983a; ibid. 1983b; ibid. 1983c). Angelika Wolf, finally, addresses the cultural embodiment of HIV/Aids in a number of publications (Wolf 2004; ibid. 2003; ibid. 2000; ibid. 1996).

[20] A lot of work has been done in a transcultural context, contributing valuable information to the

addition to the overall research question and will thus only be considered to a limited degree while the main focus of this thesis is on medical anthropology as well as its common ground with intercultural disability studies.

As one of the first scholars to question the prevalent psychiatric doctrine, Thomas Szasz supports a critical stance on the definition of mental difference. Questioning both the supremacy of psychiatry as such and expounding the problems of labelling a given condition as pathological, Szasz's works on the *Myth of Mental Illness* as well as the *Manufacture of Madness* have done a great deal to disenchant Western psychiatry and reveal the arbitrary – or rather, culture-specific – character of its models of categorization. In his view, the term mental illness signifies nothing else than culturally disapproved forms of behaviour (Szasz 1976; ibid. 1961). Michel Foucault reaches similar conclusions in *Madness and Civilization*, challenging the understanding of psychiatry as an exact medical science (Foucault 1989).[21] The works of Ari Kiev have contributed greatly to delineate transcultural psychiatry as an independent field of research. Following a number of previous publications in that field,[22] his fundamental work on *Transcultural Psychiatry* questioned cultural definitions of 'normal' and 'abnormal'. Stressing the importance of culture-bound syndromes (also known as culture specific-disorders), Kiev had a significant impact on psychiatry, anthropology, and other, related fields (Kiev 1972: 65-92).

Especially from the 1990s onwards, the interdisciplinary faculty of disability studies has produced a substantial amount of publications. While some authors argue strongly in terms of anthropological field data and intercultural comparison for the sake of a wider theoretical discussion, others take a more sociological approach, including public health, policy, or activist approaches for their argument. Up to the present day, anthologies are the richest source of data on the anthropology of disability. Distinguished scholars such as Benedicte

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question as such. It should be stressed that the notion of inter-cultural comparison differs significantly from the approach applied here. In spite of the fact that Arthur Kleinman has contributed significantly to the branding of the "new cross-cultural psychiatry" (Kleinman 1977), it is nonetheless important to note the methodological differences. The present study explicitly follows an anthropological approach, i.e. locating, describing and analysing a phenomenon (mental disorder) in its all-encompassing cultural context – as opposed to contextualizing it in the broader international framework of comparative analysis. It is, therefore, a case study that aims to formulate results derived from and valid for a particular cultural framework rather than develop universalist theories on the cultural conception of mental disorder as a whole.

[21] In this study, Michel Foucault takes a culture-historical attitude towards mental illness, examining its representation throughout from the European middle-ages onwards. Here, he reveals the highly controlling character of current psychiatric treatment, questioning its humanitarian as well as its scientific basis (Foucault 1989).

[22] His classic study on *Magic, Faith and Healing* (1964) deserves special attention in this context. Here, Kiev examines the mechanisms of 'primitive' psychiatry, describing the interconnection psychiatric systems and the cultural contexts these models derive from.

Ingstad and Susan Reynolds Whyte merit highest attention for their anthropologically motivated compilations on *Disability and Culture* as well as their more recent anthology on *Disability in Local and Global Worlds* (Ingstad & Whyte [ed.] 2007; ibid. [eds.] 1995). Including rich field data from their own research in Botswana and Uganda and articles with other ethnographic foci, Ingstad and Whyte make a crucial contribution not only to the cultural semantics of disability but to its African conceptions in particular. Following a more sociological line of argument, an anthology by Colin Barnes and Geoff Mercer explores disability in the common ground between activism, medical sociology, and disability theory (Barnes & Mercer [eds.] 1996). Later, Barnes and Mercer publish another book in cooperation with Tom Shakespeare in 1999. In their study *Exploring Disability*, the authors give special attention to Goffman's notion of labelling and stigmatization (Goffman 1967) as well as the impact of factors such as the political recognition of disability or its embodiment in the media (Barnes, Mercer & Shakespeare 1999). A number of other anthologies similarly explore the cultural representation of disability.[23]

Edited by Richard Jenkins in 1998, *Questions of Competence* is another anthology that takes a more anthropological perspective on the phenomenon by including ethnographic data from a wide range of cultural contexts. Their collection elaborates on the notion of (in)competence as derived from Edgerton's 1967 classic, thus providing important contributions to the understanding of disability in its cultural setting (Jenkins [ed.] 1998). Also compiling ethnographic data on *Disability in Different Cultures*, Brigitte Holzer, Arthur Vreede and Gabriele Weigt provide valuable material to the anthropological discourse on disability. The collected articles address not only the cultural conceptualization of the phenomenon as such, but they also focus on cultural processes such as migration, knowledge transfer, self-help movements, and its theoretical implications on the intercultural study of disability (Holzer, Vreede & Weigt [eds.] 1999). A multitude of further contributions exist, some of which follow innovative approaches to the issue.[24]

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[23] Thus, Len Barton edits another compilation of articles which subsume current theoretical and methodological developments and give special consideration to the connections between disability and issues such as education, social embodiment, and cultural representation (Barton [ed.] 1996). In 1997, Lennard J. Davis edited a *Disability Studies Reader* which gives a wide overview over the field of disability studies by drawing together contributors from various academic fields such as biology, education, or fine arts. Commencing with a historical outlook on the phenomenon, the articles analyse disability with regard to its legal representation and social stigmatization, once again giving Goffman's stigma approach a critical appraisal. Further, questions of gender, education, and other cultural factors including literature are discussed in connection to disability (Davis [ed.] 1997).

[24] A particularly interesting approach is followed by Jane Hubert whose anthology, edited in 2000, discusses disability as well as mental illness in a cultural as well as historical context (Hubert

As it has been emphasized fairly recently, the inclusion of questions of disability into the field of medical anthropology – as well as into other disciplines of cultural anthropology as a whole – still require some intensification (Sagner 2001: 175; Shakespeare 1994: 283). Up to the present, only a small number of more circumstantial monographs have been published, whereas the bigger part of the essential works in this field are available as articles in journals and anthologies. One of the earliest anthropological studies focussing on issues of disability is the 1934 article *Anthropology and the Abnormal* by Ruth Benedict who, comparing the social concept of epilepsy in North America and Siberia, points out the differences – and thus arbitrariness – of cultural interpretation. Normality and abnormality, she argues, is an allocation based on socially defined values and forms of behaviour (Benedict 1934: 71-73).[25]

It has been argued already that only a small number of anthropological monographs have been published with an explicit focus on issues of disability. Likewise, it has been emphasized that these are required in order to broaden the debate by providing more ethnographic substance to it. One of the earliest theses on the culture of disability was provided by John Gwaltney who examined 'the cultural accommodation to blindness and other disasters in a Mexican community' (Gwaltney 1970). Robert Murphy, later, gives a powerful insight into *The Different World of the Disabled* in Western societies (Murphy 2001).[26] In a specifically African context, the number of monographs discussing the interaction of disability and culture are still limited. On the basis of her field data from Eastern Zimbabwe, Deliane Burck published a monograph on the *Ideas and Practices concerning Disability and Rehabilitation* (Burck 1989). With reference to her studies in Indonesia, Joyce Dreezens-Fuhrke has provided material analysing disability in Javanese society according to its symbolic value (Dreezens-Fuhrke 1996).

[ed.] 2000). In an ambitious sociological study, Dieter Neubert and Günther Cloerkes interpret disability as a form of manifest otherness which results from the spontaneous identification of physical, mental, or behavioural deviance by the respective community. Likewise, they argue that this otherness is generally connected to negative connotations, conceding largely with Goffman's notion of stigma as a *quasi* inevitable allocation (Neubert & Cloerkes 2001).

[25] In the same year, John Koty gives some consideration to questions of disability in the course of his comparative survey on the treatment of the old and sick within non-Western societies (Koty 1934). Some years later, Jane and Lucien Hanks investigate the social status of persons with disabilities on its cultural basis in a comparative study, concluding that categories such as normality and deviation are largely culturally defined concepts (Hanks & Hanks 1948).

