



‘Mass Hysteria’ in the Wake of Decolonisation

In the early 1960s, medical officers and administrators in Uganda and Tanganyika (now Tanzania) began to receive reports of what was being described as ‘mass madness’ and ‘mass hysteria’ in the areas around Lake Victoria.¹ Starting with a case of ‘laughing mania’ at Bukoba, north-west Tanganyika, in 1962, further reports of ‘running manias associated with violence’ followed in 1963 in Kigezi, south-west Uganda, and Mbale, eastern Uganda. Faced with reports of up to 600 ‘victims’ in each area, local medical officers were at a loss as to how to respond.² While they had well-established measures in place for investigating and preventing the spread of infectious diseases such as cerebrospinal meningitis, there were no guidelines dictating the proper procedure for a psychic epidemic. As an account in the *New York Times* noted: ‘Near Bukoba an entire village of more than 200 persons fell ill in a matter of days To villagers with tears in the eyes from fits of hysteria, the disease is “end-wara ya Kucheka”—the laughing trouble. To doctors, it is one of Africa’s newest and most puzzling illnesses’.³

At the request of the Uganda and Tanganyika Governments, two different teams investigated the epidemics. The first, led by A. M. Rankin, Professor of Medicine at Makerere University College, and P. J. Philip, Medical Officer, described how a ‘disease’ of ‘laughing, crying and restlessness’

had started in 1962 at a mission-run girls' school twenty-five miles from Bukoba, Tanganyika.⁴ In the subsequent months, the condition spread to other schools, affecting male and female pupils equally, but none of the European or African teachers. 'The onset is sudden', they noted, 'with attacks of laughing and crying lasting for a few minutes to a few hours, followed by a respite and then a recurrence. The attack is accompanied by restlessness and on occasions violence when restraint is attempted'.⁵ They conducted a series of laboratory tests to rule out organic causes for the disorder, before reaching a tentative diagnosis of mass hysteria by process of elimination.⁶ The second investigation was based at Mbale, eastern Uganda, and led by Benjamin H. Kagwa, who had returned to Uganda from the USA for two years in 1963. Kagwa conducted a series of neuropsychiatric tests, analysing his findings alongside historical examples of mass hysteria from sixteenth-century Europe. He showed little interest in local explanations for the madness, which linked it to the anger of ancestral spirits. Instead, Kagwa stressed that the epidemics, coming in the wake of independence from colonial rule, provided evidence that Africans were suffering from a 'mental conflict' brought on by education and 'westernisation'.⁷ His research represented the first major investigation into mental illness in East Africa by an African doctor.

The idea that Africans were prone to periodic outbursts of mass instability had been present in medical and ethnographic literature since the mid-nineteenth century, and proliferated with the expansion of colonial rule.⁸ Observers of the *amandiki* women in Zululand at the beginning of the twentieth century offered a number of different explanations for *indiki* possession, including witchcraft, healing cults and 'hysterical mania'. In describing the behaviour of the *amandiki*, many colonial officials and missionaries also drew on the gendered language of hysteria that was prominent in Europe at the time.⁹ In Nigeria in 1940, M. D. W. Jeffreys, a colonial administrative officer, included an outbreak of 'religious fervour' in the Calabar Province in his account of 'psychical phenomena' in Africans. 'Victims', he noted, 'declared themselves possessed of the spirit and giving way to paroxysms of dancing finally collapsed in insensibility which usually ended in a return to sanity. Large masses moved about the country singing religious hymns'.¹⁰ In Kenya, too, ethnologists described how 'psychical disturbances of a religious character pass like epidemics over the Kamba country'. These disturbances, known locally as *kijesu*, were categorised variously as 'infectious

hysteria' and 'epidemic mania', and were given a distinctly political tone—at Ulu, according to Gerhard Lindblom, people went into convulsions at the mere sight of a European.¹¹ Such accounts formed part of a broader attempt to describe and define what constituted 'normal' and 'abnormal' behaviour in the African. Infusing their work with notions of European racial and cultural superiority, authors dismissed indigenous cultural practices and beliefs as evidence of psychopathology. As Megan Vaughan has argued, the distinction between witchcraft and madness was frequently blurred: 'It was 'normal' (if punishable) for an African to believe in witchcraft—it was not 'normal', however, to suffer from paranoid delusions'.¹² Yet such was the power of these beliefs, it was said, that Africans could will themselves to die.¹³

The epidemic nature of so-called psychic disturbances was particularly worrying for medical practitioners and colonial administrators: if unchecked, mass instability had the potential to spread and destabilise whole regions.¹⁴ These fears were reinforced from the 1920s and 1930s, when psychologists and anthropologists within the East African School of Psychiatry and Psychology started to discuss how education and urbanisation could 'detribalise' the African and trigger a particularly 'European' type of insanity, characterised by delusions of power and control.¹⁵ Such ideas were certainly present in reports on 'outbreaks' of mass fervour and spirit cults in Uganda, where they operated as useful explanatory tools. One of the most threatening movements for administrators in early colonial Uganda was that of the fertility goddess *Nyabingi* in Kigezi District, characterised by contemporary observers as an anti-colonial 'society' or 'cult', and refigured more recently as a set of logics and practices associated with attempts to gain redress for misfortune.¹⁶ In one of the most notorious incidents linked to *Nyabingi*, a horde of Kiga men and women stormed the local government station at Nyakishenyi, killing sixty-three government employees and family members working under the supervision of a colonial agent from Buganda. Responding to the attack in a report in 1917, the District Commissioner (DC) of Kigezi District, J. M. M. McDougall, dismissed the suggestion that the rebellion indicated anti-Ganda or even anti-colonial sentiment.¹⁷ Instead, witchcraft was to blame: 'As might be expected among unsophisticated savages the powers of superstition are enormous. This explains the influence of the local witchdoctors, who initially combine their claims to supernatural powers with promises of liberation of the natives from European rule and restoration to their former condition'.¹⁸

Two years later, a new DC, Captain J. E. T. Philipps, updated this theory, drawing on ideas about hypnotism and unconscious suggestion. For Philipps, *Nyabingi* practices were spreading ‘[by] means of an unusually developed form of Witchcraft, in which hypnotic suggestion plays a leading part, the country within the sphere of its operations is completely terrorised’.¹⁹

