A CULTURAL STUDY OF AUDITORY HALLUCINATIONS
IN PSYCHOTIC INDIAN MALES
FROM THE DURBAN AREA

by

ABDOOL HAQ SULEMAN KAJEE

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ABSTRACT

The aim of this project was to study the phenomenology of auditory hallucinations in Indians. The sample investigated consisted of thirty adult Indian males domiciled in the Durban area, attending neuroclinics, who had been diagnosed as having suffered from a psychosis and who had experienced auditory hallucinations.

The patients were examined by the author and in addition relevant data was extracted from their case files. This included religion, previous diagnosis, age at onset of illness and present age, mother tongue, language of daily usage, language of hallucinations, source of hallucinations, comprehensibility of hallucinations, content of hallucinations, patient's initial reaction to hallucinations, time when hallucinations were experienced, media of transmission, direction of voices and whether the patient had consulted a traditional healer.

The findings were that a significant majority of patients:

1) described their hallucinations as being voices coming from supernatural beings (84%).
2) did not attribute their hallucinations to being voices belonging to their deceased ancestors (88%).
3) did not attribute their hallucinations to voices which were being relayed by technical transmitting apparatuses (88%).
4) diagnosed as suffering from schizophrenia initially, found their hallucinations to be distressful (89%) whereas 80% of the patients diagnosed as suffering from manic depressive psychosis found their hallucinations to be pleasant.
5) did not ascribe their hallucinations to animals (100%).
6) had visited a traditional healer (100%).

Hallucinations were generally thought by the majority of patients to have occurred as a result of being possessed by spirits and that the possession had occurred following some "evil" done to them by enemies, rivals, or other persons who wanted the patient to come to harm. Their belief in spirits was derived both from religion and from folk-lore. Its connection with auditory hallucinations arose from the notion that evil spirits can invade human beings causing abnormal behaviour and also symptoms of mental illness including auditory hallucinations. All the patients had visited traditional healers presumably to exorcise the spirits that had possessed them.

The Durban Indian community has been reported to be a deculturing community with many of its members adopting Western cultural attitudes and values. The following factors (religion, language grouping, and beliefs derived from folk-lore), specific to Indian culture, appear to have an important influence in shaping some aspects of the phenomenology of auditory hallucinations of psychotic Indian males.

PREFACE

This study represents original work by the author and has not been submitted in any other form to another university. Where use was made of the work of others it has been duly acknowledged in the text.

The research described in this dissertation was carried out in the Department of Psychiatry, University of Natal, under the supervision of Prof. W H Wessels.

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CHAPTER 1

INTRODUCTION

Auditory hallucinations are common perceptual symptoms found in mental disorders (Wessels, 1976). The clinician places a great emphasis on the symptom and often it plays a significant role in helping him arrive at a diagnosis (Tomb, 1981). It has often been said that mental disorders do not occur in a vacuum but within boundaries which are well demarcated by the culture in which a person lives, and that cultural factors play a major role in shaping the nature and content of certain symptoms found in these disorders (Bührmann, 1977).

As yet, no study on the important phenomenon of auditory hallucinations has been undertaken in the South African Indian who has significant cultural differences as compared to Westerners. It is proposed that these cultural differences will be reflected in the nature and content of auditory hallucinations experienced by Indian psychotics. If this proposition is borne out by this study, the clinical application of this finding will enhance the clinicians' understanding of the psychopathology of this symptom as it occurs among Indians and which in turn will have a bearing on diagnosis and management of the patient.

CHAPTER 2

REVIEW OF LITERATURE

There have been numerous definitions pertaining to the concept of hallucinations. Bleuler (1911) has defined hallucinations as perceptions without corresponding stimuli from without. From this definition one can deduce that hallucinations are actually sense deceptions and the implication is that the experience involved is one of actually *sensing* something and not just thinking about or believing something.

Stevenson (1983) has recorded that the word 'hallucination' was used originally to refer to the unshared sensory experiences of persons who were mentally ill. He points out, however, that many persons who are not mentally ill also have unshared sensory experiences. A few of these convey information paranormally but the longstanding association of hallucinations with mental illness prohibits many persons who have such experiences from reporting them so that they can be studied. Because of this, he suggests a new word 'diophany' to designate all unshared sensory experiences and the restriction of the word 'hallucination' to the unshared sensory experiences of the mentally ill.

Hallucinations may occur in any of the sensory modalities and Mullen (1979) has listed the following characteristics of hallucinations.

1) They are actual false perceptions and not distortions of real perceptions.
2) They are perceived as being in the world and as inhabiting objective space.
3) They are perceived as having the qualities of normal perceptions being just as vivid, whole and immediate.
4) They are experienced alongside and simultaneously with

normal perceptions.

5) They are independent of our will in that they cannot be conjured up or dismissed.

The hallucination may actually show a greater independence of our will and action than a normal perception. For example, although I can turn away from looking at the page before me or cease attending to the voice of a lecturer, my hallucinations will continue to force themselves on my attention. A hallucinated voice will usually penetrate the most efficient ear muffs. However, patients frequently find no difficulty in discriminating between their hallucinations and true perceptions. Hallucinations are usually confined to a single sensory modality and this may lead the patient to awareness of the false nature of the perception. The ease with which hallucinations are distinguished from real perceptions is illustrated by Mullen (1979) who relates the history of a telephonist who, despite being troubled by constant auditory hallucinations, continued to work efficiently and unerringly, distinguishing them from the disembodied voices of callers.

2.1. THEORIES OF HALLUCINATIONS

There are many theories which attempt to explain the mechanisms of hallucinatory experiences. West (1962) lists the following three theories to explain their causation.

1) The neurophysiological dissociation theory.

According to this theory, auditory hallucinations are produced by functional dissociation between the auditory centre in the brain and the association areas which normally control the primary centres. This is brought about by inhibition of the association areas which does not affect the primary centres. LSD which

causes hallucinatory experiences was found by Marrazzi (1962) to cause inhibition of the visual association area without any effect on the primary visual cortex. He repeated his animal experiments in humans and reported the same effect. He also found that administration of chlorpromazine prior to giving LSD nullifies this selective action of the association areas and prevents or reduces the hallucinogenic effect of LSD.

2) The perceptual release theory.

According to this theory, hallucinations are caused by loss of control of one area of the brain over the rest of the brain areas resulting in release of the normally checked hallucinatory tendencies.

3) The neural traces theory.

Hallucinations are neural traces permanently recorded in the brain, normally prevented from merging into consciousness by the presence of an effective external sensory input. If the level of arousal is lowered sufficiently to impair the effectiveness of the sensory input, the hallucinatory neural traces will be released. Factors which lower the level of arousal e.g. confusional states, sensory deprivation or hypnogogic states are known to be responsible for the production of hallucinatory experiences.

Fischer (1969) has proposed the sensory/motor ratio theory to explain the mechanism of hallucinations. According to this theory hallucinations are due to increased sensory awareness and lowered motor responsiveness, i.e. an increased sensory/motor ratio. This ratio is normally increased during rapid eye movement (REM) sleep due to

increased cortical activity and lowered muscle tone. It is also increased by LSD with the hallucinations increasing during the peak of the sensory/motor ratio increase and diminishing with its decline. In support of this theory is the ability of some people to prevent the hallucinogenic effect of drugs by increasing their voluntary movements.

McGuigan (1966) has suggested that patients reporting auditory hallucinations may merely be talking to themselves. In a study, McGuigan instructed patients to press a key whenever they experienced an auditory hallucination. At the same time, recordings were made of electrical activity in the subject's larynx. In this fashion, McGuigan could compare the outputs of the larynx when the patient was experiencing auditory hallucinations and when he was not. The patient's report that he was hallucinating correlated remarkably with an increase in electrical activity in the larynx. From these experiments McGuigan concludes that patients reporting auditory hallucinations may merely be talking to themselves but interpreting the internal speech as coming from the external world.