[26] Due to his own health condition occurring later on in his academic career, the late Robert F. Murphy (1924–1990 AD) acquired first-hand data on the social factors determining disability in the United States, considering his own life situation as "a kind of extended anthropological field trip" (Murphy 2001: xi).

With respect to Malaŵian conditions, only a very limited amount of publications are dedicated to questions of disability and/or mental illness. One of the few thorough ethnographic investigations in this field was provided by Karl Peltzer. From a methodological perspective, his extensive study on traditional psychosocial health care in Malaŵi may be characterized as taking a psychological approach (Peltzer 1987).[27] Apart from this, most of the few literary sources on mental disorder in this country argue from an education or a development perspective. In an unpublished manuscript handed in at Chancellor College in Zomba, Alastair and Wendy Ager investigate the needs of mentally retarded persons in the country, stressing the need for appropriate medical facilities and a change in medical paradigm (Ager & Ager 1989). It is a most fortunate coincidence that, just prior to the realization of this field research in Malaŵi, local disability agencies conducted a representative survey on activity limitations nationwide in cooperation with an independent European development research organization (Loeb & Eide [eds.] 2004). While providing important statistical data on the basis of a mainly quantitative methodology, their survey also gives a glimpse into the cultural realities within which disability is located. Additionally, Stine Hellum Braathen has contributed some important material in the context of the cultural representation of albinism, evaluating the character and process of social stigmatization (Braathen & Ingstad 2006; Braathen 2005).

All in all, the need for more concise anthropological accounts on the cultural conceptions of disability and mental illness – as subsumed here under the superordinate term *mental disorder* – is recognizable. This thesis represents a contribution that, hopefully, will encourage the discussion on issues of mental health in the complex framework of Malaŵian cultural traditions.

1(d) Methodology

The research was structured according to a number of research focuses. In the beginning, networks had to be re-established with Chancellor College and other scientific institutions. Parallel to that, research was conducted in some of the major archives in the country, including the National Library in Lilongwe, the National Archives, Chancellor College Library, and – some time later – the National Herbarium Library, all of which are located in Zomba. Furthermore, networks with significant organizations in the area needed to be created.

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[27] While giving thorough consideration to its cultural background, Peltzer examines mental disorder on the basis of a psychosocial paradigm, obtaining and evaluating field data according to a clearly defined structural model that has been criticized as a simplification of the actual cultural conditions (Morris 1996: 108-109).

Organizations – governmental and non-governmental – for persons with disabilities as well as mental health facilities were central, and the introductory interviews conducted here proved tremendously helpful to gain an insight into the cultural conditions from a public health perspective.[28] Within the mass of information obtained during this first phase of the research, particular emphasis was given to the terminology as applied in the different cultural contexts for addressing mental disorder. Over time, this formed a catalogue of mental disorder categories which served as a discussion basis – and was further clarified – in later phases of the field research. In the successive research phases, a number of interviewee groups were included on the basis of their professional and/or personal background. All along, follow-up interviews were conducted in order to both clarify and deepen the data received earlier, and on a number of occasions, field trips throughout the Southern Region were made to ensure cross-regional comparability, thus giving a clear picture of the wider, national validity of the field research information received. All through the research period, close connections to Chancellor College of the University of Malaŵi were maintained.

The largest part of field research data was collected by means of interviews, frequently including follow-up interviews in order to attain a higher degree of in-depth information. Further accounts – e.g. on the social interaction within communities, therapeutic rituals, and the like – are derived from etic data received through participant observation. Overall, research has been conducted on the basis of a complex method that examines a given phenomenon throughout the different levels of cultural representation. Here, emic concepts – as expressed in traditional laws and behavioural rules, proverbs, classificatory as well as explanatory systems – have acquired considerable importance due to *(a)* the scarcity of previously published material as well as *(b)* the high relevance of this intentional data (Mühlmann 1938) for the overall question. Nonetheless, etic data was incorporated as well – by means of participant observation, or the study of primary as well as secondary literary sources – in order to control, complement, contextualize, and correlate otherwise unchecked field information.[29]

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[28] Among the NGOs, the Malaŵi Council of the Handicapped (MACOHA), Malaŵi Against Physical Disabilities (MAP), Feed The Children Malaŵi (formerly Cheshire Homes) or the Parents' Organization of Disabled Children in Malaŵi (PODCAM) need to be mentioned, while government organizations included the Federation of Disability Organizations in Malaŵi (FEDOMA) as well as the Office of the Minister of State Responsible for Persons with Disabilities (OMSPWD). Additionally, government health facilities such as Zomba Mental Hospital (ZMH) or Queen's Hospital in Blantyre, among others, were also contacted and interviews conducted.

[29] Following the terminology as presented by Mühlmann (Mühlmann 1938: 108-114), László Vajda questions the practicability of clear distinctions between intentional and functional data due to the fact that cultural phenomena as – as perceived and explained from an emic perspective – may not always be directly traceable from an etic perspective. Here, the cultural construction

The data presented and analysed in this study was obtained through intensive literature review in both German and Malaŵian archives, and through undertaking twelve months of anthropological field research as carried out February 2004 and April 2005. The actual research was preceded by preliminary field stays in Malaŵi in 1998 and again in 2001.

Interviews were conducted in the form of qualitative, semi-structured interviews, and especially well-informed interview partners were consulted on consecutive occasions to further elaborate on former statements. Some interview partners hereby assumed the position of a key informant. Language skills improved during the course of the research due to private language training with a local instructor as well as by its everyday in-field application. Still, most of the interviews conducted in Chicheŵa involved the participation of a research assistant in counteracting potential language problems and facilitating social contact. Whenever applicable and agreed to by the participants, interviews were tape-recorded and transcribed into bilingual Chicheŵa/English documents at an early stage of the research by linguistically trained personnel as contacted via Chancellor College, thus eliminating the biggest part of the possible translation-related challenges.[30] Interview data was complemented significantly by further findings made by means of participant observation.

As the primary research setting, the district of Zomba in the Southern Region of the country was selected. This choice was encouraged not only by direct cooperation with the University of Malaŵi's Chancellor College located there, but also by the specific character of the wider area. Forming a minor urban center, Zomba municipality attracts some extent of regional labour migration – partly due to the presence of Chancellor College, the social sciences branch of the University of Malaŵi. At the same time, rural communities of the district are poorly accessible and therefore offer good samples for comparative analysis within a relatively small geographical area. Zomba District allowed the inclusion of both urban and peri-urban settings as well as rural locations into the research, while other districts were also accessible due to favourable infrastructural conditions. As an in-depth setting for intensive data collection in a rural context, long-term field research was conducted in Nkagula Village, Sakata Trading Centre, in the area of SubT/A Nkagula, T/A Kuntumanji, in rural Zomba

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of a given phenomenon may reflect historical processes in a way that, as Vajda put it, a society may still regard the horse as the most important animal even though the sheep has long since have obtained a much more central economic position (Vajda 1964: 770-771). It is therefore the inclusion of different types of data that allows a clearer understanding of a given phenomenon within its cultural setting.

[30] The transliteration applied here has been double-checked in cooperation with staff members of Kachere Series publishers, Zomba. Frequent reference has been made to the linguistic standards established by Steven Paas in his recent Chicheŵa dictionaries (Paas 2005; ibid. 2004).

