

Africa: Diversity and Development

**Conversations at Butabika: A snapshot of the tensions between biomedical
and spiritual knowledge systems in Ugandan psychiatric care**

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Introduction

Mental health aspects of development have often been neglected in international policy, and yet compelling reasons exist for redressing this (Lund 2012). Studies show that mental illness plays a significant role in increasing the global burden of disease¹, and has additional associations with low education, food insecurity, inadequate housing, class, socio-economic status and financial stress (Lund 2012). Mental illness has a bidirectional and cyclical relationship with poverty, of which Africa has some of the highest global levels (Flisher et al. 2007), however only half of the nations in WHO's African region had a mental health policy in 2005 (Ssebunya et al. 2012). There is an additional problem however that draws on recent work in the fields of psychiatric anthropology and cross-cultural psychiatry which questions the broadly accepted universality of psychiatric constructions (Kirmayer & Young 1998, Kirmayer 2005, 2006, Kleinman 1982, 1987, 1999) around which such policy is created. The relevance of this for international development efforts in the African region lies in the recognition that psychiatry in itself can be an agent of globalisation in which nosology and treatment remain highly biased toward the Euro-American constructs developed over the preceding century (Kirmayer 2006, p136).

In many of the complex religious modernities of the African region, a diversity of both indigenous and expropriated spiritual practices and beliefs systems form an important aspect of the cultural landscape within which psychiatric treatment is performed. Here as elsewhere, the efficacy of treatment - for mental illness perhaps more than any other aspect of health care - depends on shared interpretive frameworks, both between different medical professional and care personal in a multiplex clinical environment, and between the patient

¹ As measured by disability-adjusted life years

and their carers (Kirmayer 2004). However since the slow cleaving of religious and psychiatric practice from the 18th century onwards (Ellenberger 1970) there has been a notable neglect of the role of spirituality and religion in relation to health, mental health, and psychiatry, which has only begun to be redressed over the past two decades (Rensburg et al. 2014). To date much of the scholarship that *has* emerged on the topic has continued to focus on sensitizing mental health professionals - who are portrayed as objective, rationalistic beings - to the spiritual needs and beliefs of their patients (D'Souza 2007, Turbott 2004, Sperry 2000). Far fewer studies have examined the role of spiritual or religious beliefs in the lives of psychiatric practitioners and carers themselves (Bulbulia & Laher, Kelly & Kahn 2001, Yen & Wilbraham 2003a, 2003b).

Turbott writes that scepticism is implicit in most medical teaching (2004), however writing from Australasia his experience perhaps differs from those researching with in less secular, more religiously saturated and pluralistic places, as many African nations are. In South Africa, Kahn & Kelly (2001) examined how Xhosa psychiatric nurses managed “the apparent incompatibilities between their practice of Western psychiatry and the use of traditional healing services” (p35). As they note, psychiatry and faith are often seen as competing, incommensurable systems of knowledge and meaning. Bulbulia & Laher (2013), also in South Africa, examined the role of Islam in the clinical work of a group of Muslim psychiatrists, insisting that since most psychiatrists are trained within a Western paradigm giving primacy to empirical biological models of illness, research on Islamic and other religious practitioners within these systems is essential (p53, 2013). Answering the call from such scholars, this paper presents a brief case study of the way in which Christian mental health professionals in Uganda mediate, negotiate or manage the tensions between spiritual and biomedical knowledge systems in their everyday life worlds.

Methods and Field Site

This case study emerged from a broader PhD research project focussed on care labour, spirituality and mental wellbeing among Christian youth workers in Kampala, Uganda. It was primarily ethnographic, involving 6 focus groups, 25 semi-structured in-depth interviews, 65 questionnaires, 3 months participant observation over two separate visits, numerous informal conversations and some secondary textual analysis. It also included two visits to the Christian fellowship at Butabika, Uganda's National Mental Hospital, established in 1945² and located around 10km South East of Kampala City.

