CHAPTER XVIII

CULTURAL FACTORS IN THE INTERPRETATION OF ILLNESS

A Case Study

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IT has become increasingly recognized that an intimate knowledge of the local culture is necessary for the successful planning and administration of health programmes.

In seeking to apply knowledge of the local culture to health programmes two points require stressing. The first as emphasized by Paul (1955) is that it is not sufficient to recognize the various customs and beliefs common to a people but that the pattern or system into which such customs and beliefs fit must be elucidated. Secondly, the significance of the cultural patterning as a determinant of health behaviour of groups is largely a function of the social situation. Similar cultural processes, for example, may differ in their significance for an urban industrial in contrast to a rural agricultural family; for an isolated nuclear family living among strangers in contrast to an extended family group living among lifelong neighbours.

This case study is presented as an illustration of the insight provided by a knowledge of the cultural patterning and social situation into behaviour which would otherwise appear as a series of inexplicable unrelated acts.

Among the people of Pholela the 'M' family were known as one of the better educated, more wealthy families of the area. At the age of 13 their eldest son 'G' had demonstrated his ability as a superior student. His parents were prepared to make all necessary sacrifices to continue providing him with the best available education. Their ambition was that he should become the first Pholela child to qualify as a doctor, but shortly after entering high school 'G' became ill, and pulmonary tuberculosis was diagnosed at the Health Centre.

Such an event occurring in any family would constitute a crisis.

In a Pholela family the news was little short of catastrophic. Of all diseases tuberculosis was the most dreaded and carried the gravest prognosis in the minds of the people.

The Health Centre personnel were well aware of local beliefs concerning tuberculosis and understood some of the major reasons underlying the community's fear of the disease. The prevailing concept was that any disease associated with laboured breathing, pains in the chest, loss of weight and coughing up blood-stained sputum could be attributed to the machinations of a potent enemy. He produced the syndrome in the sufferer through a poison placed in the victim's beer or food. This poison could be introduced by the enemy personally or through the services of a familiar over which he had control. The poison was not excreted through the bowel but remained indefinitely in the stomach or liver, causing the symptoms, and the only effective remedy was the drinking of a specially prepared emetic concocted by a skilled *inyanga*, causing the poison to be vomited.

The people maintained that this syndrome was one of the oldest known to them, frequent cases having occurred long before contact with the Whites was made. All available evidence, however, indicates that tuberculosis was extremely rare, if not unknown, among these African tribes prior to contact with Europeans. In all probability the symptoms described by the people were originally those associated with pneumonia, chronic bronchitis or congestive cardiac failure. The similarity of the symptoms to those produced by advanced pulmonary tuberculosis disguised the fact that a new disease had been introduced with the coming of the Whites.

A firm conviction thus existed that patients presenting symptoms of pulmonary tuberculosis were suffering from a disease that could only be treated by a skilled *inyanga* and about which White physicians could be expected to know little. In addition, it was known that the Health Centre personnel strongly advocated hospitalization for tuberculosis, which to the majority was tantamount to a death sentence. The most unpleasant aspect of such a sentence was that death would occur in a foreign place far distant from home, relatives and the protection of the spirits of the ancestors. Should the patient refuse hospitalization further tribulations faced him. Pressure would be exerted by the Health Centre to isolate him, at a time when he most needed the presence of his kinfolk to advise and aid him in his recovery. Of even

graver significance it would become common knowledge that he was regarded by the Health Centre as an individual capable of spreading tuberculosis. Considering the beliefs surrounding the symptoms of this disease such an accusation could be interpreted to mean that the patient had control over malevolent familiars. Should the Health Centre viewpoint be accepted, therefore, the patient was in danger of being feared and ostracized by his community.