District. Due to personal acquaintance with a subsistence farmer and father of a child with severe disabilities in the area, a small network of parents with children with disabilities could be accessed. In addition, repeated research trips were conducted to other rural communities of Zomba District – such as Namirongo Village in T/A Mlumbe, Govala Village, T/A Jali, or Jali Village itself. Many other areas were included in the form of more extensive field research and interview sessions, providing multi-sited ethnographic data. Developing a bigger picture of the cultural conditions of persons with mental disorder throughout the Southern Region, interviews were also conducted in adjacent districts – including Blantyre, Chiradzulu, Machinga, and Balaka. Moreover, extended field trips were made in order to obtain comparative data from more remote districts of the Southern Region.[31]

Due to historically defined settlement areas as well as more recent migration processes, Zomba District – as well as many parts of the country as a whole – is an ethnically heterogeneous district. The ethnic groups most highly represented in this area are Yao, Lomwe, Mang'anja, and Nyanja. Due to migratory effects – and also by extending the range of research into other districts of the Southern Region –, persons from a Cheŵa, Ngoni, Tumbuka, Sena, Tonga, and Shona background were also among the interviewees, thus creating room for additional insights into the specific cultural notions in their respective home communities. The exact ethnic composition of the interview partners is given in the appendices attached to this study (see *Appendix 4*).

Due to its focus on medical anthropology, the current study endeavours to provide room for interdisciplinary discussion between the faculties of medicine and social or cultural anthropology. While the qualitative research techniques as depicted above demonstrate a clearly anthropological methodology, basic medical categories are nonetheless applied in order to provide a basic terminological structure for the otherwise extremely complex notions of medicine in Malaŵi. Therefore, it is necessary to make some efforts in differentiating systematic – i.e. etic – categories which are not clearly distinguished in their emic context in order to clarify the conceptual logic of medical processes. The necessity of introducing analytic tools in order to give a better understanding of Malaŵian medical concepts is supported by Brian Morris who states that

> "Although no rigid demarcation can be made between nosology, the principles behind disease classification, and etiology, the underlying causes of the affliction, it is conceptually important […] to consider those separately. A failure to do this has led to a lamentable tendency, reflected in the writings of many scholars, to

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[31] These included Nsanje, Chikwawa, Mangochi, Mulanje, and Phalombe.

> view all illness as caused by witchcraft or other mystical forces" (Morris 1996: 104).

Accordingly, the analysis of issues of mental disorder in Malaŵi paradoxically operates on the basis of central, basic biomedical concepts in order to reveal their benefits and limitations.

2. Introducing Mental Disorder in Malaŵi

In every given culture, mental disorder challenges society in terms of medical and economic support strategies as well as mechanisms of social inclusion. In spite of explicit governmental efforts to improve the situation of persons with mental disorders in Malaŵi, a severe lack of integrative success must still be attested. With substantial anthropological data missing, the cultural background of the problem itself remains unclear up to the present day, reducing hope for more effective approaches to questions of mental disorder. Recent statistical research has substantiated the significance of disability issues in Malaŵi, revealing that the problem is disproportionately prevalent in rural areas (Loeb & Eide [eds.] 2004).[32] In spite of government programs designed to alleviate the prevalence of disability in Malaŵi – such as the installation of a Government Ministry Responsible for Persons with Disabilities –, little change for the better is visible. With a million persons with disabilities and an even higher number affected indirectly nationwide, the question of disability is an issue of highest national and international importance in terms of the medical, political, economic and social problems it causes in Malaŵi.

2(a) Setting Presentation

Some basic data about the setting of this study is required in order to comprehend the embedding of the present study. As elementary knowledge, the geographical, historical, political, ethnic, and demographic background of the country shall therefore be depicted in brief. Particular consideration will be given to the Southern Region of the country, reflecting the fact that the field data forming the ethnographic basis for this study originates from this area.

The Republic of Malaŵi is a land-locked country situated along the South of the Great Rift Valley in South-Eastern Africa, bordering on the neighbouring

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[32] Due to the low degree of urbanization in Malaŵi, 93 percent of the disabled population lives in a rural setting (NSO 1987: 4).

states Tanzania, Zambia, and Mozambique.[33] Out of its 118,484 km^2 of national area, only 94,276 km^2 are dry land, the rest being taken up by its various lakes – the largest being Lake Malaŵi (formerly known as Lake Nyasa). As one of the most densely populated countries in sub-Saharan Africa, Malaŵi's population is estimated at about 13 million, indicating a population density of more than 130 inhabitants per square kilometre (WHO 2006b: 172). By comparison, the Southern Region is the most densely populated area with close to 6 million inhabitants, with population density approximating 180 persons per square kilometre. An estimated 88 percent of the population live in rural environments, and for most, farming represents the main source of livelihood. Particularly in the South, maize (*chimanga*) is by far the most important food crop – predominantly used in the form of *ufa* (maize flour) and prepared into *nsima* (a stiff maize porridge) or *phala* (maize gruel), the main ingredient of virtually every Malaŵian meal. Some cash crops are also planted and sold on local markets to provide small income. With 78 percent of the economically active population being smallholder subsistence farmers (*mlimi*) and others living from fishing or forestry, more than 90 percent of Malaŵian households' livelihoods rely directly on natural resources. National export trade is dominated by cash crops such as tea, tobacco, sugar cane, and coffee (Munthali, Konyani & Loeb 2004: 28; NSO 1998: xix).

In 2005, the country's development index was ranked on position 165 out of 177 nations worldwide. 65 percent of the Malaŵian population lived in dire poverty, with the Southern Region having the highest regional poverty rate.[34] The ensuing developmental challenges are manifold. As one of them, education levels are also low. While 64.1 percent of the adult population are literate nationwide, the Southern Region has the lowest literacy rate of the three national regions, and only 44 percent of Malaŵian grade 1 students reached grade 5 education in 2003 (NSO 2005a: 139; UNDP 2005; NSO 1998: xv).

The population of Malaŵi falls into a number of different ethnic groups which are generally defined by common descent, language, cultural representations and/or history. While most of these groups have their historical population centers, many areas in Malaŵi feature a highly heterogeneous ethnic composition due to factors such as labour migration, considerable regional mobility, and high population density. At present, about one third of the national population belong to the historically related groups of the Cheŵa, Nyanja, and

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[33] Malaŵi stretches between the latitudes of 9 degrees 45 minutes to 17 degrees 16 minutes south, and from the longitudes of 32 degrees 40 minutes to 35 degrees 51 minutes east.

[34] Poverty is closely related to reoccurring food crises in Malaŵi. In 2002 and 2003, 33 percent of the population was considered undernourished and directly affected by famine and starvation (UNDP 2005: 243). In 2005 AD, food shortages affected an estimated five million Malaŵians.

Mang'anja – while Lomwe, Yao, Ngoni, and Tumbuka constitute other strong ethnic units of the population; smaller groups such as the Sena, Tonga, or Nkhonde are of more regional importance (NSO & ORC Macro 2005: 26).[35] In the Southern Region where the field research for this study was conducted, the Mang'anja, Nyanja, Yao, Ngoni, Lomwe, and Sena are the most prevalent ethnic groups.

Both originating from the historical Maravi ethnic cluster (see below), the Mang'anja mostly live in the Lower Shire area in the extreme South while the Nyanja inhabit parts of the South-West (Lienau 1981: 85; Crosby 1980: 46).[36] Like all other ethnic groups in Malaŵi, the rural majority of the Mang'anja and Nyanja engage in agriculture, and their social organization consistently recognizes a matrilineal system of descent and uxorilocal, segmentary forms of settlement. The Chicheŵa language spoken by all these ethnic groups is recognized – along with English – as the national language of Malaŵi.[37] The former homeland of the matrilineal Yao, in contrast, lies in the Niassa Province of North-Western Mozambique. Due to their involvement in trade with Arab trading posts on the Indian Ocean, the Yao migrated into Malaŵi around the 1860s where they engaged in slave-trade as well as other mercantile activities. At present, most Yao also practice subsistence farming, and they apply their own Bantu language, the Chiyao (Peltzer 1987: 3; Alpers 1972: 168-170).[38] The patrilineally structured Ngoni, in turn, left Natal and Swaziland during the *mfecane* period (c. 1815 to 1835) after military conflicts with the ruling confederation of the Zulu king Shaka (1787–1828 AD) in 1819 AD. From the 1840s onwards, they established themselves in parts of Central and Southern Malaŵi, and presently, their main centers lie in Mzimba District (Northern Region) as well as in Ntcheu, Dedza, and Dowa Districts of Central Region. Their original Bantu language, closely related to isiZulu, has largely disappeared so that most Ngoni now use Chicheŵa as their first language (Phiri 2004: 79; ibid. 1982; Read 1979: 132; Pachai 1972: 179). The likewise patrilineal Lomwe formed as a loose federation of clans in Western Mozambique as late as the 19th century AD. While some units migrated into South-Eastern Malaŵi in the late

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[35] For full numbers see *Table 1*.

