

Dissociative Fugue: Diagnosis, Presentation and Treatment Among the Traditional Shona People

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Abstract: Dissociative fugue seems to exist in all societies of the world. It could be noticeable but its prevalence in the general population is very low. Different societies of the world could identify dissociative fugue in different culturally relevant terms. The objective of the study was to assess the diagnosis, presentation and treatment of dissociative fugue among the traditional Shona people of Zimbabwe. The case study research methodology was used in this study to describe the diagnosis, presentation and treatment of dissociative fugue-related behaviours among the traditional Shona people. Participants were two men who were presenting with dissociative fugue-related behaviours before the study. An ethnopsychological approach was used to analyse the behaviours and treatment methods used by the traditional Shona people. The results of this study were that, although the diagnosis and treatment methods of the Shona were different from Western procedures, their methods of treating dissociative fugue-related behaviours were found to be useful in treating dissociative fugue-related disorders in a culturally relevant manner. The findings of the study are expected to prompt further research to establish the therapeutic efficacy of the traditional Shona methods of diagnosing and treating dissociative fugue-related disorders in an African context.

Key Words: Dissociative fugue, culture, Shona people, Zimbabwe.

INTRODUCTION

Dissociative fugue is characterized by a sudden and unexpected travel away from home, geographical location, and experiences of impaired recall of past events and personal identity [1]. People with dissociative fugue are sometimes referred to as schizophrenics, alcohol and substance abusers, or people with criminal tendencies [2]. However, in the Shona traditional culture, individuals presenting with symptoms of dissociative fugue could be treated and accommodated as deviant members of the community in need of community help. Community-based therapeutic procedures for various psychological and sociological-related dysfunctions are common among the Shona people [3, 4]. The rationale of this study was to highlight some of the traditional therapeutic interventions that might not be recognized by western methodologies as effective therapies for psychological disorders.

This study sought to examine some of the traditional Shona methods of explaining and treating dissociative fugue-related disorders. An ethnopsychological perspective was used in this study in order to highlight some aspects of the traditional treatment procedures that could complement modern methods of psychotherapy. An action-research approach was adopted; the researcher and the participants worked together in the diagnosis and treatment process. This approach enabled the researcher to observe and study the cultural practices from a participant-observer perspective. The researcher tried to work closely with the families and communities of the participants. The study sought to use

non-intrusive methods that would not offend the cultural values of the participants and their communities. The families of the participants and their immediate communities took a leading role in deciding the cultural remedies that were considered suitable for the individuals with dissociative fugue-related disorders.

DIAGNOSIS, PRESENTATION AND TREATMENT OF DISSOCIATIVE FUGUE ACCORDING TO WESTERN METHODS

Dissociative fugue is considered to be a rare mental disorder in the general population [5]. It could be a rare condition that therapists may see only once or twice over the course of their professional career [5]. The disorder may be known by different names and the criteria for diagnosing it could be met by a number of culturally relevant behaviors [1]. The diagnostic features of dissociative fugue are; running away from home, or one's customary place of daily activities, fleeing, or aimless wandering in an altered state of consciousness [6, 1]. The individual could be presenting with confusion about personal identity and the affected individual could assume a new identity and forget about his previous name or details [1].

The travel in a fugue state may range from brief trips over relatively short periods of time. This could take, hours or days, to complex, usually unobtrusive wandering over long time periods. Some individuals with dissociative fugue could cross numerous national borders and traveling thousands of miles away from home [1]. During a fugue, individuals may appear to be without psychopathology and generally do not attract attention. At some point, the individual is brought to clinical attention, usually because of amnesia for recent events or a lack of awareness of personal identity

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[1]. Once the individual returns to the pre-fugue state, there may be no memory for the events that occurred during the fugue [1, 7].

However, most fugue states do not necessarily result in the formation of a new identity. In the case of the formation of a new identity, the individual may be more gregarious and uninhibited in their relationship with the new community. The individual may assume a new name, take up a new residence, and engage in complex social activities that are well integrated in society such that the community may not suspect the newcomer to have a mental disorder [1].