Such accounts of mass instability during colonial rule tell us more about the anxieties and vulnerability of the colonial project than they do about the behaviours and actions of those involved. They overlook personal testimonies, and the ways such behaviours might also be read as forms of protest, as expressions of wider social and political anxieties, or as ways of coping with distress within evolving frameworks of healing. Whether such behaviours are labelled ‘mass hysteria’ or not, they are always subject to multiple, shifting opinions and explanations, of which (Western) medical diagnosis is only one part. This is no less the case for the epidemics of ‘mass hysteria’ that emerged in the early 1960s, for which the medical reports obscure the wider socio-economic and political disruption of decolonisation. Rankin, Philip, and Kagwa, among others, could have found plenty of tensions and potential causes of conflict, had they looked for them. Indeed, the broader emotional landscape of Uganda in the run-up to Independence in 1962 was one of ‘widespread passionate politics’, to borrow a phrase from Carol Summers.²⁰ Nationalist and monarchical politics became more vocal across Uganda through the 1950s, with multiple competing local interests undermining hopes of a ‘unified’ nation state, and prompting uncertainty about the future. One of the most prominent political confrontations resulted from the colonial government’s exiling of Buganda’s *Kabaka* (King) Mutesa II to London in November 1953, following increasingly tense discussions about plans for an East African federation. The ‘Kabaka crisis’ of 1953–1955 saw public demonstrations of grief and loyalty, with Ganda women weeping openly in the streets.²¹ What was more worrying for the colonial government, however, was what they interpreted as a ‘resurgence’ of spirit possession practices, particularly in the already emotionally charged context of the Kabaka crisis.²² The *lubaale* (hero-god) prophet Kigaanira Ssewanyana, channelling the principal *lubaale* of warfare, *Kibuuka*, openly contested colonial authority by urging the Ganda to

withhold taxes until the return of the exiled Kabaka, to stop attending church and mosque services, and by handing out his own medicines.²³ Kigaanira was eventually arrested amidst violence between his supporters and the police, culminating in the death of the Head Constable of the Buganda Native Police.

Psychiatry occupied a marginal space in these upheavals of decolonisation. Aside from the extension of responsibility to Ugandan psychiatrists, as examined in the previous chapter, psychiatry saw little change—the number of patients admitted to Mulago and Butabika Mental Hospitals continued to rise, and there was no overhaul of diagnostic or therapeutic practices. When Kigaanira was charged with murder following his arrest, his defence of insanity was rejected by the High Court of Uganda and the medical practitioners who examined him.²⁴ As political tensions continued into the 1960s, moreover, including ongoing conflict between the Uganda Government and the Buganda Kingdom, and the collapse of constitutional governance, psychiatry remained insular.²⁵ This was no less the case in eastern Uganda, where administrative restructuring and controversies surrounding circumcision saw the Gisu of eastern Uganda develop a reputation for extreme violence.

This chapter uses the 'mass madness' that swept across the Mbale region of eastern Uganda in the early 1960s as a lens through which to explore the place of psychiatry in the context of political instability. In situating the epidemic in its wider social and political context, I aim not only to explore how broader anxieties may have found expression in spirit possession, but also to highlight the difficulties facing the first generation of Ugandan psychiatrists as they took over responsibility for psychiatry. Responses to the epidemic remind us that the practice of psychiatry was not necessarily transformed with the emergence of African psychiatrists, even if contemporaries had credited them with having natural cultural 'insight' into 'the African mind'. Psychiatrists like Kagwa found it just as difficult as their expatriate colleagues to bridge what Frederick Cooper and Ann Laura Stoler have called 'the stretch between the public institutions of the colonial state and the intimate reaches of people's lives'.²⁶ Not only did their education, class and language skills set them apart from their patients, but there remained fundamental differences between their understandings of mental illness and the types of treatment deemed to be effective.

ANXIETIES IN THE WAKE OF DECOLONISATION

In the years following Independence in 1962, administrative structures at the local level were dismantled as Prime Minister Milton Obote and the Uganda People's Congress (UPC) attempted to assert their control over the districts.²⁷ The reorganisation of boundaries came as no surprise to officials in eastern Uganda, where territorial claims over Mbale Town had resulted in growing tensions through the 1950s. In 1954, Mbale had been designated as the administrative centre of two districts, Bugisu and Bukedi, with both the Gisu and Gwere (the main ethnic groups in these two districts, respectively) keen to secure ownership of the town. In these disputes, as Pamela Khanakwa has shown, *imbalu* (circumcision) practices, and associated discourses of manhood and the traditionally circumcised male body, were invoked by Gisu administrators and nationalists as a way of undermining the territorial claims of the Gwere, who were uncircumcised. This conflict over Mbale led to riots in 1954 and 1956, during which a number of Gwere and uncircumcised Gisu men were forcibly circumcised.²⁸ In the following years, the region saw a spate of forced circumcisions, as well as increasing tension, as Uganda headed towards independence with the Mbale question still unresolved. In June 1962, when the Boundary Commission was considering the Bugisu/Bugwere boundary dispute, 300–400 Gisu, including large numbers of *imbalu* dancers, gathered in protest, prompting the police to respond with tear gas and gunfire.²⁹ Anxieties about *imbalu* were felt throughout the region. In 1964, Israel K., an elderly man visiting the Bubule Health Centre with a scrotal hernia, appealed for help from the District Medical Officer for protection from neighbours who he feared were planning to forcibly circumcise him.³⁰

Against this backdrop of political instability, the Mbale region—already densely populated—saw increasing pressure on land, as well as fluctuating coffee prices, contributing to a perception that theft, *bhango* growing, drinking, witchcraft, and violence were getting out of control.³¹ Highlighting the complex relationship between political authority and generational tensions, the Intelligence Committee noted in 1964 that ‘the traditional customs and superstitions which tamed the man to abide by certain rules of laws have disappeared. Religio[n]s which have been brought in by foreign powers are heavily under criticism and losing ground. Many fathers have lost the old control that they used to have over their children. Drunkenness has increased with little criticism

from parents'.³² Such was the extent of fear over these issues that from the mid-1960s two types of neighbourhood organisations—vigilante groups and drinking companies—were formed across the area in order to curb social activities that were deemed to be dangerous.³³ The local administration, too, started to meet regularly to question how they could respond to the rising homicide rate and general unrest in the area. One proposed approach was to increase agricultural activity in the area. Yet, as a frustrated District Agricultural Officer, F. X. Lubega, complained in June 1965, this approach was futile 'because it is not basically an agricultural problem'.³⁴