[36] Along with the Cheŵa, smaller groups such as the Chipeta or Nsenga are also mentioned as descendants of the Maravi (Kubik 1987: 7; Bruwer 1955: 113). Matthew Schoffeleers, however, identifies the Chipeta with the pre-Maravi clan Banda which was later incorporated into the Cheŵa. By intermarriage with the powerful Maravi clan Phiri, the Banda formed a moiety of the royal Cheŵa lineage (Schoffeleers 1992: 27-32).

[37] Also called Chinyanja, Chicheŵa is a Bantu language which, according to linguistic classification, belongs to the Benue-Congo branch of the Niger-Congo language family which, in turn, constitutes part of the Niger-Kordofanian super-family (Greenberg 1963).

[38] Prior to their migration, the majority of the Yao converted to Islam. At present, the areas with the largest Yao population are Mangochi, Machinga, and Zomba Districts in the Southern Region.

19th and early 20th centuries AD, significant numbers of Lomwe still live in Mozambique (Phiri 2004: 100; Schoffeleers 1997: 34; Peltzer 1987: 3).[39] The Chilomwe, a Bantu language closely related to the Makhuwa used in parts of Mozambique, is also widely spoken (Phiri 2004: 107; Soka 1999). The Sena, in turn, reached Southern Malaŵi from the Zambezi valley of Mozambique in the 19th century (Schoffeleers 1997: 34; Peltzer 1987: 3). Today, the patrilineally structured Sena make up a considerable part of the population in the districts of Chikwawa and Nsanje in the Lower Shire area, and they apply their own Bantu language, the Chisena.[40]

It is important to note here that, in spite of their historical distinctiveness, the different ethnic groups represented in this study do have a history of close inter-ethnic contact and exchange. Consequently, not all results discussed in this thesis do merit a distinction according to a given ethnic affiliation; many representations of culture in Southern Malaŵi have, in fact, developed the character of shared cultural representations (Morris 2000: 13-19). In this perspective, Brian Morris refers to differences between ethnicity and culture, pointing out that

> "[…] many cultural ideas and beliefs – with respect to the divinity, medicine, witchcraft, ideas about bodily humours and the dangers of 'heat', disease concepts, human/animal relationships, and beliefs relating to the spirits of the dead (*mizimu*) – are widely shared and common throughout the country. […] The important point, however, is that in Malawi 'culture' cannot be equated with 'ethnicity', and that cultural representations, as noted earlier, are diverse and exist on many different levels, one of which reflects the common cultural heritage shared by all the matrilineal people of Malawi. Given the fact that all these matrilineal people have common origins and historical traditions, and that there have been complex and long-standing cultural, economic and linguistic interrelationships between all the matrilineal people of Malawi, it is hardly surprising that common social institutions and cultural representations are evident" (Morris 2000: 18).

This observation is shared by a number of scholars who also report the consent between different ethnic groups with respect to various areas of cultural representation (Vail & White 1989; Alpers 1975: 7; Gamitto 1960: 63; Mitchell

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[39] Most of the Malaŵian Lomwe live in Mulanje, Phalombe, Thyolo, and Chiradzulu Districts of the Southern Region.

[40] Numerous studies have addressed Malaŵian historical developments, and this issue shall therefore not be elaborated at length. For more concise studies on different eras of Malaŵian (pre-)history see Rotberg 2005; Phiri 2004; Welling 2000; Shepperson & Price 2000; Muyebe & Muyebe 1999; Phiri 1999; Booth 1998; Schoffeleers 1997; ibid. 1992; ibid. 1979; Englund 1996; Lwanda 1993; Kubik 1987; Crosby 1980; Linden 1979; Phiri 1976; Langworthy 1973; Ntara 1973; Clark 1972; Gamitto 1960; Bruwer 1955; Young 1950.

1956: 14; Young 1950: 37). Especially due to increasing population density and high spatial mobility, cultural discourse is no longer necessarily restricted to a given ethnic context, but it discusses issues on a wider, inter-ethnic level. Cultural concepts travel fairly easily and may be adopted among different ethnic groups.[41] Brian Morris thus observes that

> "Many contemporary scholars, however, still write of the Chewa or Tumbuka as if they constituted ethnic enclaves with their own specific bounded culture or cosmology. Yet to stress this intermingling and common cultural heritage is not to deny that ethnic affiliation and ethnic identity are not important in Malawi. But it is probable that ethnic consciousness itself came to be fully articulated only during the colonial period, partly through the system of indirect rule and the ethnic stereotyping of the European colonialists, and partly through the struggles of local people themselves, for political autonomy, for economic and educational advance, and as a form of resistance against the missionaries and the colonial state" (Morris 2000: 18-19).

It may be regarded as a result of historical processes to categorize people in Malaŵi according to numerous ethnic communities, each of which have their own distinctive cultural heritage and regional provenience. This notion, however, has been identified as misleading, rather reflecting the quintessentially Western – and, historically speaking, colonial – idea of ethnicity as some kind of 'primordial' and monolithic concept. The struggle of political elites for power, as Brian Morris argues, may also have contributed to the acceptance of ethnic units as a means of collective identification (Morris 2000: 15-16). As a result, field research indicates that for many Malaŵians, ethnicity may have a situational, changeable, or even ambiguous character and be negotiated according to the given social occasion. Therefore, many persons characterize their own ethnic affiliation by statements such as being 'half Mang'anja and half Yao' or as 'being Nyanja but also Lomwe'. This more complex concept of ethnic specificity also expresses itself in terms of the representations of traditional culture. At present, a broad cultural common ground transcends ethnic affiliation and forms the basis for public discourse, and it is by far not uncommon to hear the ethnic origin of a given concept disputed among the local population. This interplay between ethnically distinctive and shared representations of culture is a complex process that is reflected in the way data is presented in this study.[42] And it is,

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[41] On a grassroots level, the population of a given Southern Malaŵian village frequently composes of more than one ethnic group, and due to the high occurrence of inter-ethnic marriage, the question of defining affiliation – and thus the ethnic identity of future offspring – is frequently open to negotiation.

[42] It is in recognition of this condition that the current thesis does not focus on one ethnic group alone but, as elaborated in the methodology section (see *Chapter I.1.d*), investigates cultural

after all, exactly this wide ongoing discourse and its specific character of consenting, conflicting, and negotiating cultural notions – along with its different discernible elements including ethnic factors in the same way as gender, religious, social, or regional affiliation – that forms the dynamic layers of the complex cultural process of construction in question here, and it is therefore at the very bottom of this thesis' objective.

The historical dimension of the various Malaŵian cultures as outlined here provides the basis for a wider understanding of the setting in general terms, but it also highlights some more specific factors that are directly relevant for the more specific question of this thesis. The migratory movements mentioned represent the direct cause of the rich cultural pluralism prevalent in Malaŵi today. Geographic factors relate to some of the most pressing challenges in Malaŵian development including its economic weaknesses, and the political processes mentioned here further clarify that, in spite of its national independence in the 1960s, truly democratic political structures are still a comparably recent introduction into Malaŵian society. Moreover, the importance of certain legal measures has already been emphasized, and it will be shown that Malaŵian law plays a particularly considerable role in the context of questions of mental disorder.

2(b) Legal Framework

National policy can be seen as a result from both international guidelines and pre-colonial, cultural notions of morally right behaviour, shaping a specific sense of justice at the grassroots level of society. The inclusion of persons with disabilities and the protection of their rights have a broad ethical basis of international laws and conventions. As a first fundamental guideline, the Universal Declaration of Human Rights issued by the United Nations General Assembly in 1948 set the humanitarian standards in the treatment of persons with disabilities as well. Accordingly, civil as well as political rights are guaranteed to people with disabilities (UN 1948).