² The first psychiatric service in Uganda began to operate in 1924, with the first psychiatric hospital built in 1945, and Butabika itself established ten years later. In 1967 the Makerere University

Neuropsychiatric disorders are estimated to contribute to 5.3% of the global burden of disease in Uganda (WHO, 2008), with some estimates suggesting that 35% of Ugandans suffer a mental disorder³, and 15% of these require treatment (Ssebunya 2011). A qualitative study completed in Uganda by Ssebunya (2011) indicates that mental health professionals there still feel that mental health work is a marginalised stigmatized area, despite consensus from Ministry of Health officials that it was being prioritized (2011)⁴. Butabika Hospital has an initial bed capacity of 500 beds (WHO 2011⁵), receiving patients through referrals from general practices and regional hospitals nationwide. They boast a 300-acre complex⁶, of which 180 acres are hospital infrastructure and buildings, and the remainder are the training facilities and recreational grounds for the staff of 426, including medical personnel and support staff (<http://www.butabikahospital.com/>). In fact, the vast majority of clinical staff is psychiatric nurses, with 0.31 nurses per bed compared to 0.02 psychiatrists per bed. (WHO 2008, Kigozi et al 2010). This paper particularly draws primarily from a focus group conducted at Butabika in February 2014 with a group of six psychiatric nursing students (3 female and 3 male) who were also members of the interdenominational, charismatic Christian fellowship there.

Colonised in 1860 by the British, Uganda quickly became one of Africa's most successful Christian mission fields. Today around 85% (WHO 2008) of the population is nominally Christian, and the Ugandan Pentecostal church in particular is thriving after an (arguing ongoing) period of 'revival' through the mid-20th century. An ethnically plural nation, traditional cosmological belief systems in Uganda can be described loosely as 'animist', with traditional⁷ notions of witchcraft, spiritual possession and ancestor veneration continuing to

Psychiatry Department was founded and soon began to indigenously train psychiatrists and psychiatric nurses, of which most of the residential units and teaching facilities are now located on the Butabika grounds. (Boardman & Ovuga 1997)

³ Boardman and Ovuga (1997) attribute the burden on Uganda psychiatry to AIDS, supported by recent research (Ager et al 2012, Allebeck et al 2011, Okeke & Wagner 2013), and post-traumatic-distress disorder (likely sustained since the time of their writing by further conflict in the north of the country).

⁴ Through policy and funding prioritization, although the National Mental Health Policy remained in draft policy some ten years after its conception (WHO 2011).

⁵ Or 967 according to their website. Another 42- psychiatric beds are available in general hospitals (WHO 2011).

⁶ Pending sale of some land

⁷ I use the term 'traditional' reluctantly throughout this paper as broad-stroke characterisations of indigenous African belief systems which do have internal diversity around the ethnically plural nation of Uganda, but tend to include components of animist and ancestral spirit cosmological beliefs.

be pervasive in many regions, and often practised pluralistically with Christianity⁸ (Allen & Storm 2012.)

This study additionally draws closely from several in-depth (1-2 hour) interviews with Christian youth leaders who were also trained in medical profession⁹. These were conducted in English, as all were proficient in this language and as it remains the language of education and medicine in Uganda. Data was coded iteratively for significant themes drawn from existing studies, and emerging themes specific to this field site.

As this paper focuses on material from a relatively small number of participants, it is presented as a snapshot only of a particular place and moment in time. Through contextualising this within broader ethnographic data and within existing literature on the topic, the case study is intended to contribute to wider interdisciplinary conversations around culture, religious faith, and psychiatric care.

I will now outline some of the results which emerged around the themes of; spiritual possession, schizophrenia, miracles, medication and chronic conditions. These will be discussed and contextualised in the specific socio-cultural, socio-economic and historical moment, with reference to professional identities, modernity, care practices, the clinical environment, the sick role and narratives of illness and healing. Conclusions focus on analysing the particular relationships of co-existence, tension, pluralism and integration between the overlapping epistemologies in the everyday lives of the Butabika students and other healthcare professionals.

Results & Analysis

Spiritual Possession

You find that some of the causes that cause depression are when some of the spiritual powers come, and if you don't detect them early... well, that is why we are doing with the spiritual battle. Because some people are not born again, they are practicing their witchcraft, and there are those demons. The demons will COME and sleep in you, and hibernate in you, and keep there, and keep you. Some people present with muteness, they can't speak anything because

⁸ I wish to avoid dichotomising Christianity as 'western' and animist beliefs as 'traditional' here, since the Ugandan church has its own rich history and roots and sense of indigeneity, rather than simply functioning as a cultural outpost for the western world, although these ideological basis remain significant. Additionally traditional beliefs are often articulated in and through this and sometimes practices pluralistically (Kyriakakis 2012).