Dissociative fugue is associated with traumatic life events. The traumatic event could cause an overwhelming traumatic stress that may go beyond an individual's coping mechanisms. Trauma could cause incidences of forgetfulness or problems associated with retention of information [8]. On the contrary, researchers on trauma also contend that traumatic events or terrifying experiences could be remembered with extreme vividness while other scholars argue that the experiences could totally resist integration with memory in the long-term memory [8]. Individuals experiencing traumatic distress may report a combination of vivid memories and forgetting some aspects of the traumatic event [9, 10, 11]. Some aspects of traumatic events appear to get fixed in the mind, unaltered by the passage of time or by the intervention of subsequent experience. For example, in a study of posttraumatic nightmares, respondents claimed that they saw the same traumatic scenes over and over again without modification over a fifteen-year period [12, 8]. These alternating incidences of flashback memory for traumatic events and forgetfulness or repression of traumatic events tend to cause confusion and dissociation in individuals.

AMNESIA AND TRAUMA

Trauma can affect a wide range of memory functions. The memory loss could be in form of traumatic amnesia, global memory impairment, dissociative disorders, and the disturbance of the sensori-motor organization of traumatic memories [8]. Traumatic amnesia is characterized by dramatic expression of PTSD, loss of or absence of recollections for traumatic experiences [13, 8]. Amnesia is usually for some or all aspects of the traumatic event. Amnesia is common among combat soldiers, and victims of natural disasters, accidents, kidnapping, torture, murder, physical abuse, sexual abuse, childhood sexual abuse [14]. The disorder is also common among people who witness murder or suicide of a family member or among murderers and serial killers [8]. Amnesia for these traumatic events may last for hours, weeks or years [8]. However, African soldiers who served in World War 1 and World War II might have witnessed or participated in military assault but could not have received western forms of counselling due to language and literacy barriers.

There could be a global memory impairment involving autobiographical memory gaps and continued reliance on dissociation in order to cope with traumatic stress. Consequently, that could make it difficult for the individual to reconstruct a precise account of their past or their current reality [8]. Dissociation refers to the compartmentalization of the elements of the experiences that are not integrated into a unitary whole but are stored in memory as isolated fragments

consisting of sensory perceptions or affective states [8]. This peritraumatic dissociation could be regarded as a significant predictor for the ultimate development of PTSD. As people are being traumatized, there could be a narrowing of consciousness but individuals may remain focused on the central perceptual details that are necessary for survival [8]. This centrality on adaptive living skills could make it appear as if the individual is functionally normal in society.

The diminished consciousness may degenerate into amnesia for parts of the event or for the entire experience. The individual may be left in a state of "speechless terror" in which they lack words to describe what has happened [8]. They may not be able to articulate feeling or explain why they are behaving in a particular way. This could be referred to as retrograde amnesia, the inability to recall events before the traumatic episode, the prevention of integration or synthesis of traumatic events or the splitting off of traumatic memories from ordinary consciousness [8]. These dissociative experiences are positively correlated with long-term psychopathology [15]. The dissociation tends to protect the individual from the intrusive memories of the traumatic event [15]. The sensori-motor organization of the traumatic experience could be in form of visual images, olfactory, auditory or kinesthetic sensations or an intense wave of feelings [8]. Traumatic events could cause flashback memories that may cause hyperarousal. These flashbacks or flushbulb memories may cause the individual to act out the original trauma in a dissociative state [15].

After the return to the pre-fugue state, the following behaviors may be observable; amnesia for traumatic events, depression, dysphoria, anxiety, grief, shame, guilt, psychological stress, conflict, suicidal and aggressive impulses [1]. The individual may lose employment or there might be a severe disruption of personal or family relationships. The individual with dissociative fugue may have mood disorders, posttraumatic stress disorder or substance-related disorders [1].

