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Psychiatry, traditional healers, and the vimbusa, in northern Malawi

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Last year I was fortunate enough to visit two GP friends running a district hospital in northern Malawi. As I had just taken Part 1 of the Membership Examination, they were intrigued to know my professional view of a condition called 'the vimbusa'. In their experience, the vimbusa was a common complaint with a wide variety of presentations, none of which corresponded with disease entities they had learnt during their training. After a fascinating two weeks I was unable to categorise the vimbusa according to ICD-9, but the following essay summarises my attempts to understand this condition.

The people of northern Malawi believe in witchcraft. Within the small, agriculture dependent villages, in which the majority of the population live, most of the villagers are related. Even if the blood bond is tenuous, individuals refer to other villagers as their uncle, aunt, sister, or brother. The family structure is usually an extended, monogamous, matriarchal arrangement, but in the northern rural areas it tends to be patriarchal and may be polygamous. Only 'relatives' can bewitch an individual.

Bewitchment usually involves the use of herbs or potions, collectively called *nyanga*. The effect of nyanga can be neutralised, or protected against, by *mbozgha*. Certain plants are mbozgha and if planted around a house, often at the time the foundations are constructed, can protect the home and its occupants from bewitchment by jealous relatives.

There are various anecdotal parables believed by villagers. The following are two examples:

A Malawi man leaves his family to obtain work in South Africa. After he has been gone for two years his wife falls pregnant. She insists that her husband flies back from South Africa during the night to be with her and that her husband is the baby's father. Her in-laws disbelieve this explanation and accuse her of infidelity. She visits the local sing'anga for advice and is given some herbs to scatter around the house which will stop her husband leaving. Next time he flies back from South Africa for a nocturnal visit he is trapped. He supports the wife's explanation, insisting that the baby is his and that he has indeed been making secret nocturnal visitations. No alternative explanation is entertained, let alone considered as a viable hypothesis.

Traditionally, in rural environs, the prevalence of thieving is low. The story goes that if a man tries to steal maize and the maize is bewitched, he will be paralysed in the act of taking his booty. His petrified carcass, with a bag of maize balanced on his head, will be found the following morning by the rightful owner who will simply retrieve his grain before it even leaves his premises. What then happens to the paralysed criminal is left unstated. The message is as clear as a biblical commandment or an Aesop's fable. Besides relating graphically a valid and wholly acceptable moral, it instils fear and conformity. In urban areas this fear seems to be somewhat eroded. Maybe the beliefs are less prominent, the fear of justifiable punishment is less, or the pressures to acquire goods by deception are greater.

The Malawi traditional healers, the sing'angas or mururas, practise against this background of belief in witchcraft, spirits and magic, held by a superstitious and jealousy-ridden population. They are attributed with superhuman powers, mystical insight, and omnipotent therapeutic solutions to the myriad of problems presented to them by desperately frightened, unsophisticated people. An illness is a bewitchment. There are various preventive measures taken by anxious mothers, usually encouraged and pressurised by grandmothers, to ensure that their babies grow up healthy and strong. They tie pieces of string or beads, obtained from the sing'angas, around the infant's neck to ensure that the fontanelle will close, and around an ankle to ensure that the child will walk. A particularly coy mother confessed that the elaborate, colourful, 1 cm band of beads around her child's abdomen was to ensure that should another woman, living with a man but not married to him, touch her baby it would not get a cough; the belief presumably being that a cohabiting woman inflicts tuberculosis on the children she touches.

Predictably, most of these 'African immunisations' work! So the beliefs are perpetuated and it becomes negligent not to take adequate precautions. These traditional immunisations exist alongside the under-5s immunisation programme against diphtheria, tetanus, polio, whooping cough, measles, and tuberculosis, without apparent conflict.

Strings of beads are worn around the waist by women as colourful ornaments. Plain string from a

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sing'anga may be worn to prevent conception, or by habitual aborters to prevent miscarriage, in which case the string must be removed for labour to proceed.