2.1.1. Conditions in which Hallucinations may occur

Guirguis (1978) lists the following conditions or states in which hallucinations may occur.

1) Intense Emotions: e.g. Severe depression with sense of guilt may cause hallucinations consisting of accusatory or reproaching voices.

2) Suggestion: In normal suggestive persons and in hysteria. In these cases it is usually determined by fantasy and cultural background.

3) Local organic lesions in the sense organs e.g. eye or

ear disease. They are usually unilateral.

4) Sensory Deprivation States: Reduction of the incoming stimuli to a minimum e.g. deafness.

5) Brain Lesions: e.g. Focal brain lesions or temporal lobe epilepsy.

6) Hypnogogic or Hypnopompic States: These are pseudo-hallucinations which are usually recognized as unreal by the subject experiencing them. It occurs in normal people in whom it is of no significance and in narcolepsy as part of the clinical picture.

7) Occurrence in Functional Mental Disorders: e.g. Schizophrenia

2.1.2. Culture and Hallucinations

Psychiatry has recently become very curious about mental illness in other societies and has shown concern with cultural aspects of personality, behavioural disorders and healing practices. Systematic exploration of culture and psychopathology in different groups is being investigated. Many studies have focussed on the cultural aspects of the symptomatic expression of certain psychiatric conditions, particularly schizophrenia. The famous Hutterite study provides an interesting commentary on cultural background in a community and the frequency and kind of mental disorder found there (Eaton and Weil, 1955). Investigation has also focussed on various practices. Psychotherapy had been considered a Western scientific approach to mental illness, whereas folk healing - and in some parts of the world primitive or magic rituals, - had been termed superstitions. The controversy of the therapist has also been tackled. Can

a majority psychiatrist effectively treat a minority group member and vice versa?

Cultural beliefs about the nature, cause, and cure of illness, greatly influence a patient's awareness of symptoms and the way in which he behaves in response to them. These beliefs give rise to a particular pattern of behaviour. In many developing countries, for example, a belief in the prevalence of witches, demons, ghosts and other supernatural agencies is widespread and the concept of spirit possession, according to Murphy (1977) is taken for granted as a relatively common experience in these developing countries.

Carstairs (1979) notes that instances of socially unacceptable behaviour occur in every society and every society has developed explanations to account for them, and for procedures for dealing with such deviant persons. He concludes that the commonest explanation, inspired no doubt by the subject's change of personality and his often incomprehensible speech, is that of spirit possession.

Mental disorder, according to Alexander (1953) can in a sense be defined by the culture in which a person lives. Cultural factors will determine whether deviant members of a society are regarded as saints, geniuses, or lost demented souls. More specifically a hallucination is labelled as such rather than a vision or visitation depending on whether the experiences of an individual are regarded as heretical or commendable in the judgement of his society. Masserman (1953) elaborates on this theme by stating that, as a culture is never static for long, this judgement of society will change from time to time. The man regarded as mentally disordered by one age and people may be regarded as a sage or prophet by another.

Having done much transcultural work in Senegal, Collomb *et*

al., (1973) asked "How many of the normal Sener tribe in Senegal will be regarded as psychiatrically ill by Western standards?" They concluded that mental disorder differs from culture to culture in symptomatology, course and prognosis.

Much anthropological work has been done in various cultural groups but psychological and psychiatric research has, to a large extent, been neglected.

Favazza and Osmani (1978) note that the study of culture has not yet been established as a cornerstone of psychiatry. They emphasize that cultural dimensions must be added to basic psychiatric concepts, as has been the case with biology, psychology and sociology.

Wessels (1985a) appears to be in agreement with this view when he declares, "Our present classification systems tend to focus only on the similarities in mental disorder among different races but completely disregard the rich variety stemming from different cultural influences on the development of psychiatric conditions. Culture includes the customs, beliefs, knowledge, morals and laws of a region and is fundamental to our proper valuation of a fellow human being in distress. In order to assist such a person the biopsychosocial approach, taking into account also the cultural and spiritual needs, offers the only comprehensive treatment modality".

In many cultures in which people believe in the existence of another or supernatural world and in which people after death are supposed to enter this other world, hallucinations are regarded as a means of communication with this supernatural world. In these cultures people who are hallucinated are often regarded as especially favoured by the gods and they are consequently accorded respect and

esteem or are regarded with awe and dread by their fellow men. Conversely, they may be thought to be attacked by evil powers and thus considered to be in need of support, sympathy and defence.

Understanding of cultural factors thus appears to be vital, not only in understanding the psychopathology of the individual patient but also in therapy. Bührmann (1980) has put this very aptly when she declares "The question raised is whether personnel trained in the Western tradition, applying Western categories of mental states, are able to overcome their ethnocentricity. When the interviewer and the person interviewed are from widely different cultural groups, the former should make every effort to enter the inner world of the latter". In another article she elaborates on this theme when she states, "It is, however, important to have a real understanding of their culture, customs, beliefs and philosophy of life. On the whole psychiatrists have paid scant attention to their view on illness and the beliefs about causation and therapeutic technique of the Black people of this country or for that matter, to those of the Malays, Hindus and others. To work with traditional healers (diviners) can have a sobering effect and an effort to enter their world and share their experiences can be enriching and rewarding as well as making the sharing of relevant psychological and psychiatric material possible and meaningful. Without this background knowledge, psychiatric assessment is hazardous." (Bührmann, 1977).

Wessels (1985b) strongly advises all clinicians to familiarize themselves with the culture and language of their patients. He stresses that all illnesses, especially psychiatric disorders, are coloured by culture and that cultural and spiritual needs must be taken into account in the planning of a comprehensive treatment programme.

2.1.3. Incidence of Hallucinations

Hunt (1966) observes that hallucinations (auditory more often than visual or other sensory forms) are the most common form of perceptual symptoms. He notes that hallucinations are found among the symptoms of from 60-80% of schizophrenics. In a study on the symptomatology of schizophrenia in the Bantu, Wessels (1976) found that 79% of Bantu male schizophrenics experienced hallucinations. Rees (1969) also maintains that hallucinations, especially of hearing, occur at some time or other in most forms of schizophrenia. According to Hunt (1966), auditory hallucinations are a feature in some 35% of patients suffering from manic depressive psychosis. He also notes that in the organic psychoses, hallucinations are less common than in the functional psychoses and are only found in 20% of patients. He also draws attention to the fact that the statistical study of the frequency of psychopathology in different parts of the world has yielded but inconclusive results. He states "the method of diagnosis and especially the method of selecting deviants for commitment to institutions vary so widely from country to country and function so irregularly in those parts of the world where European medicine is in contact with preliterate people, that none of the statistical data is fit for comparative study".

Margetts (1958), writing about the Kenyan African, states that when Africans hear 'voices' they are usually those of God or of dead relatives, rarely of anybody else.

2.1.4. Hallucinations in Various Diseases

Noyes (1951) declares that in no other form of mental disorder do hallucinations, or the projection of inner

experience into the external world in terms of perceptual images, occur in the presence of clear consciousness as frequently as in schizophrenia. Their mechanism is not like that of hallucinations in other abnormal states but they tend to be more highly disguised in nature and to constitute a primitive form of adjustment and are therefore, of much more serious significance than their presence in delirium or in intense emotional disturbances.

Although the schizophrenic realizes that the 'voices' are different from ordinary perceptions, Rees (1969) notes that the schizophrenic patient fails to recognize their pathological nature. They also, he contends, tend to be split off from the rest of the personality so that a patient who has obviously been entranced with auditory hallucinations may, when his attention is attracted, be honestly unable to describe what the voices have been saying. Commenting on organic reactions, Rees states that the type of hallucination in certain cases seems to be specific to the process at work e.g. the animals of delirium tremens, the imagined creatures of belladonna poisoning and the tactile hallucinations of cocainism and gustatory hallucinations of temporal lobe epilepsy. The hallucinations of delirium are usually visual in contrast to those of the functional psychosis, although auditory hallucinations are not infrequent.