⁹Edson: GP, Collins: psychology professor, Hillary: laboratory scientist. These will be referred to by their actual first names where directly quoted

demons are holding their teeth. You have heard of those attacks? We have actually experienced and seen them, where someone cannot chew anything, cannot talk, who was talking and suddenly cannot do that, so basically that is spiritual power in manifestation, you realize 'Ohhhh this one has now been bewitched!'. It is a battle of demons now. Others manifest with mania, with the psychotic features. They start reacting, hyperactive, because of demons. So demons have the capacity to do both.

- Edson

The attribution of mental disturbance or distress to spiritual forces illustrates a moment of coherence between animist and Christian belief systems. Evil spirits are well known to cause mental illness, according to all those with whom I spoke; an association firmly rooted in biblical scriptures¹⁰. The Christian belief system acknowledges the Holy Spirit and also demons, which work can work intimately inside people's mind in order to "lead them to destruction" and "drive them crazy" (Hillary). Similarly, in traditional cosmological belief systems, ancestral spirits, or evil spirits, can move independently and often maliciously, or can be summoned or provoked by another human party as part of the practice of witchcraft however this is something both dangerous and sinful for Christians to dabble in.

Being 'mad', being 'possessed', and being 'bewitched' represent descriptive terminology from the three different knowledge systems that nonetheless was used to describe patients somewhat interchangeably. The same clusters of symptomatology may be attributed to either system.

Schizophrenia

When you really read books about schizophrenia, they really don't tell you 'this is the causative cause'... [They say] 'these are the theories.'

- Focus group participant 2

[Schizophrenia is] something beyond pathology. It is really, it is something, I consider it somehow spiritual.

- Focus group participant 5

Schizophrenia as cluster of symptoms was the closest fit with the cultural schema (or stereotype) of mental illness as 'madness' which predominates in Uganda. As a diagnosis it

¹⁰ Such as John 10:20: Many of them said, "He is demon-possessed and raving mad. Why listen to him?" (NIV)

also typifies the emphasis of the Butabika nurses' limits of scientific knowledge and the 'mystery' of mental disorder.

For most of [the patients], what you call hallucinations, are simply visions. As a Christian you can see visions [...] so as a Christian you don't consider it as a minor thing, you consider it as a spiritual thing.

- Focus group participant 3

Thus, particular symptoms (i.e. hallucinations) form another touch point between belief systems that allow them to draw symbolic and interpretive resources from both belief systems, and 'translate' the symbolic resources from a Christian belief system into a psychiatric one.

Miracles

One thing I will always say I believe in MIRACLES. Because a miracle has no theory part of it, I mean you cannot explain a miracle. Just as like someone cannot explain the cause of mental illness, then I cannot explain the miracle [...] Because I do not have the theory behind the healing, I do not need the theory behind the causing; I mean the real cause, either. Because when [God] is healing he doesn't need to know the physiology. No. he doesn't need to know how did it begin.

- Focus Group Participant 2

The limits of science itself (where the underlying cause of mental illness is not always established) are emphasised in parallel with the mysteries of faith, where healing of that same illness can occur without either the healer or healed understanding the processes behind how this works.

I cannot say I pray for the mentally sick because I believe they are spiritually possessed, although to some extent they are, but because I believe God can heal any kind of illness, be it of spiritual origin or be it just a normal medical conditions. [...] That is what I know. So I can pray for someone with cancer the same way I can pray for someone with schizophrenia, because it's all ILLNESS. And God heals all illnesses, no whatever what they originate from, no matter the cause.

- Focus group participant 2

The nurses seemed able to disarticulate the interpretive process of determining the “real cause” (Focus group participant 1) of a disorder, its either spiritual or biophysical origins, and the efficacy of treatments offered by alternative treatments.