DIAGNOSIS OF DISSOCIATIVE FUGUE

The Western methods of diagnosing dissociative fugue involve the use of DSM-IV diagnostic criteria A, B, C and D. The Dissociative Experience Scale is used to assess for dissociative experiences [16]. The Structured Clinical Interview for Dissociative Disorders questionnaire is strongly recommended for assessing dissociative fugue [2]. Some researchers would prefer to use baseline laboratory examination to complement the neuropsychological tests. These could be the electrocardiogram, blood screening tests such as complete blood count, electrolytes, glucose, heavy metal screen, kidney, and liver. Other laboratory tests are the thyroid-function tests, drug screening, and blood-alcohol level tests [2]. There could be further tests such as the use of the electroencephalogram (EEG) to rule out epilepsy or computed tomography scan to detect brain masses [17]. Dissociative fugue may not be diagnosed if the fugue-like state or "black-out" occurs as a result of drug or alcohol intoxication [1].

Dissociative fugue may be associated with a number of comorbid diagnoses including bipolar disorder, major depression, and schizophrenia [2]. Other methods of assessing dissociative fugue could be the evaluation of family history,

social history, mental status and neurological functioning. Personality tests such as the MMPI, TAT, and Roscharch could be employed to diagnose personality disorder [2]. The collateral interview with a family member could complement diagnostic procedures by supplying information on the daily functioning skills of the individual [2]. In contrast to the western individualistic perspective on personality disorder, the Shona people would attribute behavioural pathology and personality disorder to a dysfunctional kinship system that starts at the family level up to the ancestral or spiritual levels of the clan [3, 4].

SPECIFIC CULTURAL FEATURES RELEVANT TO THE DIAGNOSIS OF DISSOCIATIVE FUGUE ACCORDING TO THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-IV (1994)

Individuals with various culturally defined "running" syndromes, for example "pibloktoq" among natives of the Arctic, "grisi siknis" among the Miskito of Honduras and Nicaragua, "Navajo frenzy witchcraft" and some forms of "amok" in Western Pacific cultures, may have symptoms that meet diagnostic criteria for dissociative fugue [1]. These behaviours are characterized by a sudden onset of high levels of activity, a trance-like state, potential dangerous behaviors in form of running or fleeing, and ensuing exhaustion, sleep and amnesia for the episode [1].

These culture-bound syndromes involve being possessed by spirits and these communities may view all these psychological states as "illness" that require cultural remedies. Culturally relevant interpretations of these disorders could give an individual and their family an option to follow a culturally relevant procedure in treating dissociative fugue-related disorders. Even though the western approach to fugue among non-western societies is that of recognizing that such phenomena exists, the problem could lie in the recognition of the condition as medical and recognizing the cultural remedies as medically or therapeutically efficacious. Dissociative fugue could be diagnosed using western methods but there could be no effort on the part of the therapist to find culturally relevant methods of treating dissociative fugue.

TREATMENT OF DISSOCIATIVE FUGUE: THE WESTERN APPROACH

Sodium amytal is one of the types of medication that are prescribed to treat individuals with dissociative fugue [2]. Hypnosis is applied in helping individuals with dissociative fugue to come to terms with the traumatic events [2]. Hypnotherapy is used to help the individual recover from the ostensibly repressed or dissociated memories of the traumatic event [2, 18]

Some therapists, instead of using medicine, advise families to use ceremonies like the "welcome-home ceremony" as therapeutic to survivors of traumatic events [19]. The ritual is meant to confirm and reaffirm the worth of the survivor as invaluable among their people. The family and community will mobilize societal participation to reintegrate the survivor in their immediate and larger community [19]. This ceremony could reinforce the spiritual and existential support of the kinship in a culturally relevant format [19]. These interventions in form of ceremonies were found to be effective