The sing'angas, as well as providing 'immunisations', are able to diagnose bewitchment and identify the offending individual. They do not use any random divination methods, or herbal potions to do this, but somehow they 'just know'. As likely as not, they are the centre of the local grapevine and eager recipients of all gossip.

The employees of a small rural health centre became terrified when the maid and her daughter awoke one morning to find small chunks of hair from just above their ears had been snipped off in the night. This is a ritual performed by grieving relatives as part of their bereavement, so it was an ominous sign in the absence of a death. Reports of flashing lights at night time in an establishment with no electricity added to the terror. The entire staff of the health centre trooped off to the local sing'anga with their story. He confirmed a bewitchment but would only identify the culprit to the chairman of the health committee. It was widely rumoured that the medical assistant was responsible, although at the time of writing, this crisis has not been amicably resolved and may precipitate closure of the health centre.

Similarly, the entire staff of a village school visited the sing'anga to find out who was bewitching them. They found out that, and many other details of illicit intramural affairs as well which, as a package, helped them to resolve their staffroom problems.

There are no psychiatrists employed in Malawi. The population of six million are serviced by one psychiatric hospital at Zomba run by psychiatric nurses, and a series of regional community psychiatric nurses, all of whom are trained abroad. I spoke to the CPN for the northern region who informed me, very generally, that schizophrenia and depression were "very common", and that he used a lot of Modecate, Haldol, and Moditen. He was not impressed by families' abilities to support their psychotic relatives and community treatment was inadequate. He never visited patients at home but hoped to do so when he got a motorbike for transport. He currently had four to five in-patients at the local district hospital. The psychiatry ward consisted of a corridor where patients slept on the floor in voluntary seclusion – hidden under blankets, or were handcuffed to another patient's iron bedstead. The psychiatric patients appeared not to warrant beds of their own but slept in corridors, corners, or under beds of proper patients with fractures or laparotomy scars.

These patients were considered 'mad'. The sing'angas, the CPNs, and the villagers seemed able to identify 'mad'. It seems to correlate with psychotic; those individuals out of touch with reality, behaving inappropriately, responding to voices, and deluded. People who are not mad, are not subnormal, brain damaged or physically ill, but are not their normal selves, have the *vimbusa*.

No-one can define the vimbusa. The CPN thought some people with the vimbusa became schizophrenic, some were depressed or manic, some hysterical, and some suffering "psychosocial problems". He was unable to be more specific. A young Malawi doctor, training to be a surgeon, dismissed vimbusa as "a dance they do in the north".

People who experience the vimbusa wear a tight bracelet of small white beads around their wrists, usually the left one. This indicates their predicament to others, rather like a medicalert bracelet or necklace. It does not protect them from further attacks. There do not appear to be derogatory implications to having the vimbusa, unlike being 'neurotic' or 'hysterical'. Indeed, to become a sing'anga an individual has to be susceptible to the vimbusa.

I was able to talk to a 23 year-old primigravida woman in the last trimester of pregnancy, with a haemaglobin of 6, who wore a vimbusa bracelet. The antenatal ward sister translated some of the above information, together with the following. The patient had had the vimbusa since the age of 12 years. She experienced palpitations only. These lasted for about one hour, occurred about once per month usually when she was feeling unwell, and were not related to menstruation or situation specific. She never lost consciousness, felt dizzy or fearful, or experienced abdominal discomfort. She did not hallucinate. She apparently was usually physically well, and accepted the vimbusa with no shame. Her anaemia was thought to be due to malaria and since admission to the antenatal ward she had been treated with weekly chloroquine, daily iron and folic acid. She also wore a bracelet to stop her having nightmares – the treatment worked well so she kept the bracelet on to prevent the nightmares recurring. This seems to be a fairly typical presentation, although more dramatically, patients may be brought to hospital paralysed or fitting, with organic illness; a presentation rather like an hysterical conversion syndrome except that the afflicted individuals recognise their state as the vimbusa may occur. Such patients have what may be called 'insight' into their conversion symptoms.