If tensions in eastern Uganda prompted mass action or healing in the form of a protest cult, it was not recognised as such by anthropologists, psychiatrists or those affected. Nevertheless, Gisu elders living in the area surrounding Mbale recalled that there was a time around *kukwihula* (Independence) when madness was common, when 'so many people were attacked around the villages', and it was 'catching many people in one go'.³⁵ The madness (*tsitsoli*) was said to have come suddenly during the years immediately preceding and following Independence, lasted a few months, and never recurred. It was as if mass madness, as a number of elders described it, was a 'disease of that time' (*lufu lwembuka yo*), just as HIV/AIDS is regarded as a 'disease of today'.³⁶ This way of remembering both indicates the extent to which it had affected families and communities, and points to the ways Gisu elders periodise time by major events and disturbances. Gisu circumcision names (*kamengilo*), for example, were usually associated with social, economic and political events.³⁷ In reflection of the spate of forced circumcisions, the 1966 circumcision name was *muwambe*, meaning 'capture, catch or hold him'.³⁸

'It came by wind [*imbewo*]', as a Gisu elder described it.³⁹ Just as the *basambwa* (ancestral spirits) were 'like the wind', so the madness was said to have come and spread in this way.⁴⁰ In describing the madness, a number of explanations were put forward, including a curse from the ancestors and witchcraft (*liloko* and *bulosi*).⁴¹ 'It was a result of misfortunes [*bisilani*], because it came as wind and people contracted it', posited one Gisu elder.⁴² 'In our area', another stressed, 'people said it was a curse [*shitsubo*]'.⁴³ Speaking about his own madness during the epidemic, moreover, one man remained uncertain about why he was affected: 'I don't know, maybe it came by spirits [*were*]. But what I know, is that it affected many people'.⁴⁴ While it was more common among the youth, it did not discriminate by gender, education or age.⁴⁵ This, according

to a number of elders, was due to the will of *were*, the creator spirit.⁴⁶ No contradiction was seen in the diversity of explanations—ideas about agency behind the madness reflected the more general belief that while *were* (the creator spirit) was in charge of fate, agency could be ascribed to sorcery, the anger of the ancestors, or other spirits.⁴⁷ As one elder commented, ‘Everybody had his or her own theory, because some said it came from the ancestors and others, that it was a curse from God’.⁴⁸

In line with the broader unrest in the region, as well as ethnographic accounts of madness among the Gisu, violence and aggression were cited as key features of the behaviour of those affected.⁴⁹ ‘He was very much aggressive and sometimes silent’, one informant spoke of a man in a neighbouring village. Such was his confusion in his final days, she added, that he wandered into the path of a vehicle and was killed.⁵⁰ Others might ‘cry too much, become aggressive, become quiet, or laugh too much’.⁵¹ Or they might ‘become very violent and would keep away from noise or cry uncontrollably’.⁵² Those who went mad themselves, however, offered different views. ‘At times I would feel like I was losing my senses’, one Gisu elder recalled, ‘and sometimes could not trace my home’.⁵³ Another reported how it gave her headaches and left her ‘quiet’ and ‘docile’.⁵⁴ What was clear was that the scale of the madness caused considerably anxiety, with reports of rumours about its spread moving between villages, particularly during periods of *imbalu*.⁵⁵ On hearing a rumour, one elder explained, ‘Some people became scared and isolated themselves’.⁵⁶ While another, speaking of her own disturbance, recalled feeling isolated, adding that ‘People became scared that if they came near they would be affected’.⁵⁷

In a context in which there was some uncertainty over the cause and spread of the madness, rumours flourished, pointing to anxieties that transcended local politics. One theory was that the scale of the madness was due to ‘sophisticated bombs’, something that may have reflected heavy news coverage on nuclear testing (including that within Africa) at the time.⁵⁸ Another, perhaps related idea, was that it had come from ‘outside’, as an unknown force from Europe.⁵⁹ Fears about nuclear testing, and its effects, certainly linked the epidemic to that in Tanganyika, where Rankin and Philip reported a ‘belief that the atmosphere has been poisoned as a result of the atom bomb explosions’.⁶⁰ Yet it also highlighted uncertainties about the intentions and actions of foreigners. One Gisu elder recalled two Europeans coming to investigate the local water supply at the same time as people in his and nearby villages were

running mad. These Europeans, he believed, were only interested in the water because the madness had 'started from abroad....In countries like Germany'.⁶¹ This explanation might be best attributed to anxieties about the nature of medical research and colonial rule.⁶² But it might also be taken as an indication of the cultural and political gulf between the Gisu, the local authorities, and foreign researchers. What for the two Europeans was a routine and unobtrusive water test, became for this man something altogether more disturbing. Indeed, because the Europeans 'knew about the disease', they could avoid being infected, having 'covered themselves with protective masks'.⁶³

The extent to which Gisu elders recalled uncertainty and suspicion, both towards the behaviours they witnessed and the people who came to investigate, remind us that historians should not focus solely on diagnosis. Yet proving, 'without doubt', the diagnosis of mass hysteria was a foremost concern for Kagwa when he arrived to investigate the epidemic in 1964.⁶⁴ In doing so, Kagwa would show little interest in local explanations for the madness or the wider social and political context in which it emerged and took hold.