when dealing with individuals who experienced rejection after recovering from the dissociative disorders. The victim was likely to experience disappointment and disillusionment on returning home from war if they felt that they were being rejected by their own people who were expected to be the survivor's "sanctuary" [19]. This practice was common among Mexicans, developing communities, and the low-income communities of western societies after World War 1, World War II and the Vietnam war [19]. In view of this approach to the treatment of dissociative fugue among the less privileged communities, dissociative fugue could be treated by putting in place a welcoming family sanctuary in communities to mitigate the effects of loneliness and poverty among the survivors of traumatic life events. In situations when the family sanctuary treats the victim with indifference or hostility, the trauma victim could feel isolated and alienated [19, 20]. The ceremony could be curative in that it would involve the victim, the family and community members. They would share the experiences of the survivor in a way that would make the community appreciate the situation of the survivor. The ceremony could give the survivor a social role or moral role that would educate others about the problem [19]. The issue of forgiveness by society could be addressed in those ceremonies [19]. The individual with dissociative fugue could be reunited with their families and communities. The social support and love that accompanies the home-coming ceremony could be expected to be therapeutic in the treatment of dissociative fugue [19]. Despite this initiative after the world wars, it seems as if no substantial attempt was made to revive the practice or to incorporate it in modern therapeutic remedies.

DISSOCIATIVE FUGUE-RELATED STATES AMONG THE TRADITIONAL SHONA

The behaviours that follow a traumatic event could be similar among people across the cultural, racial or regional divide. In some cultures, the behaviors are well pronounced and articulated, such that the survivor and the community would not be very much disturbed by the occurrence of such events. The Shona people are found in Zimbabwe and they constitute the majority of the people in the country. Among the traditional Shona culture, behaviours associated with wandering off aimlessly are well articulated and this calls for the participation of the entire family and the support of the immediate and wider society to treat dissociative-related behaviours.

Dissociative fugue can be described as "kutetereka nesango" in Shona. It means traveling across forests and distant places without coming back [21]. The family members and the village members may not know of the whereabouts of the individual. The individual with dissociative fugue would not tell anyone about the immediate and unexpected travel away from home. It is the duty of the community that receives the survivor to protect and help the individual recover from the fugue. The individual would not be violent and normally would not commit crimes. Perhaps, the non-violent nature of the behaviours could be related to the community support that the affected individuals receive. The stories about fugue states are covered abundantly in Shona fairy tales [3, 22]. The stories illustrate the manner in which the Shona people are socialized and educated to protect strangers, nature, customs, the sick and the poor.

CAUSES OF FUGUE-RELATED BEHAVIOURS AMONG THE TRADITIONAL SHONA PEOPLE

The traditional Shona people regard aimless travel and dissociative behaviours as emanating from the individual being involved in a traumatic event. Traumatic events associated with wandering off behaviours are, killing an innocent person, (**ngozi**) witnessing a relative commit murder and then keep quiet about it, beating up or harassing one's mother or committing any other horrendous crime against humanity [21]. The traditional Shona people would recognize and sanction killing that is related to war situations but would condemn murder. In that case, the soldiers were expected to fight according to the rules of combat and when they left the army society was expected to make traditional ceremonies for the returning soldiers [23].

PRESENTATION OF DISSOCIATIVE FUGUE AMONG THE TRADITIONAL SHONA PEOPLE

The person who commits a heinous crime would be possessed by the spirit of the victim such that the spirit of the victim would take the individual out of his community. The affected individual would wander off without knowing where they would be going. The avenging spirit is known as **ngozi** among the traditional Shona people [21]. The individual would not be aware of most of their behaviours (**kuzungaira**). This isolation and removal from the rest of the community would send signals to relatives that something was wrong. According to the traditional Shona people, it would then be easy to identify murder suspects because they would present with mental disorders. When mental disorders occur, the community would like to seek more information from the suspect and their relatives as responsibility for crime is communally shared among the traditional Shona people.

Another phenomenon which resembles wandering off behaviours is **kutanda botso**. An individual who beats up their mother was expected to develop mental disorders. The presentation of mental disorders associated with abusing and beating up of one's mother were that the individual would be seen wandering from village to village aimlessly. The affected individual would be dirty, thirsty and hungry. The individual may have no place of fixed abode according to the Shona oral tradition and folklores [22].

