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Depression as a clan illness (eByekika): an indigenous model of psychotic depression among the Baganda of Uganda

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Abstract ***Rationale:*** *Available literature and clinical observations in Uganda suggest that depression is one of the most common psychiatric disorders presented to general practitioners but rarely recognized. Depressive disorders not only differ in symptoms by sub-type and dimension, but also have significant cultural variation in clinical presentation. Cultural beliefs have been noted to influence and in turn are influenced by the core symptoms, giving the various stages of depression different conceptualizations. This article presents the results of a qualitative study exploring how people in Buganda, Uganda, conceptualised psychotic depression and how this shaped their beliefs about appropriate treatment.* ***Methods*** *The study was conducted among members of a general population belonging to the Ganda cultural group aged 18-75 years, using the following methods: in-depth interviews (N=31), focus discussion group (N=12) and case vignette techniques for psychotic depression. Respondents were asked to conceptualise the problem described and answer questions regarding its causes, effects and sources of help.* ***Findings:*** *Depression with psychotic features with mood congruent delusions was conceptualised as eByekika (Clan) illness that was caused by actions or behaviour of the living toward the dead - neglect of traditional rituals, breaking taboos, or mixing African and Western belief systems. Traditional healers were a preferred source of help and modern medicine was considered inappropriate for such condition. The family/clan was the target for therapeutic actions as opposed to individual therapies.* ***Conclusion:*** *The study results suggest several important implications for the management of depression among the Baganda. First, one needs to appreciate the importance of the lay understanding of the ultimate cause of illness of depression as this lay model of causality impacts on help seeking. This calls for a review of the way this subtype of depression is managed by mental health services based on western conceptualization of psychiatric distress. Secondly, the role of social support groups (the family or clan) in the management of this eByekika (clan) illness by traditional healers, indicates that the individual patient approach employed by 'western' psychiatrists and other mental health workers, may fall short of what the patient and carers expect from the intervention. This could have a negative impact on their attendance in follow up care, and any suggested psychotherapeutic managements.*

Key words: Psychotic depression, indigenous model, qualitative research, lay concepts, help seeking

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INTRODUCTION Within the last decade, depression has emerged as one of the world's major health / social problems (Bebbington, 1993; Desjarlais et al., 1995). This can be attributed to a spectrum of biological, psychological, socio-cultural and environmental factors associated with the etiology, exacerbation and maintenance of the depressive experience and disorder. In Uganda these socio-cultural factors have included conflict and displacement due to war as well as natural disasters, urbanization, and rapid social change (Musisi et al, 2000). As a result of the increased worldwide risk and burden of depressive disorders (Murray & Lopez, 1996), it is essential for researchers and professionals to improve their understanding of the complex cultural issues and concerns related to this problem.

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Marsella (1980) defines culture as: "Shared learned meanings and behaviors that are transmitted within social activity contexts for purposes of promoting individual and societal adjustment, growth, and development". Thus culture has both *external* (e.g. artifacts, roles, activity contexts, institutions) and *internal* (e.g. values, beliefs, attitudes, activity contexts, patterns of consciousness, personality styles, epistemology) representations. The shared meanings and behaviors are dynamic and subject to continuous change and modification in response to changing internal and external circumstances.

Culture is the lens or template used in constructing, defining, and interpreting reality. Thus people from different cultural contexts and traditions define and experience reality in very different ways including their views about mental disorders since these cannot be separated from cultural experiences. This paper will take a psycho-anthropological approach in its presentation.

In the past decades, the debate in cross-cultural psychiatric research has been between those who advocate for the universality of psychiatric symptoms irrespective of culture (etic) and those who argue that western psychiatric categories cannot be applied across cultures (emic) (Littlewood, 1990). The etic approach assumes that mental illness is similar throughout the world and that psychiatric taxonomy, instruments and models of health care are globally applicable. This triggered the debate about 'category fallacy' (Kleinman, 1988). On the other hand the emic approach evaluates phenomena from within a culture and its context, aiming to understand its significance and relationship with other intra-cultural elements. However, neither of these approaches provide satisfactory results when taken independently (Littlewood, 1990; Patel et al., 1995b). Today it is increasingly accepted that the integration of these approaches is essential. The current study was an attempt to integrate these approaches by giving equal value to folk beliefs and explanations about symptoms, and its categorization in western biomedical psychiatry.

