CLINICAL MANIFESTATIONS OF MENTAL DISORDERS AMONG SESOTHO SPEAKERS IN MANGAUNG

N.L. MOSOTHO

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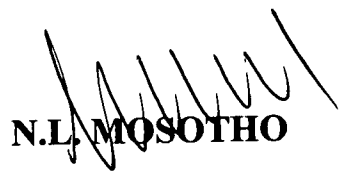

N.L. MOSOTHO

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FOR THEIR LOVE AND MOTIVATION

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READER'S ORIENTATION

In accordance with the regulations of the University of the Free State, this thesis is presented in article format. Consequently, each article should be viewed as an independent yet related entity. A list of contents, tables and figures precedes each article. The questionnaire used to evaluate the participants and informed consent forms used are presented in the appendices at the end of the thesis.

By virtue of the fact that different mental disorders were investigated, the instrument and methodology employed with the first four clinical groups were very similar. This may translate into a perception of overlap and repetition between articles. It is therefore suggested that the reader view each article independently although they deal with interconnected mental disorders of the same cultural group.

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ARTICLE I

Depression among Sesotho Speakers in Mangaung

Abstract

Depression will be the most common mental disorder by 2020 and it will be the second leading cause of disability after cardiac diseases. Moreover, depression is expected to be a major public health burden in the future. This study evaluates the influences of culture on the symptoms of depression among Sesotho speakers. A sample of 100 participants diagnosed with depression was evaluated using the Psychiatric Interview Questionnaire. It was found that depression among Sesotho speakers is expressed in three areas: somatic symptoms, perceptual disturbances and disturbances of the thought processes.

INTRODUCTON

The World Health Organisation (WHO) predicts that depression will be the most common illness in the world by the year 2020 and that it is expected to be the second leading cause of disability after heart diseases (Holden, 2000). Sartorius (2002) reports that depression meets the criteria to be considered a major public health burden. This is not unexpected as depression was viewed for years as the "common cold of mental illness". Regardless of this alarming situation, there is a paucity of research in this field in developing countries. A major reason for this has been the misconception that such countries are relatively free from psychiatric problems such as depression which are

encountered in industrialised nations. This notion arose from the belief that disorders such as depression were created by excessive stress imposed by technological developments (Hollifield, Katon, Spain & Pule, 1990).

Attempts to rectify the situation were hindered by the fact that in many, if not most cases, the research was conducted by "foreigners" who could not speak the local languages and had superficial knowledge of the culture they were investigating. It therefore goes without saying that the data derived from such research more often than not had serious limitations.

In order to contribute to the knowledge base of depression in developing nations, especially in Africa, it was decided to conduct a study among Sesotho speakers in the Free State Province of South Africa. In an attempt to avoid a major pitfall of cross-cultural research, namely the language factor, a researcher who is a member of Sesotho culture and therefore Sesotho-speaking conducted the study. The reason for this is that several authors (Shiraev & Levy, 2001) have pointed out that the differences in manifestation or symptomatology might be an important factor in the erroneous diagnosis of depression.

CULTURE AND DEPRESSION

Although links between culture and depression do exist, they are multifaceted and complex (Engelsman, 1982). They are therefore difficult to assess and

interpret. "Culture can have an effect on the development and course of depression as well as on response to treatment. Culture can minimise the development of depressive illness and influence the choice and development of depressive phenomena" (p251). The above-mentioned controversy on the precise impact culture has on depression is emphasised by authors such as Kaiser, Katz and Shaw (1998). They stress that an understanding of depression and cultural competence is crucial for all clinicians involved in the mental health field.

EPIDEMIOLOGY

According to the DSM-IV-TR (APA, 2000), the life risk of depression ranges from 10,0% to 25,0% for women and from 5,0% to 12,0% for men. The point prevalence varies from 5,0% to 9,0% for women and from 2,0% to 5,0% for men. American psychiatrists diagnosed 16,6% of consecutive admissions as depressed, while the rate for a comparable sample in Britain was 46,2% (A1-Issa, 1995). The lifetime prevalence in Germany is 9,0%, in Canada 8,6%, in Taiwan 16,8%, in Puerto Rico 4,6% and South Korea 3,5% (Rossouw, 1998).

As far as the situation in South Africa is concerned, Laubscher (1937) reported that depression was not common among African people. However, later research has rejected this claim. For example, Uys, Dlamini and Mabandla (1995) found that 13,0% of psychiatric outpatients in Umtata (Eastern Cape)

suffered from depression. Research conducted in the general practices in Free State Province of South Africa, Lans, Seane, Gagiano and Joubert (1994) and Jordaan, van Rensburg, Gagiano and Joubert (1994) found a point prevalence of between 6,0% and 19,0% in the population of black patients. Moreover, Kale (1995) found a point prevalence of 34,0% according to the available data.

SYMPTOMATOLOGY

The symptoms of depression in the Western world are well known. The American Psychiatric Association (APA) (2000) put forward, among others, the following: depressed mood, loss of interest or pleasure in nearly all activities, changes in appetite or weight, change in sleeping patterns, and psychomotor activity, cognitive disturbances characterised by difficulty thinking and concentrating, or making decisions, decreased energy, feelings of worthlessness or guilt, and recurrent thoughts of death or suicidal ideation, plans or attempts. The World Health Organisation (WHO) (1992) lists additional symptoms such as reduced self-esteem and self-confidence, bleak and pessimistic views of the future and marked loss of libido. Kaplan and Sadock (1995) include daily (or sustained) fatigue or loss of energy as one of the key common symptoms in the Western world.

However, it seems that although there are certain core symptoms present across the different cultures, it is equally true that depressive symptomatology often

has unique manifestations in some cultures (Thakker & Ward, 1998). This uniqueness usually finds expression in two ways. Firstly, some symptoms, which are quite common in certain cultures, may be totally absent in others. Secondly, although a specific symptom may appear in several cultures, the intensity of the symptom may vary from culture to culture. In this regard Young (1997, p38) rightly points out that "the lack of consistency in the presentation of depression across cultures tends to decrease the sensitivity of any method used to diagnose this disorder. For this reason, it is essential for the clinician working with cross-cultural populations to become familiar with these variations, in order to accurately assess the patient in whom depression is suspected. The clinician will also find it useful to have a framework for understanding the reason that depression presents as it does across cultures". Most authors agree that, although depression is common in non-Western countries, it manifests differently from Western depression (A1-Issa, 1995; Thakker & Ward, 1998). Non-Western patients suffering from depression complain much less of depressed mood and guilt feelings. Instead, they tend to project (blame) and complain of somatic symptoms more often, but they rarely manifest suicidal behaviour.

In a widely quoted review article, Singer (1975) indicated that depression is common in Nigeria, characterised predominantly by somatic presentation. According to Singer, a similar clinical picture of somatic manifestation exists in Senegal, although the Senegalese also show more paranoid and manic

symptoms. In Ghana there is a high frequency of self-accusation and they tend to blame witchcraft for their conditions. In Sudan, feelings of shame seem to supersede feelings of guilt. Swartz (1998) explains that research has shown that depressives in West Africa less often report feelings of guilt than is the case in Britain. However, hallucinations may be present among depressive patients in West Africa.

In a study of mental illness in Algeria, which has a strong Arab culture, A1-Issa (1990) found that masked and delusional depression is the most frequent types of depression seen by clinicians. As in other non-Western countries, the manifestation of depressive mood in contrast to somatic symptoms is negligible. This could be ascribed to the fact that in most Arab countries there is reluctance among people to express depressive mood as such expression is regarded as shameful. In the case of a delusional depression, delusions of persecution, bewitchment, possession, and poisoning, as well as aggressive behaviours are common.

The World Health Organisation (WHO) under the supervision of Sartorius, Jablensky, Gulbinat, and Ernberg (1980), launched a study on depression in Canada, Iran, Japan, and Switzerland. They found that depression in different social and cultural settings has "core symptoms" such as sadness, joylessness, anxiety and tension, lack of energy, loss of interest, impaired concentration, and ideas of insufficiency, inadequacy, and worthlessness. Moreover, variations

encountered between the groups of patients in the different centres were relatively minor, varying in severity rather than in kind.

One of the most recent studies in the field of cross-cultural psychopathology is research in which the symptomatology of depression was compared between Chinese psychiatric outpatients and non-patients (Yen, Robins & Lin, 2000). The researchers also investigated cultural groups: Chinese, Chinese American, and Caucasian American students. They found that Chinese psychiatric outpatients, in contrast to non-patients, tend to complain more of somatic symptoms. Unexpectedly Chinese students manifested significantly fewer somatic symptoms than American students. These findings rejected the original hypothesis by researchers that Chinese students would display higher rates of somatic complaints than American students would. However, Chinese students did not significantly manifest positive aspects of depression such as hopelessness, lack of pleasure and happiness.

Three studies have been conducted among black depressive patients in the Free State Province, South Africa. The findings are reflected in Table 1. Swartz (1998) also reported symptoms such as dark rings under the eyes, eating and sleeping disturbances, tearfulness, and loss of weight and fatigue among Xhosa-speaking depressive patients in the Western Cape, and although the patients seemed depressed, they usually did not complain of a dysphoric mood

The prevalence of depressive symptoms among Blacks in the Free State is given in Table 1.

Table 1: Prevalence of symptoms of major depressive disorders among black patients in the Free State

	Rossouw (1998) N=16	Gericke (1995) N=8	Jordaan et al. (1994) N=23
Depressed mood	87,5%	87.5%	87,0%
Lack of interest/pleasure	68,7%	50.0%	96,0%
Weight and eating disturbances	87,5%	50,0%	91,0%
Sleeping disorders	81,2%	-	87,0%
Psychomotor agitation or retardation	93,7%	37,5%	39,0%
Lack of energy or fatigue	87,5%	87,5%	87,0%
Feelings of guilt or worthlessness	81,2%	75,0%	39,0%
Impaired concentration/Or indecision	68,7%	37,5%	87,0%
Thoughts of death & suicide	56,2%	62,5%	64,0%

Expanded from Rossouw (1998)

The present author holds the view that although many major depressive symptoms are shared across cultures, they still remain culturally structured (cf. Kleinman & Good, 1985) and could therefore have unique manifestations in various cultures.

LANGUAGE AND DEPRESSION

Our emotions and feelings are usually shaped by the words we use and our sentence constructions (Swartz, 1998). The quality of vocabulary also plays an important role in this issue. If language variations or barriers between the clinicians and patients are not addressed, they can negatively affect the much-needed communication and limit the evaluation and management process (Tseng, 1997). This situation may lead to the need to have an interpreter who should possess special skills and experience in mental health issues. The said interpreter has to be well-trained and oriented hence translation can sometimes become very complicated, because language expressions play a role in exhibiting our emotional realities.

It is often heard that some emotions are expressed more easily in some language than in others. For example, Manson (1995) suggests that the word "depressed" does not exist in the languages of some cultures. However, this absence of the word does not preclude the existence of depressive illness. Trying to understand depression only from a Western language perspective

and assuming that depression does not exist in certain cultures because they are not verbally expressed in the same way, could make the evaluation and treatment process more difficult (Thakker & Ward, 1998).

The various ways in which we experience, express and cope with perceived distress are termed "distress idioms" (Kaiser et al. 1998). These idioms of distress ascribe to variations in presentation of symptoms across cultures. Flaskerud (2000) argues that there is a relationship among culture, ethnicity, and idioms of distress because cultural aspects shape symptoms and the mode of distress expressed by depressive patients. The World Health Organisation (WHO) acknowledges the need to develop a common mental health language that could be used globally in the field of mental health. The proposed language could be used and understood by all concerned. Such consensus must cover all the terms used in describing all mental and neurological conditions and functioning, as well as pathology in a broad sense. However, it is doubtful whether it will ever be possible to create a common international language, which will exclude misunderstandings and omissions. Researchers should nonetheless do their utmost to avoid pitfalls in this regard

METHODOLOGY

The Mangaung Township in Bloemfontein, South Africa, was selected as the geographical area for the completion of the research. The main reason for this is that researcher is a member of a mental health team providing services at different clinics and health establishments in this area. Secondly, Sesotho (the main language in Mangaung) is the mother tongue of the researcher who is also familiar with the area and the culture. Thirdly, the South African government recommends that researchers should rather focus on their immediate areas in order to meet the needs of their own communities.

For this exploratory descriptive study, the participants consisted of 100 Sesotho speakers diagnosed with depression. They were drawn from patients visiting various health establishments in the area. All patients presenting to a specific health establishment who qualified, during the time period when researcher was based at that establishment were included. The duration of collection data was almost four years (January, 2001-October, 2004). The participants were evaluated and diagnosed by a multi-professional team which generally consisted of a (registrar) psychiatrist, clinical psychologist and psychiatric nurse (in certain areas, social workers, occupational therapists and/or physiotherapists also formed part of the team). The DSM-IV-TR criteria for major depressive disorder were used as the inclusion criteria. The participants

were between 18 and 65 years of age, and both genders were represented. Written informed consent was obtained from each participant.

A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) used by the Department of Psychiatry at the University of the Free State, was used to elicit the information. The PIQ is based on *Clinician's Thesaurus: the Guide for Writing Psychological Reports* (Zuckerman, 2000) and *Outline of the Psychiatric History and Mental Status Examination* (MacKinnon & Yudofsky, 1986). This instrument provides data on preliminary identification (including biographical information), main complaints, personal description, history of present illness, psychiatric review of systems, previous mental illness, past personal history, a mental-status examination consisting of: appearance, attitude and behaviour, thought processes, perception, mood and affect, consciousness, orientation, memory, tempo, intelligence, mode of thinking, judgement and insight, both hypothalamic functioning and autonomic functioning. The PIQ is the standard assessment instrument used by all governmental mental health establishments in the Free State Province. The present researcher personally conducted the interviews with each individual patient.

Qualitative methods were used to describe the experiences of the participants regarding their symptoms, as well as a way to elucidate the quantitative data. Qualitative methods consisted of two types of data collection: the open-ended

interview and direct observation. The interview data consist of direct quotations from participants about their experiences, feelings, emotions, opinions and knowledge, while observation data refer to detailed descriptions of participants' activities, behaviours, actions, and full range of interpersonal interactions and organisational processes that are part of observable human experience (Patton, 1990). Individual interviews were transcribed, and information gathered was grouped into themes. Themes are written in the subject's own words or transcribed as closely as possible (or a close rendition of the subject's account). These themes were divided into psychological symptoms, physical (somatic) symptoms, as well as behavioural and social symptoms. Quantitatively, a descriptive statistical analysis was performed to provide indications of frequency (incidence) of identifying demographic characteristics, signs and symptoms of mental illness, and socio-cultural variables associated with depression as covered by the questionnaire.

The study was approved by the ethics committee and the council of the University of the Free State. The project was also discussed with the Head of the Department of Psychiatry, at the University of the Free State, who is also the provincial clinical head for mental health. He pledged his full support. Also, permission was obtained from the Head of Health in the Free State Province to conduct this study in the various health establishments. The researcher conducted a pilot study on 40 patients to investigate the practical feasibility of

the research. Based on the pilot study findings; minor adjustments on coding of the questionnaire had to be made

RESULTS AND DISCUSSION

The results of the study are reported next. A short summary of the main findings follows each presentation (tables, figures) after which a comparison of the findings is made with other findings.

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

Table 2: Socio-demographic characteristics of the participants.

Characteristics	N (%) of the sample
Age	
18-25	17,0
26-35	38,0
36-45	29,0
46-65	16,0
Gender	
Male	37,0
Female	63,0
Education	
None	1,0
Grades 1-4	7,0
Grades 5-7	11,0
Grades 8-10	14,0
Grades 11-12	22,0

Table 2 (continued)

Grades 12 plus	25,0
Other	20,0
Marital status	
Single	46,5
Married	34,3
Separated	2,0
Divorced	9,1
Widowed	5,1
Cohabitation	3,0
Employment and occupation	
Unemployed and looking for a job	7,1
Unemployed and not looking for a job	13,1
Formally employed	53,5
Informally employed	6,1
Pensioners	1,0
Student	13,1
Disability grant	6,1
Religion	
Christianity	94,9
Islam	1,0
Atheism	3,0
Other beliefs	1,0
Housing	
Shack (informal settlement)	17,2
House/part of a house	76,8
Traditional dwelling (hut)	1,0
Outbuildings	3,0
Combination of buildings	2,0
Criminal convictions	
Assault	3,0
Larceny	1,0
Other crimes	3,0

Table 2 (continued)

Social support system	
Both parents	9,1
Single mother	14,1
Single father	2,1
Grand parents	9,1
Alone	19,2
Staying with spouse/own family	39,4
Staying with friends	7,1
Substance abuse	
Cannabis	4,0
Alcohol	43,0

* It should be taken into account that some frequencies may not add up to 100% because the information on a small (insignificant) number of the participants was not available.

Fifty five percent of the participants were 35 years and younger. Almost twice as many females as males were included in the study. This finding is not surprising as research and the literature have suggested that significantly more women complain of depression than men do. Kennedy (et al. 1999) reported that most mood disorders (excluding bipolar I) are twice as common in females as in males. This suggestion confirms what Gregory (1999) highlighted that on average, clinical depression is found in two women in the US for every man, a female-to-male ratio being 2.4 to 1, according to Epidemiologic Catchment Area Research while findings from the National Comorbidity investigation were 1.7 to 1. Some subtypes of depression may occur three to four times more frequently in females than in males. Other reason for the findings of this study

may be the fact that men in the Sesotho culture are not encouraged to express emotions of sadness, depression and grief, among others. There is an idiom that says "*Monna ke nku ha a lle*". Literally, it means that a man is like a sheep, he is not supposed to cry.

The educational levels of the sample were surprising, as these were significantly higher than those of the general population in South Africa. A possible explanation for these somewhat unexpected findings could be the following reasons. Firstly, the more educated they are, the less they are concerned or worried about the stigma of mental illness, especially depression. Secondly, educated Sesotho speakers may be more able to identify and express depressive illness easily. Thirdly, the less educated people in the traditional cultures tend rather to visit (consult) traditional healers for their illness, i.e., the more educated individuals with physical or mental symptoms prefer instead to visit the Western trained health professionals. The fact that 55,0% of the participants were 35 years and younger, as previously stated, is not surprising. This age group benefited since the beginning of the 90s with the new political dispensation in which the need for improvement of educational standards of black people became a major focus in South Africa. It should be taken into account that the "grade 12 plus" category also includes post-grade 12 certificates and courses other than those in university degrees.

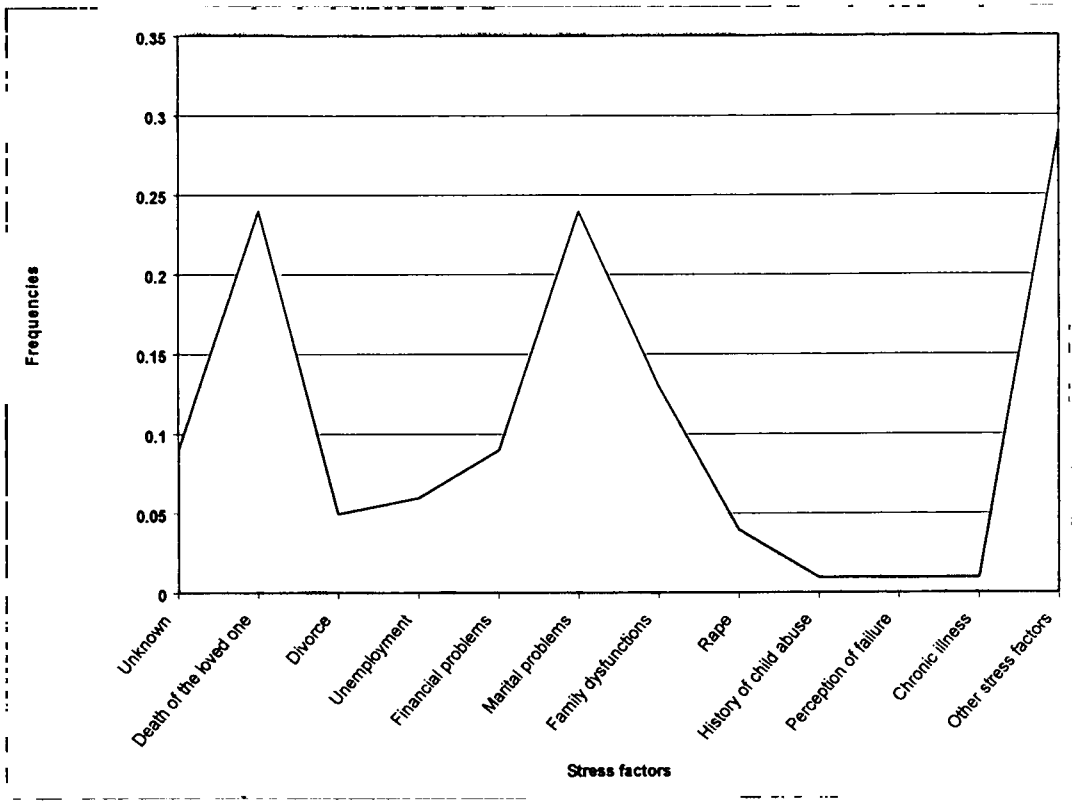
The majority of the participants were single. This is understandable when seen against the backdrop that the average age at which South Africans enter into marriage is 30 years. The fact that half of the participants were formally employed is worrying; however, it should be taken into account that the unemployment rate in South Africa is 41,0% (Statistics South Africa, 2001).

The dominance of Christianity (among participants) corresponds well with the distribution of religious groups in South Africa. The finding that only the minority lived in an informal settlement confirms the above-mentioned finding that the sample was from middle rather than lower income groups.

Factors associated with the prognosis of mental disorders, such as social support systems, social isolation and co-morbidity of substance abuse (being alcohol and cannabis) were also considered. Seventy one percent of the Sesotho-speaking depressive patients had a strong social support system, thus making the prognosis and course more favourable. As far as substance abuse is concerned, the majority of the participants mentioned that they "used" alcohol rather than cannabis or other hard drugs.

The relationship between stressful life events and depression is indicated in Figure 1.

Figure 1: Stressful life events and depression



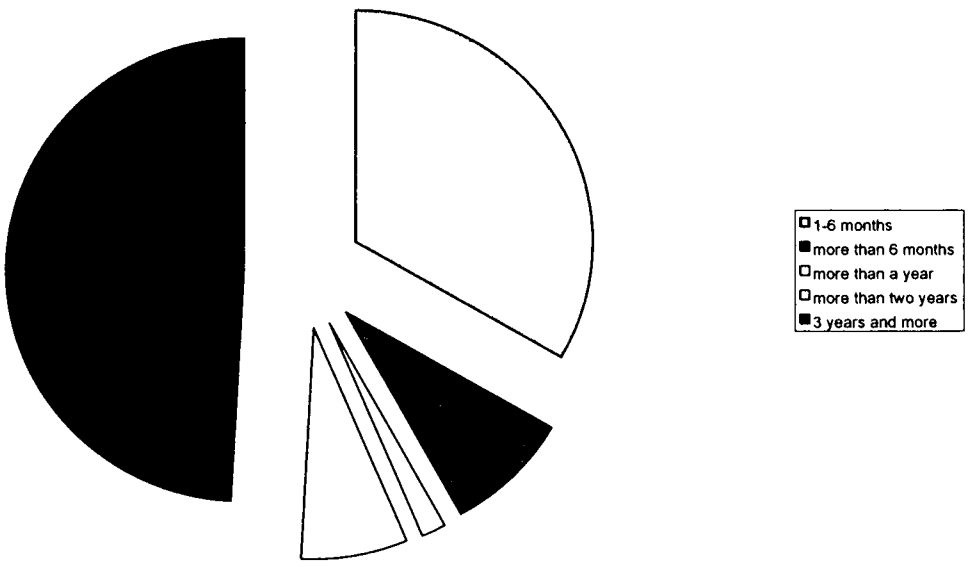
Although, in some cases, depression sufferers could not offer an explanation for their disorder, it is apparent that various stress factors played a role. Examples are the death of loved ones, marital dysfunctions, family dysfunctions, financial difficulties and unemployment.

As far as a history of mental illness (not only of depression) in the family was concerned, the results showed that about 50,0% of the patients indicated that

their close relatives were diagnosed at least once with one or more mental disorders. The figures varied as follows: father (3,0%), mother (8,0%), siblings (12,0%), paternal and maternal relatives (10,0%) and (9,0%) respectively.

The data in Figure 2 shows the extent or duration of suffering experienced by people suffering from depression in Mangaung

Figure 2: Duration of symptoms of depression.



The depressive symptoms of almost 75,0% of the participants lasted longer than 6 months. The reason might be that, because of the prominence and the severity

of somatic complaints, the clinicians tend to ignore the possibility of psychological dysfunctions or disorders during the initial assessment.

The findings concerning the primary symptoms and secondary symptoms are presented in Table 3. The inclusion criteria for classifying symptoms as primary revealed a prevalence rate of at least 20,0%. The present author realised that dividing symptoms into physical and psychological categories could be regarded as overlapping and superficial. However, for practical and discussion purposes, it was decided to categorise the symptoms into primary (20,0% and more) and secondary symptoms (less than 20,0%). The frequencies are the sum total of the symptoms reported by the participants, as well as those identified by the researcher.