THE TREATMENT OF DISSOCIATIVE FUGUE-RELATED BEHAVIOURS ACCORDING TO THE TRADITIONAL SHONA CUSTOMS

The prescribed treatment for individuals with wandering off disorders that were associated with murder "**ngozi**" involved communal payment to the offended family. The payment was in form of cattle and if the murdered victim was a woman, a girl child would be required to marry a member of the offended party. The traditional Shona people have stopped marrying girls to appease the spirits due to modernization and that the law now regards the forced marriage of minors as statutory rape. A traditional healer would assist the two families reach an agreement. It is the traditional Shona people's belief that the spirit of the murdered victim would harass the perpetrator's family in revenge until compensation was made [21]. The perpetrator could be seen and heard talking to themselves alone and may show a number of dissociative disorders that could resemble schizophrenia. The disso-

ciative fugue-related behaviours may be observable in the murderer or a close relative. According to the traditional Shona, if a family member commits murder, the avenging spirit of the victim would affect the perpetrator or their immediate family members and that implies that the treatment procedures would have to involve all the blood relatives present [21]. A cleansing ceremony was held to allow the feuding families to get together and reach an agreement on the terms of the compensation.

The cleansing ceremony was deemed to leave the perpetrator, the affected individual and the entire family cleansed of any mental disorders if the ceremony was carried out according to the traditional requirements of the offended family. In case of soldiers, or freedom fighters involved in a war, the same ceremony would be held to welcome the soldiers home. The traditional healer would direct the appeasement prayers to all the offended spirits in the forest. The healer would ask the spirits to forgive the victim as they would be seen as having served national and ancestral interests to protect the land or country [21]. The individual returning from war would be seated in the middle of the hut among elders with no shoes. The traditional healer would act as the medium between the client and the spirits [24, 25]. Tobacco is usually recommended and given to the returning soldier as a gesture of recognition and acceptance by the ancestral spirits that their "child" is back home. Some of the traditional beer is poured to the ground for the ancestors to partake of the ceremony according to traditional beliefs of the Shona people.

The treatment procedure for **kutanda botso** (appeasing the spirit of a wronged deceased mother) involved a traditional healer, elders, beer brewing and community participation. If a son grossly offended his mother without asking for forgiveness, the mother's family spirit would cause dissociative fugue-related behaviors to the maladaptive son [21]. Sometime after the mother's death, misfortune could strike the son. His children may fall ill, or die, his cattle may die or some other disaster would befall him [21]. The individual could wander off away from home in confusion and he would not expect to receive community support until he made reconciliation with his mother's relatives. A traditional healer would recognize this behaviour as the wrath of the maternal spirit that would be imposing punishment. Beating up one's mother is considered as a grave sin according to the traditional Shona [21].

The treatment procedure required the son to dress in old and ragged clothes and to walk from house to house, village to village and everywhere cursing himself "I beat my mother, I regret it, I beat my mother, I regret it" [21]. Children would be expected to attack him by throwing mud and stones and beating him. He was not allowed to defend himself. No friendly household would give him shelter for the night, he must sleep rough [21]. The practice of beating up the individual carrying out the wandering off ritual **kutanda botso** is outlawed today as the law views it as an infringement of an individual's human rights when society exposes an individual with dissociative fugue-related disorders to humiliation and physical abuse. Anyone pitying the individual would assist them by giving a handful of millet or maize that would be used in making beer and food for the ceremony. The practice was meant to be a fund-raising campaign as well as a self-parade to self-humiliation and self-reproach.

After enduring the humiliation and collecting grain, the individual undergoing treatment according to the traditional Shona customs would return home, brew beer and present an animal for sacrifice at a ceremony. The relatives of his late mother would be invited; the individual would confess his misdeed to them and would ask for their forgiveness [21]. The beer and animal of sacrifice offered to the offended spirit were seen as a sign of reconciliation. Neither the son nor his blood relatives would eat of the meat but only non-blood relatives [21]. The elders would address the angry spirit and say that the son was sorry and that he was asking for forgiveness [21]. The son's head would be shaved, washed and rubbed with oil. The individual with dissociative fugue-related disorders would say "I have held the chicken for you – **ndabata huku**" meaning I have apologized or repented by offering the sacrifice. A gift is paid, for example, a chicken, a bull or a cow for a female spirit [21].