As another milestone, the United Nations developed the World Program of Action (WPA) concerning Disabled Persons in 1983, marking the beginning of a United Nations Decade of Disabled Persons from 1983 to 1992 (UN 1983).[43] By

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conditions both on their specifically ethnic level as well as on a larger, inter-ethnic scale. In this thesis, the specific relevance of ethnic affiliation – and of the similarities and dissimilarities of cultural concepts – will be pointed out on numerous occasions. For that purpose, all interviewees directly related to are specified with their ethnic group.

[43] This program promoted the prevention of disability as well as the rehabilitation and equalization of opportunities for the affected persons, aiming to provide persons with disabilities with full

the end of this decade, the United Nations General Assembly adopted a resolution on the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, corroborating their statements as formulated in the 1983 WPA and mapping a toolbox for achieving equality for persons with disabilities which could be applied by organizations working on national and international levels alike (UN 1993).[44] In 2006, the United Nations Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities finally issued a draft convention on the rights of persons with disabilities. Being the result of year-long endeavours and intensive negotiations between government officials and disability organization representatives from around the world, the agreement, reached at the eighth session of the Ad Hoc Committee was applauded among the disability community. With the treaty still requiring ratification on the respective national levels, it focuses on the fight against discrimination against persons with disabilities, protecting their civil rights, their access to justice, as well as other basic rights such as education, health care, and means of transportation (UN 2006).

Expectedly, the global concerns about persons with disabilities as well as mental health issues have major impact on national policies and legislative measures. While, during the colonial period, British legislation had been applied, Malaŵian independence in 1964 directly led to the freedom as well as the necessity of structuring national law in accordance with a Malaŵian understanding of society. In the year 1971, the national government started issuing legal regulations meant to increase the care and protection for handicapped persons. This text, known as the Handicapped Persons Act, underwent minor changes until its final issue in 1973. This act, marking the founding stone of a national Malaŵian disability policy, defines itself as

> “An Act to make provisions for the improvement of the care, assistance and education of handicapped persons in Malaŵi; to establish a Council for the handicapped; to provide for the voluntary registration of handicapped persons; to provide for the registration, direction, control and regulation of associations whose objects include the welfare of the handicapped; and further to provide for

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participation and equality in social life and personal development. In the same year, the International Labour Organisation (ILO) issued Convention No. 159 in Geneva which concerned the vocational rehabilitation and employment of disabled persons. Calling states around the world to establish appropriate vocational training and rehabilitation facilities for persons with disabilities, the ILO Convention 158 emphasizes the need to support disabled persons in developing their personal skills and employment opportunities (ILO 1983).

[44] In the context of mental health issues, the year 2001 marked the launch of the WHO Mental Health Global Action Plan (mhGAP), coming as a reaction to the results of the 2001 World Health Report which focused explicitly on mental health issues (WHO 2001c).

> matters incidental thereto and connected therewith" (Government of Malaŵi 1971: Preamble).

By this act, associations and organizations for persons with disabilities are encouraged to operate in Malaŵi, and cooperation with governmental institutions is also welcomed (Government of Malaŵi 1971). A second important measure implemented by the 1971 Handicapped Persons Act is the establishment of the Malaŵi Council for the Handicapped (MACOHA) in the same year. This newly founded governmental organization acts as an implementer of all government disability programs. These measures include providing and coordinating rehabilitation services as well as awareness-raising towards a better integration of persons with disabilities into Malaŵian society.[45]

In the time before multi-party democracy – especially between 1971 and 1994 –, the active services for persons with disabilities had a strong focus on charity while personal development or human rights were not primary motivations. At the same time, no official policy had yet been implemented to provide guidance for activities (Munthali, Konyani & Loeb 2004: 35). Following the first multi-party elections in 1994, another significant step in terms of the legal situation of persons with mental disorders – and here, more explicitly of persons with disabilities – is the Constitution of the Republic of Malaŵi as implemented in 1995. In full accordance with international standards, the Malaŵian constitution gives recognition to the situation of persons with disabilities and demands the implementation of programs based on the principle of non-discrimination (Munthali, Konyani & Loeb 2004: 35; Government of Malaŵi 1995). In 1998, the office of the Minister Responsible for Persons with Disabilities was established by presidential directive as a coordinator institution for all issues pertaining to persons with disabilities. Before that, disability issues had been under the responsibility of changing ministries such as the Ministry of Health or the Ministry of Community Services (Munthali, Konyani & Loeb 2004: 35-36).[46] It can be seen as one of the main achievements of the mentioned Ministry to develop a National Disability Policy which is meant to provide a

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[45] Up to the present, MACOHA also acts as an advisor to the government on all questions touching persons with disabilities. Currently, a number of Community Based Rehabilitation programs are run by MACOHA nationwide, and some Institutional Based Rehabilitation centers are also part of MACOHA strategy. The Institutional Based Rehabilitation projects resemble vocational training facilities for persons with mainly physical limitations, such as the Kamuzu Vocational Rehabilitation and Training Center in Magomero in Zomba District. Additionally, a few outreach services and some workshops for persons with disabilities are also under MACOHA coordination.

[46] By 2004, this office was restructured into the Ministry of Social Development and People with Disabilities (MSDPWD), thereby becoming independent from the Office of President and Cabinet it was formerly affiliated to.

closer legislative basis for the inclusion of persons with disabilities into society (Government of Malaŵi 2006). As the new National Disability Policy argues,

> “It is now widely accepted that disabled people have a right to live a dignified and independent life-style within the community; to take an active part in the general, social and economic development of the country; and to receive education, medical care and social services within the ordinary structures of their societies. The new approach stresses abilities, not disabilities. It promotes disabled persons’ rights, freedom of choice and equal opportunities” (Government of Malaŵi 2006: xii).

The necessity to legally protect the rights of persons with disabilities is frequently emphasized and commented on in the public discourse of present-day Malaŵi. Therefore, court cases against someone violating the rights of persons with mental disorders are covered at some detail in national media.[47]

While national legislation constitutes the main body of Malaŵian jurisdiction,[48] rural communities have the opportunity to negotiate minor legal conflicts internally, by the power of so-called traditional courts. A traditional court (*bwalo*) is under the responsibility of traditional authorities on different hierarchical levels. While minor issues on grassroots level may fall under the competence of a village headman (*mfumu yaing’ono* or *nyakwawa*), he or she usually brings all cases of higher public interest to the attention of the group village headman (*mfumu yaikulu* or *grupu*) who has the duty of acting as a traditional judge. If a lawsuit is seen as being of even greater importance, the Traditional Authority (T/A, *mfumu* or *chalo*) of the area is called upon as supreme judge. In addition to referring touchy cases to a higher level of jurisdiction, headmen and headwomen can also turn to their own superiors for advice and instructions on how to negotiate a particularly difficult court case.

The legal tradition frequently reiterated implies that all persons must be regarded as equal in the face of traditional law. This explicitly includes persons with mental disorders, so that every case of abuse against such a person would be brought to the *bwalo*, as the *mafumu* of different ethnic groups point out. In the event of such a court case, though, opinions are split about the question whether or not a person with a mental disorder has the right to speak in front of the

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[47] As an example, a 27 year-old Malaŵian was sentenced to a three years’ prison charge for sexually abusing a 12 year-old girl described as mentally retarded. In reaction, the Ministry of Social Development and Persons with Disabilities was quoted as demanding “stiffer penalties for such […] horrendous crimes” and “barbaric behaviour”, reminding the general public of the equal right to security and participation on the side of persons with disabilities (Kasunda 2005: 3).