Table 3: Primary and Secondary symptoms among Sesotho speakers with depression

Symptoms	N(%)	Symptoms	N(%)
Primary Symptoms			
Somatic and autonomic symptoms		**Psychological symptoms**	
Chest pain	39,0	Irritability	71,0
Stiff and painful neck	23,0	Depressed mood	80,0
Fatigue	23,0	Loss of interest and pleasure	72,0
Headaches	86,0	Impaired concentration	69,4
Constipation	44,0	Aggression	23,0
Dizziness	71,0	Grief	50,0
Insomnia	87,0	Anxiety	70,0

Table 3 (continued)

Excessive sweating	53,0	Suicidal ideas (thoughts)	49,0
Decreased appetite	56,0	Memory disturbances	34,1
Palpitations	65,0	Guilt	54,0
Poor Libido	77,0	Agitation	36,0
		Shame	46,0
		Abreaction	21,0
		Hallucinations (See Figure 3)	

Secondary symptoms expressed by depressive Sesotho-speaking patients

Psychological symptoms

Labile affect	
Resentment	Feelings of mistrust
Feelings of frustration	Poor academic performance
Nerves	Difficult thinking
Lack of assertiveness	Loneliness
Fear	Mental exhaustion
Feeling down	Feelings of worthlessness
Poor self confidence	Rage feelings
"Talking with heart"	Impatience
Excessive worries	Emotional turmoil
Sadness	Cognitive defects
Negative attitude towards life	Inability to be in touch with feelings
Noise intolerance	Mental block
Absent- minded	Feelings of uncertainty
Lack of motivation	Hopelessness
Feeling hurt	Low self-esteem
Poor self-image	Tearfulness
Nightmares	Inability to express oneself
Unfounded fear	Feeling terrified
Preoccupation	Emotional misery
Stress	Self-doubt

Table 3 (continued)

Feeling of rejection	Short temper (anger outbursts)
Feelings of insecurity	Holding unresolved issues
Losing mind	Mood swings
Panic	Hallucinations (See Diagram 3)
Somatic symptoms	
Stomach-aches	Loss of weight
Painful shoulders	Hypertension
Backaches	Swollen feet
Painful muscles	Swelling stomach
Painful waist	Urinary incontinence
Bodily pains	Heaviness of the head
Heartaches	Vomiting
Painful feet	Nausea
Abdominal pains	Numbness of the left arm
Moving pains	Stiffness of the neck
Bone pains	Loss of muscle tone
Spinal pains	Painful left side of the body
Painful legs	Heart burns
Suffocation	Unlocalized pain
Tense shoulders	Hearing impairment
Poor drive	Hearing impairment
Sleepiness	Collapsing
Muscular vibrations	Fluctuating weight
"Steamy" head	Excessive thirst
Heat in the head	Nasal bleeding
Feeling hot	Feeling extremely cold
Weight gain	Cold shoulders and neck
Running nose	Heaviness of the shoulders
Blurred vision	Early ejaculation
Fainting	Cold backbones

Table 3 (continued)

Dry mouth	Hotness of the body
Weak body joints	Poor erection
Nasal sensations	Cold feet
Tremors	Feeling hot
Weight gain	Sleepiness
Running nose	Muscular vibrations
Blurred vision	"Steamy" head
Fainting	Heat in the head
Dry mouth	Hot flushes
Weak body joints	Feeling hot
Nasal sensations	Weight gain
Hot flashes	Running nose
Feeling hot	Blurred vision
Weight gain	Fainting
Running nose	Dry mouth
Blurred vision	Weak body joints
Fainting	Nasal sensations
Dry mouth	Breathing difficulties
Weak body joints	Tense shoulders
Nasal sensations	

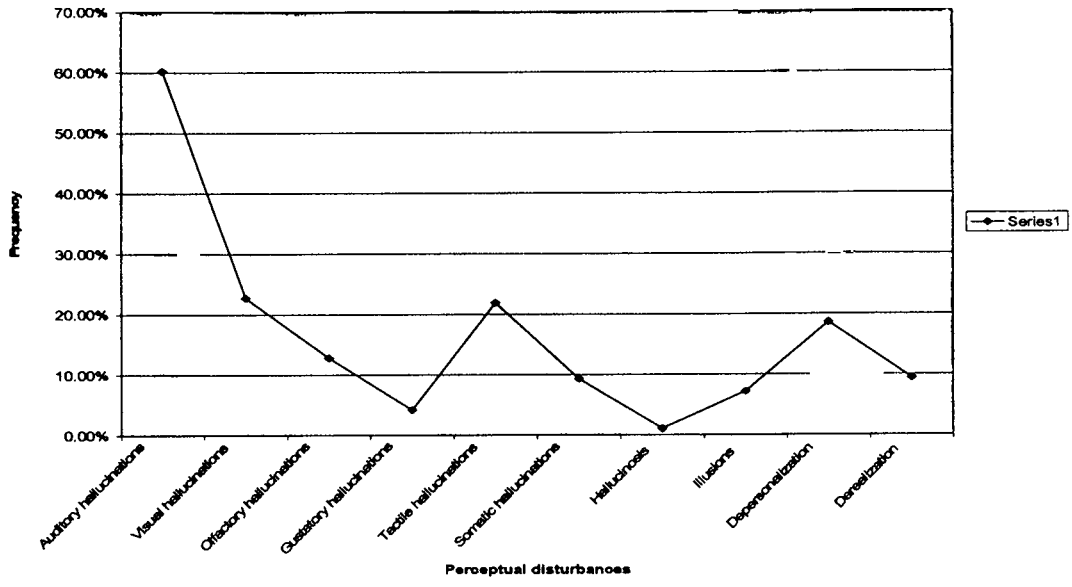
Behavioural and Social symptoms

Crying easily	Unwise use of money
Social withdrawal	Lack of stability in relationships
Restlessness	Poor interpersonal relationships
Violent behaviour	Inability to achieve goals
Wandering aimlessly	Suicidal attempts
Talking alone	Poor communication skills
Occupational impairment	Involuntary movements of the face skin

The manifestation of depression among Sesotho speakers seems to have much in common with counterparts in other cultures. As previously mentioned, cultures share several universal symptoms such as depressed mood, suicidal ideas, lack of interest and pleasure in activities, anxiety, guilt feelings, as well as hypothalamic dysfunctions. However, in the present study, somatic complaints, in terms of both severity and frequencies, dominated the manifestations of depression. These findings are supported by Hollifield et al. (1990) who found that in Lesotho, a country that has a direct cultural link with Mangaung, somatic complaints were reported to be more prominent than depressed mood in patients with depression. The implication of the present findings is that clinical depression could easily be misdiagnosed, as physical complaints are not always realised as manifestation of depression. Another interesting finding was that the participants expressed somewhat more of feelings of guilt rather than shame. This differs from Singer's (1975) findings that depressive patients in Sudan complained more of shame than guilt.

A variety of perceptual disturbances also formed part of the significant symptoms (see Table 3 for both primary and secondary symptoms). Because of the uniqueness (higher prevalence) of these manifestations among Sesotho speakers, the prevalence of these perceptual disturbances is depicted in Figure 3.

Figure 3: Perceptual disturbances among Sesotho-speaking depressive patients



Other notable features of the manifestation of depression among Sesotho speakers was the prevalence of hallucinations, illusions, depersonalization and derealization, symptoms which are often regarded as indicative of psychotic disorders in the Western world. Although psychotic symptoms may sometimes accompany major depression in Western cultures (Carson, Butcher & Mineka, 2000). In the present study psychotic symptoms, especially auditory hallucinations seemed to be much more prevalent. Some participants complained of experiencing multiple hallucinations simultaneously, while others experienced single incident of hallucinations. These hallucinations were

especially auditory, tactile, but also visual and olfactory. The content of these hallucinations was mainly centred around hearing people calling them by their names, voices of their ancestors, seeing a human shadow passing by, seeing their late loved ones (ancestors), burning sensations, insects crawling over their skins and inside their heads, bells ringing and hearing music without stimuli. The present findings are also confirmed by Littlewood and Lipsedge (1997) who suggest that hallucinations may be considered a feature of even minor depression in West Africa. It also seems that even within Western cultures, non-Western individuals display significant more psychotic features. For example, Olfson, Lewwis-Fernandez, Weisman, Gameroff, Pilowsky and Fuentes (2002) who investigated the prevalence of psychotic symptoms among outpatients attending urban general medical practice in New York in which the sample consisted mainly of immigrants from Puerto Rico and Dominican Republic, found that 20,0% of the participants were experiencing one or more psychotic symptoms, most commonly auditory hallucinations.

Another important finding of the present study was that 55,0% of female patients complained of hallucinations, while only 4,0% of males presented the same symptoms. The higher prevalence of perceptual disturbances among females should not be too surprising. Authors such as Saipanish and Lotrakul (1999) have found a similar trend.

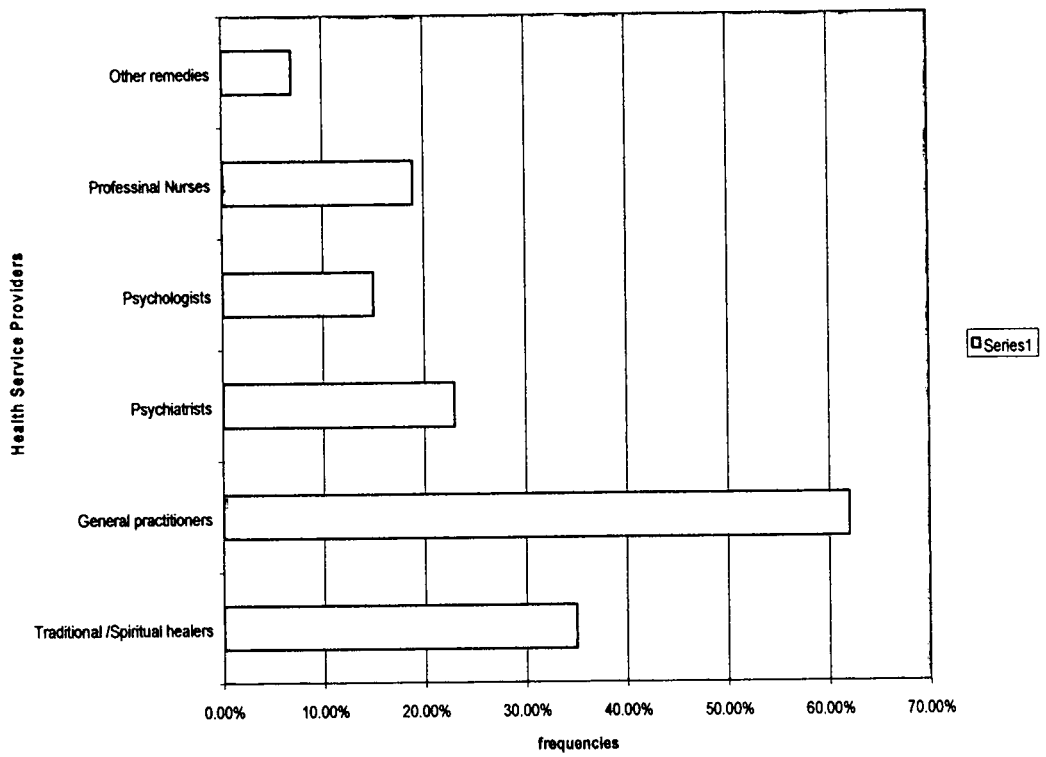
The disturbances of content of thought processes among Sesotho-speaking depressives were characterised by suicidal ideas, homicidal ideas (4,0%), and paranoid delusions (14,0%). Although paranoid delusions were sometimes present, it is critically important to mention that these delusions were not bizarre as is usually the case with patients suffering from schizophrenia. Indeed, the prevalence of delusions among depressive Sesotho speakers was more than twice that of the WHO study findings which suggested that in all five centres of the study, Montreal, Tehran, Nagasaki, Tokyo and Basle, the prevalence of delusions among depressive patients was less than 5,0% (Sartorius, et al. 1980). In Algeria, Al-Issa (1990) reported that delusions of persecution, bewitchment, possession and poisoning dominated symptomatology among depressive Algerian patients.

In the present study, as far as disturbances of form of thought processes were concerned, Sesotho-speaking depressive patients displayed blocking, irrelevant answers and derailment. However, it is important that most of the mentioned cognitive symptoms, with the exception of impaired concentration, were neither common nor severe.

Presence of both delusions and hallucinations among depressive patients often cause confusion in diagnosis. In this regard, the present researcher cannot agree more with the DSM-IV-TR (2000) that psychotic symptoms among depressive patients should not be dismissed because it is viewed as a norm.

The specific health- services providers the participants made use of are shown in Figure 4.

Figure 4: Health Service providers consulted by participants



It is significant that, even though the majority of Sesotho-speaking depressives did consult the Western-trained health professionals for their conditions, about 1/3 of the participants would still consult the traditional and/or spiritual healers. From the personal interviews, it became apparent that a significant number of these participants would first consult the traditional or spiritual

healers for their illness. The number of participants visiting traditional and spiritual healers was less than reported by other South African researchers (Louw & Pretorius, 1995). A possible explanation may lie in the fact that none of the other researchers have focused on one disorder (such as in the present study), but reported the rate concerning all visits to traditional or spiritual healers for a wide variety of minor ailments. The present study, nonetheless, shows that the traditional and spiritual healers do play a significant role in the provision of mental health care services in South Africa. It is therefore important that their specific roles in the mental health teams should be clarified by official policies. Moreover, the World Health Organisation (WHO) has called on African governments to officially recognise traditional medicine and to integrate it into their national health systems. The World Health Organisation (WHO) argues that for many centuries traditional medicine had played an important role in combating multiple and complex conditions affecting Africans. Because of its popularity, accessibility and affordability, more than 80,0% of the people in the region still continue to rely on it for their health- care needs (*Daily Sun,* 1st September, 2003, page 3).

CONCLUSION

This study confirms the findings of other authors that depressive illness exists across cultures. The Sesotho-speaking participants in the present study manifested certain symptoms which are distinctive in manifestation in the

Western world, but which have, nonetheless, been supported by other African research.

Different clinical manifestations among Sesotho speakers present in especially three areas: somatic complaints, perceptual disturbances and disturbances of the thought processes. Concerning somatic complaints, the present study reveals that Sesotho speakers fundamentally complained of headaches, palpitations, stiff and painful neck, excessive sweating, dizziness, constipation and chest pains. As far as perceptual disturbances were concerned, hallucinations appeared to be more common among the Sesotho speakers than have been reported by Western researchers. The content of these hallucinations included hearing voices, their ancestors calling them, seeing the images of their ancestors, some bodily sensations, bells ringing or hearing some music. Regarding the disturbances of thought processes, the same patterns occurred as in hallucinations. Sesotho-speakers expressed suicidal ideas, homicidal thoughts and paranoid delusions. The common type of these delusions were delusions of reference, in that, people talking about them and referring to them, and delusions of persecution, in that some people were after them, planning to harm or kill them. Delusions of bewitchment were also present, although these were not very common. It is important to mention that Sesotho-speaking depressives expressed non-bizarre delusions.

However, it is important to emphasise that a significant number of symptoms among Sesotho-speaking depressives were similar to those described in the DSM-IV-TR. These areas or symptoms are depressed mood, impaired concentration, suicidal ideas, lack or loss of interest and pleasure in activities, anxiety, fatigue and guilt feelings, as well as hypothalamic dysfunctions. These symptoms are cross-culturally overlapping, and labelled "core symptoms" of depression by World Health Organisation (WHO).

As far as treatment of depression is concerned, the approach taken by Sesotho speakers is similar to other Africans in the Sub-Saharan regions. Traditional medicine was not left out. Some African researchers and scientists argue that mental health care in Africa has been in the hands of both traditional and spiritual healers for centuries. The fact that a significant number of the participants did consult or visit either traditional or spiritual healer makes these sample not an exception as far as African culture and practices are concerned. Other participants reported that they simultaneously consulted both traditional and Western trained practitioners for their ailments.

Although the present study revealed significant findings, the results should, however, be interpreted with great care, especially as far as generalization is concerned. For example, there were about twice as many females as males, which could have affected representativeness of the sample. The same applies to the locality of the research. The participants were almost exclusively from

one area in the Free State Province, while Sesotho speakers are widely spread throughout the Free State Province, other regions of South Africa and Lesotho. Another limitation to generalisation of the findings is that this is biased sample- it was selected only from subjects attending health establishments. There are probably many subjects with depression who do not get to the health establishments, that is, it is not representative of the general Sesotho community in the area. Sub-cultural differences among Sesotho-speaking groups should also be taken into account in this case. Other significant factors that should not be ignored are educational levels and socio-economic status of the participants. Regarding educational levels; the participants in the present study were fairly educated. This might have made it easier for them to identify and express symptoms of depression without difficulties. As far as socio-economic status is concerned, the people who possess resources are more likely to have accessibility to modern mental health services than those with limited resources. However, its significance should not be under-estimated because it does not only contribute to important academic data in a field that has been largely neglected in South Africa, but also provides information on biographical and socio-cultural factors associated with depression among Sesotho speakers. There is no doubt that this research will contribute to the improvement of the reliability of diagnosing depression among Sesotho speakers. Thus, the study will also improve our understanding of mental disorders in this culture.

As most mental health professionals are still trained in Western models especially DSM-IV-TR and ICD-10, it is clear that certain changes in these training systems should be made to incorporate cultural differences that were found in the present study. The above-mentioned training systems are understandable because there is a significant portion of South African population that is still part of Western culture. Furthermore; Western models like DSM-IV-TR and ICD-10 are widely accepted also in non-Western nations. Well, it is therefore essential that the training in these models should be maintained because Western Psychology and Psychiatry have much to offer to the Africans suffering from various mental disorders. However, it is also time that the unique South African cultures with their diversity should play more significant role than at present situation. By only incorporating either an African or a Western model, not only the training of the psychologists, but also the applicability of the profession will suffer.

It is equally important that research in South Africa should rather focus more on epidemiology, especially on the manifestations of mental disorders, in the different cultural groups in the country.

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ARTICLE II

SCHIZOPHRENIA AMONG SESOTHO SPEAKERS

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ARTICLE II

Schizophrenia among Sesotho Speakers

Abstract

Various studies on schizophrenia have been conducted throughout the world confirming its existence across cultures and nations, focusing mainly on the epidemiology, incidences, manifestations and course. The aim of this study is to investigate the clinical presentation of schizophrenia among Sesotho speakers. The finding is that core symptoms of schizophrenia among Sesotho speakers do not differ significantly from other cultures. However, the content of positive symptoms such as delusions, hallucinations and behaviours are strongly affected by cultural variables.

INTRODUCTION

Schizophrenia is generally considered to be one of the most severe mental disorders. In the previous article on depression, it was stated that clinical depression will dominate the field of mental health by the year 2020, becoming a major burden for public health, also causing gross impairment in functioning of those affected. However, it can be said with certainty that schizophrenia is already imposing a very heavy burden on health services (A1-Issa, 1982). Consequently its management, research and general attention have an enormously negative impact on public health budgets.

Many studies on schizophrenia have been conducted in different parts of the world, emphasizing its existence across cultures. These investigations have been focusing on epidemiology, incidences, presentation and courses of this disorder. In the last few decades

studies have compared schizophrenia in different cultures. However, a lack of commonality among various methodological approaches and clear criteria for diagnosis and management makes comparisons difficult. This problem is especially apparent in South Africa with its cultural diversity. Nonetheless, very little research has been done on the clinical manifestations of schizophrenia in South Africa.

The aim of the study was to investigate the ways in which schizophrenia is clinically manifested among Sesotho speakers in Manguang in the Free State Province of South Africa.

CULTURE AND SCHIZOPHRENIA

Many authors hold the view that in order to explore the relationship between culture and schizophrenia, it is essential to define both concepts of culture and schizophrenia in detail (Maslowski, Jansen van Rensburg & Mthoko, 1998).

There is no single definition of culture accepted by all. Alarcón, Westermeyer, Foulks and Ruiz (1999) define culture as a set of meanings, norms and values that determine the typical opinion of human groups about the world and about themselves. Culture has an impact on personality development, behaviour, and attitudes, and can be communicated through language. Traditionally culture is viewed as values, beliefs and practices related to a certain ethno-cultural group. The way people think, their ideas and symbols are part of their

culture. Culture is a set of attitudes, behaviours and symbols shared by a large group of people usually communicated from one generation to the next (Shiraev & Levy, 2001).

An important dimension of schizophrenia is thought process disturbances, perceptual disturbances, depersonalization and derealization (APA, 2000). These characteristics are such that culture could have a significant influence on the way in which they manifest. In other words, the basic functioning of the individual that yields individual feelings of individuality; willingness and self-direction can hardly escape the impact of the cultural environment. For example, certain beliefs and perceptual distortions may be normal in one culture, but be considered pathological in another. It is therefore important that cultural variables should not be confused with psychopathological features.

EPIDEMIOLOGY

Studies throughout the world have concluded that even though the prevalence of schizophrenia is similar across nations, variations do occur. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA, 2000), the lifetime prevalence of schizophrenia in different parts of the world ranges between 0, 5 and 1 percent. Point prevalence is estimated to range from less than 0,010% to 3,0% across populations (Scully, 1996), while its annual incidence is reported to be approximately 1 percent. Daubenton and Van Rensburg (2001) point out that the prevalence rate of schizophrenia is generally much lower in developing compared to industrialized countries. However, as it was not always possible to take into account cultural differences, these

statistics should only be viewed as an indication, and as especially applicable to Western cultures. Examples of cross-cultural and cross-national studies on the prevalence of schizophrenia are summarized in Table 1

Table 1: Selected prevalence studies of schizophrenia

Author	Country	Prevalence
Bash and Bash-Liechti (1969)	Iran	2,1 (prevalence per 1000)
Brugger (1931)	Germany	2,4 (prevalence per 1000)
Chen et al. (1993)	Hong Kong	Lifetime prevalence 1,2 (males) 1.3 (females)
Crocetti et al. (1971)	Croatia	5,9 (prevalence per 1000)
De Salvia et al. (1993)	Italy	5,2 3 (prevalence per 1000)
Dube and Kumar (1972)	India	2,6 (prevalence per 1000)
Essen-Moller et al. (1956)	Sweden	6,7 (prevalence per 1000)
Jablensky (2000)	Australia	3,1–5.9 (point) 3.9–6.9 (1 year)
Jeffreys et al. (1997)	UK	5,1 (prevalence per 1000)
Kabede et al. (1999)	Ethiopia	0,9 (lifetime and 1 month prevalence)
Keith et al. (1991)	USA	7,0 (point prevalence)
Lemkau et al. (1943)	USA	2,9 (prevalence per 1000)
Lin et al. (1989)	Taiwan	2,1 – 1.4 (prevalence per 1000)
Mata et al. (07-07-04)	Spain	0,8 (annual prevalence)
Padmavathi et al. (1987)	India	2,5 (point prevalence)
Rin and Lin (1997)	Taiwan	2,1 – 1.4 (prevalence per 1000)
Rotstein (1977)	Russia	3,8 (prevalence per 1000)
Salan (1992)	Indonesia	1,4 (point prevalence)
Stromgren (1938)	Denmark	3,9 (prevalence per 1000)
Waldo (1999)	Kosrae	6,8 (point prevalence) age 15 +

Expanded from Jablensky (2000)

Regarding the incidences of schizophrenia, Selten, Slaetes and Kahn (1997) investigated the incidence of schizophrenia among Surinamese and Dutch Antillean immigrants to The Netherlands. These researchers found a significant increase in incidence of schizophrenia among Surinamese (3,8%) and Dutch Antillean (3,9%) immigrants to The Netherlands. The immigrants were three to four times at risk of developing schizophrenia compared to the Dutch-born (1,4%). Similar study took place in London, England, in which the incidence and outcome of schizophrenia were compared between Whites, African Caribbeans and Asians (Bhugra et al., 1997). The findings suggest that African-Caribbeans (5,9%) in the United Kingdom had a higher risk of developing a first episode of schizophrenia than white Anglos. Even though Asian rates (3,6%) were higher than Whites' (3,0%), they were generally lower than the African-Caribbean rates.

The results of London study triggered an interest so that similar research was launched in the Caribbean Islands of Barbados. The conclusion reached here was that the incidence of schizophrenia among African-Caribbeans in the UK (5,9%) is almost double that of Barbados (2,96%), but there are no significant differences regarding their sociodemographic variables (Mahy, Mallet, Leff & Bhugra, 199). In Navarra, Spain, Mata, Beperet and Madoz (2002) estimate the annual incidence of schizophrenia to be approximately 0,2%, making it similar to many other regions of Europe.

The most widely quoted international study on schizophrenia is the one that was commissioned by the World Health Organisation (WHO) under the guidance of Jablensky et al. (1992). This study was conducted in different centres such as Aarhus (Denmark),

Agra and Chandigarh (India), Cali (Columbia), Dublin (Ireland), Honolulu and Rochester (USA), Ibadan (Nigeria), Moscow (Russia) Nagasaki (Japan), Nottingham (UK), Prague (Czech-Republic). The outcome of this study demonstrated significant differences in incidence of schizophrenia among the centres, and these differences are presented in Table 2.

Table 2: WHO 10-Country Study: annual incidence rates of schizophrenia per 10 000 population at risk aged 15-54

Area	"Broad" definition (ICD-9)			"Restrictive" definition		
	Male	Female	Both sexes	Male	Female	Both sexes
Aarhus	1,8	1,3	1,8	0,9	0,5	0,7
Cali	1,4	0,6	1,0	0,9	0,4	0,7
Chandigarh (rural)	3,7	4,2	1,3	0,9	0,9	1,1
Chandigarh (urban)	3,4	3,5	3,5	0,8	1,1	0,9
Dublin	2,3	2,1	2,2	1,0	0,8	0,9
Honolulu	1,8	1,4	1,6	1,0	0,8	0,9
Ibadan	1,1	1,1	1,1	0,9	1,9	1,0
Moscow	2,5	3,1	2,8	1,0	1,4	1,2
Nagasaki	2,3	1,8	2,1	1,1	0,9	1,0
Nottingham	2,8	1,5	2,4	1,7	1,2	1,4
Prague	0,6	1,2	0,9	0,4	0,8	0,6
Rochester	1,5	1,4	1,5	0,9	0,8	0,9

Although the importance of the World Health Organisation (WHO) study on schizophrenia in different countries is widely accepted, others also criticized it. For example, Edgerton and Cohen (1994) argue that the results of the study are not conclusive and that longitudinal direct observation of the patients should be carried out before differences in the course of schizophrenia can be appropriately understood.