The traditional Shona regarded beating up of one's parents as one of those social crimes that society would not forgive. This called for a harsh and humiliating compensation. The symbolic meaning of the ceremony was that the begging symbolized an orphan's life, the ashes symbolized dirt and neglect that an orphan suffers alone without parents [21]. The beer called **donhodzo** implied cooling off the anger of the deceased's spirit, and the sacrifice of an animal and the three pieces of meat cut off, symbolized the wiping out of the anger of the spirit [21]. The exclusion of the perpetrator and his blood relatives from the meal meant contrition; one may not enjoy oneself when one should be repenting [21]. The animal which the son gave to his mother's relatives was a living symbol of his own sorrow and sincere remorse [21].

AIM OF THE STUDY

The study sought to answer the following questions:

1. What are the indicators of dissociative fugue among the traditional Shona people?
2. How do the traditional Shona people treat dissociative fugue?

METHOD

Research Design: Case study

The study assessed two individuals who were presenting with dissociative fugue-related behaviours. The participants were observed over a period exceeding one year. The researcher worked with the participants, their relatives and their immediate communities. A participative approach was preferred in this study as it enabled the researcher to view the problem from an ethnopsychological perspective. The researcher followed the treatment procedures as they occurred between the client and the traditional therapist and tried to relate the methods of treatment to modern methods of psychotherapy.

PARTICIPANTS

Participants were two men who were presenting with dissociative fugue-related disorders. They gave their consent to participate in the study and relatives provided collateral consent for their relative to participate in the study. The first participant was assessed when people in his community

asked the researcher to talk to the man. The second participant's relatives approached the researcher for psychological assessment and counselling. The participants were presenting with dissociative fugue-related behaviours that were interpreted in a traditional Shona cultural context. The people who acted as informants and the relatives of the participants described the participants as people with identity disorders, dissociative disorders and that they had no place of fixed abode or origin. Some informants regarded the participants as people who needed to be treated according to the traditional Shona customs.

MEASURING INSTRUMENTS

The Dissociative Experiences Scale

The Dissociative Experiences Scale measures dissociative experiences in clinical populations [26]. The instrument was translated from English to Shona and back from Shona to English by a panel of translators. The reliability of the instrument for this study was .90 (Cronbach alpha). The instrument was used as a screening device for identifying dissociative fugue-related disorders in the two participants. The instrument is, arguably, not a definitive measure for diagnosing dissociative fugue. It assesses general dissociative experiences and this could include dissociative amnesia, depersonalization disorder, dissociative identity disorder, and other dissociative states not specified [1]. The measure is usually used together with other diagnostic devices to determine the diagnosis of dissociative fugue [2]. However, in this study, the instrument was found to be useful as a general screening device for dissociative fugue-related disorders in the two participants.

Procedure

The participants were seen over a number of sessions in which the researcher acted as a participant. The first step that the researcher took was to build a trusting relationship with the participants and to get their informed consent and the consent of their relatives. The interviewer asked the questions in Shona out of office in the participants' places of residence. The research procedures tried to establish a relationship in which the participants would regard the process as voluntary and familiar. The participants were made to take the role of a story-teller and they felt excited about narrating their personal experiences of living a solitary life away from home and relatives. At first the stories were disjointed and incoherent but improved with time. When there was need to ask them questions from the Dissociative Experiences Scale to assess for the presence of dissociative fugue, the participants were not asked all the questions at once. The staggering of questions was meant to ease the tension that could be associated with interviews; the participants were expected to respond when they were in a relaxed mood and willing to talk without interruption.

CASE PRESENTATION

Case Example 1

A stranger in a village was reported to be behaving in a manner that was not socially approved as normal. He was referred to the village head (**sabhuku**) according to the traditional Shona customs for receiving strangers. The matter was

communicated to the Psychological Service Department by a member of the village who wanted to know how this man could be assisted. The researcher got interested in the story and went to the village to make a preliminary psychological assessment of the man.