Culture and depression

Culture influences the depressive experience through a number of different areas of cultural variation such as:

i. The concept of self
ii. The nature and causes of abnormality and normality; disease and health; social deviancy and conventionality
iii. Practices around, and attitudes toward, depression as an illness; and help seeking behavior
iv. Resources and support systems; including institutional supports, social networks, as well as religious beliefs and practices.

A major cultural influence of depressive experience is the concept of personhood or self held by a particular cultural tradition. It has been argued that non-western cultures tend toward non-individuated structures of self - socio-centric, collectivistic, etc (Marsella, 1980; Marsella et al., 1985). Various studies allude to the socio-centric concept of self, and its relationship to mental disorders (Kleinman & Good, 1985; Koenig, 1997; Shweder, 1991). Thus, when the depressive experience is considered within a historical and cultural framework, the potential for cultural variations in meaning and consequence become more apparent.

In western societies and among mental health professionals trained along western models, there is an assumption that the problems reside in the individual's brain or mind, and this forms the focus of treatment and prevention (Marsella, 1998). This assumption stands in direct contradiction to the current views about culture and mental health. Current opinion emphasizes the importance of the socio-cultural context of psychological problems in understanding the etiology and expression of psychopathology, and hence its assessment, diagnosis and treatment. Problems such as the depressive experience and disorder are to be understood within the cultural context that socializes, interprets, and responds to them.

Cross-cultural studies of depression from the 1980s, and before, drew the following conclusions (Marsella, 1980; Marsella et al., 1985):

i. There is no universal conceptualization of depressive disorders;
ii. The experience, meaning, and expression of depressive experience vary as a function of culture.
iii. Standard personality correlates of depression in Western societies (e.g., low self-esteem) may not be universal across all cultures;

More recent studies have sustained these earlier conclusions (Bebbington, 1993; Jenkins et al., 1990; Manson, 1995). It is now clear that cultural variations exist in all of the following areas of depression: meaning, perceived causes, patterns of onset, epidemiology, symptom expression, course and outcome. These variations have important implications for understanding clinical activities including conceptualization, assessment, and therapy (Aidoo & Harpham, 2001; Baingana, 1994; Patel, 1995).

Buganda's Indigenous Religion and Beliefs

The Baganda live in the south-central part of Uganda. They call their nation 'Buganda'. The Baganda, like many other cultural groups in Africa, believe in a spirit world beyond the one they can see. This belief features strongly in their lives in matters of health, illness, and death both at the personal level as well as in matters of community. The occupants of the spirit world are believed to be on three levels - *Katonda* (the supreme creator or God), *Lubaale* (godly spirits) and the *Mizimu* (ancestral ghosts) (Kyewalyanga, 1976)

The *Lubaale* (godly spirits), of whom there are more than two-dozen, are of major significance to the community and the day-to-day life of the people. Their spirits, after death, are said to intercede favorably in community affairs when asked. They are thus more like guardians of the living but could cause illness when offended (Nzita & Mbaga-Niwampa, 1998)

Of more immediate importance to the ordinary folk are the innumerable lesser spirits. These are mostly of the departed ancestors (*Mizimu*), but also include spirits that live in mountains, hilltops, rivers and forests. These are thought to be mostly benevolent but some are known to be viciously harmful if not kept happy. They can sometimes take on an visible form and be called *misambwa*. Rituals aimed at ensuring the goodwill of all these various spirits are part of everyday Baganda life. Every household contains a shrine to the family's ancestors, usually a small basket to which small offerings of money and coffee beans (*Bigali*) are made regularly. The Baganda believe that after death one goes into the spirit world of the dead called *Magombe,* and lives happily alongside the ancestral spirits.

Rationale

In Africa in general, and Uganda in particular, no formal studies have been done to establish how meaning and perceived causes of depressive symptoms could relate to psychotic depression as defined by the DSM-IV. Such information about the lay meaning and beliefs about psychotic depression would help health care providers to utilize effective strategies in the treatment of depression and in developing culture-sensitive intervention strategies.

The general objective of this study was to explore the Baganda's conceptualization of psychotic depression in terms of illness identity, causes and treatment. The specific objectives were:

i. To identify local concepts used in describing psychotic depression;
ii. To describe lay beliefs about causes and treatment of psychotic depression.

METHOD

Design. A descriptive qualitative study design, based on the Explanatory Model Framework (Kleinman, 1980) was used. Qualitative methods using focus group discussions and individual

interviews were employed in order to gain a richer and more complete description of how depressive symptomatology was conceptualized and expressed from the emic viewpoint, using hypothetical case vignettes to stimulate discussion.