I was fortunate enough to be able to visit a traditional healer, Mama Bamanta, a female sing'anga which is unusual. We set out after dark one Saturday evening, carrying a live chicken as a present, stumbling across recently dug maize fields by torch light. Our destination was a small mud and straw 'temple', measuring approximately 30 feet by 10 feet. We were warmly greeted by Mama Bamanta's husband and guided towards three small wooden chairs lined against a wall in the distant corner. From that dark corner came Mama Bamanta

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and an attendant to greet us with their traditional three stage handshake (palm to palm, clasp thumbs, palm to palm) and express their gratitude at having three mzunga (white) doctors at their ceremony as we increased their business.

The ceremony started lit by two hurricane lamps at opposite ends of the temple. Mama Bamanta commenced a harsh, melodic song; an audience of approximately 30 women, a few men, and many children of ranging ages, answered her as a chorus. They stood crushed close together, clapping vigorously, and slowly closed in on the dark corner where Mama Bamanta chanted, forming the hypotenuse of a triangle. Two drummers beat out their hypnotic rhythms, standing astride hollow tree trunk African drums, with animal skins stretched taut. They were 'heating up the vimbusa'. The rhythm droned on. Some translateable phrases indicated that they were singing hymns, and calling to Jesus and the spirits to act through them to heal and cure the afflicted. Voices became louder, shiny black faces crushed closer. The characteristic smell of Malawi sweat perfumed the air. Women started falling in jerky grunting heaps on the pressed red-earth floor. They were identified by Mama Bamanta and her acolytes and diagnosed as having the vimbusa. The rest of the evening would be dedicated to treating them. As far as I could see, there were approximately four women and one man from an audience of around 30.

The first woman to be treated had been a patient of Mama Bamanta's for two months, living in her community and receiving regular herbal medication in porridge and drinks. The husband of one of Mama Bamanta's acolytes explained her history and answered questions in fluent English.

She was a 37 year-old married woman from Lilongwe, the country's capital 450 km away, with seven children and three grandchildren. Her illness had started four years previously and she had received treatment in Lilongwe hospital; this consisted of 'sleeping tablets' which had not helped. Her symptoms were sleeplessness, anorexia, loss of weight, irritability, tearfulness, avoidance of loud noises, social isolation, and the ubiquitous palpitations. She did not experience hallucinations and was not considered 'mad'. These symptoms had apparently improved dramatically since treatment from Mama Bamamta. She had of course been separated from her family for two months, was paying for her treatment, and had partaken in at least weekly vimbusa dancing sessions to complement the herbal concoctions.

This week's dancing session started. The patient was wearing a sleeveless vest and a local chitenge – a two metre length of printed cotton fabric wound around the waist and reaching to below knee length. It is a legal requirement that women in Malawi wear skirts covering their knees. If a woman falls to the ground exposing her knees, the first action taken by her friends is to cover them. The ritual adornments consists of strings of bells around both ankles, a belt with a rustling ruffle over the bottom – resembling a cluster of tinfoil pie cases – and two swatches of horse hair held one in each hand and swished around in time to the music. The drums beat, singing is loud and melodic, solo and choral, stamping and clapping. The 'patient' stamps and rattles, clangs and swishes, sings and shakes. A few women ululate. The drums move closer. The throng moves closer. Mama Bamanta sits on a low table beside a hurricane lamp with a baby tied in a chitenge across her back. The patient hurls herself to the floor – head right, head left, then forehead to the pounded earth floor, recently sprinkled with water to reduce the dust. She is bowing to the spirits. Up she bounces again and continues her frenzied dance. She hauls a child from the crowd onto her back and continues stamping and shaking. The child flops astride her, apparently unperturbed by the noise and movement. A final hurtle to the ground, and she is immediately surrounded by Mama Bamanta and her group of about eight acolytes. They start a slow, quiet handclap and all other sounds cease. They are communicating with the spirits. In quiet peaceful tones they drone on. Mama Bamanta holds the patient's left hand and winds a string of small white beads around her waist. What they say to the spirits remains a mystery. Some say they consider the vimbusa to be a possession state and they are exorcising the evil spirits; some say they ask the spirits to act through them to heal the patient. Once completed the patient is guided out of the temple and stripped of the communal ritual ornaments which then adorn the next patient. The process is repeated.