SYMPTOMATOLOGY

As a result of variables such as different diagnostic criteria and cultural factors, the clinical picture of schizophrenia is still being debated among mental health professionals. In a review article, Al-Issa (1968) concluded that although schizophrenia is a universal mental disorder, its manifestations form distinctive patterns across cultures. Western patients are reported to experience more auditory than visual hallucinations. African patients, in contrast to Iranians and Italians, showed less violent behaviours and more blunted affect, and a higher rate of visual hallucinations.

In another review article by Carter and Neufeld (1998), it is reported that there are variations in symptoms of schizophrenia among European Americans, Hispanics and African Americans. Hispanics usually internalize and somatize symptoms. Delusions and hallucinations are found more often in African Americans than in other racial groups. These symptoms might explain why schizophrenia has historically been overdiagnosed in African Americans at the expense of mood and anxiety disorders. Delusions and hallucinations are very common among depressive patients in Africa, the continent of

origin of African Americans, which might suggest a genetic link. Memory disturbances, disorientation and impulsivity, common among African Americans, are said to be relatively rare in white Americans.

In a cross-cultural comparative study on schizophrenia in Liverpool, England and Sakalwara-Bangalore, India, Sharma, Murthy, Kumar, Agarwal and Wilkinson (1998) found that patients from England had a significantly longer duration of illness than Indian patients. The age of onset in England was also much earlier than in India. A greater proportion of the English sample had co-morbidity of illicit drug abuse, which might negatively affect the course and lead into poor prognosis.

Catatonic behaviour during a schizophrenic episode was found to be rare in Western cultures compared to Africa, Asia and other developing countries according to Chandrasena (1986). The author is, however, not specific enough about the parts of Africa he is referring to; hence his findings contradict Al-Issa (1990) who concluded that in Algeria, Africa, there is a relatively high incidence of paranoid schizophrenia and relatively low incidence of both disorganised and catatonic types of schizophrenia. The most common signs and symptoms displayed by Algerian patients were somatic passivity, thought insertion and thought broadcast, thought withdrawal, delusions of influence and auditory hallucinations. Systematic delusions with richer content related to scientific and socio-political dimensions were more common than delusions of bewitchment and possession.

Jablensky et al. (1992) found that schizophrenia patients in developed countries showed a higher frequency of depressive symptoms than patients in developing countries. The core

symptoms of schizophrenia also appeared to be more prevalent among patients in developed countries than among patients in the third world. Additionally, auditory and visual hallucinations were more prominent among patients in the developing countries than those in developed countries. However, there were no significant differences in relation to negative signs and symptoms, but the general course and prognosis were reported to be better in the developing countries than in the developed ones.

In Missouri (USA) and Istanbul (Turkey) Çentingök, Chu and Park (1998) explored cultural influences on gender differences in clinical characteristics and symptomatology of schizophrenia in those two countries. The findings were that both Americans and Turkish male patients were much younger than their female counterparts. No gender differences were found regarding the age of onset. The results also showed that culture does not impact on gender: ambivalence, inappropriateness, silliness, euphoria, dissociation, muteness, and disorganized behaviour were equally displayed in both male and female Turkish patients, but less in American male and female patients. Stereotypic behaivour and irrelevant answers were more severe in Turkish male and female patients than in the same cohort of American subjects.

In South Africa, Laubscher (1937) conducted the first cross-cultural study on schizophrenia and other mental disorders among Xhosas, Basotho, and other sub-groups. He found that male patients especially presented with auditory hallucinations. Their hallucinations were centred on hearing the voices of ancestors while Christian patients heard the voice of God. Visual hallucinations consisted of seeing the African equivalent of gremlins and goblins.

Tactile hallucinations were often felt inside the female sexual organ, abdomen or throat. *Mamlambo* (a hallucination of a beautiful seducing female at a river or a lake) was the most common visual hallucination among male schizophrenic patients. Delusions of poisoning were prominent among female schizophrenic patients, followed by delusions of bewitchment. Delusions of grandeur among females were centred on owning cattle, land and money, and among males having many cattle, many wives, and much money. However, the study has been widely criticized by new generations for its lack of vision and cultural sensitivity.

A few other cross-cultural studies on schizophrenia have been conducted since Laubscher. In Cape Town, South Africa and Windhoek, Namibia, Maslowski, Jansen van Rensburg and Mthoko (1998) investigated the differences in symptoms of schizophrenia among different cultural and ethnic groups. The groups were composed of the Coloured population from Cape Town and black subjects from Windhoek. Variations in symptoms of schizophrenia were detected, which was primarily attributed to differences in culture rather than differences in ethnicity. The hallucinations experienced by black patients centred on hearing the voices of traditional healers and animals, while the Coloured sample was hearing the voices of very important people like politicians. Both groups developed delusions of persecution founded on their racial diversity, especially hatred or fear between the two groups. This could be ascribed to the history of both South Africa and Namibia where, in the past, Coloureds and Blacks were racially, culturally and geographically separated by the system. The Coloured group manifested a more restricted affect than the black participants did.

In Cape Town, Ensink, Robertson, Ben-Arie, Hodson and Tredoux (1998) investigated the ways in which schizophrenia is manifested among black Xhosa speakers compared to white English speakers. The findings were that Xhosa schizophrenic patients had marked behavioural disturbances, particularly aggression and disruptive behaviour. The Xhosa patients also scored high in irritability and hysteria compared to white patients. Delusions of persecution, poor self-care, sexual and fantastic delusions were significantly more common in Xhosa speakers than white patients. Mood and specifically depressive symptoms were reported more in Whites than in Xhosa patients.

It should be noted, however, that several other schizophrenia-like syndromes have also been reported in South Africa: for example, one of the most common forms of these syndromes is *amafufunyana,* which has especially been reported among Zulus and Xhosas. The sufferer presents with a history of listlessness, poor appetite and social withdrawal. During an acute episode the sufferer "hears voices coming from his own stomach which speak in a different language to his own. Often these voices threaten to kill him. It is believed to be a kind of possession by evil spirits, which is caused by witchcraft. It is said that a piece of fat is taken and placed in a graveyard to attract the ants that have been feeding on the dead. These are captured and ground up to make a powder, which is put in someone's food. The person so poisoned will become possessed by *amafufunyana* and go mad. The sufferer's behaviour may go out of control and he may run out wildly, and assault people. Often the disease will bring about his death" (Edwards, 1987, p.315).

In a study of psychosis and *amafufunyana,* Lund and Swartz (1998) also found that *amafufunyana* patients presented with vivid auditory hallucinations. Other symptoms were fearfulness, disorientation, strange moving sensations in the stomach, visual hallucinations, aggression and destructive behaviours, excessive salivation and an inability to speak, sleep disturbances and physical pressure on the head. The patient's view of *amafufunyana* was that it is always caused by witchcraft, jealousy of neighbours, relatives or a wife.

Indiki is said to be mainly experienced in Kwazulu-Natal region since the beginning of the 19th century. It was thought to be caused by spirits of people who came from north of Limpopo River to work in South African mines (Ngubane, 1977). These immigrants often die at their workplace, without their families back home knowing of their death. Consequently, the families could not perform the necessary rituals to put their spirits to rest. The spirits would then wander about in desperation, taking possession of local people. More specifically, *indiki* is often defined as a male spirit that enters the person and resides in the chest. The sufferer becomes deranged and manifests by crying in a deep bellowing voice and speaking strange languages.

METHODOLOGY

The Mangaung Township in Bloemfontein, South Africa, was chosen as the geographical area for the completion of the research. The main reasons for this are that the principal researcher is a member of a mental health team providing services at different health establishments in that area. Secondly, Sesotho (the main language in Mangaung) is the

mother tongue of the principal researcher who is also familiar with the area and the culture. Thirdly, the government of South Africa always recommends that scientists should rather focus on their immediate areas in order to meet the needs of their own communities than look elsewhere.

For this exploratory descriptive study the participants consisted of 100 Sesotho speakers diagnosed with schizophrenia. They were drawn from patients visiting various health establishments in the area. All the patients to a specific heath facility who qualified during the time the researchers were based at the facility were included. The time periods varied from one month to four years. The participants were evaluated and diagnosed by a multi-professional team. The DSM-IV-TR criteria for schizophrenia were used as the inclusion criteria. The participants were between 18 and 65 years of age, and both genders were represented. Written informed consent was obtained from each participant.

A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) used by the Department of Psychiatry at the University of the Free State, was used to elicit the information. The PIQ is based on *Clinician's Thesaurus: The Guide for Writing Psychological Report* (Zuckerman, 2000) and *Outline of Psychiatric History and Mental Status Examination* (MacKinnon & Yudofsky, 1986). The PIQ provides data on preliminary identification (including socio-demographic information), main complaints, personal description, history of prevent illness, psychiatric review of systems, previous mental illness, past personal history, a mental-status examination consisting of : appearance, attitude and behaviour, thought processes, perception, mood and affect,

consciousness, orientation, memory, tempo, intelligence, mode of thinking, judgement and insight, both hypothalamic and autonomic functioning. The PIQ is the standard assessment tool used by all governmental mental health establishments in the Free State Province. The present researcher personally conducted the interviews with each individual patient.

Qualitative methods were used to describe the experiences of the participants regarding their symptoms, as well as a way to elucidate the quantitative data. Qualitative methods that were used consisted of two types of data collection: the open-ended interview and clinical observation. The interview data consist of direct quotations from participants about their experiences, feelings, emotions, opinions and knowledge, while observation data refer to detailed descriptions of participants' activities, behaviours, actions and full range of interpersonal interactions and organisational processes that are part of observable human experience (Patton, 1990). Individual interviews were transcribed, and information gathered was grouped into themes. Themes are written in subjects' own words or transcribed as closely as possible (or a close rendition of the subjects' account). These themes were divided into psychological symptoms, physical symptoms, as well as behavioural and social symptoms. Quantitatively, a descriptive statistical analysis was performed to provide indications of frequency (incidence) for identifying socio-demographic characteristics, signs and symptoms of mental illness, as well as socio-cultural variables associated with schizophrenia as contained in the questionnaire.

The pilot study on 40 patients was conducted to investigate the practical feasibility of the research. Based on the pilot study findings, certain adjustments were made in the coding of

the questionnaire. The project was also discussed with the Head of the Department of Psychiatry at the University of the Free State, who is also the provincial clinical head of mental health. He pledged his full support. The study as approved by the ethics committee and the council of the University of the Free State. Also, permission was obtained from the Head of Health in the Free State Province to conduct this study in the various provincial health establishments.

RESULTS AND DISCUSSION

The socio-demographic characteristics of the participants are presented in Table 3.

Table 3: Socio-demographic characteristics of the participants

Characteristics	% of the sample
Age	
18 – 25	14,0
26 – 35	26,0
36 – 45	27,0
46 – 55	19,0
56 – 65	14,0
Sex	
Male	58,0
Female	42,0
Education	
None	7,1
Grades 1 – 4	21,4
Grades 5 – 7	34,7
Grades 8 – 10	20,4
Grades 11 – 12	10,2
Grades 12 Plus	4,2
Other	2,0
Marital Status	
Single	62,0
Married	16,0
Separated	4,0
Divorced	8,0
Widowed	5,0
Cohabitation	5,0
Employment and occupation	
Formally employed	7,0
Informally employed	2,0
Pensioner	1,0
Disability grant	65,0

Table 3 (continued)

Students	5,0
Religion	
Christianity	77,3
Atheism	18,2
Belief in Ancestors	4,5
Housing	
Shack (informal settlement)	41,4
House / part of a house	56,6
Outbuildings	2,2
Crimes committed	
Assault	6,0
Rape	1,0
Murder	2,0
Hijacking	1,0
Larceny	9,0
Burglary	1,0
Malicious damage to property	7,0
Drugs	4,0
Alcohol	4,0
Public violence	4,0
Other crimes	5,0
Social support system	
Both parents	9,1
Single mother	24,2
Single father	2,0
Step parent(s)	1,0
Foster parent(s)	3,0
Grand parents	8,1
Alone	14,1
Staying with other relatives	28,3
Staying with friends	10,1
Substance abuse	
Cannabis	29,0

Table 3 (continued)

Alcohol	57,0
Nicotine	55,0
Snuff (inhalants)	19,0

* It should be taken into account that some frequencies may not add up to 100% because the information on a small (insignificant) number of the participants was neither available nor adequate.

Just over fifty percent of the sample was aged between 26 and 45 years. These findings correspond with a claim by Häfner and an der Heiden (1997) that schizophrenia is mainly a disease of adolescence and early adulthood and their findings that the average age at first contact with mental health services is between 25 and 35 of age for both females and males. Unlike study on depression among the same cultural group (Mosotho, Louw and Calitz in press) which occurred almost twice as often among females as men, male participants in the present study largely outnumbered females. To an extent, this is at variance with the DSM-IV-TR (2000), which holds that schizophrenia is equally common in both genders. The findings do not differ significantly from a study by Insink et al. (1998) among Xhosa and white English-speaking samples suffering from schizophrenia. The present research is also in accordance with the meta-analysis by Kulkarni (1997) who concluded that women have not been well represented in many empirical studies on schizophrenia. Possible reasons for this disparity are that women tend to have a better prognosis and favourable course of schizophrenia compared to their male counterparts. They also tend to develop less negative symptoms and good social adjustment (Angermeyer, Kuhn & Goldstein, 1990). The result

is that they experience fewer hospitalizations, and are also inclined to short-term stays as in-patients. This makes them less available for research projects..

The educational levels of the participants are not surprising. Less than 5,0% had Post-Grade 12 qualifications. This might be due to the impact that schizophrenic illness usually has on the gross functioning of the individual sufferer; indeed, it is common knowledge that schizophrenia usually causes deterioration and cognitive impairment; moreover, it negatively affects many areas of functioning of these individuals. These findings are more or less in agreement with the situation in more developed countries such as the USA, Czech Republic and Japan (see WHO study), while it is in strong contrast with findings in developing countries such as Nigeria and India (Chandigarh/rural& Agra).

The majority of the participants were never married. Bhugra et al. (1997) reported the same trend among African-Caribbeans suffering from schizophrenia in London. The reason could be that the illness of schizophrenia disrupts the personal, social, emotional and mental development and functioning of these individuals. Moreover, blunted affect displayed by these patients may also be a contributing factor, because affective processes play a significant role in one's developing passion, feelings and sentiments which are, of course, the base for a person to fall in love, and eventually enter into marriage. Another possible explanation is that the side-effects of neuroleptics given to schizophrenic patients, could also significantly affect the behaviour of a person and therefore his or her chances of marriage. Another reason may be social withdrawal by the patients suffering from schizophrenia in general.

Most of the participants were unemployed; they live on public assistance known as a disability grant provided by the Government. The finding is supported by Mohlahle, Calitz, Gagiano, Joubert and Nel (1999) who reported that 80,0% of the patients suffering from schizophrenia in the Free State were unemployed. It is also consistent with other international studies. For example, Kabede and Alem (1998) found a similar trend (71,0%) in Ethiopia. In the United Kingdom in general, the unemployment rate among schizophrenic patients is reportedly as high as 95,0% (Grove & Morris, 2003). In a comparative study of Liverpool and Bangalore, Sharma et al. (1998) reported an unemployment rate of more than 75,0% in Liverpool. Bangalore had less unemployment (13,4%) among patients suffering from schizophrenia. This is surprising taking into account that India is a poor third world country. However, a possible explanation is that the Indian patients were better looked after in terms of vocational rehabilitative opportunities. The high unemployment rate of people suffering from schizophrenia is understandable when the intense impact of the illness on the individual is taken into account.

The various types of crimes committed by schizophrenic patients are similar to those committed by other members of society at large. Although the general public belief is that people with mental disorders are more likely to become violent and commit serious crimes, researchers in this field emphasize that mental illness itself is not a significant cause of crime (Wessely, 1997). There are different points of view regarding the link between mental illness and criminal behaviour. The correlation between mental illness and crime is not strong, and the argument is that there is no scientific evidence that suggests that people with mental disorders, especially schizophrenia, are more likely to become violent and to

harm others around them (Everett & Higgins, 2001). The bottom line is that crime and violence are not symptoms of schizophrenic illness. However, psychiatrists in England, (Taylor and Gunn, 1984) had earlier reported that at Brixton Prison, 6,0% of the inmates convicted of various crimes were suffering from schizophrenia while Gibbons, Horn, Powell and Gibbons (1984) also reported some harmful behavioural patterns among 49,0% of the patients suffering from mental illness in the community of Southampton. In the present study the criminal tendencies among participants could be attributed to impairment of judgement and poor insight as well as substance abuse, poverty, and dysfunctional family conditions, among other possible factors. In Denmark, Hodgins, Medrick, Brennan, Schulsinger and Engberg (1996) found that people who had a history of admission to the psychiatric institutions were more likely to commit crimes than people without any history of psychiatric admission.

More than 80,0% of the participants had a good social support system, that is, they live with family members, relatives and friends. Many researchers, including the WHO-ten country study, have also observed that the social support system is good in the developing world. For example, Dani and Thienhaus (1996) found and stated that schizophrenic patients in the developing countries have a better prognosis and course than those in the developed nations because of the mentioned support system. In their comparative study of Pune, India and Cincinnati, U.S.A., their findings suggest that schizophrenic patients in India were more married and employed, as well as lived with minimal supervision compared to their U.S. counterparts. Another reason could be the fact that traditional

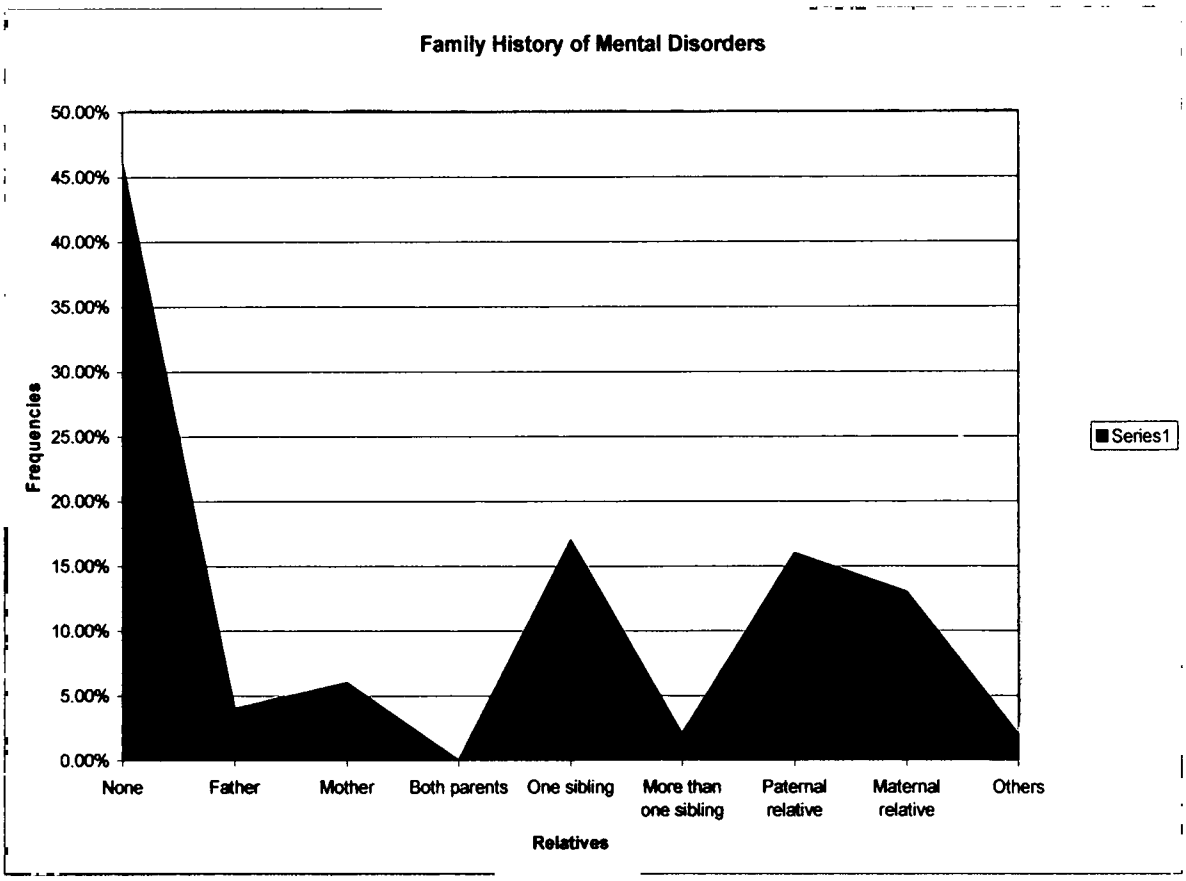
nations usually put more emphasis on group life and marriage which are eventually the base for a good social support system.

The high incidence of abusing substances such as cannabis, alcohol and inhalants by present participants is worrying as it could have a negative impact on the course and prognosis of the illness. It has been reported that high risks of crime and violence are associated with substance-induced psychoses and with schizophrenia coexisting substance abuse (Tiihonen, Isohanni, Rasanen, Koiranen & Moring, 1997). The abuse of alcohol and cannabis is higher compared to other drugs such as cocaine, heroin and mandrax because of differences in accessibility and financial affordability which means that the cost of alcohol and cannabis is relatively low. This finding on higher levels of substance abuse among schizophrenic patients is in close relation with other international studies. For example, in a review article, Soyka (2000) stated that patients with schizophrenia and comorbidity of substance abuse exhibits significant differences compared to patients with schizophrenia alone. The most significant difference is that patients with both conditions have poor compliance with treatment; consequently, they experience a high rate of relapses and admissions. It is also evident that there is always a poor prognosis and course of the illness among those patients. Trying to unpack the complexity of the link between schizophrenia and substance abuse, Allebeck, Adamsson, Engström and Rydberg (1993) revised in-patient care in Stockholm County in order to identify cases of cannabis dependence and psychosis. They found that the majority of schizophrenics had a history of strong cannabis abuse at least one year prior to the development of psychotic features; hence the conclusion or assumption was that cannabis could be considered a risk factor in the development of

schizophrenia and not other way round. However, this notion is still highly debatable and it has been rejected by many authors.

As far as a family history of mental disorders is concerned, the findings are displayed in Figure 1. The criteria for inclusion were severe disorders such as psychotic disorders, mood disorders and anxiety disorders. Relatively mild disorders such as nicotine abuse and learning disorders were not included.

Figure 1: Family History of Mental Disorders



The results show that more than 50,0% of the sample indicated that either close or distant relatives were diagnosed with one or more mental disorders, not necessarily schizophrenia, though in many cases the specific diagnoses of such mental disorders were not known. The results confirm the general finding that schizophrenia aggregates strongly in families (Bromet & Finnig, 1999). The risk for the development of schizophrenia in close relatives is about 5 to 15 times greater than in the general population (Kaplan & Sadock, (1997). A noteworthy finding was that siblings or paternal relatives of Sesotho speakers suffering from schizophrenia are more likely to develop major mental disorders than either father or mother.

The findings concerning the primary and secondary symptoms are presented in Table 4. The inclusion criteria for classifying symptoms as primary revealed a prevalence rate of at least 20,0%. The researcher realized that dividing symptoms into physical, psychological and behavioural categories could be regarded as overlapping and superficial. However, for practical and discussion purposes, it was decided to categorize the symptoms into primary symptoms (prevalence of 20,0% and more) and secondary symptoms (less than 20,0%, but more than 5,0%). The frequencies are the sum total of the symptoms reported by the participants, as well as those identified by the researcher.

Table 4: Primary and Secondary symptoms expressed by Sesotho speakers

Symptoms	(%)	Symptoms	(%)
Primary symptoms			
Psychological symptoms		**Somatic and autonomic symptoms**	
Auditory hallucinations	90,0	Palpitations	39,0
Visual hallucinations	52,5	Headaches	39,0
Olfactory hallucinations	20,0	Constipation	29,0
Delusions of persecution	67,0	Excessive sweating	39,0
Suicide ideation	23,0	Dizziness	47,0
Poverty of speech	23,0	Anxiousness	64,0
Concrete mode of thinking	74,0	Poor Libido	59,0
Poor concentration/attention	68,0	Insomnia	55,0
Poor memory	34,0	Poor appetite	22,0
Irrelevant answers	26,0		
Poor insight	43,0		
Poor judgment	54,0		
Depersonalization	26,9		
Anhedonia	26,0		
Paranoid ideas	28,0		
Irritability	25,0		
Aggression	23,0		
Blunted affect	43,0		

Secondary Symptoms	
Appearance, behavioural and social symptoms	
Dirty	Inappropriate dressing
Poorly groomed	Agitated
Poor personal hygiene	Ignoring questions
Wetting oneself	Looking around continuously
Unkept hair	Refusing to eat
Smelling alcohol	Preaching in the street
Red eyes	Restless behaviour
Deterioration	Bizarre behaviour

Table 4 (continued)

Talking slowly	Difficult to manage
Talkative	Pulling up hair
Violent behavior	Restless leg
Collecting rubbish	Inappropriate behavior
Assaulting people	Walking around naked
Demanding	Stubborn
Catatonic	Mannerisms
Screaming	Roaming around aimsly
Social withdrawal	Academic impairment
Drinking a lot	Walking bare-footed
Neglecting family	Social impairment
Occupational impairment	Eating rubbish from dustbin
Eating faeces	Sleeping away from home
Disturbing neighbours	Singing endlessly
Using vulgar language	Damaging properties
Laughing inappropriately	Running away from home
Psychological Symptoms	
Depression	Abreaction
Monotonous speech	Abulia
Sadness	Losing mind
Euphoria	Excessive worries
Alexithymia	Hyperactive mind
Residual	Feeling like a robot
Dysphoric mood	Being confused
Derealization	Inability to communicate
Ambivalence	Becoming too exited
Mute	Possessing ancestral spirit
Incoherence	Homicide ideas
Tactile hallucinations	Pressure of speech
Somatic hallucinations	Suffering from "moya"
Gustatory hallucinations	General Spirit possession
Shame	Suffering from nerves
Apathy	"Thoasa"

Table 4 (continued)

Perseveration	Being a "Sangoma"
Emotionless	Having Stress
Tearful	Becoming dull
Slurred speech	Communicating with ancestors
Disturbed articulation	Delusions of control
Mood swings	Delusions of reference
Loosening of associations	Somatic delusions
Illusions	Hyper-religious
Disoriented	Being an enemy of the world
Feeling "crazy"	Anxiety
Elevated mood	Guilt
Somatic and Autonomic symptoms	
Tremors	Visual cloudiness
Fainting	Painful bones
Painful waist	Blackouts
Fatique	Loss of weight
Stiffness of the body	Fluid moving up the spinal cord
Feeling week	Stiffness of the neck
Chest pains	

In general, the findings of the present study indicate that the prevalence of core symptoms of schizophrenia such as delusions, hallucinations, disorganized behaviour and speech, as well as negative symptoms among Sesotho speakers, do not differ significantly from those in other cultures. It supports Maslowski's et al. (1998) point of view that cultural variables are responsible for the differences in symptoms of schizophrenia in different cultural groups.