THE 'PROBLEM' OF MASS HYSTERIA

Kagwa returned to Uganda in August 1963 on the invitation of the newly independent Ministry of Health. It was his first visit home after thirty-five years overseas, and driven, according to his wife, Winifred Kagwa, by a 'moral responsibility' to 'contribute to the development of his homeland'.⁶⁵ Indeed, it was the political upheavals of decolonisation, and their effects on mental health, that had concerned Kagwa. In the context of conflict in Congo and the 'new winds of change in Africa', he wrote in his memoir, 'it would be a shame if I shunned the responsibility of offering my services where they are acutely needed'.⁶⁶ In Uganda, he noted, 'one sees a mixture of poverty and prosperity, cleanliness, and boiling political as well as intellectual activities'.⁶⁷ And the political situation was changing quickly: 'Since I have been here many things have happened: the king of Buganda has become the *President of Uganda*. Kenya has become independent. A group of Europeans organized by some Kenya-born whites to mock the Kenya *Uhuru* on Ugandan soil were summarily deported, and the concept of the Rhodesian federation is dead, bringing about the resurrection of Nyasaland (Malawi) and Northern Rhodesia (Zambia) as living entities preparing for whooping *Uhurus*'.⁶⁸

Between 1963 and 1965, Kagwa was on ‘safari’, as he termed it, as a consultant psychiatrist for the Uganda Government. Joining Stephen B. Bosa and T. W. Murray as Uganda’s only psychiatrists before 1966, Kagwa divided his time between Mulago and Butabika Hospitals, and took on inspection visits to hospitals across the country. Yet while Bosa was unable to take any leave due to pressures on his workload, Kagwa’s memoir speaks (in the manner of other doctor memoirs of Africa), of visits with his wife to the source of the Nile, Murchison Falls National Park, Nairobi, Mombasa, Zanzibar and Ngorongoro Crater, where they encountered a rhino ‘on the loose’ in their camp.⁶⁹ Refuting any notions of savagery, and continuing an ongoing preoccupation in his memoir with beautiful women, he stressed how ‘it is markedly difficult in Kampala to find a sloppily dressed woman...always gorgeously dressed and meticulously neat’.⁷⁰ ‘Maybe I shouldn’t say this’, he added, ‘but one day I made a remark about my impression of the neatness of the Kampala African woman to a clinician in the large city hospital who has been examining them for years. His remark was, “Even their underwear is clean”’.⁷¹

Despite his expressed interest in the relationship between decolonisation and mental health, Kagwa’s reflections on his clinical experiences received significantly less attention in his memoir than comments about scenery, socialising and African women. Nevertheless, he noted his surprise at how similar the symptomatology of psychotics and psycho-neurotics was to that encountered in the USA. It was only in the content of the delusions that differences, or ‘local cultural shades’, could be found. While in the USA ‘paranoids...may express their ideas of reference by saying that the neighbors are sending some radio waves or electricity through their bodies, trying to kill them’, in Uganda, ‘paranoids...substitute magic for radio waves’.⁷² Such comments echoed the preoccupations of colonial psychiatrists with understanding differences between ‘African’ and ‘European’ delusions, but were much more in line with the emergent stream within transcultural psychiatry that saw mental illness as both universal and shaped by culture. The idea that there might be syndromes bound by culture was also an area of fascination. He wrote how a series of neuropsychiatric cases, ‘which do not fit in any pathological or clinical entities I have known in the USA’, presented themselves as ‘peculiar “tough nuts”, but they are evocative and stimulating to study’.⁷³

Kagwa’s interest in the epidemics of ‘mass hysteria’ sweeping across eastern Africa marked the conflation of his interest in culture-bound syndromes and the political upheavals of decolonisation, and with permission

from the Uganda Government, he travelled to Mbale to investigate. In describing the epidemic of 'running mania', Kagwa divided the madness into three stages. The first came on suddenly and lasted three to four days. It was characterised by 'marked agitation, talkativeness, violence, attempted assaults and petty robbery, with anorexia and a craving to smoke'.⁷⁴ The second was marked by sporadic relapses of hyperactivity, lasting one to two weeks. And the third was characterised by 'improvement in mood, affability and a willingness to be interviewed'.⁷⁵ According to his research, all of the original cases were Gisu men and women, either illiterate or near-illiterate, and in no position of authority.⁷⁶

In discussing possible causes for the outbreak, Kagwa noted that those affected believed very strongly that the madness was caused by ancestral spirits. 'All this was said to be done', Kagwa asserted, 'in response to the orders of the spirits of dead family elders. This phase had a quality of a quasi-manic reaction with obvious transparent delusions and hallucinations. Those affected stated that they could see the faces and hear the voices of their dead elders'.⁷⁷ Surprisingly, Kagwa did not pursue this line of inquiry, or consider the broader context of political instability in the Mbale region, despite expressing sympathy for prominent psychoanalysts such as Sigmund Freud, who argued that an individual or group's ideas, fears and anxieties could produce hysteria.⁷⁸ Instead, he initiated a series of invasive physical and neuropsychiatric tests that included lumbar punctures, hypnosis, drug abreaction and the pushing of pins an inch deep into the flesh in order to show total anaesthesia.⁷⁹ Ignoring the possibility that his actions might in themselves cause distress, Kagwa asserted that his tests and interviews showed 'several objective classical hysterical findings'. These included 'sudden onset of the attacks, sudden clearance of symptoms', and total numbness. For Kagwa, 'all clinical studies proved, without doubt, the diagnosis of conversion hysteria'.⁸⁰

In making this statement, Kagwa was using his examination of individuals to diagnose the collective. This he justified by noting that 'one striking feature' of the three epidemics across East Africa was 'the stereotypy of symptoms in each particular ethnological group. The "attacks" and spread of similar symptoms ran along tribal lines. Even in instances where it spread over geographical borders the epidemics affected only members of the same tribe and culture'.⁸¹ The statements mirrored those made by Rankin and Philip in their investigation of the epidemic in Tanganyika, which had stressed that mental illness was 'influenced by the culture of the particular community'.⁸² Yet while Rankin and Philip were

reluctant to draw further conclusions before a study of the cultural context in Bukoba had been undertaken, Kagwa was more confident of his understanding of mental illness across East Africa. As a psychiatrist—and an African one at that—he not only confirmed that these epidemics were linked, but that they had implications for political, social and economic stability in the region—epidemics of mass hysteria were a new East African ‘problem’. In his analysis, Kagwa would fall back on many of the assumptions of the East African School of Psychiatry and Psychology, and would conflate ethnicity and culture with race.