This method allowed the researchers to gain access to the communication that people use in their day to day interactions when talking about issues related to health and illness; and it allowed culturally sensitive interpretation of data (Ekblad & Baarnhielm, 2002; Greenhalgh, 2001).

Study site and setting. The study sites were Rubaga division in Kampala district and Kimenyede and Buyikwe sub-counties in Mukono district. All these are located in southern Uganda or Buganda, the land of the Baganda peoples. Baganda people occupy the largest part of south-central Uganda covering twelve administrative districts in south-central Uganda.

Sample. Purposive sampling was used in order to obtain the broadest range of information and perspectives. Three criteria guided this sampling method: age, gender, and ethno cultural background. We were interested in how various age groups conceptualized depressive symptoms. This was intended to capture any possible trans-generational differences. We focused on one cultural group, the Baganda, in order to avoid diluting the responses due to cultural diversity. Gender was another aspect that had indicated differences in conceptualization of illness. The focus groups were therefore stratified by age and gender. Five different categories of individuals were included in individual interviews. These were individuals who would be regarded as opinion leaders in the community. They included local leaders at village level, elders in the community, traditional healers, faith healers and community health workers.

Procedure. The Research Ethics Committee of Makerere University (Uganda) and Karolinska Intitutet (Sweden) approved the study. A trained moderator who was familiar with the culture and a bilingual speaker (Luganda and English) led each group. The first author, EO attended and took notes for all the focus group discussions. The discussion started with an introduction in which the moderator explained the purpose of the research. A case vignette containing a diagnostically unlabelled psychiatric case history of psychotic depression was read to the participants and they were asked to label the problem, identify what they thought was the cause and appropriate treatment for the symptoms. Psychotic depression was the diagnostic category chosen for study because of a number of reasons. Firstly, depression is a very common illness in Africa, and that includes Uganda. However, it is often under-diagnosed and remains untreated. Secondly, it is usually the severe categories of depression such as psychotic depression and depressive stupor, and suicidal attempts that people will actively seek help for; as these cause disruption in the social milieu (Okello & Neema, In Press). Focus group discussions were all arranged in a free and convenient environment. The moderator's role was to encourage comments from members and to guide the discussion to the central theme of identifying explanatory models of depression with psychotic features as a composite syndrome but not its component signs and symptoms. Individual interviews were conducted in the participants' homes. The interviewer used semi-structured interviews which allowed him to follow important leads that were brought up by the participants. All the sessions were audio taped and transcribed verbatim. The case vignette used in this part of the study is described below:

> *Ms/Mr. Nansubuga/Nsubuga is a 19/35/55 year-old woman/man. For the past six weeks she/he has been complaining of lack of interest in any pleasurable activity. She/he is withdrawn to her/himself. S/he is not sleeping and not eating. S/he has lost a lot of weight. S/he does not look after him/herself, does not groom clean him/herself. Sometimes s/he urinates or defecates on him/herself. She claims that the ancestors are unhappy with her/him and they are calling her to die, telling her/him that she/he is worthless and useless. They blame him/her for past bad acts/sins. That she/he should disappear/kill her/himself to join them in death. Sometimes she/he sees these dead ancestors or their skeletons or dreams of the dead bodies. Sometimes she/he talks to her/himself asking for forgiveness and sometimes she/he just stares.*

This case vignette was based on the DSM IV criteria for major depressive episode with psychotic features (American Psychiatric Association, 1994). For the purpose of content validity, it was presented to a number of senior psychiatrists who concurred with the diagnosis. The names of the individuals used in the vignettes were chosen from a range of local Baganda names of both sexes to situate the symptoms in an appropriate context.

Analysis. We used the focus groups and individual interview methods, which utilized semi-structured interview techniques to produce transcripts for the group discussion (Morgan, 1988). During analysis meaningful units or segments were organised into categories or codes in order to construct and interpret common themes or patterns (Crabtree & Miller, 1992). Sample focus group transcripts were checked for accuracy and verified against the original by the first author (EO), prior to formatting and entering into the qualitative software analysis program, NVIVO (QSR, 1999). All the data was entered, retrieved and analyzed using the software. Independent meaningful units or segments of text were identified, labeled and organized. After the initial coding was completed, the data were reviewed, reinterpreted and reorganized into categories. The iterative process was used to search for systematic relationships, common patterns and themes. The two authors (EO and SM) continually discussed emerging themes and interpretations.