The most prominent symptoms (50,0% and more) experienced by the participants were auditory and visual hallucinations, delusions anxiousness, poor judgement, poor concentration, poor libido and concrete mode of thought. It seemed that, especially hallucinations and delusions were affected by cultural variables. The content of auditory hallucinations was mainly centred on hearing voices of people, especially ancestors and undefined sounds. Visual and olfactory hallucinations mainly consisted of seeing ancestors and wild animals, and smelling rotten materials and *muti* (traditional medicine) respectively. The delusions were not always systematized. Some content aspects were related to political issues, like being state president or being associated with prominent political figures. There were also delusions of grandiosity such as having much money, being an important member of the society, and delusions of being loved by many women. Also expressed were thought insertion, thought broadcast, thought withdrawal and delusions of being bewitched.

Headaches, palpitations, dizziness, constipation and excessive sweating were the most prevalent somatic complaints among the participants. It must be noted that somatic features of schizophrenia such as weight problems, insensitivity to temperature and pain, were mentioned in the manuscripts of the so-called father of psychiatry, Emil Kraepelin (Tyler, 1995). Although little is known about the prevalence of physical complaints among schizophrenia sufferers, in a comparative study on psychiatric symptoms between Anglo-Americans and Mexican-Americans, Weisman, Lopez, Ventura, Nuechterlein, Goldstein and Hwang (2000) found that Mexican-Americans complained more of somatic symptoms than their Anglo-American counterparts. In his study on factors attributed to somatization

in schizophrenia patients, Ritsner (2003) concluded that somatic complaints among schizophrenics are prevalent, and these are linked to emotional distress attributed to many factors such as psychopathology itself, neuroleptic side effects and expressed emotions by family members.

Another noteworthy finding in this study was the degree of suicide risk among the participants suffering from schizophrenia. Suicide risk analysis was carried out by means of assessing the prevalence of suicidal ideation, previous suicidal attempts, depression and anxiety, disposal to means of suicide, feelings of helplessness and hopelessness, substance abuse, major losses experienced by the patients and including commanding hallucinations and delusions. It has been reported that 10,0% to 13,0% of the schizophrenic patients commit suicide (Kaplan & Sadock, 1997). In a comparative study of individuals with a diagnosis of a broad spectrum of schizophrenia who had and those who had not attempted suicide, Harkavy-Friedman (1999) found that 33,0% of their study subjects had at least attempted suicide once, meaning that suicidal behaviour of those individuals with schizophrenia was high and could be compared to that found in other studies. Exploring the possible role played by the command auditory hallucinations in the development of suicidal behaviour, Harkavy-Friedman et al. (2003) reported that only 8% of their study subjects stated that they had attempted suicide in response to these hallucinations. In the present study, the high risk of suicide behaviour could be mainly attributed to the high prevalence of depressive symptoms and substance abuse as already mentioned. Stephens, Richard and McHugh (1999) state that suicide among individuals with schizophrenia is strongly linked to previous suicide attempts, depressive or affective symptoms, preoccupation with death or

suicide, affective illness in close relatives, poor premorbid social and work history, sexual worries and psychomotor agitation. All these and other factors could not be ruled out as the possible causes of high suicide risk among the participants in the present study.

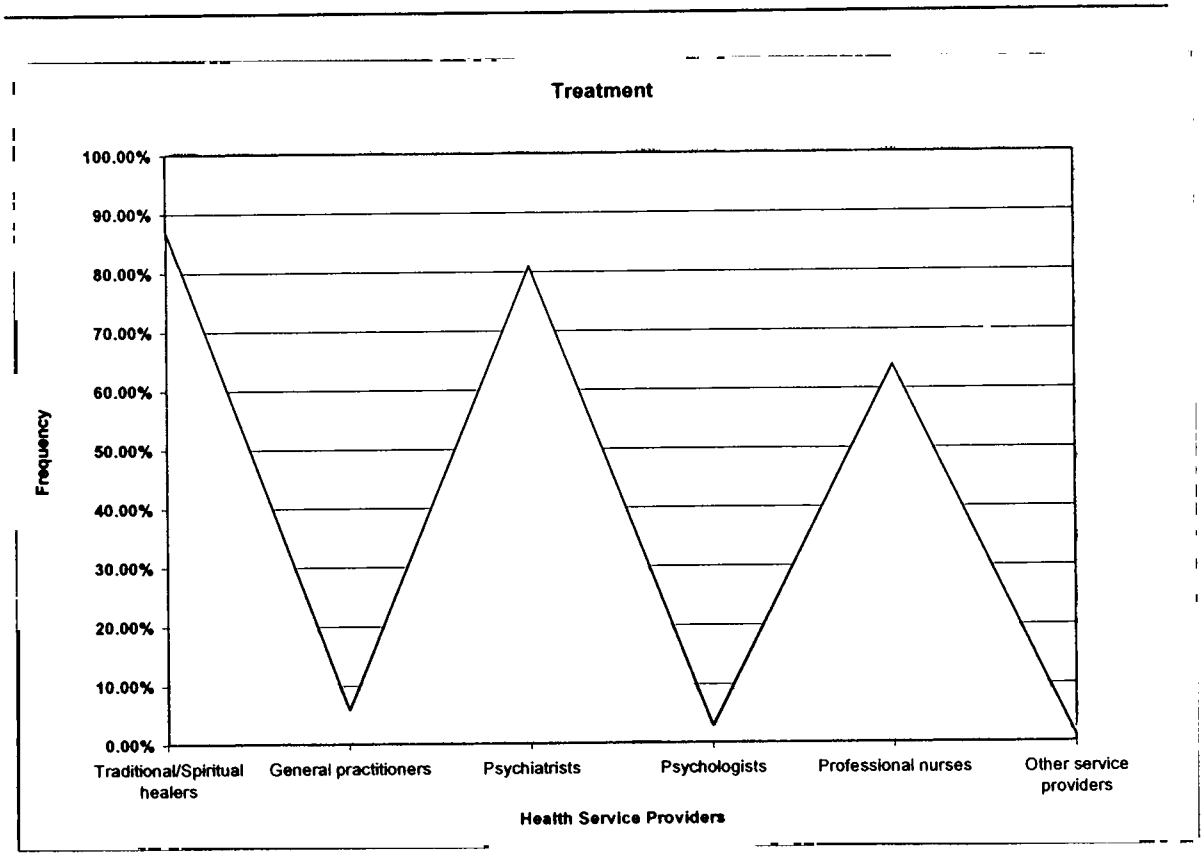
Catatonic behaviour among Sesotho speakers with schizophrenia was rare. This finding is consistent with Al-Issa (1990) who found that in Algeria, an African country with strong Arab and Muslim culture, there was a low prevalence of catatonic type of schizophrenia. On the other hand, this finding contradicts other authors such as Chandrasena (1986) who reported a relatively higher incidence of catatonia in developing countries than developed ones, especially in Africa and Asia. The participants in the present study also displayed marked behavioural disturbances like gross disruption and aggression. Ensink et al. (1998) found a similar trend among black Xhosa patients suffering from schizophrenia in Cape Town. Lucht (1998) reported that the physical outlook of the patients might be of clinical significance. In this study some marked deterioration and poor personal hygiene were noted as significant signs of pathology. These above-mentioned signs of personal appearance may also be seen as warning signs of deterioration of these schizophrenic patients.

Although it is sometimes difficult to differentiate between negative symptoms of schizophrenia and depressive symptoms, in the present study frequency of signs and symptoms of depression was significantly notable among the participants ranging from 8,0% and 57,0%. In a review article on depressive symptoms in schizophrenia, Matete et al. (2001) stated that the subject of depressive symptoms in schizophrenia has been neglected as a field of study. It is reported that depressive symptoms in schizophrenia, especially

during the first episode, are between 7,0% and 70,0%. At Mapperley Hospital, House, Bostock and Cooper (1987) conducted a study on the prevalence of depression among patients with first episode of schizophrenia. They found the prevalence rate of depression to range from 22,0% to 30,0%. The frequency of irritability and poor memory coincides with the findings by Ensink et al. (1998) who reported a similar trend among Xhosa-speaking patients with schizophrenia and the culture-bound syndrome known as *amafufunyana*.

The specific health-service providers the participants made use of for treatment of their illnesses are shown in Figure 2.

Figure 2: Health service providers consulted by participants



It is interesting that almost the same high number (nearly 90,0%) of Sesotho speakers suffering from schizophrenia consulted both Western-trained health professionals and traditional/spiritual healers. The present study confirms the important role traditional medicine plays in mental health services in the Free State Province. There are ongoing debates and discussions in South Africa on the role, policies and legislation that pertains to traditional medicine. As previously stated in the research on depression, the World Health Organisation (WHO) has called on African governments officially to recognize traditional medicine and to integrate it into their national health systems. The World Health Organisation argues that for many centuries traditional medicine had played an important role in combating multiple and complex health conditions affecting Africans. Because of its popularity, accessibility and affordability, more than 80,0% of the people in the region still continue to rely on it for their health-care needs (*Daily Sun*, 2003, 1 September, p. 3). The reason why more participants rather consulted psychiatrists than psychologists could mainly be ascribed to the mental health system in place. The procedure is such that the patient is first assessed by a psychiatrist who, if necessary, refers him/her to a clinical psychologist. Because schizophrenia is viewed more as a psychiatric disorder with more biological base than a psychological disorder, very few are referred to a psychologist.

CONCLUSION

The present study confirms the findings of other international researchers that schizophrenia, as an illness, does exist across cultures. Although core symptoms of

schizophrenia, such as perceptual disturbances, thought process disorders and behavioural signs and symptoms, do not vary significantly cross-culturally, it is important to mention that there is a marked cultural influence playing a role in the shaping of those symptoms, particularly the content of delusions and hallucinations. It was also revealed that clinical manifestations of schizophrenia, varying from individual to individual within the same cultural grouping, imply that emphasis should not only be put on general cultural similarities, but also on individual differences.

Aggression, walking around naked, changes in physical appearance and poor personal hygiene should be taken seriously by clinicians as possible warning indicators that schizophrenic illness is developing in an individual. Affective, somatic and autonomic symptoms, as well as substance abuse, seemed to be notable among Sesotho speakers suffering from schizophrenia.

Another interesting aspect of this study is the finding that the majority of the participants, as found in other international studies, were never married. Nonetheless, the majority of those patients enjoyed great social support systems in that more than 80,0% of them were not living or staying alone. It has been stated frequently that patients in developing world do boast a better course and prognosis on several measures than subjects in developed countries. Although schizophrenia places a very heavy burden on the country's budget and health services, its consequences are better dealt with in the third world due to the availability of social support systems.

As far as the treatment of schizophrenia is concerned, the approach taken by Sesotho speakers is similar to other fellow Africans in the Sub-Saharan regions, and other parts of South Africa in particular. Traditional medicine is usually the first choice of treatment, followed by the Western approach or the simultaneous combination of the two. African authors argue that mental health care in Africa has been in the hands of both traditional and spiritual healers for many centuries. The argument is that there is much that African knowledge can offer and contribute to Western science, and vice versa. Those two worlds should not negate, but rather complement each other.

In South Africa, as is the case throughout the African Continent, health professionals are still trained in Western models especially DSM-IV-TR and ICD-10. It is necessary that certain changes in these models should be made to include cultural differences that were found in this research. The above-mentioned training models are still acceptable and understandable in non-Western nations because there is a significant proportion of South African and African populations that are still part of Western culture.

Although this study has revealed significant findings, these results should, however, be interpreted with care, particularly as far as generalization is concerned. The concern largely applies to the locality of research because the patients were almost exclusively from one area of the Free State Province, while Sesotho speakers are widely dispersed throughout the province, other parts of South Africa and Lesotho. Another factor for consideration is that, within the population of Sesotho speakers, there are many sub-cultural differences. However, the study remains significant because it does not only contribute to important

academic data in a field that has been largely neglected in South Africa, but also provides information on demographic and socio-cultural factors associated with schizophrenia among Sesotho speakers. This research will, again, contribute to improving the reliability of diagnosing schizophrenia among Sesotho speakers and thus also improves our understanding of mental disorders in this culture.

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ARTICLE III

ANXIETY EXPRESSION AMONG SESOTHO SPEAKERS

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ARTICLE III

Anxiety Expression among Sesotho Speakers

Abstract

Mental health research in black communities in South Africa has been neglected to an alarming degree. Consequently the health system finds itself in a precarious situation due to a lack of accurate mental health data to facilitate proper planning. In this regard, anxiety is no exception. This study investigates the way in which anxiety is clinically expressed among Sesotho speakers. The results are that there are marked variations in presentation of anxiety symptoms among Sesotho speakers in comparison with what has been reported in the Western literature. Anxiety among Sesotho speakers is characterised by prevalence of hallucinations, and there were also overlapping symptoms of anxiety and depression.

INTRODUCTION

It cannot be denied that mental health research in black communities in South Africa has been neglected to an alarming degree. In this regard, Scarr (1988) holds the view that the sensitivity surrounding racial differences is primarily responsible for such lack of research. She rightly points out that such differences often exist and should be investigated. Whatever the cultural, historical and political reasons for the lacuna mentioned, the South African health system finds itself in a precarious situation where there is a lack of health data which impedes future planning. Without such data, it will be difficult to ensure appropriate and effective development of mental health resources and services in especially black communities. The need for data on mental

disorders is intensified by the fact that the experiences and circumstances of many black South Africans are conducive to the development of psychopathology (Albee, 1986; Gericke, 1995).

The studies on mental disorders carried out in communities or in primary health-care settings suggest that mental disorders are common. Anxiety disorders constitute anything from a ¼ to ½ of the burden (Costa-e-Silva, 1998). It has been observed that patients suffering from anxiety make more visits to public health services and for that reason more expensive, extensive, and often unnecessary medical procedures are performed. Medicines are given to manage symptoms. There is also marked social and occupational impairment, resulting in decreased productivity. For these reasons, anxiety disorders meet the criteria to be considered a public health burden.

Taking into account the above-mentioned issues, it is, therefore, very important to mention that socio-cultural factors play a significant role in the aetiology, presentation, course and management of mental disorders. It is for this reason and interest that the author decided to investigate the ways in which anxiety is manifested among Sesotho speakers in Mangaung, Bloemfontein, South Africa.

EPIDEMIOLOGY

Essentially, signs and symptoms of anxiety are widespread in the population (Eaton, 1995). Nearly three quarters of the world population will develop one or more irrational fears, spells of sudden panic, or general nervousness. However, most of these symptoms do not meet criteria to be considered a mental disorder.

Table 1 presents a descriptive lifetime prevalence of various forms of anxiety disorders according to DMS-IV-TR.

Table 1: Lifetime prevalence of anxiety disorders.

Form of anxiety	Lifetime prevalence
Panic disorder	Between 1,5% and 3,5%
Agoraphobia	Not known
Specific phobia	10,0 – 11,3%
Social anxiety disorder	Between 3,0% and 13,0%
Obsessive compulsive disorder	2,5%
Post traumatic stress disorder	8,0%
Acute stress disorder	No information
Generalized anxiety disorder	5,0%

A large epidemiological survey on mental disorders is currently under way in South Africa, a study conducted by The South Africa Stress and Health Study (SASH), which is an initiative and part of World Health Organisation's World Mental Health (WMH) 2000 initiative. For this reason, accurate data on mental disorders in South Africa are not yet available.

CULTURE AND ANXIETY

Basic to the cross-cultural study of mental disorders is the concept of culture. Most research continues to rely on an outdated definition of culture (Lopez & Guarnaccia, 2000). Culture is defined as the values, beliefs and practices pertaining to a given ethno-cultural group. Alarcon, Westermeyer, Foulks and Ruiz (1999) define culture as a set of meanings, behavioural norms and values that determine the unique view human groups and societies hold about the world and about themselves. Culture influences the development of personality and individual behavioural styles through parental attitudes, child-bearing methods, and the use and transmission of language. Butcher, Nezami and Exner (1998) define culture as: patterns of behaviour acquired and transmitted by symbols or cognitions, that make up the aggregate achievement of human groups which are embodied in artifacts or materials passed on to others. The essential elements of culture consist of materials, traditional ideas,

and values surviving within a group intergenerationally. An important point is that cross-cultural psychopathology addresses the definition, description, evaluation and management of mental disorders as they reflect cultural factors within a biopsychosocial context.

Anxiety, like depression, is a universal phenomenon and a variety of phobias or anxieties are virtually seen in all communities. However, cross-cultural investigations have indicated that there are significant differences in the way anxiety is described and potentially experienced (Guarnaccia, 1997; Kirmayer, Young & Hayton, 1995). These include variations in the prominence and subtypes of anxieties as well as associated symptoms and syndromes. There are also several culture-bound syndromes that are manifested in the form of anxiety states.

Cultural variables are apparent in the content and focus of anxiety disorders. Phobias, panic disorders and sleep paralysis are more prominent among African Americans than in the general population (Heurtin-Roberts, Snoden & Miller, 1997). The way African Americans present and experience anxiety is influenced significantly by culture; hence, the literature suggests that anxiety disorders may be significant in their incidence among African-Americans. Simple phobias are reportedly more common among African Americans compared to European Americans. Moreover, African Americans present anxiety differently from the general population because of the presence of

hallucinations, delusions and violent behaviours. Lastly, it is mentioned in the literature that African Americans express distress in terms of somatic idioms, such as physical complaints which serve as metaphors for a stressful psychological situation. Examples of the common anxiety symptoms expressed by African Americans are summarised in Table 2.

Table 2: Anxiety Symptoms among African Americans

Wooziness in the brain	Seeing black dots
Weak knees	Red eyes, seeing red
Blind staggers	Blood on the breath
Vomiting	Tasting blood
Heartburn	Excess salivation
Tight throat	Frequent urination
Gagging	Carrying on
Heaviness in arms, chest and head	Constant worrying
Stiff neck and shoulders	Startle easily
Itching	Anger
Rashes	Screaming, yelling
Drowsiness	Disorientation

Adapted from Heurtin-Roberts et al. 1995.

In some cultures, the understanding of anxiety disorder differs significantly. The word anxiety is not used in many cultures and languages. For example, according to findings by Chen, Reich and Chung (2002), Asians do not use anxiety to describe the symptoms accompanying the disorder, and patients

from Asia usually use terms such as being nervous or being tense. Referring to oneself as anxious, in many cultures, is perceived as a sign of weakness.

In Qatar, in the Middle East, panic disorders mainly involve fear of the after death rather than the fear of dying as is the case in Western societies. Muslim religion usually emphasises that an individual may be punished and tortured in his or her grave once the person dies if his/her wrongdoing outnumbers his/her good deeds (Kirmayer et al., 1995). So people become obsessed with their inability to take control of their own harmful impulses. Islamic upbringing emphasizes and focuses on religious rituals, including ritual cleansing before prayer five times a day, as well as warding off blasphemous thinking through the repetition of phrases asking for forgiveness.

Hinton et al. (2001) investigated panic disorder among Vietnamese refugees attending mental health clinics in the US. The prominent symptoms presented by Vietnamese refugees suffering from panic disorder included, among others, orthostatic dizziness, gastro-intestinal disturbances, headaches, palpitations, sudden shortness of breath and micturition. These were attributed to ethnic differences in physiology and were possibly precipitated by catastrophic cognitions generated by cultural syndromes.

Although research in Africa has increasingly pointed to anxiety-based reactions having basically the same pattern among members of all cultural groups, there

are various findings in the literature which indicate that the somatoform disorders (especially conversion and hypochondria) are the most characteristic of these disorders in Africa (Corin & Murphy, 1979; German, 1987). Epidemic hysterical clinical pictures have been described, such as, for example, the large-scale incidence of *amafufunyana* in Transkei school (Eastern Cape Province) during the period 1981-1984, during which 400 children developed symptoms such as a swollen abdomen, rolling eyes and generally wild behaviour. Furthermore, conditions which would be regarded as a specifically anxiety-based syndrome in Western nosology are conceived in different terms by black South Africans. Edwards (1987) describes, for example, the following Xhosa constructs which all refer to an anxiety-related condition: *intloko engxolayo* (which can be loosely translated as a noise in the head), and which is indicative of a condition during which the person trembles and is nervous; and *umbilini,* which refers to an experience of gastric discomfort, palpitations, debility and a proneness to be frightened.

One of the anxiety-based syndromes about which most research has been done in Africa is the so-called *brain fag* syndrome which is found especially among scholars, students, teachers, clerks and other office workers (Morakinyo, 1980; Prince, 1960). This is an anxiety-depressive disorder marked by depersonalisation and conversion phenomena. The symptomatology includes, among others, the following: sensory disturbances such as unpleasant experiences of pain, heat, itchiness, or constriction of especially the scalp, visual

disturbances, especially the shape of burning or teary eyes, or an inability to see properly, a limitation of the patient's cognitive abilities, such as, for example, an inability to understand the meaning of learning content, as well as disturbances of memory and concentration. The presence of reactive anxiety and depression is also striking. At times anxiety can assume such proportions that a diagnosis of acute personality disintegration or a brief psychotic reaction is indicated. The origin of the disorder is often linked to an over-emphasis on academic achievement or pressure to do office-bound administrative work.

In Senegal, West Africa, there is a high frequency of anxiety states characterised by agitated motor and verbal symptoms plus several physical complaints, vegetative and metabolic disturbances (Collignon & Gueye, 1995). Witchcraft attacks provoke severely acute anxiety, experienced as attacks on the body, which threaten to cause the imminent death of the affected person. Other symptoms include enuresis, impotency, physical or intellectual impairment, and phobia of completion. Phobia in general is considered to be part of daily life, imposed from outside and experienced collectively in a socialized expression of the prohibitions, while performing rituals do help to prevent and avoid obsessive thoughts. Separating psychosis from affective disorders, as well as delusions from hallucinations, seems to be difficult. Vivid images, dreams, fantasies and hallucinations are usually confused, and it may also be difficult to distinguish between delusions and social beliefs which are the core

social and cultural organisation. In South Africa, there is no known literature on the cultural presentation of anxiety disorders.

METHODOLOGY

The Mangaung Township in Bloemfontein, South Africa, was selected as the geographical area for the completion of the research. The main reason for this is that the researcher is a member of a mental health team providing services at different clinics and health establishments in this area. Secondly, Sesotho (the main language in Mangaung) is the mother tongue of the principal researcher who is also familiar with the area and the culture. Thirdly, the South African government recommends that researchers should focus rather on their immediate areas to meet the needs of their own communities than elsewhere.

For this exploratory descriptive study, the participants consisted of 101 Sesotho speakers diagnosed with anxiety disorders. They were drawn from the population of patients visiting various health establishments in the area. All patients presenting to a specific health facility who qualified, during the time period when the researcher was based at that facility were included. The time periods varied from one month to two years. The participants were evaluated and diagnosed by a multi-professional team which typically consisted of a psychiatrist (registrar), clinical psychologist and psychiatric nurse (in certain areas, social workers, occupational therapists and/or physiotherapists also

formed part of the team). The DSM -IV -TR criteria for anxiety disorders were used as the inclusion criteria. The participants were between 18 and 65 years of age, and both genders were represented. Written informed consent was obtained from each participant.

A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) used by the Department of Psychiatry at the University of the Free State, was used to elicit the information. The PIQ is based on *Clinician's Thesaurus: The Guidebook for Writing Psychological Reports* (Zuckerman, 2000) and *Outline of the Psychiatric History and Mental Status Examination* (MacKinnon and Yudofsky, 1986). The PIQ provides data on preliminary identification (including demographic information), main complaints, personal description, history of present illness, psychiatric review of systems, previous mental illness, past personal history, a mental-status examination consisting of: appearance, attitude and behaviour, thought processes, perception, mood and affect, consciousness, orientation, memory, tempo, intelligence, mode of thinking, judgement and insight, as well as hypothalamic and autonomic functioning. The PIQ is the standard assessment tool used by all governmental mental health establishments in the Free State Province. The researcher personally conducted the interviews with each individual patient.

Qualitative methods were used to describe the experiences of the participants regarding their symptoms, as well as a way to elucidate the quantitative data.