2.2. THE SOUTH AFRICAN INDIANS

In the multiracial society of South Africa, there is no more clearly separated part of the population than the Indian. They have clung to the culture of their ancestors. However, this is not peculiar to the South African Indian as this phenomenon has also been observed elsewhere. Cox (1977), commenting on the Asians settled in England, states "The

relationship of the immigrant community to the host community varies considerably among different ethnic groups. The West Indian migrant generally wishes to assimilate with the host society, in contrast to the Asians who retain their distinctive traditional customs."

According to Meer (1966), the majority of Indian South Africans are the descendants of indentured workers brought to Natal between 1860 and 1911 to develop the country's sugar belt. "Free" or "Passenger" Indians followed the indentured workers but white colonists became alarmed by the competition offered by these merchants and by those whose labour contracts had expired. By 1913, Indian immigration was generally prohibited by law. The result is that, with few exceptions, Indian South Africans today are South African citizens by birth.

However, the Indians are not a homogeneous group and there are important distinctions within the group. An important group distinction within the community is the religious one, involving Hindu and Muslim and also a Christian group. The main Indian languages spoken in South Africa are Tamil, Telegu, Hindi, Urdu and Gujerathi.

The various groups differ from one another considerably as regards dietary habits, body build, colour of skin, marriage and social customs, cultural activities, dress and place of origin in India.

Mistry (1965) notes that the Tamil and Telegu speaking people immigrated to South Africa from the South Indian states of Madras and Andhra Pradesh. Those who have migrated to South Africa from the Northern and North-Eastern parts of India come mainly from the states of Uttar Pradesh, Bihar, and Orissa and speak mainly Hindi or Urdu. Gujerathi is spoken by both Muslims and Hindus who migrated from the

state of Gujerat.

Cheetham et al. (1983), have noted that among the firmest restrictions operating between sub-groups are those relating to marriage in which bonds between persons of different religions, language, and caste are generally avoided and deprecated.

In the 1980 census (S.A. Statistics of 1980) there were 430 318 Hindus, 125 987 Muslims and 53 851 Christians. Home language classification was as follows: English 200 416; Tamil 153 641; Hindi 116 485; Gujerathi 46 037 and Telegu 30 690.

The Muslims are adherents to the religion of Islam. A significant number of the early settlers in the last century were Muslims and the present day Muslims are their descendants with a small number being converts, mainly from Hinduism.

In his commentary on the Quran, Ali (1960) states that the fundamental belief of Islam dwells in the concept of 'Tawheed' or'oneness of God' and it is considered an unpardonable sin to associate other deities with God. Muhammad, like Jesus and Moses, were Messengers of God. The Quran (the Holy Book of the Muslims) was revealed to the Prophet Muhammad in the 6th Century A.D. and consists of recordings of direct revelations from God to the Prophet brought by the Angel Gabriel over a period of twenty three years. Regarding the concept of God, Islam differs from Christianity in that it does not subscribe to the concept of Trinity, but considers Jesus to be a Prophet of God and the Holy Spirit as an angel. No divinity is ascribed also to the Prophet Muhammad who, like Jesus and Moses, are considered to be mortals.

In Islam, according to Crim (1981) the existence of spirits is recognized and they are referred to as 'Jinns' - a group of beings created from smokeless fire who can change size and shape, can help or harm people and are capable of receiving salvation or damnation.

'Iblis' (Satan) is reckoned to be one of the Jinns. Some commentators of the Quran make Jinns a 'tribe of angels'. Post Quranic commentaries join these ideas with elements of folklore and stories about Jinns and their relations with human beings abound throughout the Islamic world. Jinns were evidently thought to be able to possess a person, making him 'Majnun' (Arabic: lit. 'crazy', possessed by a Jinn).

Zaehner (1959), writing on Hinduism, states that a Hindu is one who chiefly bases his beliefs and way of life on the complex system of faith and practice which has developed in the Indian sub-continent over a period of 3 millenium. According to him, the fundamental beliefs of Hinduism include:

1) The respect for the 'Vedas'. These are ancient scriptures, the three main derivatives of which are the 'Upanishads', the 'Brahma Sutra' and the 'Bhagvad Gita'. They are held to be the revealed word of divine beings and go back to the early centuries of Aryan migration into India.

2) Worship of deities. E.g. 'Vishnu', 'Rama', 'Krishna', 'Ganesh', 'Shiva' and his consort 'Kali'.

3) A strange mystic strain pervades most of Hinduism and a respect for the 'Sanyasi' or Holy Man is universal.

4) The principle of non-injury or 'Ahimsa', though not

universal, is widely held.

5) The principle of Caste. i.e. the social framework through which most of the Hindus operate and for which they find religious authority.

6) The principle of 'Karma' and Reincarnation.

According to Crim (1981), Karma and Reincarnation are concepts of rebirth and redeath. These themes teach that individual souls exist from the beginning of time, passing on from one form of existence to another in a continuous rebirth-redeath cycle. The conditions and circumstances of each new form of existence are determined by the merit or demerit of the actions (Karma) that have taken place in previous forms of existence. Further, this process of rebirth-redeath is not limited to humans - it is the inherent nature of existence itself. All beings are in such states of flux, a process of developing and withering away only to develop again and go through the same cycle over and over.

CHAPTER 3

PATIENTS AND METHOD

3.1. PATIENTS

The sample investigated consisted of thirty patients seen by the author between December 1983 and July 1984 at two Neuroclinics in the Durban area.

These patients were:

1. All males
2. All from the Indian group
3. All diagnosed as having suffered from a psychotic illness
4. All domiciled in the Durban area
5. All sufficiently accessible mentally to be able to supply the relevant information
6. All subject to auditory hallucinations in the waking state. Care was taken to differentiate these from delirium, pseudo-hallucinations, images of fantasy, dreams, hypnogogic and hypnopompic hallucinations. As a further qualification the auditory hallucinations had to be verbal i.e. the patients described hearing the spoken word.

3.2. METHOD

1. Informed consent was obtained either from the patient or from his guardian or next of kin if he was unable to give informed consent.
2. Relevant data was extracted from the patients' case notes and in addition each patient was personally examined by the author.

3. The data obtained included:

Name
Address
Age
  Present
  At onset of illness
Mother tongue
Religion
Marital Status
  Present
  At onset of illness

DETAILS OF AUDITORY HALLUCINATIONS

1) Source: Human, Animal or Other
Living or Dead
Inside or Outside the Head
Male, Female or Mixed
Stranger or Acquaintance
Radio, Television, Telephone or Other
Supernatural: God, Devil, Spirits

2) Perception: One or both ears
Other parts of the body

3) Time Experienced: Day/Night
Working or Resting

4) Comprehensibility: Intelligible/Non-intelligible

5) Content: Grandiose, Persecutory, Accusatory,
Other

6) Language of Hallucinations: Mother Tongue, English,
Other

7) Patient's reaction to hallucinations.

8) Patient's interpretation as to the origin, nature and cause of the hallucinations.

9) Did patient consult a traditional healer.