RESULTS The results are presented in four parts; first, a demographic description of the study participants; second, the participants' ideas about illness identity and causation; third, their ideas about appropriate sources of help (help seeking) for the individual with the problem as presented in the case vignette. Finally the justification for, and limitations of the methods, findings and their implications are discussed.

I. Socio-demographic characteristics of the participants

Twelve focus group discussions and 36 individual interviews were conducted over a period of twelve months in the two districts of Kampala and Mukono. A total of 83 individuals participated in twelve focus group discussions and each focus group comprised of 5 to 9 participants.

The socio-demographic characteristics of the focus group participants are described in table 1

Table 1: Socio-demographic characteristics of the Focus Group participants

Type of group and total Number of groups	Number of participants by gender	Age		
		Range	Mean	SD
Youths (3FGDs for men, 3 for women)	*Men (n=21)*	*18-24 years*	*20*	*1.6*
	Women (n=19)			
Adults (3FGDs for men, 3 for women)	*Men (n=20)*	*35-50 years*	*42*	*5.12*
	Women (n=23)			

Individual interviews were conducted with (i) Faith healers -these were people who provided part of the lay mental health services in the community. (ii) Community elders, both men and women, who were respected in their community and regarded as having a good knowledge of their culture and who were the source of wisdom and advice. (iii) Community health workers - lay people who had been given basic training to provide basic health care. (iv) Traditional healers - people who deal with around 90% of the mental health care needs of the community in Uganda, and in other parts of Africa (Baingana, 1994; Good & Kimani, 1980; Patel, 1995), and lastly (v) the local leaders i.e. the local chiefs.

The socio-demographic characteristics of the interview participants are presented in table 2.

Table 2: Socio-demographic characteristics of the in-depth interview participants

Type of respondents	Total number by gender	Age		
		Range	Mean	SD
Faith healers	*Men (n=6)*	*35-48 years*	*42*	*5.51*
	No women			
Traditional healers	*Men (n=7)*	*40-65 years*	*44.6*	*6.46*
	Women (n=5)	*37-55 years*		
Community elders	*Men (n=4)*	*55-73 years*	*66.4*	*8.16*
	Women (n=3)	*55-75 years*		
Community health workers	*Men (n=1)*	*28 years*	*37.6*	*8.56*
	Women (n=4)	*32-48 years*		
Local Leaders	*Men (n=6)*	*35-68 years*	*54.7*	*11.76*
	No women			

IIa. Naming/Labeling the Illness

After the vignette was read to the participants in Luganda the local language, the discussion started with the question "What do you call this condition?"

The results of the descriptive analysis of the illness indicated no difference between the labels given in the focus group discussions, and the ones presented by individuals in the in-depth interviews. Various labels such as family problems, *Lubaale* (ancestral gods), *eByekika* (clan problems), *empewo* (wind-spirits), *mizimu* (ancestral spirits) were given by the participants.

eByekika (clan) family problems and *Lubaale* (ancestral gods) were mentioned as labels more often than other labels. However, the largest response label, which was used by most respondents, was the Luganda word "e*Byekika*" that literally translates as "clan issues/problems". When participants were asked to elaborate on the difference between the various concepts, there was an indication that all these labels could be used interchangeably to indicate something that needed cultural redress in the relationship between the living and the dead ancestors. The following quotes were typical responses to the question "What would you call this condition?"

> *"Clan issues- you can't take that one to the hospital. If he sees those things, it is the Lubaale illness"* (Elderly man, 5)

> *"According to her symptoms, that girl must be having clan problems. You see some people do not believe that clan problems can cause illness, but I do"* (FGD3 female youth*)*

> *"According to the Baganda religion a person gets these symptoms when clan spirits make demands" (*FGD3 male youth)

Many participants believed that Mr/Ms Nsubuga's/Nansubuga's head/brain will ultimately get "spoilt" and he/she could run mad if the family/clan members did not fulfill the demands of the ancestral gods (*Lubaale*). This was discussed in relation to what is involved in the prescribed traditional ritual to rectify the problem.

Although the majority of the participants related the symptoms to clan problems, few participants indicated that giving a label to the symptoms was difficult. This often suggested that the identity of the condition is better understood when it is accompanied by a full description of the context within which the symptoms had occurred.