A major objective of the community health education programmes planned by the Health Centre was the modification of some of these attitudes. Over a period of years some change was discernible, but, as might be anticipated, considering the potent emotional factors involved, the rate of change was slow. Many Pholela families were still not prepared to accept a Health Centre diagnosis of tuberculosis and insistence on such a diagnosis would lead, in many instances, to a disruption of all future relationships between the family involved and the Health Centre.

The 'M' family fortunately was not typical in this respect. For a variety of reasons, including the higher than average educational level of the parents, the family identified relatively closely with the Health Centre. Despite the arguments of their kinfolk and neighbours they agreed to have 'G' hospitalized. Arrangements were made for the boy to continue his education in the tuberculosis hospital and for the first several months his clinical and scholastic progress was very satisfactory.

The next report received by the Health Centre was that 'G' was back at home seriously ill. His parents had suddenly decided to remove him from the hospital and place him under the care of an *inyanga*. Their only explanation for this action was that the boy had been complaining of headaches. 'G's' condition deteriorated rapidly and shortly thereafter he became comatose and died. Despite every effort, the Health Centre team was unable at that time to discover the reasons for the unexpected behaviour of 'G's' parents.

Two years later Mrs. 'A', a nurse-aide employed at the Health Centre, asked one of the doctors to intercede on behalf of her son, 'H', who was 16 years old and a boarder at a near-by Mission School. According to his mother, who appeared unduly agitated, he had been complaining of headaches for several weeks, but the school authorities did not believe that he was ill, and refused him permission to see the school doctor. Mrs. 'A' wanted the boy

examined at the Health Centre. Discrete enquiries revealed that 'H' was doing poorly scholastically and, in defiance of the strict discipline of the school, was leaving the premises at night and gambling and possibly drinking with some acquaintances.

Before proceeding further a routine review of the 'A' family file was undertaken. From its inception the Health Centre had devoted considerable time to determining the kinship patterns of the area and a series of maps had been prepared which showed the relationship between family groups. In reviewing the 'A' family it was noted that they were close relatives of the 'M' family, Mr. 'A' being called 'brother' by Mrs. 'M'. The significance of such a relationship being dependent more upon social than genetic processes, the fact that Mr. 'A' was not Mrs. 'M's' biological brother was less important than that he was sufficiently closely related to be regarded as a brother.

It was noted further that Mrs. 'M' had another 'brother','D', whose wife had died under what were regarded by the people as suspicious circumstances. 'D' had married about eight years before the death of the 'M's' child, 'G'. Shortly after his marriage he had deserted his wife and formed a liaison with another woman in town. Periodically, however, he would return home and precipitate a series of violent arguments with his wife, during which he would frequently assault her. Over the years his behaviour towards his wife became ever more callous and rejecting. His actions were deplored by his own family as well as hers and his infrequent visits home were marked by bitter quarrels with both families, but in spite of all the social pressure brought to bear upon him, 'D' persisted in his behaviour towards his wife.

After some five years of unhappy marriage 'D's' wife became ill and started to lose weight rapidly. Her family had her examined by both the Health Centre doctors and an *isangoma*. The Health Centre diagnosed an inoperable carcinoma of the cervix. The *isangoma* diagnosed bewitchment by an enemy who desired her death with clear implications that this enemy was her husband. The fact that she was losing weight so rapidly with no external signs to account for it was strong evidence in favour of bewitchment. The Health Centre diagnosis, being entirely outside the framework of knowledge and basic concepts of disease held by the people, was rejected. Shortly thereafter, Mrs. 'D' died, leaving her family convinced that the death was due to 'D'.

'D's' family, including Mrs. 'M', also believed in 'D's' guilt and presumably anticipated the next development. Mrs. 'D's' family swore revenge. They would have the culprits bewitched in their turn. As the family as a whole were held responsible for an individual's behaviour, this threat applied not only to 'D' himself, but to his whole family group.