Kagwa drew heavily on J. C. Carothers’ notion that the introduction of Western culture into Africa was upsetting an ‘equilibrium’, and that Africans were ill-equipped, both culturally and environmentally, to cope with these changes.⁸³ Echoing Carothers, Kagwa noted that:

Consciously or unconsciously, at this period of their development, the majority of Africans have conflicts of great psychological dimensions, though they may differ in character. For example, among the educated the conflict may be verbalized in terms of political, economic or educational unrest and action, while among the illiterate and near-illiterate confusion of ideas and emotions, as well as substitution of mysticism for logic, is the rule....the latter group, which is of course in the majority, has been thrust into sudden religious and political changes without preparation.⁸⁴

Kagwa’s use of Carothers is not entirely surprising given the continued interest of psychiatrists and psychologists in the idea of the African in transition. While statements about the dangers of ‘development’ and other assumptions of ethnopsychiatry were increasingly being contested, not least by African psychiatrists such as T. A. Lambo, ethnopsychiatry nevertheless represented the only substantial body of literature on African psychopathology.⁸⁵ Moreover, the World Health Organization (WHO), which had commissioned Carothers’ *The African Mind in Health and Disease*, stood publicly by the text as late as 1962 as a ‘good example’ of an investigation ‘of the peculiar qualities of mental organization in individual cultural groups’.⁸⁶

Despite his reliance on ideas about ‘psychic trauma’, ‘culture contact’, and ‘detrribalisation’, Kagwa certainly believed that his investigation was less racially motivated than that which had come before under colonial rule. Significantly, Kagwa was keen to stress that his analysis did

not mean that mass hysteria was a cultural or racial peculiarity affecting Africans alone. Discussing the historical background of mass hysteria, Kagwa noted that 'Hysteria, as a human behavioural phenomenon, can be traced as far back as the beginning of man's rational psycho-social development'; it was functional, providing an 'outlet for dammed-up instinctive demands'.⁸⁷ In doing so, Kagwa stressed the universal applicability of Western psychiatry alongside the existence of a linear scale of development on which African 'civilisation' was passing through one stage. There was 'much historical evidence', Kagwa added, 'to prove that emotional upheavals associated with hysteria occur whenever a people's cultural roots and beliefs become suddenly shattered'.⁸⁸ These precedents included demon possession in the Bible, the hysterical deliria of saints, and epidemics of dancing mania in Metz, Cologne and Aix-la-Chapelle in the fourteenth and fifteenth centuries.⁸⁹

By including these examples Kagwa was following a trend in medicine of analysing historical accounts of disease, as if it might aid understanding of why and when epidemics of hysteria occur.⁹⁰ In ways reminiscent of older theories of recapitulation, this body of literature linked the 'primitive' mentalities of peasants from medieval Europe with twentieth-century schoolchildren, members of religious cults and black Americans, among others. The problem with this approach was the way it assumed that mass hysteria had always existed in a universal and recognisable form, and that retrospective diagnoses could shed light on present understandings.⁹¹ Indeed, for Kagwa, as it had been for Rankin and Philip, mass hysteria was an objective reality; it could spread from person to person just as other types of epidemic disease were 'caused by the spread of viruses, bacteria or parasites'.⁹²

Despite Kagwa's attempts to distance himself from ideas about racial difference, he could not escape the assumption that African societies were undergoing a period of psychological transition. He saw no contradiction between his finding that the epidemics ran along ethnic lines and his belief in the existence of a homogenous African culture that was, at this particular time, susceptible to mass instability. This 'African culture' was the only useful unit of analysis, just as it had been for Carothers—there was little room for socio-economic change, cultural diversity or individuality. It was Kagwa's attempt to understand the epidemics through this particular theoretical lens that accounts for the conceptual gap between him and his Gisu patients.

MULTIPLE RESPONSES TO 'MASS MADNESS'

These different ways of 'seeing' and understanding psychological distress were not resolved with the coming of Independence or with the emergence of African psychiatrists. Kagwa may have been an African by birth, but he was from central rather than eastern Uganda, and his years in the USA had further distanced him from the people he was trying to help. As Kagwa noted later, he had returned to Uganda with a set of assumptions about the African mind that were rooted in Western psychiatric theory, rather than any special insight derived from being Ugandan.⁹³ His analysis of the epidemic as a wider cultural and developmental issue stands starkly against the social, political and economic tensions that existed in the area, as well as the explanations of the Gisu. In spite of this, or perhaps because of it, there remained a large question mark over how the 'problem' of mass hysteria should be handled.

If Kagwa believed in the universal applicability of psychiatry for understanding mental illness, he was nevertheless aware of the limits of his power. A Psychiatric Unit to serve the Eastern Region had opened at Mbale Hospital in 1963–1964, staffed by a small group of psychiatric nurses, but only four beds were available during the period under question.⁹⁴ Kagwa, moreover, was only able to apply his neuropsychiatric 'test' to those in the recovery stage of the epidemic, and does not appear to have been allowed to offer his own treatments. Just because Kagwa was Ugandan, it did not mean that families and communities were any more likely to turn to him for help. Such were the limits of Kagwa's role in Mbale that he was left to describe how it was Gisu elders 'who perform the healing ritual'.⁹⁵ These elders, Kagwa continued:

start at sunrise by visiting the burial grounds of the clan and by weeding the tombs, near which they build small huts. White chickens are slaughtered and their blood used to anoint the tombs. Pieces of chicken, baked plantains and calabashes of wine are then placed in the huts. These are gifts to the spirits of dead clan elders. Finally, one elder sips the wine and spits it on the feet of the "possessed", who then becomes instantaneously and dramatically healed. Interestingly enough, the word for this ritual is equivalent to the English word "exorcism".⁹⁶

Kagwa's account fit with that described by anthropologist Jean La Fontaine on the sacrificing of white animals to 'good' spirits and to the ancestors.⁹⁷ By focusing on the dramatic, however, such accounts ignored the importance of other forms of healing, including herbs, protective charms and even Western medicine.