Medication and Chronic conditions

[Medication] is a bad side, that's when we start contradicting ourselves. The church is saying don't take medication, the psychiatric department is saying take medication, so when trouble comes these [mentally ill] people start trying to send you away from them. But me as a Christian who is in the psychiatry department, I give medication, but I believe that Christ heals. But healing comes from faith. So the truth is if I tell you to leave your medication even when your faith is low, then that is trouble, so it is better we keep on the two until God does his work [...]
I do not believe in someone telling the colleague to leave medication, not until he IS healed.

- Focus Group Participant 2

The Butabika nurses espoused particular concern around the contradictory attitudes of the broader church and the psychiatric system regarding medication.

Usually I've been interested in patients with mental illness, that to the greater extent that I've seen good results, I do not discourage them from taking their medicine. But ah it's like I show them the other side of treatment which is not physical. Which can be... you go through the spiritual part of it.

- Focus group participant 6

So mental illness cannot scare us: we take both sides. We say 'if you are of little faith, please seek the medication' and with radical faith like of Evangelist Egesa¹¹ [everyone laughs], we shall lay hands on you until you get better.

- Focus group participant 1

[This patient] went for something like 2 weeks without talking, because he is severely depressed. So for me I believe like if you are to counsel someone, their mind is really, they cannot even perceive anything you are saying, they are really DOWN. So I would decree they take some antidepressants, then as

¹¹ The Christian evangelist I was working with as my primary informant, who had provided the introduction to this group and was in attendance during the focus group.

the mood is elevating you bring the love of Jesus Christ, and you tell them that really God cares [...] then life will be transformed.

- Focus group participant 4

Here it is evident that the nurses were comfortable using medication simultaneously alongside spiritual aspects of treatment for the same patient, using medication selectively depending on the particular patient and on the circumstance, or using medication as one step in a process that enables and facilitates other forms of care that draw from a Christian framework (or prayer and counselling¹²), rather than seeing it as a final and complete solution in itself.

When you are advising these patients. Maybe some of them have schizophrenia, and you tell this person [that] according to the books they tell you that you will have to go on with this medication for the duration of their life, to go on with this sickness until you die. And according to me as a Christian, I know that this disease is not terminating on this person. So for me to tell this person [to stay on medication forever]... it contradicts. I find that challenging on my side. For me I think that there's still hope and you can HEAL. What I've studied, and what I believe, I find that a contradiction.

- Focus group participant 6

The bible has not refused sometime take medication. But what we fight is lifetime medication. So if you can get stable and then we talk.

- Focus group participant 4

There was serious discomfort with the framing of mental disorders as chronic, and it was the *chronic* use of medication (in the absence of the hope of healing through faith and prayer) which troubled these participants, who were comfortable to utilise medication as part of their prayer practice with the expectation was that once healing had occurred, medicine could be discontinued. The identification of stigma within the community that portrayed mental illness as chronic *and* medication as ineffective was also seen as problematic as another point of contrast with Christian beliefs around healing.

¹² Which in itself is a touch point between the psychodynamic element of psychiatric theory and practice, and Christian pastoral care systems.

Discussion

Identity, Modernity, and Narratives of Healing

Kirmayer outlined some of the 'theories of affliction' that are associated with various systems of medicine worldwide, and shape their associated healing practices (2004). The Butabika nurses, as has already been shown, have several different theories of affliction from which they might draw when making causal attributions and prescriptive calls around mental illnesses; a Christian model focussing on sin, moral error and demonic possession (to be addressed through prayer and deliverance/exorcism), a traditional animist model emphasising offending spirits and magical attack (to be redressed through ritual or sacrifice), and a psychiatric model focussing on physiological/chemical imbalance, depletion, or damage and (in psychodynamic aspects) psychological conflict (to be redressed through institutionalisation, medication, and talk therapy). Different systems such as these, Kirmayer writes, can form a "nested series of cognitive schemas involving knowledge about symptoms, illnesses or other models of affliction and broader sociomoral notions of self and personhood." (2005, p192 Individuals have many competing schemas at their disposal, and the weight given to each model at any particular time is shaped by the social context (Kirmayer 2005), and (I would argue), the particular moral dimensions (i.e. what is at stake, such as professional identities, roles and authority) of the fields they are in (2005).