[48] The judiciary is structured hierarchically, ranging from Magistrate Courts (located in every larger population center of every district) to the four High Courts (located in the cities of Lilongwe, Blantyre, Mzuzu, and Zomba) and to the Supreme Court situated in Blantyre.

bwalo.[49] In the event that a person is found guilty of committing an offence against a person with a mental disorder, he or she is usually sentenced to pay a fine equivalent to the value of livestock, i.e. of a chicken or, in more severe cases, a goat. If a person with a mental disorder, in turn, is convicted for violating somebody else's rights, he or she cannot be punished or even blamed according to, e.g., Yao customs. The family guardians would usually try to explain the situation to the unfortunate wrongdoer, but the only viable punishment in such a case is sending them to the next District Hospital or Zomba Mental Hospital for more specialized Western treatment.[50]

While local courts therefore constitute an important addition to the national legal system, their recognition is also subject to processes of cultural change. A Yao *mfumu* therefore laments the fact that the behavioural rules towards persons with mental disorders do not have a legally binding character anymore, and that traditional courts are losing some of their cultural standing. Legal measures mostly apply only in cases of physically violent behaviour, but all other forms of misconduct cannot be prosecuted by law. Rather, they are a matter of good manners (*khalidwe*) and politeness (*ulemu*) only, making it unlikely for people to consult the *bwalo* for clarification.[51] Moreover, though, the *bwalo* is the only legal institution in Malaŵi where cases will be heard that are seen as being related to magic practices. Given the high prevalence of magic – especially *ufiti* – in Malaŵi and its equally great importance in the context of the causation of mental disorder, traditional courts still cover an enormously important field of jurisdiction in Malaŵian society.

The Malaŵian legal system gives a direct and emblematic impression of the challenges posed by modern state structures superimposing traditional African ones. While being part of the state jurisdiction and therefore forced to comply with government policy and law, the *abwalo* still constitute a governmental

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[49] Therefore, a Mang'anja *mfumu* clearly supports this principle while a Yao *mfumu* expresses his opinion that such persons must be generally considered unfit to personally address the court. Clearly implying a changing state of mental disorder, the former *mfumu* assesses that any person with *misala* or *kuzerezeka* (see *Chapter III*) who does not comply with behavioural rules of the *bwalo* would have to be tied up and removed. When negotiating a case without the direct participation of a person with a mental disorder, a Yao *mfumu yaikulu* explains that he would conduct personal inquiries and investigations about the actual proceedings in order to make up for the claimant's inability to speak for himself or herself.

[50] While this lenience of the law against persons with mental disorders bears some resemblances with conditions of diminished responsibility, it is also subject to critical verification. A Mang'anja *mfumu* thus mentions his habit of conducting interrogations within the community in order to assess whether the condition of the accused truly justifies clemency of the law or whether it is a case of pretence.

[51] Furthermore, the cooperation between these governmental courts and the traditional *bwalo* is frequently difficult. While cases of alleged murder have to be tried before the respective Magistrate Court, national law does not acknowledge *ufiti* as a count of indictment.

concession to the limited applicability of a largely European legal system to the cultural conditions of a Malaŵian setting. This gap between mainstream political practice – as evolved from colonial notions – and traditional culture represents a considerable disruption within Malaŵian culture, questioning the socially binding character of both legal systems by providing a potential alternative that argues on the basis of different basic assumptions. This illustrates the difficulties in implementing national and/or international legal concepts into a largely traditionally defined setting. Here, global health strategies and their correlation with traditional legal concepts and institutions are of particular importance for the actual health situation in Malaŵi.

2(c) Health Conditions

Public health care is among the most pressing issues the national government and international aid organizations in Malaŵi face. In spite of ongoing involvement of both national and international agents, health conditions remain difficult in many parts of the country. Like many other countries in Southern Africa, Malaŵi faces some considerable health challenges.

Due to severe infrastructural problems throughout the country, the availability of psychiatric institutions in Malaŵi is minimal. As depicted by the National Statistical Office, the country has two official institutions for mental health care nationwide. While one of these facilities – St John of God's Hospital located in Mzuzu, Mzimba District (Northern Region)[52] – is a religious institution run by the Christian Health Association of Malaŵi (CHAM), the other and much larger one is the government-owned Zomba Mental Hospital. Together, these institutions officially provide 153 beds for mental in-patients, 25 of which are at St John of God's (NSO 2005b). For persons with disabilities, private institutions – such as Feed the Children Malaŵi, an organization formerly known as Cheshire Homes and based in the suburban areas of both Blantyre and Lilongwe Districts – are frequently seen as an alternative to hospitals. At the same time, their programs focus on rehabilitation services and vocational training for special needs children. As considerable drawbacks for potential patients, their services are comparatively pricey and only available to those situated in the immediate vicinity of the institution.[53]

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[52] This facility is an institution of the Hospitaller Order of Saint John of God, a Catholic order with headquarters in Ireland.

[53] Thus, for instance, institutions such as Feed the Children Malaŵi in Ndirande, Blantyre, have an estimated catchment area of 20 km from where students can commute for a couple of days of training per week. The biggest part of the estimated 700 students trained throughout a year are identified as suffering from cerebral palsy, but also learning difficulties, mental retardation,

Due to its relative distance from the research area, St John of God's does not have an immediate impact on the therapeutic options for people in the Southern Region of Malaŵi. Zomba Mental Hospital with its *quasi* nationwide catchment area, on the other hand, represents an institution with significant relevance to this study. As already indicated, Zomba Mental Hospital provides an official 128 beds for in-patient treatment as well as out-patient services for a varying number of persons.[54] While the explicit policy focuses on referring persons with disabilities to rehabilitation institutions, a considerable number of them still remain in the rehabilitation wards of Zomba Mental Hospital for lack of suitable alternative treatment facilities. As a general average, in-patients are said to stay for a period of at least one to two months, but cases of long-term institutionalization of ten or more years are no exception either. Due to the relative age of the facilities in Zomba as such, the regrettable condition of the institution – especially with regard to its architectural structure – is presently a source of criticism and worry.[55] In addition to the structural inadequacies of the building, Zomba Mental Hospital is also facing frequent shortages of supplies and medical equipment.[56]

The national health system in Malaŵi is controlled by two separate agencies. While governmental institutions – under the supervision of the Ministry of Health – constitute the largest part, a significant number of additional institutions are also provided by the Christian Health Association of Malaŵi (CHAM). The health care system has a hierarchical structure, with district and regional hospitals providing the widest range of medical services. Primary health centers exist in smaller towns, offering basic facilities on the level of smaller population centers, and local dispensaries provide additional aid in remote places

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physical disabilities (such as hearing or speech impediments), emotional and behavioural problems, and visual impairments. As another example, Kamuzu Vocational Rehabilitation and Training Center for Disabled Persons in Magomero, Zomba District, is a center run by the Malawi Council of the Handicapped (MACOHA). While offering vocational training for students with mainly physical challenges, they also offer accommodation to students in the fashion of a boarding school.

[54] According to interview data obtained from former Zomba Mental Hospital staff, the hospital consists of two Acute Male Wards (of c. 40 beds each) and an Acute Female Ward (c. 30 beds) as well as a Children's Ward (which doubles as Female Rehabilitation Ward, c. 15 beds), an Infirmary Ward (c. 10 beds), and a Male Rehabilitation Ward (c. 20 beds). According to these numbers, Zomba Mental Hospital thus features an estimated 155 beds altogether.

[55] A Malaŵian health worker with professional experience in Zomba Mental Hospital thus describes the situation, explaining that "the problem is that our hospital is very old so most of our patients abscond the institution because the hospital is rotting down. So patients stay while some go out – maybe without us knowing" (Vivian Changata, a Mang'anja nursing officer).

[56] Thus, as a nursing student working at Zomba Mental Hospital explained, the hospital possesses neither electroencephalography (EEG) nor electrocardiography (ECG) facilities, and even a thermometer could not be provided.

(Sommerfeld 1987: 82). With regard to the Southern Region, this situation translates into a total of 29 hospitals,[57] 135 primary health centers and 53 dispensaries, providing a grand total of 6,575 beds for an estimated 6 million inhabitants (NSO 2005b: Table 3.2).