Qualitative methods that were used consisted of two types of data collection: the open-ended interview and clinical observation. The interview data consist of direct quotations from participants about their experiences, feelings, emotions, opinions and knowledge, while observation data refer to detailed description of participants' activities, behaviours, actions, and full range of interpersonal interactions and organisational processes that are part of observable human experience (Patton, 1990). Individual interviews were transcribed, and information gathered was grouped into themes. Themes are written in the subject's own words or transcribed as closely as possible (or a close rendition of the subject's account). These themes were divided into psychological symptoms, physical (somatic) symptoms, as well as behavioural and social symptoms. Quantitatively, a descriptive statistical analysis was performed to provide indications of frequency (incidence) of identifying demographic characteristics, signs and symptoms of mental illness, and socio-cultural variables associated with anxiety that are covered in the questionnaire.

The study was approved by the ethics committee and the council of the University of the Free State. The pilot study was conducted on 40 patients to investigate the practical feasibility of the research. Based on the pilot study findings, minor adjustments on coding of the questionnaire were made.

RESULTS AND DISCUSSION

The results of the study are reported next. A short summary of the main findings follows each presentation (tables, figures) after which a comparison of these findings is made with other findings. The socio-demographic characteristics of the participants are presented in Table 3.

Table 3: Socio-demographic characteristics of the participants

Characteristics	N (%) of the sample
Age	
18-25	24,8
26-35	37,6
36-45	26,7
46-65	10,9
Gender	
Male	40,6
Female	59,4
Education	
None	3,0
Grades 1-4	4,0
Grades 5-7	5,1
Grades 8-10	6,1
Grades 11-12	40,4
Grades 12 plus	31,3
Other	10,1
Marital Status	
Single	49,5
Married	37,6
Separated	2,0
Divorced	6,9
Widowed	1,0
Cohabitation	3,0
Employment/Occupation	
Unemployed and looking for a job	12,1
Unemployed and not looking for a job	11,1
Formally employed	55,6
Informally employed	1,0

Table 3 (continued)

Self-employed	2,0
Pensioner	1,0
Disability grand	3,0
Students	14,1
Religion	
Christianity	92,0
Islam/Hinduism	0,0
Atheism	7,0
Other religions	1,0
Housing	
Shack (informal settlement)	14,0
House/Part of a house	70,0
Flat	4,0
Combination of buildings	5,0
Others	2,0
Criminal Convictions	
Assault	3,0
Rape	1,0
Larceny	2,0
Malicious damage to property	1,0
Illegal drug use	1,0
Public violence	3,0
Other crimes	4,0
Substance abuse	
Cannabis	5,0
Alcohol	55,4
Nicotine	20,8
Caffeine	23,8
Cocaine	1,0
Other substances	5,0
Social Support system	
Both parents	14,0
Single mother	4,0
Single father	1,0
Step parents	1,0
Foster parents	1,0
Grand parents	3,0
Alone	24,0
Staying with spouse and children	42,0
Staying with friends	10,0

About 64,0% of the participants were aged between 26 and 45 years. As far as gender is concerned, close to 60,0% of the participants were females. This finding is not surprising as literature and international research have suggested that more women are significantly affected by anxiety than men. Although anxiety disorders are reported to be one of the most common groups of mental disorders, women (30,5% lifetime prevalence) are more likely to develop anxiety than men (19,2% lifetime prevalence) (Kaplan & Sadock, 1997).

As in the depression study, the educational levels of the participants are surprisingly high, as these are relatively higher than those of the general population in South Africa. An explanation for these high levels of education may be the following. Firstly, the more educated they are, the less they are worried about the stigma of mental diseases, especially anxiety. Secondly, the more educated they are, the more able they are to identify and express symptoms of anxiety easily. Thirdly, the educated people in the traditional cultures easily prefer to visit Western-trained health professionals rather than traditional healers.

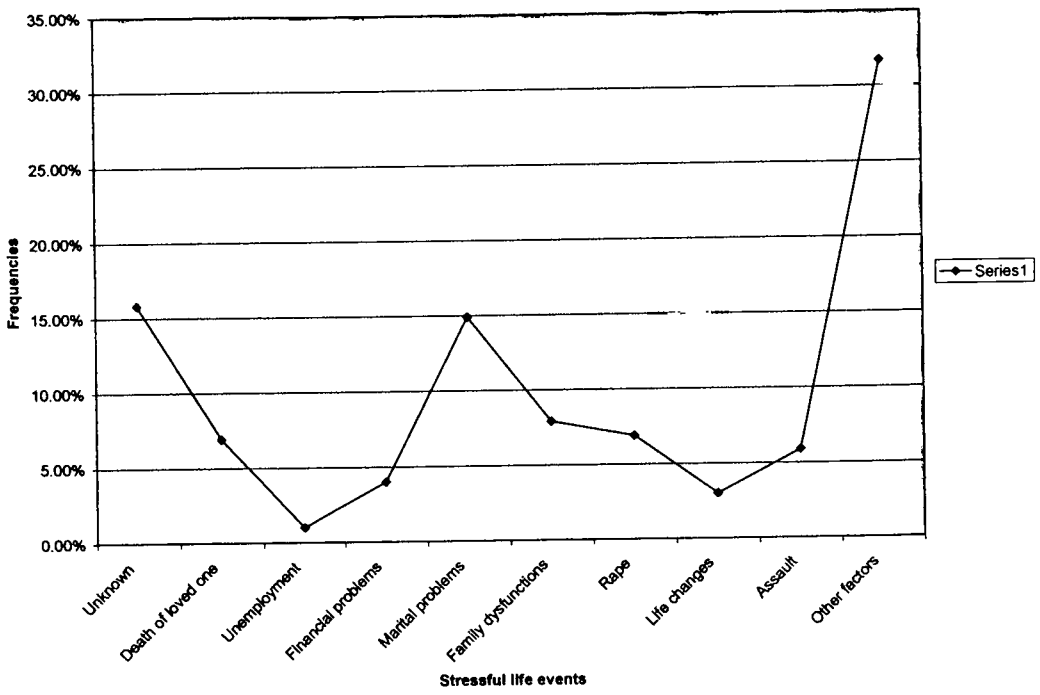
Almost 50,0% of the participants were single. This is understandable when seen against the backdrop that the average age at which South Africans enter into marriage is 30 years. But nowadays the age of getting married may surpass the age of 30 because a significant number of South Africans are concerned and occupied with personal development (professions and careers). The tendency is

to delay marital commitment to focus more on other important issues such as those mentioned above. The fact that almost half of the samples were formally employed is not surprising because the latest information at our disposal shows that unemployment rate in South Africa is 41,0% (Statistics South Africa, 2001). The dominance of Christianity among participants corresponds well with the distribution of religious groups in South Africa. In this study it was found that the majority of the participants were from the middle class rather than the lower income groups.

Factors related to the prognosis and course of psychological disorders, such as social support systems and the co-morbidity of substance abuse, were also considered. The majority of the participants claimed to use alcohol, while a small percentage also abused cannabis. Seventy five percent of the Sesotho speakers suffering from anxiety disorders had a good social support system, thus making the prognosis and course more favourable.

The relationship between stressful life events and anxiety disorders is indicated in Figure 1

Figure 1: Stressful life events and anxiety among Sesotho speakers



Although, in some cases, anxiety sufferers could not offer an explanation for their disorders, it is clear that various factors played a role in the development of anxiety among the participants. Examples are unemployment, marital and family dysfunctions, rape and assault.

Regarding a history of mental illness (not only anxiety) in the family, the findings show that about 35.6% of the patients mentioned that their close

relatives were diagnosed at least once with one or more psychological disorders. The figures vary as follows: father (2,0%), mother (6,9%), a sibling (7,9%), paternal relatives (9,9%) and maternal relatives (8,9%).

The findings concerning the primary symptoms are presented in Table 4. The inclusion criteria for classifying symptoms as primary revealed a prevalence rate of at least 20,0%. The author realised that dividing symptoms into physical and psychological categories could be regarded as overlapping and superficial. However, for practical and discussion purposes, it was decided to divide the symptoms into primary (20,0% and more) and secondary symptoms (less than 20,0%, but more than 5,0%). The frequencies are the sum total of the symptoms reported by the patients, as well as those observed by the researcher.

Table 4: Primary anxiety symptoms expressed by Sesotho speakers

Symptoms Psychological symptoms	Frequency (%)	Symptoms Somatic Autonomic Symptoms	(%)
Poor concentration	88,9	Panic attacks	50,5
Suicide ideation	44,6	Insomnia	77,2
Auditory hallucinations	59,0	Poor appetite	53,0
Irritability	67,3	Diminished libido	61,6
Depressed mood	43,6	Constipation	39,6
Anhedonia	20,0	Palpitation	70,3
Grief	21,8	Excessive sweating	62,4
Anxiety	95,0	Headaches	81,2
Agitation	61,4	Dizziness	74,3
Shame	45,5	Anxiousness	93,1
Guilt	32,7		

Although anxiety is found across cultures, its expression, in terms of concept and experiences, is influenced significantly by cultural factors. Furthermore, it was found that the core symptoms of anxiety among Sesotho speakers are not significantly different from other cultures, except the prevalence of perceptual disturbances that are shown in Figure 2. These results are also consistent with the findings by Jordaan, van Rensburg, Gagiano and Joubert (1994) who reported that symptoms such as excessive worries, irritability, headaches, excessive sweating, insomnia and dizziness were highly prevalent among many black primary care patients diagnosed with comorbidity of anxiety and major depressive disorders in Mangaung.

In the present study, it was surprising to find that within four years of the period of data collection for anxiety disorders, not even a single patient was diagnosed with obsessive compulsive disorders among Sesotho-speaking participants in Mangaung and its surroundings. This means that obsessive compulsive disorder may be very rare among Africans. Unlike in the depression study in which somatic symptoms outnumbered psychological ones in terms of severity and frequency in this study, there was a balance in frequencies of both psychological and somatic features of anxiety among Sesotho speakers.

Next to primary symptoms, there were also secondary symptoms (less than 20,0%, but more than 5,0%). However, these secondary symptoms varied

significantly in terms of diversity and severity. It was therefore decided to report only the significant symptoms to create structure, and to classify similar symptoms into groups. Furthermore, the secondary symptoms were also categorised into three clusters, namely psychological symptoms, somatic and autonomic symptoms, as well as social symptoms. Tables 5, 6 and 7 reflect these findings.

Table 5: Secondary anxiety symptoms

Fear	Alertness
Uncertainty	Paranoid
Hurt	Helplessness
Sadness	Depersonalised
Bitterness	Impatient
Blank mind	Feeling bored
Feeling of insecurity	Psychomotor retardation
Lost of interest	Mental breakdown
Generalised worries	Resentment
Stress	Feeling dirty
Aggression	Doubtful
Frustration	Lack of impulse control
Fear	Hyper sensitive loneliness
Stress	Carefree attitude
Feeling of detachment	Nightmares
Preoccupation	Lack of motivation
Mental exhaustion	Mental pressure

The Table 5 shows that there was significant comorbidity and overlapping of symptoms of depression and anxiety among the participants. Jordaan et al. (1994) found a similar trend in their research. They reported a high prevalence of major depressive disorder with comorbid anxiety in 57,0% of their study

participants. This similar finding or trend may be due to the fact that both studies were conducted in the same geographical area.

Table 6: Secondary anxiety symptoms: somatic and autonomic

Bodily pain	Breathing difficulties
Fatigue	Hot flashes
Bodily sensations	Hearing disturbances
Blurt vision	Excessive salivation
Blackouts	Sweating palms
Diarrhoea	Vomiting
Suffocation	Sleepiness
Heartburn	Tremors
Numbness	

The prevalence and the extent of somatic symptoms among the present participants are consistent with the findings of a study that was conducted in Lesotho, a country bordering on South Africa and where the majority of the population are also Sesotho-speaking (Hollifield, Katon, & Morojele, 1994). It was found that there was a significantly higher percentage of autonomic, vegetative and/or pain-related complaints among patients suffering from anxiety disorders and/or depression.

Table 7: Secondary anxiety symptoms: appearance, behavioural and social symptoms

Screaming	Laughing inappropriate
Social withdrawal	Muteness
Impulsive behaviour	Poor personal hygiene
Verbal aggression	Over eating
Occupational impairment	Slow tempo
Untidy	Walking barefooted
Poor personal management	Talking alone
Inappropriate dressing	Abusing alcohol
Running away from home	Resistant behaviour
Absenteeism	
Reluctance	
Poor eye contact	

From Table 7 it is clear that the participants manifested a wide variety of behavioural and social symptoms. Especially screaming loudly and/or feeling like screaming were prominent. This finding supports the finding of Guarnaccia (1997) that "screaming uncontrollably" is the most common manifestation of anxiety found among Latinos. As already mentioned, the findings of this study suggest some significant overlapping of symptoms of depression and anxiety among Sesotho speakers. For example, symptoms such as social impairment, eating disturbances, as well as slowed-down speech, thinking and movements are described as typical characteristics of depression according to DSM-IV-TR (2000). Furthermore, the ICD-10: Classification of Mental and Behavioural Disorders includes symptoms such as poor personal hygiene and inappropriate behaviour as indicators of mild psychotic disorders.

Table 8: Culture specific expression of anxiety

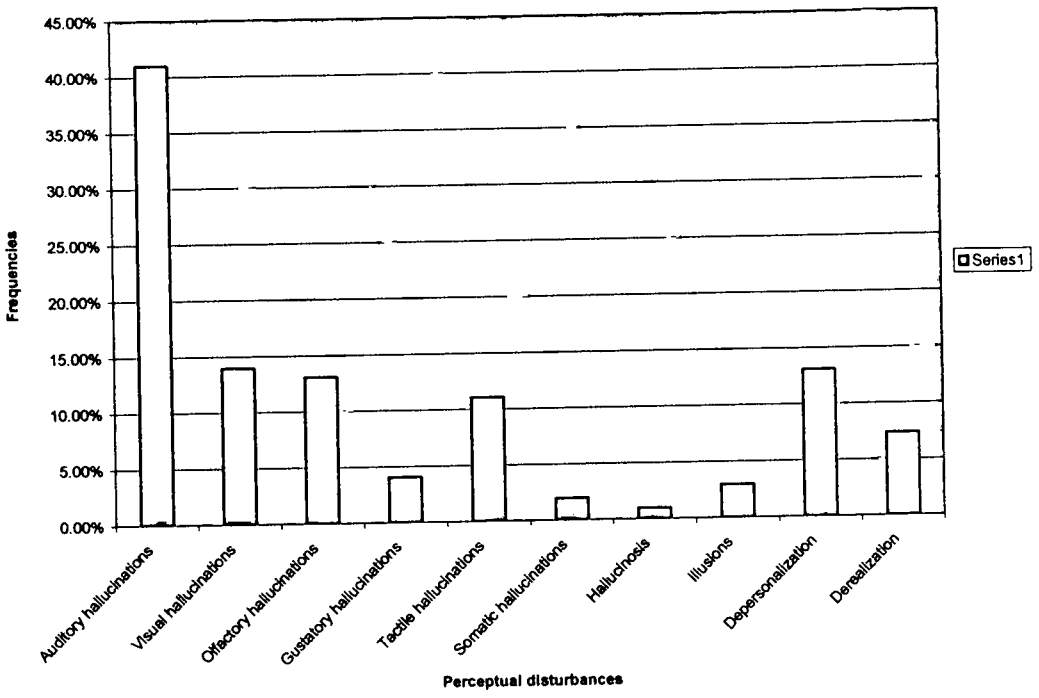
Talking with the heart
Thinking deeply
Heartache
Nerves
Hot Head
Feeling dirty

The culture specific expressions could be "translated" as follows:

- *Talking with the heart*: the patient is worrying excessively
- *Thinking deeply* refers to severe mental exhaustion
- *Hot head* equals mental confusion
- *Having nerves* means that the patient is generally experiencing mental disturbances
- *Feeling dirty* refers to depersonalisation and derealisation

A variety of perceptual disturbances also formed part of the significant symptoms for both primary and secondary symptoms. Because of the unique nature of such features among Sesotho speakers, the prevalence of these perceptual disturbances is depicted in Figure 2.

Figure 2: Perceptual disturbances among Sesotho speakers suffering from anxiety

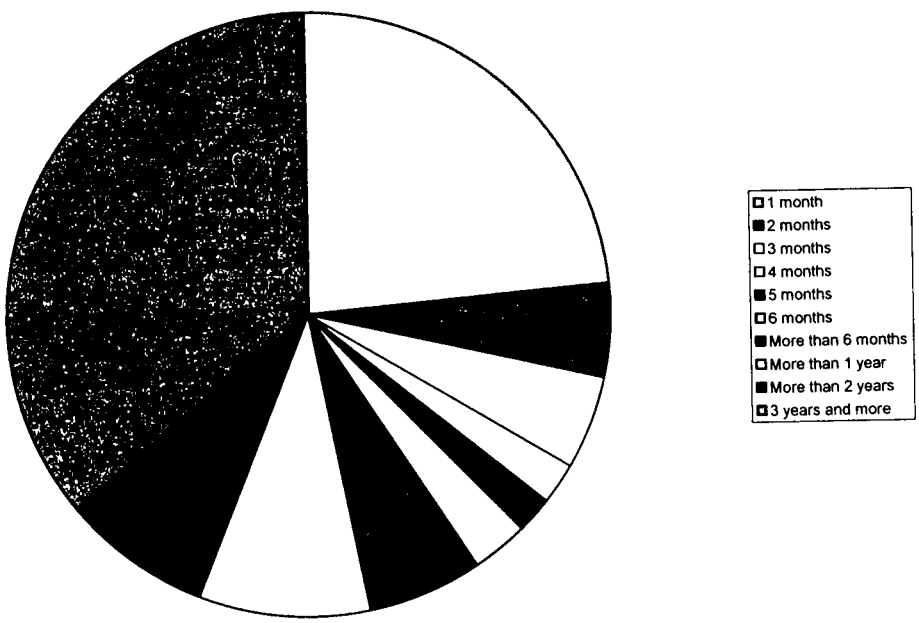


According to Figure 2 the present findings differ from findings reported in Western literature on anxiety (DSM-IV-TR). The above-mentioned perceptual disturbances are often regarded as indicative of psychotic disorders in Western cultures. The content of these mentioned hallucinations centred around hearing bells ringing, hearing voices, seeing strange and threatening objects, smelling a bad odour, and experiencing burning sensations. However, the duration and

the severity of perceptual disturbances among Sesotho speakers with anxiety are significantly lower than those who were diagnosed with depression.

The duration of anxiety experienced by participants is shown in Figure 3.

Figure 3: Duration of anxiety symptoms.



It seems that the majority of participants suffered from anxiety for a significant period of time. About 60,0% of the participants experienced these distressing symptoms for longer than six months. This finding is worrying as Costa-e-Silva (1998) rightly states that anxiety is not only a distressing mental disorder, but

also affects individual's overall capability and functioning. As a result, many Sesotho speakers complained of occupational, social and cognitive impairment as well as financial difficulties. It should be noted that the duration of anxiety among Sesotho speakers could be influenced by the unusual clinical presentation of anxiety. More specifically, the disorder, if overlooked or misdiagnosed by Western-trained health professionals, will prolong the suffering.

The specific health service providers the participants made use of for treatment of their illness are shown in Table 9.

Table 9: Health service providers consulted by participants

Health Service Providers	**N(%)**
Traditional/Spiritual healers	19,8
General practitioners	65,3
Psychiatrists	12,9
Psychologists	11,9
Professional Nurses	8,9
Other Health Service Providers (e.g. Social worker)	3,0

Table 9 shows that almost 20,0% of the participants consulted a traditional and/or spiritual healer concerning their illness. This finding is consistent with the point of view expressed by other African authors such as Mkize (2003) and

Peltzer (2001) that in South Africa and other African countries spiritual and/or traditional healers have been playing a significant role in combating a range of diseases affecting African people for centuries. The relatively low percentage of participants with anxiety who consulted a traditional and/or spiritual healer could possibly be explained in two ways. First, most of the participants were from the middle class with relatively high educational levels. As already mentioned, the more educated they are, the less they are concerned or worried about the stigma of mental illness, especially anxiety. Secondly, it seems that the less serious the symptoms, the less inclined the patients to visit traditional healers.

CONCLUSION

The present study strongly confirms other research reports that anxiety is a universal psychological or emotional disorder. However, the way anxiety is experienced and interpreted; and the way people respond to it, as for any other mental disorders such as depression and schizophrenia among others; are influenced significantly by cultural factors. These cultural forces shape the experience, description and presentation of the variability of anxiety across cultures.

Another significant finding of this research is that there was some marked variation in manifestation of the symptoms of the anxiety among Sesotho

speakers in comparison with Westerners. The main differences were observed in perceptual disturbances, specifically the prevalence of hallucinations which are regarded as indicative of psychosis in the Western world. There was also an overlapping of symptoms of depression and anxiety. Nonetheless, somatic complaints were not as prominent and severe as was the case among Sesotho speakers suffering from depression. All the same, a range of symptoms of anxiety were similar to those described in ICD-10 and DSM-IV-TR respectively. These symptoms were anxiety, anxiousness, panic attacks, constipation, palpitations, excessive sweating and dizziness. Surprisingly, obsessive compulsive disorder seems to be very rare or even non-existent among Sesotho speakers.

It can be argued that a significant range of symptoms found in the Western models, especially the DSM-IV-TR and the ICD-10, need to be expanded and elaborated further to be able to incorporate findings (symptoms) of other cross-cultural studies so that they may become more applicable and acceptable to various cultures throughout the world. Other interesting finding was an issue of language in that, certain anxiety disorders may be named differently among various cultural groups though the symptoms may resemble exactly those of the well-defined ones in the Western literature.

The present study confirms that in South Africa and Africa at large, there should be room for traditional medicine. It is therefore important that the role of traditional medicine should be incorporated and clarified by official policies.

Furthermore, the World Health Organisation (WHO) (2002) has made a call on African policy makers officially to accept and recognise traditional medicine and to integrate it into their national health systems. In this regard, Louw and Pretorius (1995) argue that the new political dispensation in South Africa is faced with challenges such as creating a health system that is applicable and relevant to the needs of the people of the country. Like the rest of the African continent, traditional healers deserve a place next to Western-trained mental health professionals, and there should be no room for cultural arrogance as Africans are neither Americans nor Europeans. African people should be treated within the framework their culture and belief systems.

Though the present study revealed significant findings, the results should, nevertheless, be interpreted with caution, especially as far as generalisation is concerned. For example, the participants were strictly from one area in the Free State Province, whereas Sesotho speakers are widely spread throughout the province, many parts of South Africa and Lesotho. However, its significance should not be under-estimated, because it does not only contribute to important academic data in a field that has been largely neglected in South Africa, but also provides information on socio-demographic and socio-cultural forces associated with anxiety among Sesotho speakers.

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ARTICLE IV

SUBSTANCE ABUSE AMONG SESOTHO SPEAKERS

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ARTICLE IV

Substance Abuse among Sesotho speakers

Abstract

Substance abuse is one of the biggest challenges facing South Africa today. Social deviances such as poverty, crime and other social disintegrations are consequences of a high prevalence of substance abuse. This research investigates clinical manifestations of substance abuse among Sesotho speakers. A sample 106 participants diagnosed with substance abuse was evaluated using the Psychiatric Interview Questionnaire. Alcohol is found to be the most widely abused substance, followed by nicotine and cannabis. The participants manifested a wide range of cognitive, affective and hypothalamic symptoms.

INTRODUCTION

Substance abuse is a major cause of social deviances such as crime, domestic violence, poverty, decreased productivity, family and marital disintegration, exacerbation of chronic and fatal diseases (e.g. HIV-Aids, tuberculosis, diabetes and cancer) in South Africa, according to the South African National Drug Master Plan (1999). The situation is aggravated by the fact that most parents do not feel free to discuss drug-related issues with their children. Substance abuse is therefore, to a large extent, a concealed psychological disorder.

Just like in most, if not all other countries, alcohol is the most commonly abused substance in South Africa. It adversely affects millions of South Africans, many of them being innocent victims. However, South African socio-economic and political changes have made the country attractive to investors and foreign trade; for this reason, the region has been turned into one of the world's drug centres, luring international crime syndicates. Also because of its climate and many isolated geographical areas, South Africa is one of the biggest producers of cannabis in the world. It is thus understandable why South Africa has become a regional and international

hub for trafficking various types of narcotic drugs. Another common but often neglected form of substance abuse in South Africa involves over-the-counter and prescription medication which, according to research (e.g. Myers, Siegfried & Parry, 2003), is highly prevalent.

Nevertheless, most research on substance abuse in South Africa has been in urban areas, leaving certain rural areas and cultural groups in particular neglected.

The aim of this study was to find out how substance abuse-related disorders are clinically manifested among Sesotho speakers in Mangaung – Bloemfontein, South Africa.

EPIDEMIOLOGY

Brady and Randall (1999) report that although the occurrence of substance abuse and dependence is more common among men than women, the prevalence rates show that a diagnosis of substance abuse is not gender specific. The literature has shown that substance abuse among men and women is not clearly as specific as far as differences are concerned. Men usually begin to abuse substances earlier than women do. In the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, 2000) and ICD- 10 (WHO, 1992) the epidemiology of specific substance abuse disorders is not clearly detailed.

Parry (1998) rightly points out that there are no reliable systems that can facilitate the thorough collection of data on substance abuse in South Africa. The available information on disposal is usually obtained from research conducted in an isolated location and from information

gathered through police arrests and seizures. However, at the same time it is generally noted that substance abuse is rapidly permeating the poor sectors of South African society (Morojele, 2000). Despite this precarious situation, Flisher and Stein (2000) report that most South African mental health professional societies do not address substance abuse as a priority issue. This point of view comes after they have observed and reviewed the conferences organized and conducted by professional societies such as the South African Society of Psychiatry, the Psychological Society of South Africa, the Epidemiological Society of Southern Africa, and the South African Association of Child and Adolescent Psychiatry and Allied Disciplines. This does not imply, however, that valuable research on substance abuse in South Africa has not been conducted. For example, Peltzer, Malaka and Phaswana (2002) state that it is difficult to estimate accurately the prevalence of substance abuse in South Africa. This may be due to, according to the present author, the social and geographical complexity of South Africa. Peltzer and Associates found that the prevalence of substance abuse especially alcohol (22,2%), tobacco (12,0%), cannabis (6,6%), opiate type drugs (6,9%) and inhalants among university students in Limpopo Province, was much similar to those found in Kenya, East Africa. The results showed that alcohol, followed by nicotine and marijuana was the most commonly abused substance.