DEFINITIONS OF MENTAL DISORDERS:

"PSYCHOSIS - Mental disorders in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality." (W.H.O. 1980)

"SCHIZOPHRENIA - A psychotic condition in which there is a fundamental disturbance of personality. A characteristic distortion of thinking. Often a sense of being controlled by alien forces, delusions which may be bizarre, disturbed perception, abnormal affect out of keeping with the real situation. Clear consciousness and intellectual capacity are usually maintained. The disturbance of personality involves its most basic functions which give the normal person his feeling of individuality, uniqueness and self-direction. The most intimate thoughts, feelings and acts are often felt to be known to or shared by others and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the schizophrenic person's thoughts and actions in ways that are often bizarre. He may see himself as the pivot of all that happens. Hallucinatons, especially of hearing are common and may comment on the patient or address him. Perception is frequently disturbed in other ways; there may be

perplexity, irrelevant features may become all important and, accompanied by passivity feelings, may lead the patient to believing that everyday objects and situations possess a special, usually sinister, meaning intended for him. In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the forefront and utilized in place of the elements relevant and appropriate to the situation." (W.H.O. 1980)

"MANIC DEPRESSIVE PSYCHOSIS - A mental disorder usually recurrent in which there is a severe disturbance of mood, mostly compounded of depression and anxiety but also manifested as elation and excitement. This is accompanied by one or more of the following delusions, perplexity, disturbed attitude to self, disorder of perception and behaviour. These are all in keeping with the patients' prevailing mood, as are hallucinations when they occur. There is a strong tendency to suicide." (W.H.O. 1980)

"ORGANIC MENTAL CONDITIONS - Syndromes in which there is impairment of orientation, memory, comprehension, calculation, learning capacity and judgement. These are the essential features but there also may be shallowness or lability of affect, or a more persistent disturbance of mood, lowering of ethical standards and exaggeration or emergence of personality traits and diminished capacity for independent decision. They are usually due to some intra- or extracerebral toxic, infectious, metabolic, vascular, neoplastic or other systemic disturbances." (W.H.O. 1980)

"EPILEPTIC PSYCHOSIS - Condition in which there is a paroxysmal alteration of intellectual, sensory, motor, autonomic or affective activity, which is time limited and presumably associated with neuronal hypersynchronous overactivity. There is clouding of consciousness, confusion, disorientation, illusions and often vivid hallucinations." (Brain and Walton, 1969).

CHAPTER 4

RESULTS

TABLE I - DIAGNOSTIC GROUPING

	No. of Patients	%
Schizophrenia	19	63
Manic Depressive Psychosis	5	18
Organic Mental Conditions	3	10
Schizoaffective Disorder	1	3
Epileptic Psychosis	2	7

TABLE II - AGE (At time of onset)

	No. of Patients	%
10 - 19	10	33
20 - 29	11	37
30 - 39	7	23
40 - 49	1	3
50 - 59	1	3

TABLE III - AGE (Present)

	No. of Patients	%
10 - 19	-	-
20 - 29	8	27
30 - 39	16	53
40 - 49	4	13
50 - 59	1	3
60 - 69	1	3

TABLE IV - DURATION OF ILLNESS

	No. of Patients	%
0 - 5 years	10	33
6 - 10 years	7	23
11 - 15 years	8	27
16 - 20 years	4	13
21 - 25 years	1	3

TABLE V - MOTHER TONGUE

	No. of Patients	%
English	2	7
Tamil	11	37
Telegu	2	7
Hindi	8	27
Gujerathi	2	7
Urdu	5	18

TABLE VI - LANGUAGE OF AUDITORY HALLUCINATIONS

	No. of Patients	%
English	20	67
English & Mother Tongue	3	10
Mother Tongue	3	10
English & Zulu	2	7
English & Arabic	1	3
English, Mother Tongue & Zulu	1	3

TABLE VII - LANGUAGE OF DAILY USAGE

	No. of Patients	%
English	30	100

TABLE VIII - RELIGIOUS GROUPING

	No. of Patients	%
Hinduism	16	53
Islam	8	27
Christianity	6	20

TABLE IX - SOURCE OF AUDITORY HALLUCINATIONS

	No. of Patients	%
God	2	7
Humans	8	27
Spirits	9	30
Devil	1	3
God and Spirits	1	3
Humans and Spirits	5	18
Devil, God and Spirits	2	7
Devil and Spirits	2	7
Animals	-	-

TABLE X - GROUPING OF SOURCE AGAINST RELIGION OF PATIENT

	Hinduism	Islam	Christianity
God	-	-	2
Humans	5	3	-
Spirits	5	1	3
Devil	1	-	-
God and Spirits	1	-	-
Humans and Spirits	1	4	-
Devil, God and Spirits	1	-	1
Devil and Spirits	2	-	-

TABLE XI - CONTENTS OF AUDITORY HALLUCINATIONS

	No. of Patients	%
1) Accusatory & Persecutory	10	33
2) Instructive	11	37
3) 1 + 2	3	10
4) Grandiose	3	10
5) Sexual Suggestions	1	3
6) Unintelligible	2	7

TABLE XII - GROUPING OF CONTENTS AGAINST CLINICAL DIAGNOSIS

Clinical Diagnosis	Contents of Hallucinations					
	1	2	3	4	5	6
Schizophrenia	4	10	1	1	1	2
Manic Depressive Psychosis	1	1	1	2	-	-
Organic Mental Condition	3	-	-	-	-	-
Schizoaffective Disorder	-	-	1	-	-	-
Epileptic Psychosis	2	-	-	-	-	-

TABLE XIII - TIME HALLUCINATIONS EXPERIENCED CORRELATED WITH DIAGNOSIS

Time	Schizo-phrenia	Manic Depressive Psychosis	Organic Mental Condition	Schizo-Affective Disorder	Epileptic Psychosis
Day	3	1	-	-	-
Night	2	1	-	1	1
Both	14	3	3	-	1

TABLE XIV - INITIAL REACTION TO HALLUCINATIONS CORRELATED WITH DIAGNOSIS

Initial Reaction	Schizo-phrenia	Manic Depressive Psychosis	Organic Mental Condition	Schizo-Affective Disorder	Epileptic Psychosis
Welcome	2	4	-	-	-
Unwelcome	17	1	3	1	2

TABLE XV - PATIENT'S ATTITUDE TOWARDS AUDITORY HALLUCINATIONS

	No. of Patients	%
Unwelcome at onset and unwelcome now	19	63
Unwelcome at onset but welcome now	3	10
Welcome at onset and welcome now	5	18
Welcome at onset but unwelcome now	1	3
Unwelcome at onset but now indifferent	2	7

TABLE XVI - VOICES TRANSMITTED VIA TECHNICAL MEDIA

	No. of Patients	%
Radio	1	3
Radio and Television	1	3
Microphone	1	3
"Electronic Gadget"	1	3

All 4 patients had been diagnosed as suffering from schizophrenia.

TABLE XVII - NUMBER OF PATIENTS WHO CLAIMED THAT THE VOICES BELONGED TO THEIR ANCESTORS

4 (13%)

TABLE XVIII - NUMBER OF PATIENTS WHO HAD VISITED PRIESTS OR TRADITIONAL HEALERS

30 (100%)

TABLE XIX - NUMBER OF PATIENTS WHO ASCRIBED THEIR HALLUCINATIONS TO ANIMALS

Nil (0%)

CHAPTER 5

DISCUSSION

5.1. SOURCE OF AUDITORY HALLUCINATIONS: SPIRITS

63% of the patients attributed the source of their hallucinations to Spirits (Table IX). Hinduism and Islam recognizes the existence of Spirits and reference has been made earlier to the fact that the Quran, the holy book of the Muslims, has mentioned 'Jinns' or Spirits. However, my interview with patients revealed that the vast majority of them do not consider the Spirits only in terms of direct connection with their religions but also in terms of their intrinsic moral character. There are good spirits and bad spirits and this notion or belief is derived both from religion and folk-lore. In general, good spirits are seen as benevolently related to human beings and that they can be enlisted to help my means of good conduct or observation of appropriate ritual. Evil spirits on the other hand must be placated or warded off with the help of rituals or witchcraft. A common belief among the Indians is that an evil spirit can invade or possess a human being, causing abnormal behaviour which is deleterious or dangerous to the possessed person or others. Manifestation of such possession may include the symptoms of mental illness including auditory hallucinations.

Schweitzer (1985), regarding this concept of possession by spirits, states "I described previously, in discussing the indigenous world view, that affliction does not occur by chance but might be the result of intervention by agencies such as witchcraft or sorcery or by the ancestors withdrawing their support."

Callan (1983) investigated the perception of the mentally

ill in a group of Papua New Guinea students and found that many of the young students still generally believed in the role of spirits and magic as causing mental illness. He notes that although Papua New Guinea is changing culturally as rapidly as any region on earth, its people, even those educated in modern schools, still maintain an almost universal belief in possession by spirits.