Like other ethnic groups in Uganda, the Gisu distinguished between the symptomatic and etiological treatment of illness, focusing first on relieving symptoms before looking for a deeper cause.⁹⁸ Herbal medicine was easily available and regarded as the first line of treatment in cases of sickness.⁹⁹ One of those affected by the madness described visiting a healer who specialised in herbs. This healer, he noted, was relied upon because of their proximity and because through herbal medicine, 'they had seen other victims heal'. While it took some time before he recovered, he credited his own health to that of the herbalist, and the support of his family.¹⁰⁰ Those seeking relief could also turn to other forms of medicine, including protective charms (*tsisale*) placed under the skin, and ritual specialists who had the ability to remove bad omens and curses.¹⁰¹ The methods and meetings of these specialists were usually highly secretive, but could include sacrifices to appease the spirits or to drive out misfortune.¹⁰² Western medicine was also an option for those seeking relief and, despite the long distances that needed to be travelled, a number of people visited hospitals and clinics at Mbale and Bududu.¹⁰³ One woman recalled how they would only initiate treatment when people became aggressive, and then a person would either be tied up, taken to hospital, a traditional healer, or left to die. One of her neighbours, she added, was first taken to the government hospital at Mbale, in part because it was not far from their home, but also because that was what their village chief encouraged them to do. This particular person recovered in the hospital, and as a result, others from her village were also taken there for treatment.¹⁰⁴

Distance was a key factor in the decision-making process for those affected by the epidemic. More often than not, distances were perceived to be too great,¹⁰⁵ particularly for those who were not convinced of the ability of Western medicine to deal with illnesses associated with ancestral spirits.¹⁰⁶ A few also regarded hospitals as places of danger, in the way Luise White has highlighted more generally for East and Central Africa.¹⁰⁷ 'Some people had a false belief', one Gisu elder recalled, 'that

in hospitals medicines were made out of dead people'.¹⁰⁸ Such a comment reveals concern over the power of European therapies, and the control that was felt over bodies and minds.

As elsewhere in Africa, it was families and the larger kinship group who played a central role in making decisions about care and treatment, displaying a pragmatism that allowed for alternative treatment options to be explored.¹⁰⁹ As John Orley noted on his experience of illness and disease in central Uganda, 'Africans, being pragmatists, looked for a system that worked, and if one traditional remedy failed then another could be tried and so on until eventually Western medical treatment could also be given its chance'.¹¹⁰ Among the Gisu, such was the extent of this pragmatism that different methods of treatment were used simultaneously. One woman, for example, described how her brother was among those who went mad, becoming extremely aggressive and feeling cold to the touch. As a family they had first taken him to Mbale Hospital, but then decided that in addition to Western medicine, they would also consult two different traditional healers. When questioned as to why they tried three kinds of treatment 'at a go', she laughed, before responding: 'We wanted him to get cured'.¹¹¹ This was not a question of selecting traditional or Western medicine, but rather a process of searching for relief.

CONCLUSION

The epidemics of the early 1960s indicate the limits, rather than the strengths of psychiatry during the upheavals of decolonisation. In the context of anxieties over nationalist politics, territorial claims and increasing violence, psychiatric practices ignored the social, focusing instead on individual, largely physical examinations of patients. Kagwa not only obscured the broader context of political instability, but also appeared unaware of the widespread uncertainty and suspicion about the epidemic, both in terms of the behaviours communities had to deal with, and the strangers who came to investigate. Rather than seeing decolonisation through the lens of the social, he presented Gisu explanations for distress as signs of psychopathology. Like psychiatrists and psychologists before him, moreover, he believed it was possible to generalise about mental illness in Africa, as well as to identify broad cultural traits and 'experiences'. While Kagwa certainly believed that he was contributing to a deracialisation of psychiatric theory, he was not able to free himself

fully from the assumptions that had pervaded his discipline under colonial rule. This rendered psychiatry irrelevant. When the Gisu looked for options for relief, they turned to their own methods of healing—methods that did not include psychiatry. Kagwa, himself an outsider, was unable to intervene, his role reduced from psychiatric expert to that of observer.

While Kagwa's reliance on psychiatrists like Carothers placed him firmly within a much longer tradition of psychiatry in East Africa, it would be unfair to present Kagwa as an anomaly among the new generation of African psychiatrists emerging elsewhere in Africa. Intellectually, Kagwa navigated an uneasy line, being on the one hand a neuropsychiatrist with training in psychoanalysis, and on the other a visitor to a continent where many of the assumptions of ethnopsychiatry had yet to be fully unpicked by psychiatrists. Even the most critical of the early African psychiatrists, Lambo, found it difficult to navigate a path through the categories and terminologies employed by ethnopsychiatrists.¹¹² Over the next decade, the epidemics of mass hysteria also became a focus for transcultural psychiatrists working both within and outside of Africa. Moving beyond Kagwa's interest in the peculiarities of the African psyche, these discussions not only questioned why such epidemics occurred, but what they revealed about treatment choices in different cultural settings. At a Ciba Foundation Symposium on Transcultural Psychiatry, held in London in 1965, the events in East Africa were compared with epidemics of mass hysteria among islanders from Tristan da Cunha, *ufufenyane* among the Zulu in South Africa and Beatlemania.¹¹³ Lambo, who claimed to have worked with Kagwa on his investigation, stressed that the finding that most people took their relatives to traditional healers was significant. Highlighting the 'differences between an African physician...with a completely Western medical education and the local therapists', Lambo observed how '[a] rural African coming from his village to consult me may say to himself: "Well, this man won't really have any sympathy with me, I will not come next time. I'm wasting my time with him"'.¹¹⁴

By the mid-1960s, the initial optimism that had accompanied calls for the training of Africans as psychiatrists had faded away. The question of how psychiatrists in Africa—both African and expatriate—could bridge the gap between Western psychiatry and African patients would come to dominate the agendas of pan-African conferences and workshops over the next twenty years. This would in turn raise further questions about

the training of other health and medical workers in mental health care, the place of traditional healers in psychiatry, and whether psychiatrists could—and indeed should—take on social advisory roles in newly independent countries. The problem of the distance between psychiatrists and patients was, of course, not limited to the African context. In the UK, where psychiatrists were drawn almost exclusively from the upper echelons of society, the 1960s saw a proliferation of studies highlighting the difficulties of communication across class, education and linguistic divides.¹¹⁵ Given the formative nature of the discipline of psychiatry in Africa, however, the problems experienced by psychiatrists in demonstrating the relevance of psychiatry took on particular significance during the late 1960s and early 1970s. It was through discussions among those working in the continent, as much as in new research conducted by psychiatrists, that the future of mental health services in developing countries started to be debated and reformed.