IIb. Causation

It is documented elsewhere that African cultures define two types of causes. First, the proximate cause. This accounts for how a disease is contracted. Second, the ultimate cause. This accounts for why a disease is contracted by that particular person (Gluckman, 1956; Liddell et al., 2005)

In the description of cause, participants in the current study combined explanations relating to both the proximate (how) and the ultimate (why) causes. However, more emphasis was placed on the ultimate (why) cause, which seemed more significant in choosing the source of help. These 'causes' can be grouped under the following categories:

(i) Neglect of traditional rituals; (ii) breaking taboos; (iii) mixing (foreign and traditional) belief systems; (iv) abandoning traditional beliefs/religion; (v) 'lost blood' e.g. placing a child in the wrong clan, or burying a family member in an alien land, hence being haunted by spirits wanting to return.

i) Neglect of or abandoning traditional rituals

People in Buganda (the Baganda), like people in many other parts of Africa believe that the survival of their ancestors in the spirit world depends upon the living according them regular attention (Liddell et al., 2005; Ngubane, 1977). This attention is affected through ritual sacrifices, the observance of taboos and through high standards of social behavior. Where these requirements are not met, the living are sent an illness as a warning or as punishment by the ancestral spirits. These ancestors can decide to kill the individual if the warning is not heeded. The following is an extract from a statement by one elderly Muganda man:

> *"When our dead great grandparents (*Bajjajja*) want a family member to work on some thing that has gone wrong, they interfere with his head. The family member then works on the problem, and after correcting the problem becomes a very calm person, who is sane again. So, when the* Lubaale *are working on him, his brain is affected. You see!"* (Elderly man 3).

This traditional African belief system is also referred to as ancestor worship. Unlike the Christian and western ways of thinking, the premise for ancestor worship is based on an understanding that the life course is cyclical and not linear. Those who are dead, though not physically seen, are believed to be alive in the world of the dead (*Magombe*). They are also believed to have supernatural powers over the living. Such powers include the ability to bless or to curse; to give life or to take life; to give health and to cause illness; to give fertility or to cause barrenness, to give rain or to cause draught etc.

Both negligence and inconsistent performance of the required rituals could yield similar consequences. The following extract from a focus group discussion illustrates this point:

> *"There are people who initiate ancestral worship rituals and then fail to continue with them. They may, for example build a shrine, and the ancestors tell them that one of them will be the head, and has to always be there in the shrine to attend to them. The person then decides not to go, and just walks away. The ancestors would then cause that individual to fail in whatever he does. For example, I know a man whose family built a shrine at their home, and he was chosen to be the head. He later decided to leave the village and to live in a town. He would however, from time to time, go back to the village to visit his family. On reaching the village, he would call his siblings and relatives for meetings in the shrine at night. He later decided to abandon that practice, and that is when he started getting spoilt in the head, gradually. But whenever he could go home and*

do those rituals, he would get better. Those ancestors are very tricky and can do anything to you if you disobey them" (FGD3 male adults).

Although such statements were made by one individual group member, there was a very high degree of consensus among the members as indicated by verbal and non-verbal responses.

Sometimes the *Lubaale* would choose to affect one member of the family, and place their demands on the clan or the family. In this case the illness was seen to have a social function. The individual who was chosen by the *Lubaale* was not always at fault. In such cases a collective effort by family/clan was needed to search for the cure to redress the situation.

ii) Lost kin

Lost blood (lost kin) was another reason that was believed to cause the *Lubaale* spirits to appear. Loss of kin could arise in two instances.

(a) Sometimes a child was born and for some (social) reason the mother did not disclose the real biological father of the child. This child would then be given the wrong name and assigned to the wrong clan. This was regarded as 'lost blood' and the ancestors of the rightful clan could attack the child in an attempt to recover the lost blood. The following quote illustrates this point:

"At times when a child is given to a clan where he (or she) doesn't belong, the spirits of the clan to which the child belongs would be struggling to get him back home. It could be that the child's dead father or aunt is using their power to see that they get this lost child back. The dead father may first come to the mother through dreams asking for the child peacefully. When this fails, he may then resort to using other means to get him back, by causing the eByekika *illness"* (FGD2 female adults)

(b) The Baganda have a strong belief in the decent burial of their dead kin. Such belief is extended to include members of the clan who have died in alien lands and are buried there. The ancestors would make one of the living ill until the dead kin is returned to the ancestral burial site called *obutaka/ekijja*. One elderly man had this to say:

*"We were once in a shrine, when something began disturbing a child. As a result of this disturbance he had been forced out of school. On bringing the boy to the shrine, in front of the spirits (*Lubaale*), a spirit spoke through the child and said, «It is I…they buried me at the ends of Kasawo, but I want you to come for me». The people asked, «But we don't know that place. Can you get on the child's head as we come for you, and direct us?» The spirit then went on the child's head and directed us, but disappeared afterward. So you can see that you can get help if you ask. The* Lubaale *comes and then disappears, but once you have been informed, you can work on it"* (Elderly man 1)

In this instance the symptoms of an individual are seen as a reflection of a social problem, and not as the individual's problem. Hence the western approach (psychology/psychiatry) of treating symptoms of depression as an individual problem would be insufficient in addressing problems that have a social significance, where individual suffering is interpreted as an indication of a problem in the social order.

iii) Breaking taboos

Other reasons that were mentioned that could incur the vengeance of the ancestors included taboos like killing someone, especially one's own child, building in a forbidden area, or eating foods which were unacceptable to the *Lubaale*, such as drinking alcohol or smoking, especially if one is appointed to keep the shrine. In a group, the discussion went like this:

"I have seen a similar case… the parents had died and he took over the clan as the heir, but he was disrespectful. He would drink a lot of alcohol. He was ill advised by a friend to sell the land. He sold his ancestral property, thereby annoying the dead, who caused him eByekika *illness"* (FGD2 Male Youth)

It has been noted that the idea of prevention among African societies goes far beyond offering a reason, or a cure for ill health. At the societal level, there is the belief that violating social, religious, or sexual codes of conduct would bring about disease, either by the action of others or one's ancestors. This belief is a powerful mechanism for ensuring social cohesion and stability (Evans-Pritchard, 1937). If supernatural forces dominate human experience, then believing that these forces were rational, would give a sense of order to unfortunate events, or fate. Through good behavior, patience and doing the community good, one could control these forces, and reduce the likelihood of a potential catastrophe (Jolles & Jolles, 2000; Liddell et al., 2005). Taboos were not to be broken, and if broken, could lead to illness.

All the behaviors described above seem to be related to what is referred to in the American Diagnostic and Statistical Manual DSM-IV as "mood congruent delusions" of 'legitimate punishment'. The difference, however is that the punishment is divorced from individual action and one individual takes the punishment on behalf of the clan or family especially when it comes to the omission of essential ritual. The feeling of shame is more profound than guilt, when it relates to a depressive illness in Africa.

Mood congruent delusions, which are the most common symptom in psychotic depression, fit in well with the idea of reasonable punishment for individual or group transgression against one's ancestors. Under these circumstances, suicidal ideation is tolerated, though suicidal behavior is otherwise condemned, and stigmatized behavior among the Baganda.

iv) Combining belief systems

There was a tendency for individuals in Buganda to combine religious beliefs, which was seen as one of the sources of trouble. This theme emerged in both focus groups and individual interviews. Participants firmly believed that the tendency to mix Christian or Islamic practices with traditional religious practices had a role in the etiology of clan illness. Respondents suggested that destroying shrines and burning *Lubaale* symbols as demanded by foreign religions had had serious repercussions in the lives of people who had done so especially where mental illness was concerned. Various examples were given during the discussions and interviews. Participants in this group thought that Christianity particularly of the Born Again sect that encouraged people to destroy shrines and burn *Lubaale* symbols was the main source of psychological distress. They saw a relationship between the prevalence of *eByekika* illness and the increase in the number of Born Again churches in the Buganda region. The following extract illustrates the point:

> *"It is* empewo *(Winds/Spirits/*Lubaale*) symbols that cause this illness. There is not a single person without* empewo*… the Bazungu (whites), the Indians, the Chinese have their* empewo*. After all don't they have ancestors? They won't tell you when they are going to work on their* empewo*. You may decide to abandon yours, and follow the ways of the Whiteman. They brain wash us, they tell us «Burn these…», you then cross over to their ways. That is when your head gets mixed up"* (FGD1 Male Adult*)*

This may suggest that the traditional concept of illness has been confronted with new epistemologies, notably Christianity and biomedicine. However, rather than replacing indigenous representations of illness, new epistemologies have usually been incorporated into the old (Liddell et al., 2005). Christianity may deny the role of ancestors in determining health and sickness, but it endorses similar views on the origin of misfortune.

III. Help Seeking

Both the immediate and the ultimate causes require effective treatment if the illness is to be cured. To treat the proximate (how) causes and the physical symptoms people may consult medical personnel and/or traditional healers. However, for the total cure of the illness, the ultimate (why) causes must also be dealt with. These were believed to lie within the supernatural realm and so the cure was sought from healers who were believed to have access to these realms.