Fern (1981) refers to spirits as beings of the invisible environment, active for good or ill in human affairs. Not only in religions of preliterate people, he maintains, but also in those of Egypt, Babylon, Persia, Greece, Rome, China, India, in Buddhism, Judaism, Christianity, Islam and Hinduism hosts of spirits worked with and against man. Their activity was seen in all startling or supernatural happenings. The good spirits could fulfil human desires, bring luck, fertility and protect from dangers. The evil spirits or demons were blamed for the dangerous and destructive moods of nature, for pestilence, sickness and death.

5.2. SOURCE OF AUDITORY HALLUCINATIONS: DECEASED ANCESTORS

Only 13% of the patients (Four patients) attributed their voices to their deceased ancestors. (Table XVII).

Margetts (1958), writing about the Kenyan Bantu, states that when Africans 'hear voices', they are usually those of God or of deceased relatives, rarely of anybody else. Ancestor veneration i.e. the ritual homage and placation of the spirits of the dead by their living descendants is common among the Bantu and this stems from the belief that the ancestors are concerned with the fortunes of members of their kin group and may intervene for good or for evil in the affairs of the living. Ancestors are pleased by dutiful attention and angered by neglect, attitudes which are

reflected in their treatment of the living. "Ancestral displeasure causes the shades to withdraw their protection. These are the direct ancestors like deceased parents or grandparents. Their wrath is aroused by familial discord and neglect to perform ritual sacrifices" (Wessels 1985). Veneration of deceased ancestors or worship through intercession of these ancestors is alien to Hinduism, Islam and Christianity and this may account for the fact that only a small minority of patients felt that the 'voices' they heard were those of their deceased ancestors, probably due to African cultural influence.

According to Bührmann (1980), the omnipotence and omnipresence of the ancestors are so fundamental to the cosmology of Black people, that failure to enter this spiritual world in an intuitive and empathic way, will detract from understanding the reality of their inner world and therefore, understanding of their psychodynamics, their behaviour and mental state.

Bührmann (1982) also comments on two mental states occurring in Black people, 'Thwasa' and bewitchment. The aetiology of this is seen as arising from the relationship of the afflicted individual to his ancestors i.e. either positive or negative. To be 'Thwasa' means that the ancestors are 'working on one'. They are calling one to have treatment and training and thus enter their service i.e. to become an Igqira. Thwasa therefore, means the emergence of new aspects of the personality and new potential. As an iqqira one understands the messages of the ancestors as conveyed in dreams, visions, illnesses and misfortunes of all kinds and is able to interpret these to the sick and troubled people who seek advice and help.

5.3. PATIENTS' INITIAL REACTION TO THEIR AUDITORY HALLUCINATIONS

89% of the patients diagnosed as suffering from Schizophrenia and all the patients diagnosed as suffering from Organic Mental Disorder, Schizoaffective Disorder or Epileptic Psychosis found their hallucinations, initially, to be unwelcome whereas 80% of the patients diagnosed as suffering from Manic Depressive Psychosis welcomed their hallucinations. (Table XIV). According to Smythies (1956), the attitude of people towards their own hallucinations depends partly on (a) the particular nature of the hallucination e.g. its immediate emotional, dramatic and aesthetic impact and (b) cultural factors. In Western culture, for instance, the response to hallucinations will be largely determined by the ridicule or fear of madness resulting from the popular belief that hallucinations are symptoms of madness or by the fear and anxiety resulting from an inexplicable happening as we have no acceptable explanation of hallucinations. Krafft-Ebbing (1965) observes that the response of people towards those hallucinated, perhaps even more than the response of people towards their own hallucinations, is also a function of the culture of the people. It is therefore not strange, he states, that there is hardly a phenomenon of human life which throughout the ages has been more variously judged by such disciplines as theology, philosophy and the natural sciences.

In this study, the majority of patients (80%) initially found their auditory hallucinations to be unwelcome and distressful. (Table XV). Several patients were, in fact, so perturbed by the 'voices' that they rushed outdoors, hoping that by so doing they would shed their hallucinations. Here again we must consider the hallucinations together with the phenomenon of 'possession'. As mentioned earlier, this

phenomenon is believed widely in the Indian Community and many patients assumed that the 'voices' belonged to a demon or spirit which had possessed them. The idea of being possessed by alien or supernatural beings generates a tremendous amount of apprehensiveness, anxiety and anger and this may explain why auditory hallucinations elicited a response of unwelcomeness in the vast majority of patients.

5.4. CONSULTATIONS WITH TRADITIONAL HEALERS

All the patients (100%) had consulted a "priest" or "traditional healer" after the onset of his illness. (Table XV).

Westerners have tended to regard spiritual healers and 'witchdoctors' with a degree of condescension as a survival from the prescientific dark ages. Recently, however, anthropologists have begun to explore the role which these healers play in their respective societies and they prove to be key roles for both individual health and social cohesion. Bührmann (1977) discussing the work of traditional healers, concludes that to work with traditional healers (diviners) can have a sobering effect, and an effort to enter their world and share their experiences can be enriching and rewarding, as well as making the sharing of relevant psychological and psychiatric material possible and meaningful. Without this background knowledge, psychiatric assessment is hazardous. Wessels (1985b) maintains that the treatment of the traditional healer appears to be effective and he recommends that reputable traditional healers also be consulted by patients suffering from culture-bound syndromes.

Bergman, who is chief of the Mental Health Programme of the Department of Indian Administration in the United States of America, was stimulated to conduct research into the methods

of the Navajo medicine men after having seen one of them cure a psychotic woman. (Bergman, 1973). Following his research he started a school for 'medicine men', where great pains are being taken to preserve their methods and to teach them to the young ones.

Kapur (1975) has written on the traditional healers found in India. He notes that besides the modern doctors, there were three types of traditional healers. 'Vaids', practising an empirical system of indigenous medicine, 'Mantarwadis' curing through astrology and charms, and 'Patris', who acted as mediums for spirits and demons. In his study he found that a large majority of those with symptoms, both physical and mental, had consulted someone. Modern doctors were more popular but most consulted both traditional and modern healers. Literacy and other socio-demographic factors had no influence on the type of consultation. He concluded that any scheme for introducing modern psychiatry into rural areas should make use of the locally popular healers, traditional and modern.

The traditional healers among the Indians in South Africa are usually priests, pseudopriests or others who have acquired the status of a healer by belonging to certain families whose members have always been traditional healers. These families are thought to derive their healing power by virtue of the fact that they have obtained blessings from 'Saints' either in India or in South Africa. These healers usually have a 'consultation' during which details of the patient and his illness are related, either by the patient himself or the relatives. The healer then ponders over and digests the information given and this may be then followed by chanting of prayers during which the traditional healer may go into a 'trance'-like state. He then gives his verdict as to the nature of the illness. Usually it is ascribed to some 'evil' done to the patient by enemies, rivals or even

relatives who may profit from the patient's illness. He often attributes the source of the illness to being possessed by a spirit and will offer to exorcise the spirit. This takes the form of some ritual and before parting, the patient is given some charm to wear around certain parts of his body or ashes which are usually smeared on the forehead.

Hallucinations are often regarded by Indians as voices belonging to spirits or demons who have possessed the patient. In the case of schizophrenic patients the 'passivity phenomenon' which often accompanies their illness enhances this belief and thus a visit to a traditional healer is thought to be necessary to purge oneself of these supernatural beings.

5.5. CONTENTS OF HALLUCINATIONS

50% of the patients who were diagnosed as suffering from Schizophrenia described the contents of their hallucinations as being either instructive or accusatory/persecutory. (Table XI).