NOTES

1. An earlier version of this chapter was published as Y. Pringle, ‘Investigating “Mass Hysteria” in Early Postcolonial Uganda: Benjamin H. Kagwa, East African Psychiatry, and the Gisu’, *Journal of the History of Medicine and Allied Sciences* 70(1) (2015), pp. 105–136. I thank Oxford University Press for permission to reproduce some of this material here.
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3. R. Conley, ‘Laughing Malady Puzzle in Africa’, *New York Times*, 8 August 1963, p. 29.
4. Rankin and Philip, ‘An Epidemic of Laughing’, p. 168.
5. *Ibid.*, p. 167.
6. *Ibid.*, pp. 167–170.
7. KDA, Minutes of the Kigezi District Team, August 1963–July 1964; ‘Mystery of the Laughing and Crying Disease’, p. 3; Conley, ‘Laughing

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 12. M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), p. 106. See also Parle, *States of Mind*, Ch. 3.
 13. See, for example, M. Wrong, 'Mass Education in Africa', *African Affairs* (1944), p. 109.
 14. Mahone, 'The Psychology of Rebellion'.
 15. J. C. Carothers, 'A Study of Mental Derangement in Africans, and an Attempt to Explain Its Peculiarities, More Especially in Relation to the African Attitude to Life', *East African Medical Journal* 25(5) (1948), pp. 142–166, 197–219; Vaughan, *Curing Their Ills*, Ch. 5.
 16. R. Vokes, *Ghosts of Kanungu: Fertility, Secrecy & Exchange in the Great Lakes of East Africa* (Kampala, 2009), Ch. 2.
 17. F. S. Brazier, 'The Incident at Nyakishenyi, 1917', *Uganda Journal* 32(1) (1968), pp. 17–27; Vokes, *Ghosts of Kanungu*, pp. 35–36.
 18. E. Hopkins, 'The Nyabingi Cult of Southwestern Uganda', in R. I. Rotberg and A. A. Mazrui, eds., *Protest and Power in Black Africa* (New York, 1970), p. 291.
 19. As cited in H. B. Hansen, 'The Colonial Control of Spirit Cults in Uganda', in D. M. Anderson and D. H. Johnson, eds., *Revealing Prophets: Prophecy in Eastern African History* (London, 1995), p. 154. On *Nyabingi* see especially S. Feierman, 'Colonizers, Scholars, and the Creation of Invisible Histories', in V. E. Bonnell and L. Hunt, eds., *Beyond the Cultural Turn: New Directions in the Study of Society and Culture* (Berkeley and Los Angeles, 1999); and Vokes, *Ghosts of Kanungu*.
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21. Summers, 'All the Kabaka's Wives'. See also, P. Kavuma, *Crisis in Buganda, 1953–55: The Story of the Exile and Return of the Kabaka, Mutesa II* (London, 1979).
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25. See especially: S. R. Karugire, *A Political History of Uganda* (Kampala, 2010); P. Mutibwa, *The Buganda Factor in Uganda Politics* (Kampala, 2008); and R. Reid, *A History of Modern Uganda* (Cambridge, 2017).
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28. P. Khanakwa, 'Masculinity and Nation: Struggles in the Practice of Male Circumcision Among the Bagisu of Eastern Uganda, 1900s to 1960s' (Unpublished PhD thesis, Northwestern University, 2011), pp. 197–204.
29. *Ibid.*, pp. 215–219.
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31. MDA MBL/4/57, letter from the District Commissioner, Bugisu, to the District Forestry Office, 9 May 1960; Heald, *Controlling Anger*, p. 1.
32. MDA MBL/4/68 (Homicide in Bugisu), 'Minutes of the Security/Intelligence Committee Meeting', 10 August 1964, p. 3.
33. Heald, *Controlling Anger*, pp. 229–230; S. Heald, 'Mafias in Africa: The Rise of Drinking Companies and Vigilante Groups in Bugisu District, Uganda', *Africa* 56 (1986), pp. 446–467.
34. MDA MBL/4/68, F. X. Lubega, District Agricultural Officer, Bugisu/Sebei Districts, 'Increased Agriculture Activity as a Means to Reduce Homicides', 16 June 1965.
35. Interview with Gisu male, approximately 74 years old (MLE-06), Mbale District, 27 October 2011; Interview with Gisu male, approximately 71 years old (MLE-11), Mbale District, 27 October 2011.
36. Interview with Gisu female, approximately 80 years old (MLE-09), Mbale District, 27 October 2011; Interview with Gisu male, approximately 77