In the Western Cape, research was conducted to investigate the incidence of alcohol intake among pregnant women attending antenatal clinics in various health establishments. Croxford and Viljoen (1999) reported a disturbingly high rate (42,8%) of alcohol ingestion among pregnant women. About 46,0% of the participants admitted smoking, whilst combined abuse of alcohol and nicotine was 29,6%. Still in the Western Cape, Peden and Bautz (2000) investigated the link between substance abuse and physical trauma in Cape Town. It was

found that about 60,0% of the injured patients were tested positive for the presence of alcohol in the blood stream. The injuries were inflicted through traffic accidents, interpersonal violence and self-inflicted injuries. Van der Spuy (2000) goes further arguing that substance abuse, in general, is one of the major causes of high rate of trauma in that 7,0% of the drivers with higher percentage of alcohol concentration in the blood stream are responsible for 29,0% of non-fatal and 47,0% of fatal driver injuries. Whilst intoxicated pedestrians also account for 40,0% of the national traffic death toll in South Africa., Cannabis and Mandrax accounted for 41,8% of injured patients.

Attempting to shed light on over-the-counter and prescription medicine abuse, Myers et al. (2003) argue that over-the-counter and prescription medicine abuse should be considered a major social and health risk and burden. It was found that benzodiazepines and analgesics are the most commonly abused drugs in Cape Town. Women were more prone to abuse these drugs than men.

The Province of KwaZulu-Natal is no exception as for as substance abuse is concerned. Taylor, Tinabhai, Naidoo, Kleinschmidt and Dlamini (2003) studied the prevalence and associated factors of substance among rural pupils in this province. It was found that there was high rate of substance abuse among these learners. Alcohol (52,9%) was the main substance of abuse, followed by cannabis (16,9%), while 13,0% admitted smoking more than one cigarette per day.

It seems that even health professionals are not immune to the dangers of substance abuse. Marais, Calitz and Rataemane (2002) investigated the prevalence of alcohol abuse among

medical students at the University of the Free State. It was found that 28,3% of medical students at sixth-year level abused alcohol excessively. Bateman (2004) reviewed research projects on substance abuse among medical practitioners in South Africa. However, the studies only focused on medical professionals who suffered from substance dependency and were therefore a highly selected group. The research, nonetheless, confirms that a significant percentage of medical professionals develop substance dependency during their training years.

As far as the prevalence of the abuse of specific substance in specialised treatment centres is concerned, Table 1 reflects the situation in various South African centres and geographical areas.

Table 1: Primary substances of abuse: by specialised treatment centres and six months period (%) in South Africa

	Cape Town	Durban	Port Elizabeth	Gauteng	Mpumalanga
Alcohol	39,0	65,0	51,0	49,0	61,0
Cannabis	15,0	24,0	12,0	21,0	20,0
Mandrax	24,0	4,0	26,0	10,0	0,2
Cocaine/Crack	8,0	4,0	2,2	7,0	2,0
Heroin	7,0	1,1	0,0	6,1	7,2
Ecstasy	1,4	0,5	0,4	0,4	2,0
Over-the-counter and Prescription medicine	2,2	0,3	5,3	3,3	6,0
Other substances	2,5	0,8	2,7	2,4	2,0

Adapted from South African Community Epidemiology Network on Drug Use (SASENDU) (Plüddeman et al. 2003)

It is clear that alcohol is the most commonly abused substance in South Africa. Next to the already mentioned consequences of substance abuse (accidents, aggressive behaviour, etc,) the correlation between substance abuse and the development of mental disorders and violent behaviour should not be underestimated. For example, there are ongoing debates on the link between substance abuse and psychosis. The fundamental question is what precipitates what? Brink, Oosthuizen, Emsley, Mabanga and Keyter (2003), upon investigating the impact of substance abuse on psychosis, reported that such abuse has a significant effect on the onset of Psychotic behaviour among patients in the Western Cape. The finding was that a significant percentage (27%) had used or abused substances more than once a week in the three months prior to their becoming psychotic. The conclusion was that substance abuse is very common among Psychiatric patients.

In a review article, Padayachee and Singh (2003) link intimate violent behaviour with substance abuse. The argument is that substances, especially alcohol, play a role in the incidence of domestic violence. However, people's response to substance abuse differs from culture to culture. It is argued that violence caused by substance abuse is assimilated socially rather than caused by involuntary reactions.

CULTURE AND SUBSTANCE ABUSE

Culture is an assimilated system of beliefs, values, rules, meanings, and practices that are transmitted from one generation to the next in patterned ways (Flaskerud, 2000). Culture therefore expresses and reflects the manner of looking at, perceiving, and experiencing the

world. Against this background, it is understandable why culture plays a vital role in the development of certain attitudes and behaviours towards alcohol and other drugs.

Heath (2001) rightly points out that it is globally recognized that various cultural and ethnic groupings use a wide variety of alcohol and drugs in many different ways. Mental health professionals are often not well equipped to work with clients from cultures different from their own (Amodeo & Jones, 1997).

The most common substances of abuse worldwide are alcohol, cannabis, cocaine, ecstasy, heroin, LSD and mandrax. Pharmacologically, alcohol is considered a depressant drug. For many, the abuse of alcohol is a multi-factorial process related to genetic, psychological and socio-cultural forces as well as a high individual indication to dependence (Battle, Philippe, Saxena & Shekhar, 1996). Each culture has its own unique interpretation and perception of alcohol abuse. The aspect of mental illness, guilt and tolerance thresholds perceived as a problem in certain cultures, is significantly different from what it is considered to be in another culture.

In many cultures, beverages of alcohol make up significant and valued dimensions of life (Barry III, 1982). In the main, most literature places excessive emphasis on alcohol, albeit other hard and harmful drugs have already penetrated many communities.

Room (2001) categorizes drinking behaviour into two dimensions: "wet" and "dry" societies. According to the nosology in dry societies, alcohol is taken apart from everyday life as a unique valuable commodity for special occasions, hence drinking is traditionally sporadic, is often used

during special days or weekends, with a high proportion of drinking involving drunkenness. But "wet" societies use alcohol as part of everyday life, and such use usually accompanies meals. An example of alcohol that is often used in "wet" societies is red wine which is often used during meals.

Drinking behaviour in various societies has been viewed in different ways in the world. Alcohol can be seen as a substance with psychoactive ingredients; for that reason, access to alcohol may be restricted. On the other hand, alcohol is seen as part of food rather than a drug, and therefore, access to alcohol is relatively unrestricted (Schmidt & Room, 1999). There are also cultural variations in the regulation of quantity, duration and behavioural dimensions of drinking and drunkenness. People across the globe may differ significantly in the degree to which particular substance-related problems are viewed as serious issues in their communities. Other cultural aspects of drinking include the problematization of dependence, drinking-related states and experiences, the extent to which attention is paid to the potential involvement of substance in adverse situations and the reality of culture specific presentation of alcohol disturbances that are not properly captured in either the DSM-IV-TR or the ICD-10.

The continuum between normal and abnormal (pathological) drinking was explored by Bennet and Janca (1993), who focused on how people from various cultural backgrounds distinguish between normal and abnormal drinking which might be labelled harmful, abusive, heavy, dependent and pathological consumption. It is also mentioned that people within the same culture display different ideas and experiences regarding alcohol consumption, whether these are normal or pathological. It was found that people (sample) from Greece and Spain agreed

that normal drinking was possible and was a very important aspect of their cultures. Arizona respondents gave mixed views concerning normal drinking and pathological drinking. The first group of respondents argued that normal drinking was not possible, hence normal drinking equalled binge drinking, while other negligible numbers of respondents believed that normal drinking was possible because it was more apparent in other cultures than among the Navajo themselves. In Bangalore, India, it was reported that respondents generally argued that normal drinking was not possible within their cultures.

Brannock and Schandler (1990) investigated cultural and cognitive factors among groups of black, white and Hispanic adolescent drinkers. White respondents manifested more frequent drinking behaviour than black and Hispanic groups. However, there was a significant difference between Blacks and Hispanics as far as drinking behaviour was concerned. Whites drank more socially, and drank in response to distress, while black respondees reported less drinking among friends and peers.

In Dallas, Houston and San Antonio, a comparative study on the link between aggressive criminal activities and substance abuse among Mexican American, black and white arrestees was carried out. The purpose was to predict the outcome of aggressive crime on the basis of substance abuse (both hard drugs and alcohol) and cultural group variables within the total male sample of 2,364 (Valdez, Yin & Kaplan, 1997). It was found that Mexican Americans were more likely to be arrested for aggressive crimes than either African Americans or European Americans. However, effects of both illicit drugs and alcohol were found to be similar for all ethnic groups. This means that although hard drug abuse and aggressive behaviours receive most of the attention across the globe, alcohol itself is still the prominent

substance responsible for violent behaviours across the range of ethnic groups consisting of Hispanics, Blacks and Whites. Alcohol is evidently linked to domestic violence, especially among middle class men.

In Singapore, in the Far East, Hong & Israiowitz (1989) conducted a cross-cultural study on alcohol consumption behaviour among Singapore college students. The assumption was that Singapore Indian college students would display higher rates of drinking problem behaviour than Chinese students. The findings were that about 70,0% of Chinese responders mentioned that they consumed alcohol in comparison to 63,0% of the Indian respondents who used the substance. Regarding gender, 80,0% of Chinese males and 60,0% of females used alcohol. Making a comparison, it can be stated that a slightly lower percentage of alcohol users were found in the Indian sample. Chinese students liked beer while Indians preferred red wine. There were differences in the effects of substance abuse among Chinese and Indian respondents in terms of having a hangover, vomiting because of drinking, driving a car under the influence of alcohol, social and occupational impairment such as missing a class because of the after effects, and causing disharmony in interpersonal relationship. Indians displayed a tendency of more problematic behaviour than the Chinese sample.

Testing the cross-cultural applicability of Jellinek's Progression Technique in a sample of Navajo men and women, Venner and Miller (2001) found the following as far as the progression of alcohol problems was concerned: that in general, Navajo respondees tasted alcohol for the first time around age 16; violation of legal, social norms and rules took place in

the early twenties, and the first experience of blackout occurred in the mid-twenties. Many happenings centred around 28 years of age, events that were related to social and interpersonal relationships, while they carried on with their drinking habits despite problems. First hospitalization, attempts to quit drinking and nutritional neglect occurred by their early thirties. Aspects typical of dependence appeared later in the progression. Changes in tolerance and the drinking of non-beverage alcohol such as mouthwash or hairspray were the last to be reported. Symptomatologically the participants (20 out of 46) experienced loss of interest in life, heavy drinking episodes lasting for at least two days. They also reported a decrease in moral standards and vague spiritual desires, physical withdrawal symptoms such as being afraid and tremors. Most importantly, Navajo women experienced hallucinations at the beginning of their progression. Feeling bad about drinking, experiencing augmented tolerance and quitting for a while occurred in at least 20 ordinal positions later for the Navajo.

Once more, in the United State of America, the study was conducted among primary care patients with alcohol problems, comparing whether race made any difference between two groups of participants (African Americans and Whites) with respect to consumption, severity, consequences, readiness to change and coping behaviour. Conigliaro et al. (2000) reported that in comparison to white patients, African-American respondents presenting with alcohol problems, and enrolled in a brief intervention programme, met all the criteria for alcohol dependence or drug dependence, but displayed the same alcohol consumption compared to white patients. There was a marked increase in drug dependence among African Americans compared to Whites who met criteria for drug dependence (43,0% versus 35,0%). Again, it was discovered that alcohol and drug abuse were more serious among African Americans than

Whites. However, there was no difference in alcohol consumption rate between the two groups. All the same, African-American patients had tendencies of reporting more on symptoms of dependence and less on consumption than white patients. In relation to readiness to change, both groups were equally ready to change their drinking behaviour, but African Americans were more highly concerned about the consequences of alcohol on their health and life in general.

A similar study was also conducted in the USA focusing on the prevalence, incidence and stability of dependence-related problems and social consequences among Whites, Blacks and Hispanics: 1984 – 1992 (Caetano, 1997). The findings were that Hispanic men displayed a higher incidence of frequent heavy drinking, much more than other ethnic groups and women. Again the higher incidence and stability of dependence problems were found to be more prevalent among Hispanic men than Blacks and Whites. Stability referred to an indicator of chronicity, while the incidence denoted the proportion of people who did not report a disturbance in 1984, but did so in 1992. The dependence-related disturbances are: salience of drink-seeking behaviour, loss of control, withdrawal and tolerance symptoms as well as relief drinking. In general, the results showed that Blacks displayed a higher incidence of both dependence-related and social consequences, as well as more marked stability of social consequences compared with whites. Social consequences refer to financial difficulties, social and legal problems, health-related issues, marital dysfunction, as well as social and occupational impairment.

In California, the sub-tribes of Chumash Indians use Datura, which is a hallucinogenic substance (Grobstein & Rios, 1992). This decoction is used in pubertal custom to celebrate the passage of the youth into adulthood. The decoction consists of the leaves, roots and stems, which are soaked in water.

There have been several reports on wide varieties of illicit dugs such s cannabis, cocaine, Lsd, ecstasy, mandrax and heroin in South Africa. As these mentioned drugs are not enough, there is also a home-made drug called methcathinone popularly known as "cat" which is a cocktail of methamphetamine mixed with other substances (Lillah, 2003). This drug is secretly prepared in the kitchen by anyone with a recipe and sold exclusively in a white powder form and can be diluted in liquids or mixed with other substances in capsule form in order to be injected intravenously. The most dangerous part of this drug is that it is deadly addictive. Common symptoms include increased energy, euphoria, flight of the mind, feelings of invincibility. Moreover, the side effects are reported to be terrible and include, tremors, insomnia, somatic symptoms, dehydration, sweating, nasal disturbances, anxiety, rapid heart rate, and loss of weight; at worst, the addicted person may present with paranoia, convulsions and various forms of hallucinations.

METHODOLOGY

The Mangaung Township in Bloemfontein, South Africa, was selected as the geographical area for the completion of the research. The main reason for this was that the researcher is a member of a mental health team providing services at different clinics and health

establishments in this area. Secondly, Sesotho (the main language in Mangaung) is the mother tongue of the researcher who is also familiar with the area and the culture. Thirdly, the South African government recommends that researchers should rather focus on their immediate areas to meet the needs of their own communities than elsewhere.

For this exploratory descriptive study, the participants consisted of 106 Sesotho speakers diagnosed with substance abuse. They were drawn from the population of patients visiting various health establishments in the area. All patients presenting to a specific health facility who qualified, during the period when the researcher was based at the facility were included. The time periods varied from one month to two years. The participants were evaluated and diagnosed by a multi-professional team which typically consisted of a psychiatrist (registrar), clinical psychologist and a psychiatric nurse (in certain areas, social workers, occupational therapists and/or physiotherapists also formed part of the team). The DSM-IV-TR criteria for substance abuse were used as the inclusion criteria. The participants were between 18 and 65 years of age, and both genders were represented. Written informed consent was obtained from each participant.

A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) used by the Department of Psychiatry at the University of the Free State, was used to elicit the information. The PIQ is based on the *Clinician's Thesaurus: The Guidebook for Writing Psychological Reports* (Zuckerman, 2000) and *Outline of the Psychiatric History and Mental Status Examination* (MacKinnon and Yudofsky, 1986). The PIQ provides data on preliminary identification (including demographic information), main complaints, personal description, history of present illness, psychiatric review of systems, previous mental illness, past personal history, a mental-

status examination consisting of: appearance, attitude and behaviuor, thought processes, perception, mood and affect, consciousness, orientation, memory, tempo, intelligence, mode of thinking, judgment and insight, as well as hypothalamic and autonomic functioning. The PIQ is the standard assessment tool used by all governmental mental health establishments in the Free State Province. The researcher personally conducted the interviews with each individual patient.

Qualitative methods were used to describe the experiences of the participants regarding their symptoms, as well as a way to elucidate the quantitative data. Qualitative methods that were used consisted of two types of data collection: the open-ended interview and clinical observation. The interview data consist of direct quotations from participants about their experiences, feelings, emotions, opinions and knowledge, while observation data refer to detailed description of participants' activities, behaviours, actions, and full range of interpersonal interactions and organizational processes that are part of observable human experience (Patton, 1990). Individual interviews were transcribed, and information gathered was grouped into themes. Themes are written in the subject's own words or transcribed as closely as possible (or a close rendition of the subject's account). These themes were divided into psychological symptoms, physical (somatic) symptoms, as well as behavioural and social symptoms. Quantitatively, a descriptive statistical analysis was performed to provide indications of frequency (incidence) of identifying demographic characteristics, signs and symptoms of mental illness, and socio-cultural variables associated with substance abuse that are covered in the questionnaire.

The study was approved by the ethics committee and the council of the University of the Free State. The pilot study was conducted on 40 patients to investigate the practical feasibility of the research. Based on the pilot study findings, minor adjustments on coding of the questionnaire were made.

RESULTS AND DISCUSSION

A short summary of the main findings follows each presentation (tables, figures) after which a comparison of these findings is made with other findings. The socio-demographic characteristics of the participants are presented in Table 2.

Table 2: Socio-demographic characteristics

Characteristics	N (%) of the sample
Age	
18-25	27,6
26-35	26,5
36-45	18,0
46-65	39,2
Gender	
Male	69,8
Female	30,2
Education	
None	4,7
Grades 1-4	14,2
Grades 5-7	29,2
Grades 8-10	21,7
Grades 11-12	13,2
Grade 12 plus	10,4
Other	6,6
Marital Status	
Single	56,6
Married	26,4
Others (divorced, separated, etc)	17,0
Employment/Occupation	
Unemployment	31,1
Formally Employed	18,0
Informally Employed	2,0
Self-employed	2,0
Public Assistance	32,1
Students	15,1
Religion	
Christianity	76,4
Atheism	22,6
Housing	
Shack (informal settlement)	28,3
House	68,9
Criminal Convictions	
Assault	7,6
Robbery	3,8
Possession of illegal firearm	0,9
Larceny	15,1
Burglary	4,7
Malicious damage to property	6,6
Drug trafficking	1,8
Public Violence	0,9
Other Crimes	4,7

Table 2 (continued)

Substance Abuse	
Cannabis	49,1
Alcohol	75,5
Nicotine	56,6
Inhalants	14,2
Social Support System	
Both Parents	13,3
Single Mother	8,6
Single Father	2,9
Foster Parents	4,8
Grand Parents	9,5
Alone	11,4
Staying with spouse and children	33,3
Staying with friends	16,2

About 54,0% of the participants were aged between 18 and 35 years. Table 2 shows that the elderly (aged between 46 and 65) were most affected by substance abuse disorders. This finding confirms what was reported by Widlitz and Marin (2002) that elderly people are also prone to develop substance addiction and dependence. However, this issue is more likely to be overlooked and ignored by health professionals. The fact remains,nonetheless, that substance abuse is common in the general population and encompasses people of all ages and socio-economic status (Weaver, Jarvis & Schnoll, 1999). As far as gender is concerned, it was found that about 70,0% of the participants were males. This corresponds well with international literature and research that substance abuse is usually higher among males than females.

As far as education is concerned, it was found that relatively few participants had passed grade 12. If the socio-economic status of the participants are taken into account (e.g. about one third of the sample was unemployed), these low educational levels are understandable. It could also be that substance abuse negatively affects an individual's social and mental functioning.

Almost 60,0% of the subjects were single. A possible explanation could lie in the fact that most South African youth do not marry before the age of 30. Also, the fact that so many of the participants were unemployed and could therefore not be able to offer the necessary financial securities to their families probably also played a role. It is disturbing that a significant percentage of participants who were diagnosed with serious substance abuse disorders were students. This result supports the findings by Marais et al. (2002) who reported a prevalence rate of more than 25,0% of alcohol abuse among medical students in the Mangaung area. The dominance of Christianity among the participants corresponds well with the distribution of religions in South Africa. Another significant finding was that more than 40,0% of the participants were involved in criminal activities. This is in agreement with what was reported by Padayachee and Signh (2003) and Heffernan, Finn, Saunders and Byrne (2003) who also found a relatively high incidence of various crimes among substance abusers.

Alcohol was found to be the main substance abused by the participants, followed by nicotine and cannabis respectively. More than one substance was abused by about 40,0% of the participants. The higher prevalence of alcohol, nicotine and cannabis than other hard drugs such as heroin, cocaine and crack, and the like, might be attributed to accessibility and affordability of the afore-mentioned drugs in the community. Taylor et al. (2003) found a similar trend in KwaZulu-Natal Province, the Eastern coastal region of South Africa. However, this finding is in contrast with other regions and cultural groups in South Africa (see Table 1).

Nearly 90,0% of the participants did have some form of social support system. This is in accordance with findings by other researchers that the social support system of individuals suffering from mental disorders is adequate in the developing world, leading to a better prognosis and course than is the case in developed nations (Dani & Thienshaus, 1996; Sartorius, Jablensky, Gulbinat & Ernberg, 1980; Jablensky et al., 1992).

The findings concerning the primary symptoms are presented in Table 3. As it was impossible to determine the cause, it should be noted, however, that the reported symptoms could not necessarily be linked unequivocally to substance abuse, because they could have been symptomatic of another underlying mental disorder. The inclusion criteria for classifying symptoms as primary revealed a prevalence rate of at least 20,0%. Dividing symptoms into somatic and psychological categories could be regarded as overlapping and superficial. However, for practical and discussion purposes, it was decided to make the distinction between primary symptoms (20,0% and more) and secondary symptoms (less than 20,0% but more than 5,0%).The frequencies are the sum total of the symptoms expressed by the participants as well as those observed by the researcher.

Table 3: Primary Substance Abuse Symptoms expressed by Sesotho speakers

Psychological Symptoms			
Aggression	32,1	Auditory hallucinations	73,1
Disorientation	23,0	Visual hallucinations	55,0
Poor concentration	77,1	Hallucinosis	27,2
Irrelevant answers	25,5	Illusions	23,0
Derailment	24,5	Inappropriate affect	27,4
Suicide ideation	20,0	Restricted affect	23,6
Delusions of persecution	36,8	Irritability	50,0
Delusion of grandeur	20,8	Anxiety	35,0
Memory impairment	53,0	Agitation	40,6
Poor insight	58,0	Poor judgment	53,0
Concrete Mode of thinking	67,0	Insomnia	71,0
Overeating	21,0	Poor libido	51,0
Somatic Symptoms			
Constipation	43,4	Palpitations	43,0
Headaches	50,0	Excessive sweating	59,0
Dizziness	52,0	Anxiousness	60,4

Table 3 shows that there was significant comorbidity and over-lapping of symptoms such as impaired concentration, poor memory, auditory and visual hallucinations, irritability, insomnia and decreased libido. These symptoms were also found in other mental disorders, especially schizophrenia and major depressive disorders among Sesotho speakers. However, it was found that the contents of hallucinations in the participants were not clearly defined as was the case with depression, anxiety and schizophrenia.

Because substance abuse and especially alcohol abuse could lead to various physical conditions, a marked deterioration in general health, malnutrition and poor personal self-care and hygiene

were also observed. It was therefore somewhat surprising that participants expressed more and a wider variety of psychological than physical symptoms. There were more impairment and disturbance of cognition than were the case with mood, affect and behaviour. Behavioral and social deviations such as violent and aggressive behaviours, violation of social and legal norms seemed to have been more frequent when a combination of substances was abused. These seemed to be alcohol and cannabis in particular. A significant number of the participants also expressed difficulties with absenteeism at work; decreased productivity, and poor labour discipline; as well as general impairment in social, academic, occupational and mental functioning. Moreover, they also experienced financial difficulties, consequently neglecting their family and social responsibilities.

Next to the primary symptoms, there were also secondary symptoms which could not be ignored. The symptoms were classified as secondary as they were less than 20,0%, but more than 5,0%. These symptoms varied markedly in terms of diversity and severity. Those secondary symptoms are shown in Table 4.