The Baganda believe that only the traditional healers and diviners can give useful insights and suggest therapies for these supernatural ultimate causes.

Participants were asked to respond to the question "Where should Mr./Ms. Nsubuga/Nansubuga go for help?" All the participants, except the Born Again faith healers, thought the traditional healer was the appropriate source of help. Traditional healers were sought not only to help the family ascertain the cause for the affliction, but also to guide the family through the necessary curative rituals. The Born Again faith healers, on the other hand, felt that the *Lubaale* was what they considered "demonic" and they believed that if the patient was prayed for, the demons would leave.

Respondents in this study believed strongly that hospital medicine had no role in *eByekika* illness. They felt that taking a person with the *eByekika* illness to the hospital was a waste of time. The participants felt that the Mr/Ms. Nsubuga/Nansubuga could not expect much from the hospital. Some participants actually suggested that any relief that a patient received from the hospital was due to the fact that the *Lubaale* left him as soon as he got to the hospital which was alien to them, but that the *Lubaale* would return the to patient the moment he left the hospital premises. The following were typical responses to the above question:

> *"The people from the clan can help you with that. You shouldn't take him/her to the hospital because there is no doctor who can say «Here, let me give you this medicine to send away those spirits». Instead you should take him to a traditional healer.* Lubaale *is untouched by hospital injections"* (Elderly woman 2, aged 65years).

> *"That sounds like* Lubaale. *That person should be taken to a traditional healer who will perform rituals, call the* Lubaale, *and do the needful. Western medicine will not drive away the* Lubaale, *which is why so many people die in hospital. The cause of the problem may be 'traditional' (spiritual), but instead of turning to healers who would handle the case effectively, people turn to medical doctors. We have to accept the fact that these things spiritual and the healers have the power to deal with it."* (Local leader3)

There was a clear agreement on the cause of the illness by people who believed in the Baganda religion as well as those who practiced Christianity. They all felt that *Lubaale*, "*empewo*", or ancestral spirits caused the illness. However, there was a divergence in help seeking. The Born Again Christians believed that the church would be the most appropriate place of help for people with 'clan illness' through prayer to drive away the demons, and the followers of the Baganda religion believed in going to traditional healers to guide them in the *okusamira* rituals. This ensured clan/family support for the patients. The traditional healer therefore played the role of a diviner rather than a healer. There was an intermediate group, which included people who were baptized, but at the same time practiced both belief systems (African duality).

DISCUSSION This paper describes the findings of a qualitative study aimed at understanding how depression with psychotic features, a subtype of depression, is culturally conceptualized amongst the Baganda and how such conceptualization influenced help seeking.

In terms of socio-demographic characteristics, the data was drawn from a cross sectional sample, which varied by gender, age, education and religious affiliations. Younger participants were on average more educated than the rest of the sample, while men were on average more educated than women in the older age groups. Given such a demographically varied sample, one would expect variations in terms of perceptions about causes and treatment of psychotic depression. However, the findings presented above seem to indicate a high degree of consensus across the socio-demographic variables. The slight difference is indicated on the sources of help where Born Again Christians believed prayer was the appropriate source of help for people with *eByekika*

illness also called depression with psychotic features. However, this difference was obscured by the fact that all the respondents in the study agreed that the ultimate cause of the illness would have to be the target in any treatment program. Modern medicine was seen to fall short of the ability to deal with this ultimate cause of clan illness. This would imply that mental health service providers will have to incorporate culturally sensitive tools and methods in the assessment and treatment of depression with psychotic features.

The totality of symptoms that DSM-IV categorizes as psychotic depression with mood congruent delusions are recognized and labeled as a clan illness translated as *eByekika* illness by the Baganda. The condition is conceptualized as the outcome of wrong doing (omissions or commissions) by the living against their clan/family dead. These took the form of the failure or inconsistency in performing essential rituals, incorporating alien beliefs into the Baganda belief systems or breaking taboos. The involvement of traditional healers and the participation of other members of the clan into the healing process were central to correcting what was perceived as a collective (clan/family) wrong. Western medicine was seen as inappropriate for this condition especially as it emphasized individual brain problems and treatments. Thus although the symptoms of depression were seen as constituting an illness, its conceptualization, name, causation and treatment were not deemed to fit into conventional western biomedical psychiatry. The illness was believed to have its origins in a problematic relationship between the living and the dead, which had to be corrected. The illness belonged to what the Baganda refer to as a *Kiganda* illness (an illness that has its origin in the collective group customs, and the relationships of the Baganda people to their clans). The help seeking behavior was therefore social and collective and was intended to address both the proximate and the ultimate causes of the illness. The closest approximation of this in western psychiatry is group therapy, the group being composed of the clan members.