All three patients diagnosed as suffering from Organic Mental Disorder (in all cases due to prolonged abuse of alcohol) reported hallucinations of the accusatory-persecutory type. Here, this type of hallucination is in keeping with classical teaching that the auditory hallucinations in such conditions consist usually of accusations and admonitions. Lishman (1978) has reported that these types of auditory hallucinations often commence as simple sounds such as buzzing, roaring or ringing of bells. Gradually they take on vocal form, usually the voices of acquaintances or enemies who malign, threaten or reproach the patient. The hallucinations may consist of a single derogatory remark repeated with relentless

persistence or the patient may be assailed by a combination of accusations and admonitions. He may be discovered arguing angrily with his voices or he may complain to the police about them. Sometimes the voices command the patient to do things against his will and their compelling quality may be such that he is driven to a suicide attempt or to some episode of bizarre behaviour. Usually the patient is addressed directly by the voices but sometimes they may converse with one another about him, referring to him in the third person as in Schizophrenia. Secondary delusional interpretations follow upon the hallucinatory experiences and the patient comes to believe firmly that he is watched, hounded or in danger.

5.6. LANGUAGE OF AUDITORY HALLUCINATIONS

Earlier on, under the heading "Theories of Hallucinations", McGuigan was reported to have suggested that patients reporting auditory hallucinations may merely be talking to themselves. If this is indeed true, then this may be the reason why 90% of the patients reported hearing voices in the English language (Table VI) as this language was reported by all patients (100%) to be the language of daily usage (Table VII). With most Indians, though conversation still takes place in the mother tongue, their everyday language of usage is English, both at home and at work.

Laski and Teleporos (1977) have described an anticholinergic crisis in a bilingual schizophrenic patient who initially had persecutory hallucinations in his second language, English. Later, after these symptoms had subsided, he developed a Toxic Confusional reaction to his medication and though the hallucinatory content was similar, hallucinations were now experienced only in his mother tongue, Spanish.

Hemphill (1971) has described auditory hallucinations in

South African polyglots. He found that those equally proficient in two languages reported hallucinations in their primary or mother tongue though they might experience drug induced hallucinations in all the languages they knew. He contrasted this with 'refugee' polyglots who had had to learn a new language after emigration. Their hallucinations were reported only in the second language and hallucinations were often denied when questioned in their mother tongue. Milun *et al* (1980) assessed ten selected Schizophrenic patients and ten control subjects in their home language and in a second language for evidence of formal thought disorder. They found that the degree of thought disorder appeared to diminish when thought disordered schizophrenics used a second language.

5.7. TRANSMISSION OF VOICES VIA A TECHNICAL MEDIUM

In this study, only four of the patients (13%) thought that the voices were coming via a technical medium (Table XVI). Most psychiatric textbooks, which have drawn heavily from the symptomatology of patients belonging to Western cultural groups, refer to patients frequently ascribing their hallucinations as voices relayed via a technical medium, e.g. radio, television or telephone (Silverstone and Barraclough 1975). The discrepancy between the textbook description and the findings of this study appear to be due to cultural differences. As stated previously, the majority of patients in this study ascribed the voices to supernatural beings, who presumably did not require the aid of technical media for relaying their voices.

CHAPTER 6

CONCLUSION

Although the Durban Indian Community has been reported by Cheetham *et al* (1983) as being a deculturing community, with many of its members adopting Western cultural attitudes and values, the findings of this study suggest that certain factors specific to Indian culture, rooted both in religion and folklore, appear to have an important influence in shaping some aspects of the phenomenon of auditory hallucinations experienced by psychotic Indian patients.

Data of this type from the various cultural groups need to be collated so that we may broaden our knowledge concerning the interaction of sociocultural factors with the parameter of psychiatric illness. A similar comparative study could be undertaken among the three other major racial groups in South Africa in order to determine whether there are any significant differences in the nature and content of the auditory hallucinations and, if any, to ascertain possible factors in the cultural milieu which may give rise to these differences. Valuable anthropological work has been done in this country but psychological and psychiatric research with emphasis on culture has lagged behind.

REFERENCES

Alexander L. Treatment of Mental Disorder. Philadelphia: W B Saunders, 1953.

Ali Y. Translation of the Quran. Karachi: Islamic Press, 1960.

Bergman RL. A School for Medicine Men. Am J Psychiat 1973; 130: 663-666.

Bleuler E. Dementia Praecox or The Group of Schizophrenias. Transl. Zinkin J. 1950. New York: Int Univ Press, 1911.

Brain L, Walton JN. Brain's Diseases of the Nervous System. 7th ed. London: Oxford Univ Press, 1969.

Bührmann MV. Western Psychiatry and the Xhosa Patient. S Afr Med J 1977; 51: 464-466.

Bührmann MV. The Inner Reality of the Black Man and his Criminal Responsibility. S Afr Med J 1980; 58: 817-820.

Bührmann MV. Thwasa and Bewitchment. S Afr Med J 1982; 61: 877-879.

Callan VJ. Cultural perception of the mentally ill by Australian and Papua New Guinea high school youths. Aust NZ J Psychiatry 1983; 17 280-285.

Carstairs GM. Cross Cultural Psychiatry. In: Gaind RN, Hudson BL, ed. Current Themes in Psychiatry. London: Macmillan Press, 1979.

Cheetham RWS, Edwards SD, Naidoo LR, Griffiths VG, Singh JA. Deculturation as a precipitant of parasuicide in an Asian group. S Afr Med J 1983; 63: 942-945.

Collomb H, Beiser M, Winthrop A. Illness of the spirit among the Sener of Senegal. Am J Psychiatry 1973; 130: 881-886.

Cox JL. Aspects of Transcultural Psychiatry. Br J Psychiatry 1977; 130 211-221.

Crim K. Comp. Dictionary of Living Religions. Nashville: Parthenon Press, 1981.

Eaton JW, Weil RJ. Culture and Mental Disorder. Illinois: The Free Press, 1955.

Favazza AR, Osmani M. Overview: Foundations of Cultural Psychiatry. Am J Psychiatry 1978; 135(3): 293-303.

Fern V. Encyclopaedia of Religion. New York: Philosophical Library Press, 1981.

Fischer R. The perception - Hallucination Continuum. Dis Nerv System 1969; 30: 161-171.

Guirguis WR. Psychiatric Symptomatology. London: S K & F Publishers, 1978.

Hemphill R. Auditory Hallucinations in Polyglots. S Afr Med J 1971; 18 1391-1394.

Hunt MJ. Personality and Behaviour Disorder. New York: Ronald Press, 1966.

Kaplan IH, Sadock JB. Modern Synopsis of Comprehensive Textbook of Psychiatry /III. Baltimore: Williams and Wilkins, 1981.

Kapur RL. Mental Health in Rural India. Br J Psychiatry 1975; 127: 286-293.

Krafft-Ebbing RV. Textbook of Insanity. Philadelphia: F.A. Davis & Co, 1965.

Laski E, Teleporos E. Anticholinergic Psychosis in a Bi-lingual - A Case Study. Am J Psychiatry 1977; 134(9): 1038-1040.

Lishman WA. _Organic Psychiatry_. Oxford: Blackwell Scientific Publications, 1978.

Marrazzi AS. Pharmacodynamics of Hallucinations. In J.West LJ ed. _Hallucinations_. New York: Grune and Stratton, 1962.

Margetts EL. The Psychiatric Examination of Native African Patients. _Medical Proceedings_ 1958; _4_: 20-26.

Masserman JH. _The Practice of Dynamic Psychiatry_. Philadelphia: W.B. Saunders, 1953.

McGuigan FJ. Covert Oral Behaviour and Auditory Hallucinations. _Psychophysiology_ 1966; _3_: 421-428.

Meer F. _Portrait of Indian South Africans_. Durban: Avon Press, 1966.

Milun M, Daneel MH, Smart D, Beumont PJV. Language Medium and Schizophrenic Disorder. _S Afr Med J_ 1980; _57_: 996-997.

Mistry SD. Ethnic Groups of Indians in South Africa. _S Afr Med J_ 1965; _39_: 691-694.