- years old (MLE-12), Mbale District, 27 October 2011; Interview with Gisu female, approximately 74 years old (MLE-13), Mbale District, 27 October 2011; and Interview with Gisu female, approximately 70 years old (MLE-15), Mbale District, 31 October 2011.
37. Khanakwa, 'Masculinity and Nation', p. 53.
 38. Ibid., p. 236. Circumcision year names from 1801–1970 are listed in M. Macpherson, 'Circumcision Year Names (Kamengilo) in Masaba & Their Meanings', *Uganda Journal* 39 (1980), pp. 59–75.
 39. Interview with Gisu male, approximately 81 years old (MLE-02), Mbale District, 27 October 2011.
 40. Interview with Gisu female, approximately 81 years old (MLE-03), Mbale District, 27 October 2011; Interview with Gisu female, approximately 75 years old (MLE-04), Mbale District, 27 October 2011; Interview with Gisu female, approximately 60 years old (MLE-05), Mbale District, 27 October 2011; Interview MLE-09. On the *basambwa*, see Heald, *Controlling Anger*, p. 205.
 41. Interview with Gisu male, approximately 80 years old (MLE-01), Mbale District, 27 October 2011; Interview MLE-03; Interview MLE-04; Interview MLE-05; Interview MLE-06; Interview with Gisu female, approximately 61 years old (MLE-07), Mbale District, 27 October 2011; Interview with Gisu female, approximately 80 years old (MLE-08), Mbale District, 27 October 2011; Interview MLE-12; Interview MLE-13; and Interview with Gisu female, approximately 78 years old (MLE-16), Mbale District, 1 November 2011.
 42. Interview MLE-02.
 43. Interview MLE-16.
 44. Interview MLE-11.
 45. Interview MLE-01; Interview MLE-03; Interview MLE-04; Interview MLE-05; Interview MLE-06; Interview MLE-07; Interview MLE-08; Interview MLE-09; Interview with Gisu male, approximately 70 years old (MLE-10), Mbale District, 27 October 2011; Interview MLE-13; Interview MLE-15; Interview MLE-16; and Interview with Gisu male, approximately 77 years old (MLE-18), Mbale District, 1 November 2011.
 46. Interview MLE-08; Interview MLE-10; Interview MLE-12; Interview MLE-15; Interview MLE-16; Interview MLE-18.
 47. J. La Fontaine, *The Gisu of Uganda* (London, 1959), p. 50; J. La Fontaine, 'Witchcraft in Bugisu', in J. Middleton and E. H. Winter, eds., *Witchcraft and Sorcery in East Africa* (London, 1963), p. 191, fn. 1.
 48. Interview MLE-12.
 49. Heald, *Controlling Anger*, p. 129.
 50. Interview with Gisu female, approximately 70 years old (MLE-15), Mbale District, 31 October 2011.

51. Interview MLE-05.
52. Interview MLE-04.
53. Interview with Gisu male, approximately 71 years old (MLE-11), Mbale District, 27 October 2011.
54. Interview MLE-17.
55. Interview MLE-04; Interview MLE-15; Interview MLE-18.
56. Interview MLE-12.
57. Interview MLE-17.
58. Interview MLE-07. On nuclear test sites, see J. Allman, 'Nuclear Imperialism and the Pan-African Struggle for Peace and Freedom: Ghana, 1959–1962', *Souls* 10(2) (2008), pp. 83–102.
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60. Rankin and Philip, 'An Epidemic of Laughing', p. 168.
61. Interview MLE-02.
62. M. Graboyes, *The Experiment Must Continue: Medical Research and Ethics in East Africa, 1940–2014* (Athens, OH, 2015); L. White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, 2000).
63. Interview MLE-02.
64. Kagwa, 'The Problem of Mass Hysteria', p. 560.
65. B. H. Kagwa, *A Ugandan: Defiant and Triumphant* (Hicksville, 1978), p. 17. On Kagwa's return, see also 'Dr. Kagwa Home—For Ever', *Uganda Argus*, 23 August 1963, p. 3.
66. Kagwa, *A Ugandan*, p. 130.
67. *Ibid.*, p. 138.
68. *Ibid.*
69. *Ibid.*, pp. 147–148. On (white) doctor memoirs of Africa, see especially: Vaughan, *Curing Their Ills*, Ch. 7.
70. Kagwa, *A Ugandan*, p. 138.
71. *Ibid.*
72. *Ibid.*, p. 133.
73. *Ibid.*
74. Kagwa, 'The Problem of Mass Hysteria', p. 560.
75. *Ibid.*, p. 561.
76. *Ibid.*
77. *Ibid.*, p. 560.
78. A. P. Noyes and L. C. Kolb, *Modern Clinical Psychiatry*, 6th ed. (Philadelphia, 1963), pp. 430–436.
79. Kagwa, 'The Problem of Mass Hysteria', p. 565.
80. *Ibid.*
81. *Ibid.*
82. Rankin and Philip, 'An Epidemic of Laughing', p. 170.

83. Kagwa quoted from J. C. Carothers, *The African Mind in Health and Disease: A Study in Ethnopsychiatry* (Geneva, 1952).
84. Kagwa, 'The Problem of Mass Hysteria', p. 565.
85. On T. A. Lambo, see especially M. M. Heaton, *Black Skin, White Coats: Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry* (Ohio, 2013).
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87. Kagwa, 'The Problem of Mass Hysteria', p. 562.
88. *Ibid.*, p. 565.
89. *Ibid.*, pp. 562-563.
90. See, for example, 'Epidemic Hysteria', *British Medical Journal*, November 1966, p. 1280; G. Rosen, 'Psychopathology in the Social Process: I. A Study of the Persecution of Witches in Europe as a Contribution to the Understanding of Mass Delusions and Psychic Epidemics', *Journal of Health and Human Behaviour* 3 (1960), pp. 200-211; and F. K. Taylor and R. C. A. Hunter, 'Observation of a Hysterical Epidemic in a Hospital Ward', *Psychiatric Quarterly* 32 (1958), pp. 821-839.
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100. *Ibid.*
101. Interview MLE-01; Interview MLE-02. For fuller treatment of the types of ritual specialists among the Bagisu, see La Fontaine, 'Witchcraft in Bugisu', p. 190.
102. Interview MLE-03; Interview MLE-04.
103. Interview MLE-08; Interview MLE-09; Interview MLE-18.
104. Interview MLE-05.

105. Interview MLE-13; Interview MLE-16; Interview MLE-01; Interview MLE-02; Interview MLE-10; Interview MLE-12.
106. Interview MLE-18.
107. White, *Speaking with Vampires*, Ch. 3.
108. Interview MLE-12.
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110. J. Orley, 'Indigenous Concepts of Disease and Their Interaction with Scientific Medicine', in E. E. Sabben-Clare, D. J. Bradley, and K. Kirkwood, eds., *Health in Tropical Africa During the Colonial Period: Based on the Proceedings of a Symposium Held at New College, Oxford, 21–23 March 1977* (Oxford, 1980), p. 127; J. C. Ssekemwa gives some examples of this in 'Witchcraft in Buganda Today', *Transition* 30 (1967), pp. 30–39.
111. Interview MLE-07.
112. Heaton, *Black Skin, White Coats*, p. 71.
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