We witnessed two females and one male being treated. The young gangly man appeared reticent initially but was encouraged by cooing words from Mama Bamanta's husband, until he too was spinning in a wild extravagant dance.

This extraordinary scene should theoretically have been maximally stimulating. All the sensory modalities were affected – loud noise, lively scenes, pungent smell, and for those partaking, close body contact and rapidly changing proprioception. Paradoxically, the effect was soporific. We three spectators felt relaxed and dozy. The whole experience seemed to banish tension. After leaving, and walking back by moonlight, we slept soundly for over eight hours and the following morning felt at peace, as if some essential, primaevel rhythm was harmonising our bodies and minds.

So how does the vimbusa correlate with western classifications of psychiatric illnesses, such as the ICD-9? It seems unlikely to be an organically based illness. People with the vimbusa do not appear intellectually subnormal, generally do not have

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neurological symptoms, although the presence of them, e.g. epilepsy, does not exclude the vimbusa. It could be argued that this may be a form of epilepsy, but its sheer ubiquitousness and atypical presentations seem to make this unlikely. It is not a drug induced state, though various herbs may be used to treat it. The word 'herbs' seems to have magical properties in itself; people use herbs to cast spells, sing'angas use herbs for countering bewitchment, treating the vimbusa and any other conditions presented to them. When herbs seem to be failing and a patient is almost dead, they are brought to the local hospital where inevitably they die within a few hours. Hence the belief, held by some, that people go to hospital to die. Although alcoholism, anaemia, malnutrition, and cerebral malaria are widespread, none of these would seem an adequate explanation for this condition.

The vimbusa excludes 'madness' i.e. psychosis. People who become 'mad' are usually taken by relatives, or referred by sing'angas, to hospitals, where they are treated by CPNs with phenothiazines and antidepressants. This leaves the vimbusa among the group of neurotic illnesses. Some presentations of vimbusa would be indicative of anxiety states (300.0) in particular palpitations. The north Malawi language, chitumbuka, seems to have few words for emotions, so somatasisation may be an accepted way of conveying psychic distress. Some presentations resemble hysterical conversion reactions – patients may be paralysed or may convulse. These symptoms do not correlate with recognised organic disease and are usually transient. Unlike hysteria (300.1) patients with vimbusa have insight, and they and their relatives freely label their condition.

Neither of the two case histories detailed, nor any of the cases discussed with doctors in Malawi, showed symptoms consistent with a diagnosis of phobias (300.2) or obsessive-compulsive disorders (300.3). Because of the extent of somatasisation some people with the vimbusa may be considered to have hypochondriasis (300.7). However, it could be argued that a diagnosis of neurotic depression (300.4), or neurasesthenia (300.5) would adequately classify the majority of symptoms referred to as vimbusa.

As Leff (1981) has argued, where conventional medicine is unsatisfactory traditional healers flourish. This is quite clearly the case with psychiatric illnesses in Malawi and many other African countries e.g. Botswana (Ben-Tovim, 1987) and Nigeria. The attraction of traditional healers is so great that, even among trained primary health care workers in Nigeria, 90% believed that mental illness could be due to charms, evil spirits and witchcraft, and 71% believed traditional remedies were the most effective treatment (Ogunlesi & Adelekan, 1988).

In short, the vimbusa can best be summarised as a culture-specific expression of psychological distress. Its treatment is a complex form of supportive, group and family therapy mediated by dance and music-induced trances, and augmented with 'herbs'. The sing'anga's role is pivotal in the diagnosis and treatment of vimbusa, as well as in preventive traditional medicine and bewitchment.

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