Mullen P. The Phenomenology of Disordered Mental Function. In: Hill P et al, ed. _Essentials of Postgraduate Psychiatry_. London: Academic Press, 1979.

Murphy HBM. Migration, Culture and Mental Health. _Psychol Med_ 1973; _7_: 677-684.

Noyes AP. _Modern Clinical Psychiatry_. Philadelphia: W.B. Saunders, 1951.

Rees JA. _Modern Practice in Psychological Medicine_. London: Butterworth, 1969.

Schweitzer RD. Folk healing among the Xhosa speaking people. _Psychotherapeia_ 1985; _36_ 27-35.

Silverstone T, Barraclough B. ed. Contemporary Psychiatry. London: Headley Bros, 1975.

Smythies JR. A Local and Cultural Analysis of Hallucinatory Sense Experience. J Ment Science 1956; 102 336-342.

South African Statistics Census 1980. Pretoria: Government Printer, 1980.

Stevenson I. Do we need a new word to supplement "Hallucination"? Am J Psychiatry 1983; 140 (12): 1609-1611.

Tomb DA. Psychiatry for the House Officer. Baltimore: Williams and Wilkins, 1981.

Wessels WH. Symptomatology of Schizophrenia in the Bantu. Psychotherapeia 1976; 2: 5-7.

Wessels WH. Understanding culture-specific syndromes in South Africa - the Western dilemma. Modern Medicine 1985a; 10: 51-63.

Wessels WH. The traditional healer and psychiatry. Aust NZ J Psychiatry 1985b; 19: 283-286.

West LJ. A General Theory of Hallucinations. In West LJ, ed. Hallucinations. New York: Grune and Stratton, 1962.

World Health Organization. A glossary of Mental Disorders and guide to their Classification in accordance with the 9th revision of International Classification of Diseases. Gèneva: WHO Publications, 1980.

Zaehner RC. comp. The Concise Encyclopaedia of Living Faiths. London: Hutchinson, 1959.

APPENDIX A

PATIENT'S PROJECT NO.:

DR A H S KAJEE

M. MED. (Psych) THESIS

QUESTIONNAIRE

PATIENT'S CONSENT : I

the undersigned, hereby consent to Dr A H S Kajee using personal data and features of my illness collected from my psychiatric file and from interviews, for his thesis. In the presence of the undermentioned witness, Dr Kajee has explained to me the nature and purpose of this study.

....

SIGNATURE OF PATIENT

WITNESS :

....

NAME :

ADDRESS :

AGE :

PRESENT AGE :

WHEN DIAGNOSED FIRST :

MOTHER TONGUE : LANGUAGE OF DAILY USE :

RELIGION :

PATIENT'S OCCUPATION:

AT THE TIME OF ONSET OF ILLNESS:

AT PRESENT :

ACCOMMODATION :

RENTING :

OWNERSHIP :

MARITAL STATUS :

AT THE TIME OF ONSET OF ILLNESS :

AT PRESENT :

TELEVISION AT HOME :

BLACK AND WHITE :

COLOUR :

DOES PATIENT OWN A CAR ?

YES :

NO :

DIAGNOSIS :

DETAILS OF AUDITORY HALLUCINATIONS :

SOURCE :	HUMAN, ANIMAL OR OTHER
	LIVING OR DEAD
	INSIDE THE HEAD OR OUTSIDE
	MALE, FEMALE OR MIXED
	STRANGER OR ACQUAINTANCE
	RADIO, TELEVISION, TELEPHONE
	RECORDER OR OTHER EQUIPMENT
	SUPERNATURAL: GOD, DEVIL, SPIRITS
PERCEPTION :	EARS (ONE OR BOTH)
	OTHER PARTS OF BODY
	VOICE OR BUZZING SOUND
TIME EXPERIENCED :	DAY / NIGHT
	ASLEEP OR AWAKE
	WORKING OR RESTING
COMPREHENSIBILITY :	DISTINGUISHABLE OR INDISTINGUISHABLE
	INTELLIGIBLE OR NOT INTELLIGIBLE
CONTENT :	GRANDIOSE, PERSECUTORY
	ACCUSATORY OR OTHER
LANGUAGE OF HALLUCINATION:	MOTHER TONGUE
	ENGLISH
	OTHER

PATIENT'S REACTION TO HALLUCINATIONS

PATIENT'S INTERPRETATION AS TO THE NATURE
AND CAUSE OF HALLUCINATIONS

DID THE VOICES BELONG TO PATIENT'S ANCESTORS ? :

DID PATIENT VISIT A TRADITIONAL HEALER OR
PRIEST CONCERNING HIS ILLNESS :

APPENDIX B

Patient's Project Registration Number	1	2	3	4	5
Clinical Diagnosis	1	1	1	1	4
Age (in years) at onset of illness	18	22	16	19	28
at present	36	34	27	33	29
Mother tongue	1	1	2	3	1
Language of Daily usage	7	7	7	7	7
Language of Hallucinations	176	7	7	7	76
Religion (See coding)	1	1	1	3	1
Hallucinations ascribed to					
Humans	-	-	-	-	+
Living/Deceased/unknown	U	U	U	D	U
Male/Female/Both	B	M	B	F	B
God	-	-	-	-	-
Devil	-	-	+	-	-
Spirits	+	+	+	+	-
Ancestors	-	-	-	-	-
Animals	-	-	-	-	-
Unknown	-	-	-	-	-
Comprehensibility of Hallucinations					
Intelligible/Unintelligible/Both	I	I	I	I	I
Hallucinations with grandiose content	-	-	-	-	-
with Accusatory/Persecutory cont.	-	-	+	-	+
with Instructive content	+	+	-	+	+
with Sexual content	-	-	-	-	-
with Other content	-	-	-	-	-
Hearing voices speaking OF him	-	+	-	-	-
Hearing voices speaking TO him	+	+	+	+	+
Hearing voices commentng on his actions	-	-	-	-	-
Patient's reaction to hallucination (Initial)					
Welcome	-	-	-	-	-
Unwelcome/Distressful	+	+	+	+	+
Indifferent	-	-	-	-	-
Hallucinations experienced during Day/Night/Both	B	B	N	B	N
Hallucinations transmitted via technical media	-	-	-	-	-
Traditional healer consultation	+	+	+	+	+

CODINGS

Clinical Diagnosis
1. Schizophrenia
2. Manic Depressive Psychosis
3. Organic Mental Condition
4. Schizoaffective Disorder
5. Epileptic Psychosis

Religion
1. Hinduism
2. Islam
3. Christianity

Language
1. Tamil
2. Hindi
3. Telegu
4. Urdu
5. Gujerathi
6. Zulu
7. English

Patient's Project Registration Number	6	7	8	9	10
Clinical Diagnosis	1	1	3	1	1
Age (in years) at onset of illness	34	17	19	18	46
at present	40	29	29	38	62
Mother tongue	7	2	1	4	1
Language of Daily usage	7	7	7	7	7
Language of Hallucinations	7	72	7	7	1
Religion (See coding)	3	1	1	2	1
Hallucinations ascribed to					
Humans	-	-	-	+	+
Living/Deceased/unknown	U	U	U	D	U
Male/Female/Both	M	B	B	B	B
God	+	-	-	-	-
Devil	+	-	+	-	-
Spirits	+	+	+	+	-
Ancestors	-	-	-	+	-
Animals	-	-	-	-	-
Unknown	-	-	-	-	-
Comprehensibility of Hallucinations					
Intelligible/Unintelligible/Both	I	I	I	I	I
Hallucinations with grandiose content	-	-	-	-	-
with Accusatory/Persecutory cont.	+	-	+	+	+
with Instructive content	+	+	-	-	-
with Sexual content	-	-	-	-	-
with Other content	-	-	-	-	-
Hearing voices speaking OF him	-	-	-	-	-
Hearing voices speaking TO him	+	+	+	+	+
Hearing voices commentng on his actions	-	-	-	-	-
Patient's reaction to hallucination (Initial)					
Welcome	-	-	-	-	-
Unwelcome/Distressful	+	+	+	+	+
Indifferent	-	-	-	-	-
Hallucinations experienced during Day/Night/Both	D	B	B	B	B
Hallucinations transmitted via technical media	-	-	-	-	-
Traditional healer consultation	+	+	+	+	+