The subsequent sequence of events now becomes more understandable. When 'G' developed tuberculosis all of Mrs. 'M's' relatives were convinced that this was the manifestation of the revenge of Mrs. 'D's' family. It took considerable courage on the part of Mr. and Mrs. 'M' to withstand their family's arguments and accept the Health Centre's concepts of the illness and proposed course of action. 'G's' progress in the tuberculosis hospital initially supported their confidence in the Health Centre diagnosis. This confidence unfortunately was completely undermined by the news that 'G' was complaining of persistent headaches. As far as they knew headaches were not in any way part of the symptoms of tuberculosis. Pains about the head and neck were, however, known to be the initiating symptoms of a very grave form of bewitchment. If left untreated, this bewitchment syndrome would progress to cause convulsions, coma and death. In all haste 'G' was removed from the tuberculosis hospital and placed under the care of a competent *inyanga*. His ministrations, however, proved to be too late as, although he was able to prevent the convulsions, he was unable to prevent the coma and death. This death was interpreted as clear evidence that 'G's' symptoms were in fact due to bewitchment.

Even this tragedy did not free Mrs. 'M' and her family from the fear that further manifestations of revenge might still occur. Thus, when Mrs. 'A's' son, 'H', began complaining of persistent headaches, the possibility of his being the next victim was immediately considered. The reasons for Mrs. 'A' seeking help from the Health Centre at this point are somewhat obscure. It was generally known by this time that the Health Centre doctors were familiar with the manifestations of the major bewitchment syndromes and possibly Mrs. 'A' hoped to be reassured that their son's complaints were due to causes other than bewitchment. It is also possible that Mrs. 'A' was seeking to secure the temporary release of her son from the Mission School, through the action of the Health Centre, to allow him to be examined by an *isangoma* or *inyanga*.

Whether 'H' was using his complaints to rationalize his poor scholastic progress or whether other factors were involved was never determined, as the Health Centre was not given permission to examine him. This failure resulted from the neglect by the Health Centre of yet other cultural factors, the beliefs and attitudes of the missionaries administering the school.

Following the review of the 'A' family history, the Health Centre promised Mrs. 'A' that attempts would be made to have 'H' examined by one of the doctors. The school authorities were contacted and asked to give 'H' leave for the week-end to come to the Centre for examination. The School Administrator, in charge of the Mission, was reluctant to do so, as he believed the boy was malingering, and if he were not, their school doctor was available to treat him. In an effort to persuade the missionary it was explained that it was thought the boy's mother believed her son had been bewitched, and it might be possible, following an interview with 'H', to discover further significant information. The response to this explanation was unexpected. The missionary did not accept that any of his flock still believed in witchcraft. He maintained his mission had stamped all this out over the past thirty years and that the Health Centre was in fact encouraging such pagan beliefs and undermining all the mission's work.

'H' was subsequently expelled from the School following discovery of his nightly escapades. The most recent reports indicated that he was fast becoming a well-recognized juvenile delinquent.

The cultural patterning illustrated by this case study includes the beliefs concerning the causation and spread of disease, the framework of knowledge within which this belief system fits and the appropriate expected behaviour of individuals under the culturally defined circumstances. The social situation involves the rôle of the kin group as the most important social group in this community. In addition to transmitting cultural beliefs and attitudes to its members, this is the major group which attempts to regulate behaviour, through the application of social sanctions. Failure of one member of the kin group to play his ascribed rôle according to community expectations has significant implications for all his immediate kin folk. In situations in which the kin group is unimportant as a social group, a similar set of beliefs and customs may well have led to quite different behaviour from that described in this case study.

Finally, the case has illustrated that without consideration of culture, the behaviour of representatives of Western society may appear quite as irrational and illogical as does that of the Pholiola community. The beliefs, attitudes and framework of knowledge of the subcultural group represented by the missionary needed as much study and understanding on the part of the Health Centre as did those of the "M" family.

Implicit in the study is the need for understanding on the part of health personnel of the degree to which their own behaviour is culturally determined if they would avoid cultural bias in their assessment of the behaviour of others.