The Butabika nurses necessarily have daily, practical engagement in the local world of psychiatric practice (even living on-site at Butabika) and thus their moral experience is rooted there (Kleinman 1999). There is therefore some level of strategic moral advantage to utilising psychiatric knowledges as their primary interpretive system, where their professional and personal identities as modern, clinical practitioners. Indeed the Butabika nurses clearly retained a strong stake in the biomedical system. A considerable amount of their conversation focused on espousing clinical knowledges and the particular habitus of the psychiatric carer. For example they expressed strong knowledge of particular psychopharmaceutical medications, and frustration that most of their typical anti-psychotic medications were the "old, old" drugs. Knowledge and utilization of medication can and was in some situations a symbol of professional identity and competency. They also often contrasted their own psychiatric (biomedical and psychodynamic) knowledge systems around disease names, categories, and causations (including the "chemical in the body" particularly of the "lack of knowledge" in the community or "the village", where people have "queer" beliefs, stereotypes, misconceptions and "stigma." Furthermore, as part of a region with exceedingly high rates of poverty (Flisher 2007), Uganda has for many years been an 'object' of development for the west, and partly through this in many parts of the Kampalan community in particular they evidence an aspirational attitude that places high value on

education, modernity, and 'western' cultural knowledges. Being part of the Christian community that is also embedded on-site here they negotiate complex moral fields in which they must not only enact the identity of the 'good nurse', and the 'good (i.e. modern, educated) Ugandan citizen' but also the 'good Christian', while remaining aware of other community and traditional belief systems that are significant in their region and for the patient and many of their other carers as well.

The Butabika nurses often contrasted knowledge about mental disorder "according to the books" with their own spiritual knowledge "that is what I know", clearly experiencing some conflict at a personal level as other theorists have posited (Turbott 2004). For example, around traditional psychiatric uses of medication they often found contradictions between "what I've studied and what I believe", as Focus group participant 6 expressed. In anthropological literature a distinction is frequently made between the notions of 'cure' (the removal of disease in relation to a restitution narrative), and the notion of 'healing' (associated with other more 'spiritual' or holistic interpretive systems). Additionally managed care tends to prioritise cure over healing, and thus it necessarily bypasses much of the spiritual dimension of medical and psychiatric care (Sperry 2000). Charismatic Christian narratives of healing tend, much like dominant medical models, to follow a 'restitution' narrative, which socially sanctions the patient adopting a sick role so long as they put all their effort into getting well, and do so (Frank 1995). This rests on the assumption of a return to a previous state of full wellbeing, and while the mechanisms may be different between spiritual and biomedical systems (e.g. prayer, faith, and faith healing vs. surgery, hospitalisation, medication), this forms a strong discourse of the appropriate set of expectations around the sick role of the patients. Chronic illness disrupts this narrative; the construction of psychiatric discourse of mental illness as a chronic condition and the additional stigma around mental illness within the community meant the nurses had to reframe the culturally problematic idea of "lifelong" medication as a key part of this. Thus they had resolved this by reframing the use of medication within a different and more-culturally acceptable narrative than the dominant psychiatric view of its use; as a temporary tool to make patients more receptive to other forms of healing.

Adjunctive or integrative: "We take both sides"

Barbee (Kahn & Kelly 2001) found that nurses were "ensnared in a dialectic between traditional and biomedical beliefs" (p. 79). However Kahn and Kelly similarly observed that while there are moments of tension and contradiction, under normal circumstance the "incongruity" between belief systems "appears unproblematic for the

respondents; these systems co-exist pluralistically in their experience” (2001), as also shown in the Butabika examples.

This case study therefore offers an alternative to the typically western (Cox 2011) view of spiritual and psychiatric/biomedical knowledge systems as competing or contradictory, showing instead how they may exist pluralistically in the life worlds of psychiatric carers. The particular relationship between the different knowledge systems in a pluralistic setting can be conceptualised in a number of different ways. One of these, is as an ‘adjunctive’ relationship (as Kahn & Kelly suggest (2001)) within which both systems remain largely separate but function alongside one another. When it came to care practices, this indicated a pluralistic form of care given even within the formal, clinical biomedical framework of the hospital. Participants all spoke of counselling and praying for patients, even while they administered medication and encouraged the taking of it. Outside the clinical setting, in their own communities of faith and family, they showed a similar integrative practice where they draw inversely from professional knowledge systems. The participants explained that they feel lucky to have the knowledge of mental disorders that others lack, and described their work to ‘sensitize’ their fellow Christians, and their approach of combining “just showing love” with psychological counselling, and in certain cases advising seeking help within the formal medical system which will sometimes include advising them to go on medication. These may sometimes appear hierarchically ranked, as in the case of community members who tried prayer and traditional healing first before bringing family members into the formal psychiatric system as a “last resort”.