CODINGS

Clinical Diagnosis
1. Schizophrenia
2. Manic Depressive Psychosis
3. Organic Mental Condition
4. Schizoaffective Disorder
5. Epileptic Psychosis

Religion
1. Hinduism
2. Islam
3. Christianity

Language
1. Tamil
2. Hindi
3. Telegu
4. Urdu
5. Gujerathi
6. Zulu
7. English

Patient's Project Registration Number	11	12	13	14	15
Clinical Diagnosis	2	3	1	1	2
Age (in years) at onset of illness	17	31	39	22	32
at present	34	33	40	44	32
Mother tongue	4	1	2	3	5
Language of Daily usage	7	7	7	7	7
Language of Hallucinations	7	71	72	7	7
Religion (See coding)	2	1	1	3	2
Hallucinations ascribed to					
Humans	+	-	+	-	+
Living/Deceased/unknown	U	U	U	U	L
Male/Female/Both	U	B	B	F	M
God	-	+	-	-	-
Devil	-	+	-	-	-
Spirits	-	+	-	+	-
Ancestors	-	-	-	-	-
Animals	-	-	-	-	-
Unknown	-	-	-	-	-
Comprehensibility of Hallucinations					
Intelligible/Unintelligible/Both	I	I	U	-	I
Hallucinations with grandiose content	-	-	-	-	-
with Accusatory/Persecutory cont.	-	+	-	-	-
with Instructive content	+	-	-	+	+
with Sexual content	-	-	-	-	-
with Other content	-	-	-	-	-
Hearing voices speaking OF him	-	-	-	-	-
Hearing voices speaking TO him	+	+	-	+	+
Hearing voices commentng on his actions	-	-	-	-	-
Patient's reaction to hallucination (Initial)					
Welcome	+	-	-	-	+
Unwelcome/Distressful	-	+	+	+	-
Indifferent	-	-	-	-	-
Hallucinations experienced					
during Day/Night/Both	B	B	B	N	D
Hallucinations transmitted					
via technical media	-	-	+	-	-
Traditional healer consultation	+	+	+	+	+

CODINGS

Clinical Diagnosis
1. Schizophrenia
2. Manic Depressive Psychosis
3. Organic Mental Condition
4. Schizoaffective Disorder
5. Epileptic Psychosis

Religion
1. Hinduism
2. Islam
3. Christianity

Language
1. Tamil
2. Hindi
3. Telegu
4. Urdu
5. Gujerathi
6. Zulu
7. English

Patient's Project Registration Number	16	17	18	19	20
Clinical Diagnosis	5	3	1	1	1
Age (in years) at onset of illness	30	51	31	25	19
at present	35	52	35	36	30
Mother tongue	2	1	4	2	4
Language of Daily usage	7	7	7	7	7
Language of Hallucinations	72	7	7	7	7
Religion (See coding)	1	1	2	1	2
Hallucinations ascribed to					
Humans	-	-	+	-	+
Living/Deceased/unknown	U	U	+	D	U
Male/Female/Both	B	B	B	M	B
God	-	-	-	-	-
Devil	-	+	-	-	-
Spirits	+	-	+	+	+
Ancestors	-	-	-	-	-
Animals	-	-	-	-	-
Unknown	-	-	-	-	-
Comprehensibility of Hallucinations					
Intelligible/Unintelligible/Both	I	I	I	I	I
Hallucinations with grandiose content	-	-	-	-	-
with Accusatory/Persecutory cont.	+	+	+	-	+
with Instructive content	-	-	-	-	-
with Sexual content	-	-	-	-	-
with Other content	-	-	-	-	-
Hearing voices speaking OF him	-	-	-	-	-
Hearing voices speaking TO him	+	+	+	+	+
Hearing voices commentng on his actions	-	-	-	-	-
Patient's reaction to hallucination (Initial)					
Welcome	-	-	-	-	-
Unwelcome/Distressful	+	+	+	+	+
Indifferent	-	-	-	-	-
Hallucinations experienced during Day/Night/Both	N	B	B	D	B
Hallucinations transmitted via technical media	-	-	-	-	-
Traditional healer consultation	+	+	+	+	+

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Language
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6. Zulu
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Patient's Project Registration Number	21	22	23	24	25
Clinical Diagnosis	5	1	2	1	2
Age (in years) at onset of illness	19	20	23	20	28
at present	29	28	23	30	36
Mother tongue	4	2	1	5	2
Language of Daily usage	7	7	7	7	7
Language of Hallucinations	78	2	1	7	7
Religion (See coding)	2	1	3	2	3
Hallucinations ascribed to					
Humans	-	+	-	+	-
Living/Deceased/unknown	U	D	U	L	U
Male/Female/Both	B	B	F	B	F
God	-	-	-	-	+
Devil	-	-	-	-	-
Spirits	+	-	+	-	-
Ancestors	-	+	-	-	-
Animals	-	-	-	-	-
Unknown	-	-	-	-	-
Comprehensibility of Hallucinations					
Intelligible/Unintelligible/Both	I	I	I	B	I
Hallucinations with grandiose content	-	-	-	-	+
with Accusatory/Persecutory cont.	+	-	+	-	-
with Instructive content	-	+	+	+	-
with Sexual content	-	-	-	-	-
with Other content	-	-	-	-	-
Hearing voices speaking OF him	-	-	-	-	-
Hearing voices speaking TO him	+	+	+	+	+
Hearing voices commentng on his actions	-	-	-	-	-
Patient's reaction to hallucination (Initial)					
Welcome	-	-	-	-	+
Unwelcome/Distressful	+	+	+	+	-
Indifferent	-	-	-	-	-
Hallucinations experienced during Day/Night/Both	B	B	B	D	N
Hallucinations transmitted via technical media	-	-	-	+	-
Traditional healer consultation	+	+	+	+	+

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Religion
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2. Islam
3. Christianity

Language
1. Tamil
2. Hindi
3. Telegu
4. Urdu
5. Gujerathi
6. Zulu
7. English
8. Arabic

Patient's Project Registration Number	26	27	28	29	30
Clinical Diagnosis	1	1	1	2	1
Age (in years) at onset of illness	24	19	37	21	28
at present	24	30	49	35	36
Mother tongue	1	1	7	1	2
Language of Daily usage	7	7	7	7	7
Language of Hallucinations	7	7	7	7	7
Religion (See coding)	3	1	2	1	1
Hallucinations ascribed to					
Humans	−	+	+	−	+
Living/Deceased/unknown	D	L	L	D	U
Male/Female/Both	B	B	B	B	B
God	+	−	−	+	−
Devil	−	−	−	−	−
Spirits	−	−	+	+	+
Ancestors	+	−	−	+	−
Animals	−	−	−	−	−
Unknown	−	−	−	−	−
Comprehensibility of Hallucinations					
Intelligible/Unintelligible/Both	I	I	I	I	U
Hallucinations with grandiose content	+	−	−	+	−
with Accusatory/Persecutory cont.	−	−	−	−	−
with Instructive content	+	−	+	−	−
with Sexual content	−	+	−	−	−
with Other content	−	−	−	−	−
Hearing voices speaking OF him	−	−	−	−	−
Hearing voices speaking TO him	+	+	+	+	−
Hearing voices commentng on his actions	−	−	+	−	−
Patient's reaction to hallucination (Initial)					
Welcome	+	−	+	+	−
Unwelcome/Distressful	−	+	−	−	+
Indifferent	−	−	−	−	−
Hallucinations experienced during Day/Night/Both	B	B	B	B	B
Hallucinations transmitted via technical media	−	+	+	−	−
Traditional healer consultation	+	+	+	+	+

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