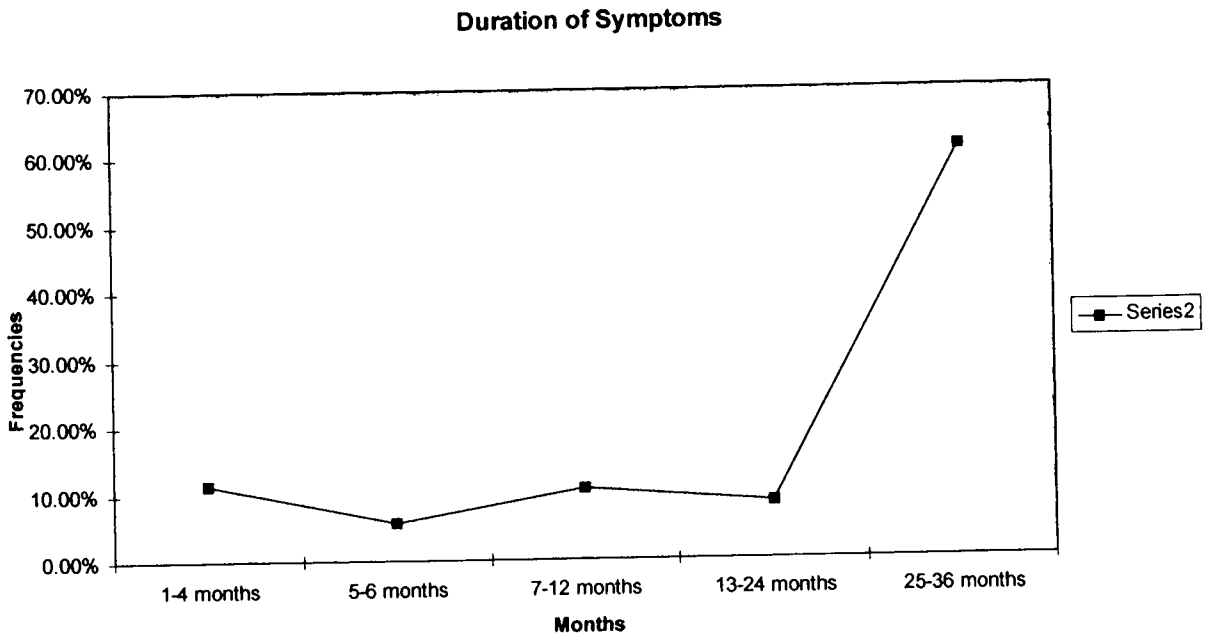
Table 4: Secondary symptoms of substance abuse expressed by Sesotho speakers

Tangentiality	Delusions of reference
Loosening of associations	Bizarre delusions
Derailment	Olfactory hallucinations
Flight of ideas	Gustatory hallucinations
Pressure of speech	Somatic hallucination
Poverty of speech	Depersonalization
Blunted affect	Labile affect
Walking around naked	Dysphoric mood
Expansive mood	Mood swings
Elevated mood	Euphoria
Depression	Anhedonia
Alexithymia	Panic
Apathy	Shame
Guilt feelings	Fainting
Acting out	Nerves
Bad smell	Boiling brain
Hot head	Fear
Poor personal hygiene	Red eyes
Stress	Deterioration
Poor academic performance	Loss of control
Numbness	Talking with heart
Decreased productivity	Poor motivation
Lack of willpower	Walking around aimlessly
Family negligence	Itching sensations
Weakness	Visual disturbances
Stiffness of the neck	Social withdrawal
Loss of weight	Running away from home
Short tempered	Intoxicated
Talkative	Feeling dull
Crying	Vomiting
Stealing behaviour	Secretive

The variety of secondary symptoms is conspicuous. However, this finding is in line with other researchers who also reported a wide range of symptoms in substances abusers (Brink et al., 2003).

The duration of the primary and secondary symptoms of substance abuse among the participants is shown in Figure 1.

Figure 1: Duration of symptoms in substance abusers



It is clear that the majority of participants experienced the symptoms for significant periods of time. In more than 60,0% of the samples, the symptoms have lasted between two and three years. This finding is disturbing because substance abuse negatively affects basically all spheres of human functioning, these being the psychological, mental, physical and social domains (see Tables 3 and 4).

As far as treatment is concerned, a relatively high percentage (66, 5%) of the participants simultaneously consulted both Western-trained mental health professionals and traditional/spiritual healers for their ailments. Although it was found that in the majority of cases the Western model of treatment was the first choice, the finding confirms the significant role played by traditional medicine in South Africa (Mkize, 2003).

CONCLUSION

The general consensus is that substance abuse is one of the major social and health problems, not only in South Africa, but throughout the world. It was found in the present study that alcohol was the most commonly abused substance in Mangaung, followed by nicotine and cannabis respectively. This finding was in contrast with other results in South Africa where the prevalence of hard drugs such as heroin, cocaine, ecstasy and mandrax was much higher among their research participants. Primary and secondary symptoms of substance abuse expressed by Sesotho speakers included a wide range. The finding that the participants had suffered for a relatively long time from the symptoms was worrying. Regarding treatment, the important role of traditional healers and medicine in the Mangaung area was confirmed.

Although the present study has revealed significant findings, these results should, however, be interpreted with caution. Firstly, the participants were almost exclusively from one area

of the Free State Province, while Sesotho speakers are widely dispersed throughout the province, other parts of South Africa and Lesotho. The generalization of the results should therefore be interpreted cautiously. Another factor to be taken into consideration is that within the Sesotho-speaking population there are many sub-cultural differences. The result is that different groups of Sesotho speakers within the same geographical areas may differ significantly. Additionally, it should be taken into account that the data gathering to a large extent relied on self-report which, as is generally accepted, often does not capture the real situation. This is especially true in the case of substance abuse which in many cases is a criminal offence in South Africa. Nevertheless, the study remains significant because it does contribute to important data in a field that has been largely neglected in South Africa.

Dealing with the substance abuse problem among Sesotho speakers will not be easy. Next to fighting the abuse of alcohol, as in most cultures, the high incidence of cannabis is an additional aggravating and complex factor. The use of cannabis by black South Africans, and therefore also Sesotho speakers, has been part of cultural practices for centuries (like for example, wine among Whites in especially the Western Cape). It is also used in certain cultural rituals, while there is a strong belief in the healing power of the drug. The fact that it is also cheaper than both alcohol and nicotine adds to the dim picture.

Special programmes that take the unique cultural value systems into consideration should therefore be developed. However, such programmes can only succeed if they are based on

thorough empirical research concerning specific targeted groups. Such research is therefore strongly recommended.

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ARTICLE V

CLINICAL MANIFESTATIONS OF SELECTED MENTAL DISORDERS AMONG SESOTHO SPEAKERS

Contents

Tables

ARTICLE V

Clinical Manifestations of Selected Mental Disorders among Sesotho Speakers

Abstract

This study compared the symptomatology of Sesotho speakers with depression (100), schizophrenia (100), anxiety (101) and substance abuse (106). The participants were evaluated using the Psychiatric Interview Questionnaire. With respect to symptomatology, it was found that, with the exception of constipation, the differences among the four groups were significant at the 1% level. However, the extent in which the symptomatology of the four groups overlapped was still noticeable.

INTRODUCTION

The concept of mental illness or mental health elicits some marked worries, anxieties and fears in many people across cultures. This is the case because they lack in-depth knowledge and understanding of the real meaning of the fundamental concept (of mental health). The fact that the role played by cultural factors on the course, epidemiology and manifestations of mental disorders is still to a large extent unexplored, adds to the uncertainty and the apprehension surrounding this phenomenon.

Clinical psychologists, psychiatrists and other mental health professionals, trained in the behavioural, affective and cognitive signs and symptoms associated with mental disorders, can easily detect such disturbances among various groups of patients. It is therefore essential to differentiate among various groups of mental disorders that have distinctive cultural implications

(Tseng, 1997). This is especially important in multicultural countries such as South Africa where there is a dearth of information on cultural differences in the manifestation of mental syndromes. One important reason for this dearth of information is that cross-cultural research poses unique problems. For example, a significant number of cross-cultural researchers are not always familiar with the cultural-historical backgrounds of their research subjects. This could easily lead to unreliable deductions and conclusions. Additionally, a factor which aggravates the situation is the specific language which serves as medium to express the nature and intensity of such symptoms. In many cases cross-cultural researchers do not adequately understand the local language of the research participants. This, of course, can also easily lead to misinterpretations. Moreover, it is not always taken into account that in most countries in the world there are various and diverse cultures and subcultures. It is generally agreed that an absolute single cultural identity that represents all the people in a specific cultural and even sub-cultural group does not exist.

Against this background, it was decided to compare symptomatology of depression, anxiety, schizophrenia and substance abuse among Sesotho speakers in Mangaung, an almost exclusive black township in South Africa. The results would hopefully shed more light especially on the diagnostic problems experienced by mental health professionals working with Sesotho-speaking mental patients. The data should also make a significant contribution to the unique multicultural challenge in South Africa with its eleven official languages and numerous cultural groups.

CULTURE AND PSYCHOPATHOLOGY

It cannot be denied that cultural forces play a vital role in the development, presentation, course and outcome of psychopathology. This is understandable as culture plays an important and integral part in the total development and expression of personality and behaviour. It speaks for itself that culture has an impact not only on "normal" but also on "abnormal" behaviour---especially the way it is manifested and the way it is perceived by the community. Certain manifestations may therefore be regarded as normal in one culture but considered abnormal in another. It is of the utmost importance that it should be realized that cultural manifestations are not necessarily the same as mental syndromes and symptoms.

This cultural uniqueness may find expression in various ways. For example, certain symptoms such as hallucinations and delusions may have a different content in different cultures while depression in certain cultures may not necessarily manifest itself in mood but rather in physical symptoms. It is also possible that certain syndromes and symptoms which are familiar in some cultures are absent in others. Furthermore, the intensity of the symptoms can easily vary from culture to culture.

The fundamental significance of cultural impact on mental health is evident from cross-cultural and cross-national studies conducted and commissioned by World Health Organisaton (Sartorius, Jablensky, Gulbinat & Ernberg, 1980; Jablensky et al., 1992). To the present researcher, the impact of culture on the manifestation of mental symptomatology is especially important. As a clinical psychologist and member of the Sesotho cultural group, there are less than ten clinical psychologists in South Africa (that belong to his cultural group of about four million people in

South Africa). From personal experience he can confirm the pitfalls and implications of misdiagnoses due to cultural misunderstandings.

As socio-demographic variables play a significant role in the development and course of mental disorders (Bhugra et al., 2000), it was decided to investigate the role of the demographic variables in the four mentioned clinical groups.

According to DSM- 1V-TR (APA, 2000), depression may begin at any age, with an average age at onset in the mid-20s, while the lifetime risk for depression varies from 10,0% to 25,0% for women, and from 5,0% to 12,0% for men, meaning that its lifetime risk is twice greater for women than men. As far as schizophrenia is concerned, the average age at onset for schizophrenia is in the early to mid-20s for men and in the late 20s for women, while lifetime prevalence is usually estimated to be between 0,5% and 1,0% which is considered to be similar throughout the world. For example, Bhugra et al. (2000), upon studying factors in the onset of schizophrenia, reported that in Trinidad (West Indies) and London, 58,0% of the people who were diagnosed with schizophrenia were under the age of 30 years, and the gender distribution differences were minimal. The same authors found a similar trend in Barbados. In Navarra, Spain, Mata, Beperet and Madoz (2004) reported that the age of onset of schizophrenia ranged from 25-37 years of age for men and 24-70 years of age for women, as for anxiety, it is known to be a universal phenomenon and a variety of phobias or anxieties are virtually seen in all communities. Most of anxiety disorders have onset during adolescence, and women, as in the case of depression, are more affected than men. Lèpine (2002) states that although anxiety is the most common mental disorder, it is difficult accurately to determine its prevalence because of distinctive diagnostic criteria, assessment tools and methodologies applied.

Dealing with substance abuse is not an easy task. According to the information at our disposal, substance abuse affects people of all ages. Plüddemann et al. (2004) reported that more than 80,0% of those who were affected by substance abuse were males. This view should, however, be interpreted with caution, hence, South Africa is reported to have no reliable systems and mechanisms in place to collect reliable data on substance abuse.

METHODOLOGY

The Mangaung Township in Bloemfontein, South Africa, was selected as the geographical area for the completion of the research. The main reason for this was that the researcher is a member of a governmental mental health team providing services at different health establishments in this area. Secondly, Sesotho (the main language in Mangaung) is the mother tongue of the researcher who is also familiar with the area and culture. Thirdly, the South African government recommends that researchers should focus on their immediate areas to meet the needs of their own communities rather than elsewhere.

For this study, the participants consisted of 407 Sesotho speakers diagnosed with depression (100), schizophrenia (100), anxiety (101) and substance abuse (106). They were drawn from the population of patients visiting various health establishments in the area over a period of two years. All patients presenting to a specific health facility who met inclusion criteria were included. The participants were evaluated and diagnosed by a multi-professional team which typically consisted of a psychiatrist or registrar in psychiatry, clinical psychologist and a psychiatric nurse. In certain areas, social workers, occupational therapists and/or physiotherapists also formed part of the team. The DSM-IV-TR criteria were used as the inclusion criteria. The

participants were between 18 and 65 years of age, and both genders were represented. Written informed consent was obtained from each participant.

A semi-structured interview, based on the Psychiatric Interview Questionnaire (PIQ) used by the Department of Psychiatry at the University of the Free State, was used to elicit the information. The PIQ is based on the *Clinician's Thesaurus: The Guidebook for Writing Psychological Reports* (Zuckerman, 2000) and *Outline of the Psychiatric History and Mental Status Examination* (MacKinnon & Yudofsky, 1986). The PIQ provides data on preliminary identification including demographic information, main complaints, personal description, history of present illness, psychiatric review of systems, previous mental illness, past personal history, a mental status examination consisting of: appearance, attitude and behaviour, thought processes, perception, mood and affect, consciousness, orientation, memory, tempo, intelligence, mode of thinking, judgment and insight, as well as hypothalamic and autonomic functioning. The PIQ is the standard assessment tool used by all governmental mental health establishments in the Free State Province. The researcher personally conducted the interviews with each individual patient.

The study was approved by the Ethics Committee of the University of the Free State. The pilot study was conducted on 40 patients to investigate the practical feasibility of the research. Based on the pilot study findings, minor adjustments on the coding of the questionnaire were made.

The Chi-square rate test for homogeneity (Howell, 2004) was used to determine whether the four groups (depression, schizophrenia, anxiety and substance abuse) differed from each other. The 1% level of significance was used. The χ^2 test was conducted with the help of the Statistical Analysis System (SAS Institute, 2001)

RESULTS AND DISCUSSION

With the exception of constipation ($\chi^2 = 6,126$ and $\rho = 0,1056$), the differences among the four clinical groups (depression, schizophrenia, anxiety and substance abuse) were significant on the 1% level. To be able ultimately to analyze and discuss the differences further, the frequencies and row percentages for the various categories for each dependant variable are provided and discussed.

Biographical data

To compare the ages of four groups (depression, schizophrenia, anxiety and substance abuse), an analysis of variance was performed. An F-value of 10,3 was found which is significant at the 1%-level. To determine which of the four groups differ with respect to their age, a Scheffé test was done. The age distribution of the study population is given in Table 1.

Table 1: Mean age of the participants

Clinical Group	Mean Age	Standard Deviation
Depression	34,78	9,72
Schizophrenia	40,65	11,75
Anxiety	32,62	8,79
Substance Abuse	38,46	13,67

These findings indicate that the participants with schizophrenia differ significantly from the participants diagnosed with depression and anxiety; but not from the substance abuse group. This means that schizophrenic and the substance group were older than the depression and anxiety groups. This finding for the schizophrenic sample, as far as age distribution is concerned, is in agreement with the World Health Organization Ten-Country study which reported the same trend in various centres (Jablensky, et al., 1992). The results may be understood in the light that Schizophrenic illness has a chronic course; therefore, it is highly probable that a significant number of the affected individuals could have been diagnosed for a long time. The gender distribution of the four clinical groups is presented in Table 2.

Table 2: Gender by group (frequency procedure)

Gender	Clinical Group				
	Depression	**Schizophrenia**	**Anxiety**	**Substance Abuse**	**Total Row**
Males	37 9,09 17,62 37,00	58 14,25 27,62 58,00	41 10,07 19,52 40,59	74 18,18 35,24 69,81	210 51,60
Females	63 15,48 31,98 63,00	42 10,32 21,32 42,00	60 14,74 30,16 59,41	32 7,86 16,24 30,19	197 48,40
Total	100 24,57	100 24,57	101 24,82	106 26,04	407 100,00

χ^2 – Value of 29,15 for 3 degrees of freedom is significant at the 1%-level.

The results in Table 2 show that there were more males diagnosed with schizophrenia and substance abuse than females. This finding is in contrast with DSM-IV-TR (APA 2000) which reports that Schizophrenia affects both men and women in roughly equal number, though women are more likely to have a later onset, which may be a sound explanation for the given gender differences. As far as depression and anxiety are concerned, it is not surprising because Kennedy and Eisfeld (1999) reported that affective disorders are twice as common in females as in males. Gregory (1999) goes further explaining that depression is found in two women in the US for every man. Other possible explanations may be that in Sesotho culture, as is the case in other African cultures, men are reluctant and discouraged to express their emotions because such behaviour can be interpreted as a sign of weakness.

As far as anxiety is concerned, it has been reported that although anxiety is considered to be one of the most common groups of mental disorders, women (30.5% life-time prevalence) are more likely to develop anxiety than men (19.2% life-time prevalence) (Kaplan & Sadock, 1997). This is the reason why the number of women with anxiety exceeded the number of men. Regarding schizophrenia, the results are not in conflict with what was found in a comparative study between Liverpool, England, and Sakalwara-Bangalore, India, on the demographic characteristics of the patients suffering from schizophrenia. With respect to gender distribution, there were twice as many males as females included in the study in Liverpool, whereas in Bangalore it was the other way round. The situation in South Africa may be attributed to the fact that females have a better prognosis than men; thus, they are not as available as men in the various health establishments. Another reason could be that there is always a higher prevalence of substance abuse among males than females; consequently, this results in a poor prognosis and frequent relapses.

The results with respect to marital status are provided in Table 3.

Table 3: Clinical Groups and Marital Status

Clinical Group	Marital Status $\chi^2 = 12,188$ $p = 0,0068^*$		
	Single	**Married**	**Row Total**
Depression	46 57,5%	34 42,5%	80 24,0%
Schizophrenia	62 79,5%	16 20,5%	78 23,3%
Anxiety	50 56,8%	38 43,2%	88 26,3%
Substance Abuse	60 68,2%	28 31,8%	88 26,3%
Column Total	**218** **65,3%**	**116** **34,7%**	**334** **100,0%**

It should be taken into account that customary marriages and cohabitation could not be considered; hence, there was a lack of clarity on this variable and in other instances, information was either unavailable or inaccurate. Sometimes it was difficult to differentiate between a customary marriage and mere cohabitation.

The results in Table 3 show that a larger proportion of participants diagnosed with depression and anxiety were married in comparison with those who were suffering from schizophrenia and substance abuse respectively. The finding is consistent with what was reported among African-

Caribbeans living in London (Bhugra et al. 1997). The finding may be attributed to the fact that schizophrenic illness disrupts the personal, social, emotional and mental development and functioning of the affected individuals. Furthermore, the blunting of affect could be responsible for retardation in the development of passion, feelings and sentiments which are, of course, the basis for a person to fall in love, and eventually enter into marriage.

Symptomatology

The results regarding the differences in symptomatology among the four groups are discussed next. Table 4 provides data on the co-morbidity of substance abuse in four groups.

Table 4: The prevalence of substance abuse in four clinical groups

Clinical Group	Cannabis $\chi^2 = 83{,}755$ $\rho = 0{,}0001^*$		Row Total	Alcohol $\chi^2 = 22{,}829$ $\rho = 0{,}0001^*$		Row Total	Nicotine $\chi^2 = 61{,}422$ $\rho = 0{,}0001^*$		Row Total
	Yes	No		Yes	No		Yes	No	
Depression	4 4,0%	96 96,0%	100 24,6%	43 43,0%	57 57,0%	100 24,6%	16 16,0%	84 84,0%	100 24,6%
Schizophrenia	29 29,0%	71 71,0%	100 24,6%	57 57,7%	43 43,0%	100 24,6%	55 55,0%	45 45,0%	100 24,6%
Anxiety	5 5,0%	96 95,0%	101 24,8%	56 55,5%	45 44,5%	101 24,8%	21 20,8%	80 79,2%	101 24,8%
Substance Abuse	52 49,1%	54 50,9%	106 26.0%	80 75,5%	26 24,5%	106 26,0%	60 56,6%	46 43,4%	106 26,0%
Column total	90 22,1%	317 77,9%	407 100,0%	236 58,0%	171 42,0%	407 100,0%	152 37,3%	255 62,7%	407 100,0%

From Table 4 it is clear that alcohol was the substance abused by most of the total number of participants, followed by nicotine and cannabis. When taken into account that cannabis is the only illegal drug of the three, its relatively high prevalence is alarming. The fact that cannabis is relatively inexpensive and easy to obtain does not make the fact less distressing. The high prevalence of alcohol among all four groups emphasizes to what extent this dangerous substance has become an integral part of society. It also confirms the extent to which substances are used as a symptom reliever. Comparatively speaking, it seems that cannabis abuse was high in people diagnosed with substance abuse and people suffering from schizophrenia. The same trend was found with regard to nicotine.

As far as aggression is concerned (χ^2 = 39,979 and ρ = 0,0001*), it seems that a significant percentage of people suffering from schizophrenia (23,0%) and those who were diagnosed with abuse substance (32,0%), displayed more aggressive behaviour than those who were diagnosed with depression (8,0%) and anxiety (3,0%). The tendency to display aggressive behaviour among schizophrenic patients and substance abusers was also reported by Ensink, Robertson, Ben-Arie, Hodson and Tredoux (1998) as well as Padayachee and Singh (2003).

Table 5 displays the results that pertain to subjects' disturbances of the thought processes.

Table 5: Disturbances in content of thought process

Clinical Group	Suicide ideation $\chi^2 = 29{,}981$ $\rho = 0{,}0001^*$		Row Total	Delusions of persecution $\chi^2 = 125{,}939$ $\rho = 0{,}0001^*$		Total Row	Delusions of grandeur $\chi^2 = 42{,}923$ $\rho = 0{,}0001^*$		Total Row	Bizarre delusions $\chi^2 = 18{,}633$ $\rho = 0{,}0001^*$		Total Row
	Yes	No		Yes	No		Yes	No		Yes	No	
Depression	49 49,0%	51 51,0%	100 24,6%	9 9,0%	91 91,0%	100 24,6%	0, 0,0%	100 100,0%	100 24,6%	1 1,0%	99 99,0%	100 24,6%
Schizophrenia	23 23,0%	77 77,0%	100 24,6%	67 67,0%	33 33,0%	100 24,6%	17 17,0%	83 83,0%	100 24,6%	11 11,0%	89 89,0%	100 24,6%
Anxiety	45 44,5%	56 55,5%	101 24,8%	3 3,0%	98 97,0%	101 24,8%	0 0,0%	101 100,0%	101 24,8%	0 0,0%	101 100,0%	101 24,8%
Substance Abuse	21 19,8%	85 80,2%	106 26,0%	39 36,8%	67 63,2%	106 26,0%	22 20,7%	84 79,3%	106 26,0%	5 4,7%	101 95,3%	106 26,0%
Column Total	138 33,9%	269 66,1%	407 100,0%	118 29,0%	289 71,0%	407 100,0%	39 9,6%	368 90,4%	407 100,0%	17 4,2%	390 95,8%	407 100,0%

A larger proportion of participants suffering from depression and anxiety expressed suicide ideas than those who were diagnosed with schizophrenia and substance abuse. However, the level of suicide risk among those who were suffering from schizophrenia and substance abuse could not be ignored; hence it elicited significant concern. Harkavy-Friedman et al. (1999) argue that people with schizophrenia are more likely to harm themselves, and are at risk of suicide behaviour. A significant percentage (13,0%) of individuals suffering from schizophrenia commit suicide. Depression and substance abuse in people with schizophrenia are risk factors in suicide attempts. As far as paranoid delusions are concerned, the following findings were noted as reflected in Table 5. Delusions of grandeur, persecution and bizarre delusions were more prevalent among the participants with Schizophrenia than those who fell in other clinical groups. However, those who presented with substance abuse significantly expressed more delusions, especially of persecution and delusions of grandeur than those who were diagnosed with

depression and anxiety respectively. Although delusions are always considered to be psychotic features as far as mental illness is concerned, other authors such as Al-Issa (1999) reported delusions of persecution, bewitchment, possession and poisoning among depressive patients in Algeria. Singer (1975) explains further that paranoid delusions are common among patients suffering from depression in Senegal, West Africa. In the US, research also suggests that African-American manifestations of anxiety disorders differ from those of the general population in that delusions and hallucinations are common among the African-American patients diagnosed with anxiety. These afore-mentioned clinical characteristics of depression and anxiety among Africans, and African-Americans could lead to misdiagnosis and misinterpretations of clinical conditions. There is also a potential for confusion if clinicians are not familiar with the cultural and historical backgrounds of their patients. The data on perceptual disturbances are given in Table 6.

Table 6: Perceptual disturbances

Clinical Group	Auditory hallucination $\chi^2 = 59{,}279$ $\rho = 0{,}0001^*$		Rows Totals	Visual hallucinations $\chi^2 = 55{,}997$ $\rho = 0{,}0001^*$		Row Totals
	Yes	No		Yes	No	
Depression	59 60,2%	39 39,8%	98 24,4%	22 22,7%	75 77,3%	97 24,3%
Schizophrenia	90 90,9%	9 9,1%	99 24,7%	52 52,5%	47 47,8%	99 24,9%
Anxiety	41 41,0%	59 59,0%	100 24,9%	14 14,0%	86 86,0%	100 25,0%
Substance Abuse	76 73,1%	28 26,9%	104 25,9%	57 54,8	47 45,2%	104 26,0%
Column Total	266 66,3%	135 33,7%	401 100,0%	145 36,2%	255 63,8%	401 100,0%

Firstly, it seems clear from Table 6 that about two thirds (66,2%) of the participants complained of auditory hallucinations. Although a significant number of participants from all groups who complained of hallucinations listed auditory hallucinations as their primary symptom, it is evident that hallucinations were more prominent among those who were diagnosed with schizophrenia. Secondly, visual hallucinations were reported to be more prevalent among those who were suffering from substance abuse and schizophrenia than those with depression and anxiety. The high prevalence of hallucinations among those who were diagnosed with depression and anxiety may be viewed by some as unusual. However, the finding corresponds well with other research. For example, Littlewood and Lipsedge (1997) suggest that hallucinations may be considered a feature of even minor depression in West Africa. It also seems that even within Western cultures; non-Western individuals display significantly more psychotic symptoms. Olfson et al. (2002) who investigated the prevalence of psychotic symptoms among outpatients attending urban general medical practice in New York, in which the sample consisted mainly of Latino immigrants, found that 20,0% of their sample were experiencing one or more psychotic symptoms, most commonly auditory hallucinations.