However I argue that this Butabika snapshot shows that African psychiatric practitioners in an environment where multiple knowledge systems are in play don't always manage discursive tension or ideological conflict through an ‘*either/or*’ approach, but often rather strategically employ a ‘*both/and*’ approach that translates and assimilates symptoms, causal attributions and prescriptive or curative pathways between systems. The examples I have given show many cases of the discursive interweaving that the psychiatric nurses may engage in as they are forced to engage with all three systems as they deal with community beliefs, personal beliefs and professional knowledge systems. In disarticulating causal attributions from prescriptive frameworks, for example, and emphasising the limits of each system (i.e. being unable to ‘speak love’ to an unmedicated, seriously depressed person, or being unable to understand the origin of schizophrenia scientifically) the plural knowledge systems were able to flow into one another and fill each other’s gaps. Certain symptoms and experiences such as hallucinations, or muteness, can simultaneously be understood as a “real” mental illness but causally attributed to demon possession, which in turn either relates

or equates to being 'bewitched'. Thus this was a much more complex strategy than simply categorising some illnesses as either/or for spiritual or natural, or toggling between identities, or picking and choosing between equal or ranked options for healing practice. Instead it was a creative way of identifying touch points and coherences between these different meaning-making systems and using these to re-create a cohesive though pluralistic understanding of mental disorder that functioned strategically as part of their own identity work and care practices day to day.

Social fields

"Some stuff has cropped up because today, I've had psychiatrists or people in the hospital saying that Christians are becoming trouble, because they pray for these guys and ah, they are confusing the people around." – Focus Group participant 3

The hospital itself is also undoubtedly a complex social field, where not all different health professionals occupy the same positionality, not all are Christians, and not all have the same implicit engagement with traditional beliefs as these factors all vary according to regional, urban/rural, ethnic, generational and other factors. This paper is provided as a snapshot not intended to generalise to all experiences of giving psychiatric care in Uganda. It is important to emphasise, in fact, that the nurses may occupy a unique positionality within the clinical environment that enables these forms of pluralism. Khan & Kelly noted, for example, that the Xhosa psychiatric nurses in their study could be called 'generalist' practitioners, considering their role in mediating tensions between roles on the interdisciplinary team (2001, p36). Additionally as nursing students, they may not have yet been fully interpellated into the professional psychiatric subjectivities. However, the similarity in their views and those of other practising medical professionals, social workers and faith leaders interviewed seems to indicate that it is the role of their multiple knowledge systems rather than their inexperience in the medical field that leads to their integrative approach.

Conclusion

In identifying an apparent epistemological chasm between psychiatry and religion Turbott calls for the embracing of "intellectual, cultural, and religious pluralism" (2004). This paper offers a brief glimpse into the lived experiences of psychiatric carers in Butabika National Mental Referral Hospital that explores some of their approaches to such a situation of multiple knowledge systems within a complex social setting. Kahn and Kelly observe that if Xhosa psychiatric nurses can find strength and flexibility rather than a problematic clash when melding these two or more categories of understanding (just as the Butabika nurses

did), then “the broader system should not be as concerned but open-minded to understanding and even utilising multiple systems of meaning-making in care practices” (2001, p45).

Given the contribution of mental disorder to the burden of disease in this region, increasing the efficacy of psychiatric care is an admirable goal and can perform valuable work towards development goals. Reflexive, culturally-engaged attitudes which acknowledge the role of spirituality in the meaning-making practices of both patients and psychiatric personnel goes some way to countering assumptions about the rigid, ‘universal’ way in which psychiatric knowledges developed in the western world might be applied in an African clinical setting. Such an approach could contribute significantly to health and development goals for Africa, particularly while much of the region’s mental health policy is still in development.

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