The amount of personnel working in these facilities is likewise insufficient to meet everyday demands.[58] According to national statistics, on average there is one physician for every 61,817 persons in Malaŵi – notwithstanding the much higher concentration and availability of doctors in urban areas as compared to the more rural, medically less accessible 88 percent of the country's population. To compensate for that, nurses have an increased responsibility in maintaining the country's health care services, but there are 2,228 patients per nurse nationwide (NSO 2005b: Table 3.12), and the lack of qualified medical personnel is recognized as a key shortage in the Malaŵian health care system – as it is in many other countries of the world, and in sub-Saharan Africa in particular (Lwanda 2008).[59] Due to the severe difficulties in meeting the basic medical demands of the Malaŵian population by biomedical means, the medical landscape of the country offers a number of therapeutic alternatives. Traditional healers (*asing'anga*) provide a wide variety of services, traditional birth attendants (*azamba*) provide maternity care, and different kinds of religious specialists offer faith healing rituals.

So far, very little information exists to provide an outline of mental disorder in Malaŵi.[60] The historical dimension of mental disorder is not very well-documented, and earliest reports on the issue include colonial records as found in the National Archives in Zomba, illustrating British attempts to address the

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[57] The numbers given here refer to a 1998 survey. With some exceptions, most of these hospitals are confined to the respective district capitals. While the districts of Zomba and Mangochi boast four hospitals each, the districts of Chiradzulu, Mwanza, and Chikwawa (three each) follow before Blantyre, Thyolo, Mulanje, Phalombe, and Nsanje (with two hospitals). Both Balaka and Machinga Districts only feature a single government hospital (NSO 2005b: Table 3.2).

[58] 2004 figures indicate the following numbers for medical staff personnel. Nationwide, 179 doctors are working along with 4,966 nurses as well as numerous clinical officers (738), medical assistants (693), health assistants (263), and health surveillance assistants (8,241). According to the National Statistical Office, this leads to national ratios of 61,817 inhabitants per doctor and 2,228 persons per nurse (NSO 2005b: Table 3.12).

[59] According to the World Health Organization, "Staffing in Malawi's health service is inadequate to maintain a minimum level of health care, and is particularly low even by regional standards. It is also insufficient for the delivery of antiretroviral therapy and other HIV/AIDS-related services in response to demand. Of 27 districts, 15 have fewer than 1.5 nurses per facility, and five districts do not have even one each, while four districts have no doctor at all. HIV/AIDS-related attrition among the workforce compounds the shortage. In addition, up to 800 qualified nurses living in Malawi choose not to work in the health sector" (WHO 2006b: 22).

[60] Here, terminology is of course an issue that must be recognized. While none of the sources mentioned below apply the term mental disorder as defined here, their results still resemble the closest indicators for the prevalence and nature of the phenomenon.

problem of mental disorder among the Malaŵian population. The little statistical information available is closely connected to the medical situation in Zomba Mental Hospital. It was only after achieving independence in 1964 that the recognition of disability as a national health concern increased significantly, and by now, different agencies operate in order to raise awareness and create political leverage on the issue.

In 1983, the National Statistical Office of the Government of Malaŵi conducted a first systematic *Survey of Handicapped Persons* in the country. Its results in the form of quantitative data paint a fairly positive picture, identifying only 2.9 percent of the Malaŵian population as disabled. According to these numbers, a total of 11 percent of the households nationwide have at least one member living with a disability, and the regional variability of the disability rate is comparably low (NSO 1987: 4) (see *Table 3*). Furthermore, the occurrence of disabilities indicates that a full 46 percent of the cases appear before the age of five years of age (see *Table 4*). In full compliance with biomedical concepts, the study differentiates mental illness from disability, consequently indicating that cases of mental illness do not occur congenitally but are only diagnosed from the age of 5 years onward. Likewise, mental retardation always occurs early in a person's life, appearing at the latest at 14 years of age (NSO 1987: 22-23). Education was identified as a considerable problem for the affected persons' social situation, while their integration into work processes was described as comparatively favourable.[61] In the context of this study, the numbers given for epilepsy as well as for mental illness or retardation may be emphasized. At the same time, it is important to note that these numbers might require re-reading with regard to mental cases due to the fact that the study explicitly leaves the inmates of prisons, schools, and hospitals unconsidered (NSO 1987: 1) – which is the place where a considerable number of persons with serious mental disorders may be expected.

In a more recent study, the Federation of Disability Organizations in Malaŵi (FEDOMA) in cooperation with the Foundation for Scientific and Industrial Research at the Norwegian Institute of Technology (SINTEF) provide a more comprehensive account of the prevalence of disability in Malaŵi (Loeb & Eide [eds.] 2004). While the percentage of households with members with a disability

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[61] School education as well as vocational skills training was therefore reported as low. Only 42 percent of persons with disabilities had over 5 years or school education while secondary school was attended by a total of 4 percent of the affected persons. Only 36 percent of persons with epilepsy and 41 percent of the mentally ill attended any kind of formal school training. Still, disabled persons were generally found to be integrated into cultural work processes: only 30 percent of the disabled population of Malaŵi stated to do no work at all, whereas 39 percent were occupied with farming and/or fishing and 26 percent performed household duties (NSO 1987: 6-8).

is virtually unchanged at 10.6 percent in this second survey, the overall picture still indicates significant differences to the 1983 census (see *Table 3*).[62] In contrast to the earlier survey, the various districts now show considerable variations in terms of the prevalence of disabilities among the population (Loeb 2004a: 82-83). The mental health situation of persons with disabilities was investigated by means of patient self-evaluation. Due to their results, the self-perception of poor mental health frequently goes along with a more severe case of disability, indicating that

> "In other words, and not unexpectedly, physical and mental health and disability are correlated. Those who experience poor physical or mental health also experience higher levels of need for assistance in carrying out daily activities as well as more activity limitations and participation restrictions" (Loeb 2004a: 135).

This study also gives some indication of the assumed reasons for the condition, alluding to the width of explanatory models as well as their relative prevalence (Loeb 2004a: 108).[63] Further on, the educational and professional background of persons with disabilities receives some special attention, indicating that disability severely exacerbates the already difficult economic situation of people in Southern Malaŵi.[64] Here, the category of 'mental and/or emotional disabilities' stands out, indicating the cases to be the most severe with regard of the persons'

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[62] Once more, the southern Region stands out with the highest percentage (11.4 percent) of households with disabled household members (Loeb 2004a: 82). In the overall identification of the phenomenon, the definition of disability is clearly a crucial issue. Arne Eide and Mitch Loeb address this problem, giving official numbers according to which high-income countries like Norway (17.8), Spain, the USA (both 15.0), Canada (14.7) or Germany (8.4 percent) have a much higher prevalence of disability then low-income countries such as Kenya (0.7), South Africa, Zambia (both 0.9), Zimbabwe (1.9), or Malaŵi (2.9 percent). This underlines the fact that statistical numbers on disability tend to lack comparability due to diverging definitions and research techniques applied (Eide & Loeb 2004b: 51).

[63] In systematic order of their assumed prevalence, the causes mentioned include physical illness (48.3), 'natural' (17.2), accident (10.6), witchcraft (3.8), mental illness (3.2), animal related (1.0), violence (0.6), alcohol and drug abuse (0.3) as well as other reasons (14.9) (Loeb 2004a: 108). Due to the high importance of explanatory models within the framework of the present research and the dire need for further clarification, this complex will be elaborated at greater length in a following chapter (see *Chapter IV*).