The various affective (mood) symptoms manifested by the four clinical groups are reflected in Table 7.

Table 7: Mood symptoms

Clinical Group	Dysphoria $\chi^2 = 91{,}945$ $\rho = 0{,}0001$*		Irritability $\chi^2 = 53{,}212$ $\rho = 0{,}0001$*		Depressed Mood $\chi^2 = 131{,}558$ $\rho = 0{,}0001$*		Grief or mourning $\chi^2 = 93{,}966$ $\rho = 0{,}0001$*		Anxiety $\chi^2 = 90{,}571$ $\rho = 0{,}0001$*		Agitation $\chi^2 = 68{,}173$ $\rho = 0{,}0001$*		Guilt $\chi^2 = 61{,}016$ $\rho = 0{,}0001$*		Abreaction $\chi^2 = 32{,}764$ $\rho = 0{,}0001$*		Shame $\chi^2 = 37{,}811$ $\rho = 0{,}0001$*	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Depression	56 56,0%	44 44,0%	71 71,0%	29 29,0%	80 80,0%	20 20,0%	50 50,0%	50 50,0%	70 70,0%	30 30,0%	36 36,0%	64 64,0%	54 54,0%	46 46%	21 21,0%	79 79,0%	46 46,0%	54 54,0%
Schizophrenia	8 8,0%	92 92,0%	25 25,0%	75 75,0%	14 14,0%	86 86,0%	3 3,0%	97 97,0%	48 48,0%	52 52,0%	6 6,0%	94 94,0%	13 13,0%	87 87,0%	1 1,0%	99 99,0%	18 18,0%	82 82,0%
Anxiety	15 14,8%	86 85,2%	68 67,3%	33 32,7%	44 43,6%	57 56,4%	22 21,8%	79 78,2%	96 95,1%	5 4,9%	62 61,4%	39 38,6%	33 32,7%	68 67,3%	17 16,8%	84 83,2%	46 45,5%	55 54,5%
Substance Abuse	10 9,4%	96 90,6%	53 50,0%	53 50,0%	13 12,3%	93 87,7%	4 3,8%	102 96,2%	37 34,9%	69 65,1%	43 40,6%	63 59,4%	12 11,3%	94 88,7%	3 2,8%	103 97,2%	18 17,0%	88 83,0%
Column Total	89 21,9%	318 78,1%	217 53,3%	190 46,7%	151 37,1%	256 62,9%	79 19,4%	328 80,6%	251 61,7%	156 38,3%	147 36,1%	260 63,9%	112 27,5%	295 72,5%	42 10,3%	365 89,7%	128 31,4%	279 68,6%

As expected a larger proportion of persons who suffered from depression displayed depressed mood and irritability. Grief expression was more prevalent among those who were diagnosed with depression and anxiety. However, agitation accompanied by irritable mood was more common among patients who were diagnosed with anxiety. Also, abreaction and shame were expressed more predominantly among anxiety and depression groups compared to other clinical groups. According to Table 7, it seems that a significant number of patients diagnosed with depression expressed higher levels of guilt than other groups.

The predominant presence of affective symptoms in depression and anxiety groups was expected. The prevalence of mood disturbances among participants diagnosed with schizophrenia and substance abuse may be higher than expected by some, but the finding is in agreement with other researchers such as Matete, Pretorius and Rataemane (2001) and House, Bostock and Cooper (1987) who reported significantly higher prevalence of affective (depressive) symptoms among patients with schizophrenia. Nakaya, Komahashi, Ohmori and Suwa (1998), upon studying the composition of the depressive syndrome in acute schizophrenia, found that symptoms of depression such as depressed mood, guilt, suicidal thoughts, retardation, sleep disturbances and somatic symptoms were common.

The disturbances related to hypothalamic functioning are shown in Table 8.

Table 8: Hypothalamic dysfunctions

Clinical Groups	Insomnia $\chi^2 = 27{,}247$ $\rho = 0{,}0001$*		Row Total	Decrease in appetite $\chi^2 = 31{,}886$ $\rho = 0{,}0001$*		Row Total	Diminished libido $\chi^2 = 19{,}395$ $\rho = 0{,}0001$*		Row Total
	Yes	No		Yes	No		Yes	No	
Depression	87 87,0%	13 13,0%	100 24,6%	56 56,0%	44 44,0%	100 24,6%	77 77,0%	23 23,0%	100 24,6%
Schizophrenia	55 55,0%	45 45,0%	100 24,6%	22 22,0%	78 78,0%	100 24,6%	59 59,0%	41 41,0%	100 24,6%
Anxiety	78 77,2%	23 22,8%	101 24,8%	53 52,5%	48 47,5%	101 24,8%	61 60,4%	40 39,6%	101 24,8%
Substance Abuse	74 69,8%	32 30,2%	106 26,0%	36 34,0%	70 66,0%	106 26,0%	50 47,2%	56 52,8%	106 26,0%
Column Total	**294** **72,2%**	**113** **27,8%**	**407** **100,0%**	**167** **41,0%**	**240** **59,0%**	**407** **100,0%**	**247** **60,7%**	**160** **39,3%**	**407** **100,0%**

Insomnia, appetite disturbances and diminished libido were compared among the four clinical groups. It seems that 72,2% of the total number of participants experienced insomnia. Insomnia was reported by more than 50,0% of the participants in each group. The high prevalence of insomnia among, especially participants who suffered from depression and anxiety was expected, but remains a cause of concern. The data also indicate that a greater proportion of those who suffered from depression and anxiety respectively complained more of a marked decrease in appetite than other groups. Approximately 60,0% of the total number of participants complained of diminished libido. Once again, the depressives were more affected. The high prevalence of hypothalamic dysfunctions confirms the broad impact it has on mental disorders (Gagiano, 2001).

The information regarding autonomic dysfunctions is provided in Table 9.

Table 9: Autonomic dysfunctions

Clinical Groups	Palpitations $\chi^2 = 30,423$ $\rho = 0,0001^*$		Row Total	Excessive sweating $\chi^2 = 125,939$ $\rho = 0,0001^*$		Row Total	Headaches $\chi^2 = 42,923$ $\rho = 0,0001^*$		Row Total	Dizziness $\chi^2 = 18,633$ $\rho = 0,0001^*$		Row Total	Anxiousness $\chi^2 = 34,462$ $\rho = 0,0001^*$		Row Total
	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
Depression	65 65,0%	35 35,0%	100 24,6%	53 53,0%	47 47,0%	100 24,6%	86 86,0%	14 14,0%	100 24,6%	71 71,0%	29 29,0%	100 24,6%	77 77,0%	23 23,0%	100 24,6%
Schizophrenia	39 39,0%	61 61,0%	100 24,6%	39 39,0%	61 61,0%	100 24,6%	39 39,0%	61 61.0%	100 24,6%	47 47,0%	53 53,0%	100 24,6%	64 64,0%	36 36,0%	100 24,6%
Anxiety	71 70,3%	30 29,7%	101 24,8%	63 62,4%	38 37,6%	101 24,8%	82 81,2%	19 18,8%	101 24,8%	75 74,3%	26 25,7%	101 24,8%	94 93,1%	7 6,9%	101 24,8%
Substance Abuse	45 42,4%	61 57.6%	106 26,0%	62 58,5%	44 41,5%	106 26,0%	54 50,9%	52 49,1%	106 26,0%	55 51,9%	51 48,1%	106 26,0%	64 60,4%	42 39,6%	106 26,0%
Column Total	220 54,1%	187 45,9%	407 100,0%	217 53,3%	190 46,7%	407 100,0%	261 64,1%	146 35,9%	407 100,0%	248 60,9%	159 39,1%	407 100,0%	299 73,5%	108 26,5%	407 100,0%

As far as autonomic dysfunctions are concerned, the participants in all clinical groups complained, to varying degrees, of palpitations, excessive sweating, headaches, dizziness and anxiousness. However, these symptoms were more prevalent in the depression and the anxiety groups. It is assumed by some authors (e.g. Lopez, 1993) that somatic and autonomic signs and symptoms are solely found among patients in developing countries and traditional communities diagnosed with so-called affective disorders such as depression and anxiety disorders because of cultural influences on the presentation of psychopathology. However, the prevalence of these symptoms in the schizophrenia group has been documented in other research. For example, Tyler, (1995) and Ritsner (2003) found that physical complaints among patients suffering from schizophrenia are common, and are linked to emotional distress. Also in a comparative study between Anglo-Americans and Mexican-Americans, Weisman et al. (2000) found that Mexican-Americans complained more of somatic symptoms than their Anglo-American counterparts. The present finding is important because it confirms that mental health professionals should not neglect to enquire about physical suffering endured patients diagnosed with psychotic disorders, especially in the case of schizophrenia.

Concerning the treatment options of the four groups, mental health professionals were the most preferred source of treatment. However, it seems that traditional healers (χ^2=36,182 and ρ = 0,0001*) and spiritual healers (χ^2=39,197 and ρ=0,0001*) also play a significant role in the treatment of mental disorders among Sesotho speakers in Mangaung. According to the results of this study, almost 30% of the participants consulted traditional healers for their illness, while about a quarter of the sample visited spiritual healers. It was also found that the more serious

and severe the disorders, the more likely they were to go for traditional/spiritual healers. Mkize (2003) states that mental health-care services have been in the hands of traditional healers for centuries. For this and other reasons, it is crucial for Western-trained health professionals to work hand in hand with traditional healers.

CONCLUSION

The patients that were diagnosed with schizophrenia and substance abuse were older than those who were diagnosed with depression and anxiety. Males were found to be more represented in the schizophrenia and the substance abuse groups, while more females were diagnosed with depression and anxiety. Participants with depression and anxiety were more likely to be married than those with schizophrenia and substance abuse. Alcohol was the most frequently abused substance although participants with schizophrenia abused cannabis and alcohol more than those who were suffering from depression and anxiety.

Aggressive behaviour seems to be more common among the patients diagnosed with substance abuse and schizophrenia.

As far as symptomatology is concerned, it was found that suicide ideas and paranoid delusions were prevalent across the four clinical groups, even though the prevalence of suicide ideas was higher among those with depression and anxiety than those in the substance abuse and the

schizophrenia groups. Fewer paranoid delusions were reported in the depression and the anxiety groups. However, the delusions among the anxiety and the depression groups were not as bizarre as in the schizophrenia group.

In Western cultures, delusions and hallucinations are usually associated with psychosis. However, according to the present study, delusions and hallucinations were significantly prevalent among participants in the depression and the anxiety groups.

Affective symptoms such as dysphoria, irritability, grief, anxiety, agitation, guilt, abreaction and shame are typically considered to be manifestations of mood and anxiety disorders. Nevertheless, according to the present findings, these symptoms were also reported in the schizophrenia group, although not to the same extent and severity as they were in depression and anxiety. Like affective symptoms, there were some hypothalamic dysfunctions across all four clinical groups. The most prevalent symptoms were insomnia and diminished libido. Another important finding was the high prevalence of somatic and autonomic symptoms across the four groups. Mental health practitioners often associate somatic and autonomic symptoms with depression and anxiety. According to this study, however, it became clear that a significant number of Sesotho speakers suffering from schizophrenia also complained of headaches, palpitations, excessive sweating, dizziness and anxiousness.

Regarding the treatment of various mental disorders, the approach taken by Sesotho speakers is not different from other Africans. Traditional medicine still remains the first treatment of choice

for a significant number of the participants. It is therefore important that mental health professionals should be aware of the important role that traditional medicine still plays in the Sesotho culture. To reject traditional medicine as unscientific would be unwise. This treatment paradigm is such an integral part of the Sesotho culture that the view point should much rather be to incorporate traditional medicine into the health system.

Although the present study revealed important findings, the results should, however, be interpreted with great care, especially as far as generalization is concerned. For example, this study was exclusively carried out in one restricted area, that is, Mangaung, while Sesotho speakers are spread throughout many regions of South Africa and Lesotho. Furthermore, even within Sesotho culture, there are many sub-cultural differences that may influence the development, presentation and outcome of mental disorders. Despite the mentioned criticism of this study, its significance should not be under-estimated, because it does not only contribute data to an important academic field that has been largely neglected in South Africa, but also provides information on socio-demographic variables and clinical symptoms associated with depression, schizophrenia, anxiety and substance abuse among Sesotho speakers.

The wish is expressed that similar research should be conducted to expand the knowledge base of culturally relevant empirical data in South Africa. Cultural differences in South Africa provide unique research opportunities for mental health professionals and the respective cultural entities can only benefit from such efforts.

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APPENDIX A

Psychiatric Interview Questionnaire

PSYCHIATRIC INTERVIEW QUESTIONNAIRE

		For Office Use		
Questionnaire Number :		1		1
Name :				2-4
1. Biographical Information				
1.1 Sex				
Male	1			
Female	2			5
1.2 Age :				
1.3 Educational Level				
None	1			
Grade 1-4	2			
Grade 5-7	3			
Grade 8-10	4			
Grade 11-12	5			
Grade 12-plus	6			
Other (specify)	7			6
				7-8
1.4 Marital Status				
Single	1			
Married	2			
Separated	3			
Divorced	4			
Widow / Widower	5			
Cohabitation	6			9
1.5 Housing (Type of House)				
Shack	1			
House / Part of a house	2			
Traditional dwelling (hut)	3			
Masionette	4			
Flat	5			
Hostel	6			
Outbuilding	7			
Combination of buildings	8			
Homeless	9			
Other (specify)	10			10-11
		12	13	

		For Office Use	
1.6 Employment / Occupation			
Unemployed and looking for a job	1		
Unemployed not looking for a job	2		
Formally employed	3		
Informally employed	4		
Self-employed	5		
Pensioner	6		
Disability grant	7		
Student	8		14
1.7 Religions and beliefs			
Christianity	1		
Islam	2		
Hinduism	3		
Atheism	4		
Belief in Ancestors	5		15
Other (specify)	6		16-17
1.8 Criminal behaviour			
Assault	1		18-19
Rape	2		20-21
Robbery	3		22-23
Murder	4		24-25
Hijacking	5		26-27
Kidnapping	6		28-29
Possession of illegal firearm	7		30-31
Other (specify)	8		32-33
Property Crimes			34-35
Larceny	9		36-37
Fraud	10		38-39
Burglary	11		40-41
Fencing	12		42-43
Arson	13		44-45
Malicious damage to property	14		46-47

	For Office Use		
Organizational Criminality			
White-collar crime	15		48 - 49
Organized crime	16		50 - 51
Public order Crimes			
Drugs	17		52 - 53
Alcohol	18		54 - 55
Multiple drug use	19		56 – 57
Illegal drug business	20		58 – 59
Sex-related crimes (e.g. prostitution, pornography)	21		60 – 61
Public violence	22		62 – 63
Other (specify)	23		64 - 65
			66 - 67
1.9 Family Structure			
Parents	1		
Single mother	2		
Single father	3		
Step parent	4		
Foster parents	5		
Adopted parents	6		
Grandparents	7		
Alone	8		
Staying with wife / husband and children	9		
Staying with friends / relatives	10		68 - 69
1.10 Substance Abuse			
Cannabis (dagga)	1		70 – 71
Alcohol	2		72 – 73
Depressants			
Barbiturates	3		74 - 75
Opium	4		76 – 77
Heroin	5		78 – 79
Morphine	6		80 – 81
Codeine	7		82 – 83
Pephidal	8		84 – 85
Tranquilizers	9		86 - 87

	For Office Use		
Stimulants			
Nicotine	10		88 – 89
Caffeine	11		90 – 91
Cocaine	12		92 - 93
Crack	13		94 – 95
Ikambi	14		96 – 97
Amphetaines	15		98 – 99
Egqwarha	16		100 - 101
Hallucigenes			
Lsd	17		102 – 103
Inhalants			
Benzine	18		104 – 105
Petrol / Gasoline	19		106 – 107
Other (specify)	20		108 - 109
			110 - 111
1.11 Health Status			
No second illness	1		112 – 113
Allergies	2		114 – 115
Epilepsy	3		116 – 117
Head injuries	4		118 – 119
Hypertension	5		120 – 121
Asthma	6		122 – 123
Diabetes	7		124 – 125
HIV / AIDS	8		126 – 127
Malaria	9		128 – 129
Fever	10		130 – 131
Physical disability (specify)	11		132 - 133
			134 – 135
Illness related to pregnancy	12		136 – 137
Tuberculosis	13		138 – 139
Cardiovascular disease	14		140 – 141
Hepatitis B	15		142 – 143
Kidney problems	16		144 – 145
Stroke	17		146 – 147
Liver cirrhosis	18		148 – 149
Diarrhoea	19		150 – 151
Flu	20		152 - 153

	For Office Use			
Measles	21			154 – 155
Cancer	22			156 – 157
Cholera	23			158 – 159
	24			160 – 161
Other (specify)				
.....				162 - 163

1.12 Main Complaint

Kindly indicate the problems for attending to the clinic or hospital.

.....

1.13 Precipitating factors				
Kindly indicate the causes of your problems				
Unknown	1			164 – 165
Death of loved one	2			166 – 167
Loss of job	3			168 – 169
Divorce	4			170 – 171
Unemployment	5			172 – 173
Financial problems	6			174 – 175
Marital dysfunctions	7			176 – 177
Family dysfunctions	8			178 – 179
Rape	9			180 – 181
Life changes (specify)	10			182 - 183
				184 – 185
History of child abuse	11			186 – 187
Perception of failure	12			188 – 189
Chronic illness	13			190 – 191
Assault	14			192 – 193
Other (specify)	15			194 - 195
				196 - 195

		For Office Use	
1.14 How long have you been ill ?			
1 month	1		
2 months	2		
3 months	3		
4 months	4		
5 months	5		
6 months	6		
More than 6 months	7		
More than a year	8		
More than 2 years	9		
3 years and more	10		
1.15 Treatment of current and previous illness			
Spiritual healer	1		200
Traditional healer	2		201
General practitioner	3		202
Psychiatrist	4		203
Psychologist	5		204
Professional nurse	6		205
Other (specify)	7		206
			207 – 208
1.16 Family mental illness history			
Is there anybody in your family suffering from mental disturbances ?			
None	1		209
Father	2		210
Mother	3		211
Both parents	4		212
One sibling	5		213
More than one sibling	6		214
Paternal relative	7		215
Maternal relative	8		216
Other (specify)	9		217
			218 - 219

		For Office Use	
1.17 Mental status examination :			
1.17.1 Appearance		2	1
			2 -4

1.17.2 Behaviour			
Echopraxia (pathological imitation of movements)	1		5 – 6
Catatonia	2		7 – 8
Negativism	3		9 – 10
Cataplexy (temporary loss of muscle tone)	4		11 – 12
Hyperactivity	5		13 – 14
Mimicry (imitative motor activity of childhood)	6		15 – 16
Aggression	7		17 – 18
Stereotypy	8		19 – 20
Mannerism	9		21 - 22
Automatism (automatic performance of an act)	10		23 – 24
Mutism	11		25 – 26
Acting out	12		27 – 28
Abulia (reduced impulse to act or think)	13		29 – 30
Other (specify)	14		31 - 32
			33 - 34

1.17.3 Consciousness		
Clear	1	
Cloudy	2	
Coma	3	
Stupor	4	
Delirium	5	35

1.17.4 Orientation

(a) What is your name ?
(b) What day is it today ?
(c) Time of the day ?
(d) Date ?
(e) Year ?
(f) Where are you at the moment ?

		For Office Use	
1.17.4.1 Person			
Orientated	1		
Disorientated	2		36
1.17.4.2 Time			
Orientated	1		
Disorientated	2		37
1.17.4.3 Place			
Orientated	1		
Disorientated	2		38
1.17.5 Attention / concentration (a) Please name the months of the year : (b) Say them backward :			
Attentive	1		
Destractive	2		
Apathic (nonresponsive)	3		39
1.17.6 Thought process and language			
Form disturbances			
None	1		40 – 41
Neologism (new word created by a patient)	2		42 – 43
Word salad (incoherent mixture of words and phrases)	3		44 – 45
Circumstantiality (indirect speech that is delayed in reaching the point)	4		46 - 47
Tangentiality (inability to have goal-directed association of thought)	5		48 – 49
Incoherence	6		50 – 51
Perseveration	7		52 – 53
Verbigeration (excessive, meaningless and repetitive speech)	8		54 – 55
Echolalia (repetition of words or phrases of one person by another)	9		56 - 57
Irrelevant answers	10		58 - 59
Loosening of associations	11		60 – 61
Derailment	12		62 - 63

		For Office Use	
Flight of ideas	13		64 – 65
Blocking	14		67 – 68
Pressure of speech	15		69 – 70
Poverty of speech	16		70 – 72
Disturbed articulation	17		73 – 74
Other (specify)	18		74 - 75
1.17.7 Disturbances in content of thought			
Suicide ideation	1		78 – 79
Overvalued ideas	2		80 – 81
Homicide ideas	3		82 – 83
Obsessions	4		84 – 85
Compulsions	5		86 – 87
Paranoid delusions	6		88 - 89
(i) Delusions of persecution	7		90 – 91
(ii) Delusions of grandeur	8		92 - 93
(iii) Delusion of reference	9		94 - 95
(iv) Delusion of self-accusation	10		96 – 97
(v) Delusion of control	11		98 – 99
(vi) Somatic delusions	12		100 – 101
(vii) Bizarre delusions	13		102 - 103

1.17.8 Memory

Short-term memory : What did you have for breakfast ?

Recent-memory : What did you eat yesterday ?

Long-term memory : When and where were you born ?

1.17.8.1 Short-term memory			
Good	1		
Fair	2		
Poor	3		104
1.17.8.2 Recent memory			
Good	1		
Fair	2		
Poor	3		105

		For Office Use
1.17.8.3 Long-term memory		
Good	1	
Fair	2	
Poor	3	106

1.17.9 Perception

1.17.9.1 Auditory hallucination	Yes	1	
	No	2	107
1.17.9.2 Visual hallucination	Yes	1	
	No	2	108
1.17.9.3 Olfactory hallucination	Yes	1	
	No	2	109
1.17.9.4 Gustatory	Yes	1	
	No	2	110
1.17.9.5 Tactile hallucination	Yes	1	
	No	2	111
1.17.9.6 Somatic hallucination	Yes	1	
	No	2	112
1.17.9.7 Hallucinosis	Yes	1	
	No	2	113

	For Office Use		
1.17.9.8 Illusions			
	Yes	1	
	No	2	114
1.17.9.9 Depersonalization			
	Yes	1	
	No	2	115
1.17.9.10 Derealization			
	Yes	1	
	No	2	116

1.18 Affect

Appropriate affect	1		117
Inappropriate affect	2		118
Blunted affect	3		119
Restricted or constricted affect	4		120
Flat affect	5		121
Labile affect	6		122
Combination	7		123
Other (specify)	8		124
			125 - 126

1.19 Mood		
Normal mood	1	127 – 128
Dysphoric mood	2	129 – 130
Expansive mood	3	131 – 132
Irritable	4	133 – 134
Mood swings	5	135 – 136
Elevated mood (air of confidence and enjoyment, more cheerful than usual)	6	137 – 138
Euphoria	7	139 – 140
Depression	8	141 – 142
Anhedonia	9	143 – 144
Grief or mourning	10	145 – 146
Alexthymia (disruption in both affective and cognitive process)	11	147 – 148
Anxiety	12	149 - 150

		For Office Use	
Agitation	13		
Panic	14		151 – 152
Apathy (indifference, unresponsiveness)	15		153 – 154
Ambivalence	16		155 - 156
Abreaction (emotional discharge after recalling a painful experience)	17		157 - 158
Shame	18		159 – 160
Guilt	19		161 – 162
Other (specify)	20		163 - 164
			165 - 166

1.20 Insight

Do you think you are experiencing a psychological problem ?

Good insight	1	
Poor insight	2	169

1.21 If "yes", kindly specify whether you need help ?

1.21 Judgment

Kindly explain what you are going to do should you find a letter stamped and has an address on it ?

Good	1	
Poor	2	170

1.22 Intelligence

Above average	1	
Average	2	
Below average	3	
Borderline intellectual functioning	4	171

1.22.1 Mode of Thinking

Concrete thinking	1	
Abstract thinking	2	172

		For Office Use	
1.23 Hypothalamic Functioning			
Sleep patterns			
Normal sleep	1		
Insomnia	2		
Hypersomnia (excessive sleeping)	3		173
Appetite			
Normal	1		
Increase in appetite	2		
Decrease in appetite	3		174
Libido			
Normal	1		
Increased	2		
Diminished	3		175

1.24 Autonomic Dysfunctions			
None	1		176
Constipation	2		177
Palpitations	3		178
Excessive sweating	4		179
Headaches	5		180
Fainting	6		181
Dizziness	7		182
Anxiousness	8		183
Other (specify)	9		184
			185 - 186

1.25 Diagnosis		
Major depressive disorder	1	
Anxiety disorder (specify)	2	
Schizophrenia	3	
Bipolar mood disorder	4	
Substance abuse	5	187

		For Office Use
1.26 Medication		189
Antidepressants	1	190
Antipsychotics	2	191
Mood stabilizers	3	192
Tranquilizers	4	193
Anticonvulsants	5	194
Other (specify)	6	195

APPENDIX B

Informed Consent Form

INFORMED CONSENT

Dear participant,

You are hereby invited to take part in a study on clinical manifestations of mental disorders among Sesotho speakers in Mangaung. Your answers will help us document the nature of unique clinical manifestations of mental disorders among Sesotho speakers. This will optimize the clinician's diagnostic and treatment skills in the future.

The interview may time to time upset you, and you are free to stop it and withdraw at any time. You may also refuse to answer any question if you feel so. Your refusal or withdrawal from the study will not, in any manner, affect the quality of services you are entitled to in this health establishment.

Your responses will be used for purpose of research only. All responses will be kept confidential and anonymous.

Thank you.

Participant's signature..... date.....

Researcher's signature..... date.....