These results suggest that the illness representation is not only part of the culture in terms of shaping experience but also mirrors and reflects cultural realities. Illness-related knowledge is a complex cultural domain that entails risk and causal factors, complications and treatment strategies. Causal explanations provide meaning to human suffering and have an important role in shaping illness behavior. Causes are typically identified by retrospectively examining past events that might relate to the symptoms. It has been suggested that memory is affected by cultural categories and that when formulating causal explanations, an individual draws on cultural knowledge or a pool of culturally shared information that is mediated through social interaction (Chrisman & Kleinman, 1983).

The study indicated clear differences between lay and biomedical explanations of psychotic depression. Such differences between the lay and biomedical explanations have been reported by a number of studies that have addressed various subtypes of depression in various cultural settings (Patel et al., 1995a; Weiss et al., 1986; Ying, 1990). These differences impact on help seeking patterns and behavior.

The findings of the study point to a number of issues that deserve comment. Firstly, the use of vignettes based on DSM-IV definition of psychotic depression which served as the stimulus for discussion between members of the general population. These DSM-IV diagnostic criteria, however, were given different interpretations by the lay Baganda and psychiatrists.

In terms of methods of investigation, the use of both *emic* and *etic* approaches to understand the clinical phenomena and the incorporation of non-clinical samples with the use of case vignettes were seen as the methodological strengths of the study.

Investigators have used case-vignettes as data collection tools since the 1950s as a method to encourage discussion of topics that respondents might find difficult (Flaskerud, 1979; Marwaha & Livingston, 2002). They have been defined as simulation of real events and they have been used in the exploration of beliefs and practices about mental illness (Marwaha & Livingston, 2002; Patel et al., 1995b). The advantage of case vignettes over asking open-ended questions without specific

scenarios is that they encourage the participants to think about concrete situations that could apply to them or people that they know. This was felt to be particularly pertinent to the aim of this study in terms of exploring ideas about depression with psychotic features and eliciting what were considered practical ideas and solutions.

Lastly, it should be pointed out that *eByekika* illness for the Baganda connotes illnesses affecting member(s) of a clan and it can thus represent more than one illness. It may include such other severe mental illnesses as bipolar disorder or some forms of severe dissociation (Van Duijl, Cardena & De Jong, 2005). Such explanatory models of mental illness are not uncommon in Bantu cultures of which the Baganda are but one.

LIMITATIONS AND IMPLICATIONS From these findings one cannot draw definitive empirical generalizations, where data may be assumed to represent a wider population in a probabilistic sense (Guba & Lincoln, 1994). However, a theoretical generalization is possible, since the data from the current study provides theoretical insights, which poses a sufficient degree of generalizability or universality to allow their projection to other contexts, or situations, which are comparable to the context in the study.

This study is also limited to a single cultural group, the Baganda. Further research may need to include other cultural groups to enhance comparison across large cultural groups within Africa.

The study used hypothetical case vignette and not real live patients of DSM-IV depression with psychotic features. One could argue that this could compromise the usefulness of the findings. However, it is difficult to access a one hundred percent culturally representative clinical sample. The question therefore is how well cultural explanatory models of non-patient samples correlate with that of actual (in-vivo) clinical samples. This broad question can only be answered by comparing the explanatory models of non-patient samples with explanatory models of real patient samples. However, comparing the two samples was not the objective of this paper.

Nevertheless, the study results suggest several important implications for the management of depression in this cultural group. Firstly, to appreciate the importance of the lay understanding of the ultimate cause of illness, as this lay model of causality impacts on help seeking. It is very important to review the way this subtype of depression is managed in the western type of psychiatry when the patients reach mental health services in hospitals. Secondly, the emphasis on the role of social support group (the family or clan) in the management of this eByekika illness (Depression). This implied that the individual patient approach employed by western trained psychiatrists and other cadres of mental health workers may fall short of what the patient and significant others expect from the intervention and hence negatively impact on their follow up attendance and suggested psychotherapeutic managements. The recent report of successful "Interactive Group Psychotherapy" techniques in the treatment of depression in Uganda (Bolton et al., 2004) may therefore be in line with cultural approach of treatment of depression through family/clan ancestral worship (*kusamira*).

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