[64] 34.8 percent of the persons with disabilities in Malaŵi reportedly do not receive formal education, compared to 19.7 percent of the non-disabled population. Here, persons with psychological disabilities are disproportionately represented with more than 36 percent. Over 61 percent of the disabled population are illiterate, and accordingly, the employment conditions for persons with disabilities are critical. 58.8 percent of persons with disabilities attested to have no professional skills, and 57.7 percent described themselves as unemployed while 47.6 percent of the disabled persons aged 15 and older even attested never having held any employment position. Vocational training as well as welfare services are reported to be not appropriately available, with only 5 percent of the respondents who expressed demand actually had access to such facilities (Loeb 2004a: 86-93, 117; Loeb & Eide 2004: 16).

activity limitations and participation restrictions. Accordingly, the affected people show the highest dependency in performing daily activities and the highest need for specialized services. At the same time, the condition of persons with mental/emotional disabilities is shown to be worse than that of all other types of disability with respect to activities such as learning and knowledge, communication, self care, domestic life, interpersonal behaviour, major life areas, as well as community and social life (Loeb 2004a: 129-130).[65]

In spite of formal and methodological differences, a careful comparison of the two surveys leads to a number of important results. A rise from 190,000 persons or 2.9 percent of the total population in 1983 up to 480,000 and 4.2 percent in 2003 clearly represents a conundrum. It may either be seen as a highly concerning development in itself or as an additional indicator of the lacking ontological clarity as to what disability represents and, hence, should be counted as one. Still, an increase of the occurrence rate of about 30 percent over a twenty years' period, and a growth of 150 percent in terms of the persons affected by disability clearly suggests that the phenomenon demands immediate attention on the political, medical, and social levels. While different definitions of disability and activity limitations restrict direct comparability, these numbers underline the high – yet continually growing – importance of disability in Malaŵi. At the same time, it has been illustrated that national health facilities do not have the appropriate means to effectively tackle the challenges set out for them, leaving the thus unsatisfied medical demands to be met by other, alternative practices of medical service which thereby take an increasingly important position within public medical discourse. But while infrastructural, political, and developmental conditions undoubtedly form a crucial obstacle for the general well-being of persons with mental disorders in Southern Malaŵi, other, more internal factors have an equally considerable impact on the issue. It is these cultural issues that are of central interest in an anthropological line of argument, and they must be seen in the context of the cosmological, religious, philosophical comprehension of the world as a whole and of health problems in particular.

In part, the challenges affecting persons with mental disorder in Malaŵi are located on a structural level. While issues of biomedical public health care and its accessibility certainly have a considerable impact on the living conditions on the ground, it would be highly misleading to consider this as a singular contributor to the situation as such. Accommodating its anthropological

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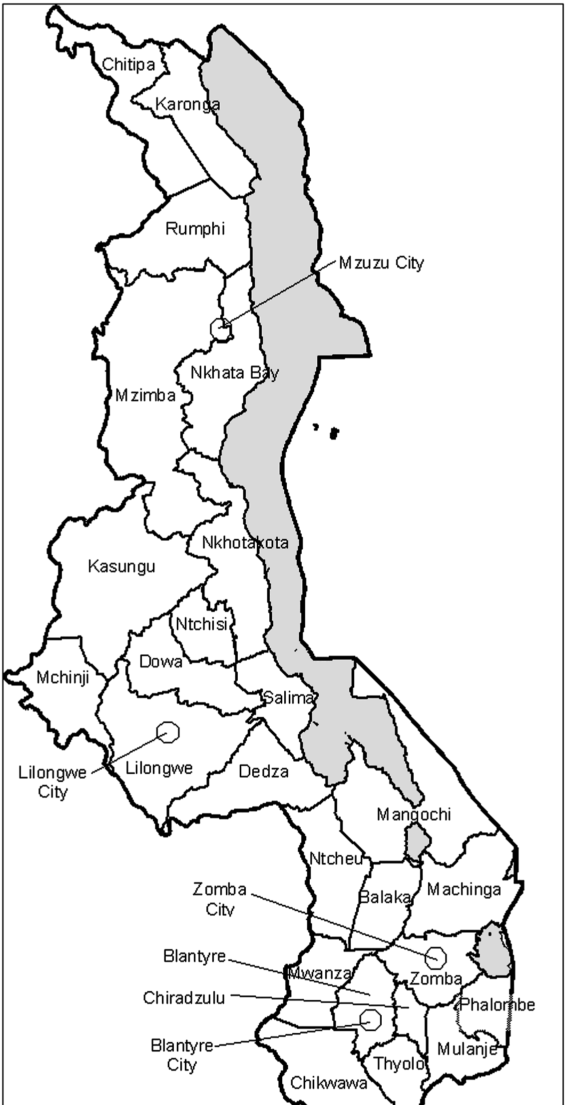
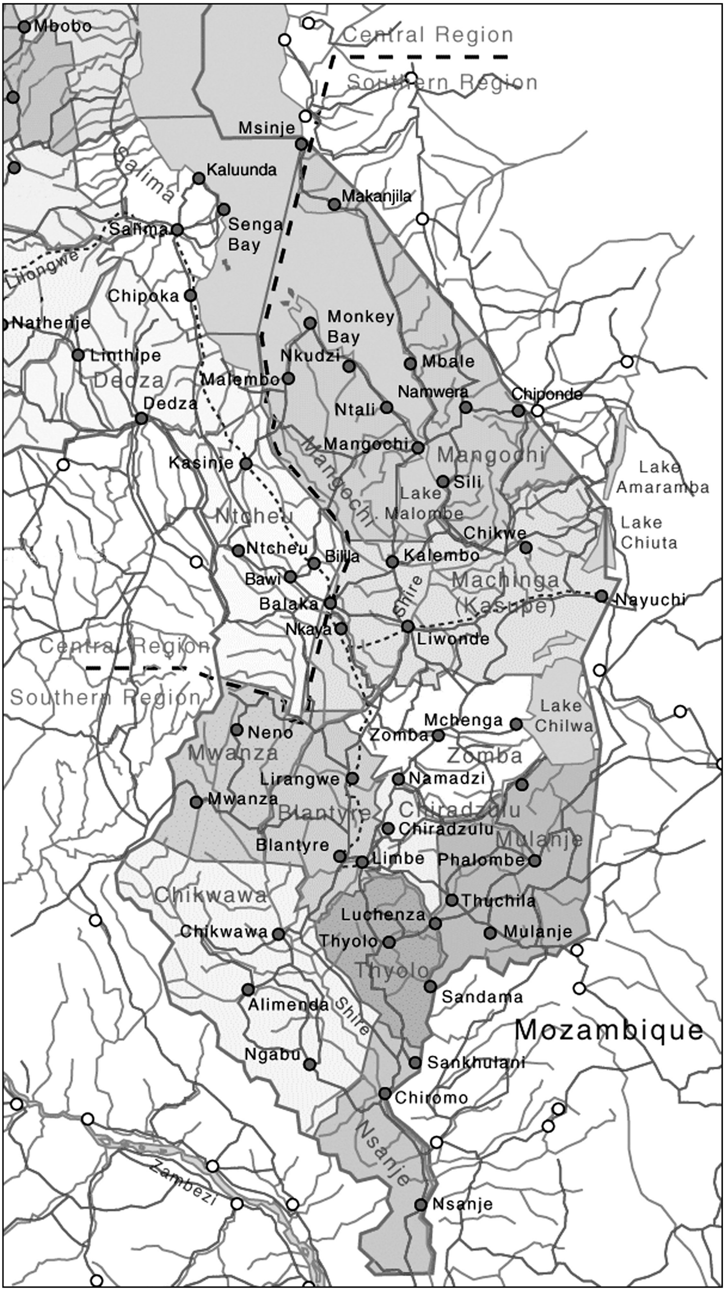
[65] Here, Mitch Loeb states that "Generally speaking this indicates that individuals with mental/emotional disabilities experience significantly greater difficulty in performing day to day activities without assistance and are to a greater extend unable to perform daily activities in their current environment. In other words they experience more barriers to full participation in society" (Loeb 2004a: 131).

orientation, this thesis focuses on the diverse cultural factors that influence – or, essentially, define – the conceptualization of mental disorder in Southern Malaŵi. A more in-depth understanding of the cultural notions connected to issues of mental disorder is required in order to comprehend its complexities.



Map 1: District Map of Malaŵi (SAHIMS 2002)



Map 2: Map of Southern Malaŵi (White Fathers 2007)