The man had a long beard and long hair that was not attended to. He wore a cap that almost covered his eyes most of the time. People of his age, except the youth, were not expected to wear caps according to the traditional Shona culture. There was no attempt to make himself clean and children were, at first, afraid of him. The strangest thing was that the man would rather use signs than talk. At first the villagers thought he had no voice or could not talk. He showed confusion about his identity or origin and the villagers said he had no name. When asked about his real name, he tended to be confused about it but was clear that he was of the zebra totem (**mbizi**). He could not say the purpose of his visit. The community insisted that he be put under the care of the village head as the traditional Shona customs require strangers to be protected by the village head or chief. When the villagers could not get the name of this man, they simply referred to him as the “non-talking man” (**Va Chimwimwi** – Mr. Not-talking). It was reported by the villagers that the man was not interested in forming relationships with women nor was he interested in any relationships with men. He did not make friends instead he would go to the village head when he needed tools or when he fell sick. He did not drink alcoholic beverages, take drugs or smoke. At first, each time the researcher wanted to talk to him, he could hardly remember previous events. His main means of livelihood was fishing and catching birds and small animals. As for grain or mealie-meal, he would go to the village-head to get his supplies. He did not like monetary transactions with the villagers. If the villagers wanted fish from him, they would give him food in exchange for the fish. If he needed vegetables he would go into anyone’s field and get what he needed without asking for it. The community said that the ancestral spirits guided him on which fields he went to and he was known to take the minimum he needed for survival and would not take more than what he needed.

The researcher made several visits to the village in order to establish a working relationship with the community so that they would volunteer more information on the participant. The researcher befriended the participant and the village-head before the interviews with the man. The researcher tried to work with the participant by assisting him in small tasks such as thatching the participant’s hut and asking the participant what he needed done in their next meeting. The man lived in a small hut with a fire-place and a storage rack for herbs. His memory of events seemed to improve as he interacted more with the researcher and the villagers.

After seeing the participant on separate occasions for more than a year, the participant said he could not remember his first name because he left his rural home when he was a teenager. He was conscripted into the army and was given a foreign name and a number for identification in the army. He had not attended school before and was not literate. It seemed as if the war he was referring to was World War II because he referred to Hitler as the enemy. He could still remember the name of his gun and roughly his military name. He said that black and white soldiers would be painted

with the same paint that acted as camouflage before the battle. The land in which they were fighting had a lot of sand, with no trees, and there were snakes with horns. He still wondered about the continent and country in which they were fighting since they were not told about war plans by their leaders. During the battle, when they sensed that they would be defeated, the soldiers would paint themselves with the blood of their dead counterparts or wounded soldiers to give the enemy the impression that there were no survivors or to avoid being targeted. When Hitler’s men were gone, they were sometimes forced to kill their own men who were seriously injured or those that were judged as having no hope of recovery due to transport problems. In situations where the soldiers were in isolated places without a road network, they would pour petrol on the corpses and burn the bodies to ashes. He said there were no proper graves for the dead on the battle-field and there were hardly any hospitals for the injured. The army vehicles were very few and could hardly cope with the huge numbers of injured or dead soldiers. He said that they were instructed to collect guns, shoes, clothes and ammunition from their dead colleagues before retreating to a safer zone.

He reported that when the war was over he worked briefly in the army before he was demobilized. He could not remember his real place of origin as his people were relocated during the Land Tenure Act of the 1940s in which government moved people from scattered rural homesteads into larger villages [27]. His parents were deceased and some of his younger brothers could hardly remember him while some feared he could claim title to the land allocated to them under the new law. The traditional Shona customs gave elder sons priority over land and inheritance from parents [27]. He complained of family hostility and resentment. Since he could not read or write, he said he never received communication from the army or friends in the army or saw or heard of his other village soldiers who were called up to join the army with him.

When they reached the main camp, the village recruits were sent to different camps in different parts of the country in which they could not communicate. He wished he could meet with his village boys after the war so that they could have the chance to reconstruct their lives together. He said he could not remember the circumstances that forced him to leave the village that he now had a haze idea about. From the narratives, it appeared as if no formal counselling was offered to the demobilized African soldiers after the war.

The researcher made an appointment with the participant to get information on his origins. The village-head had sent the researcher the message that the participant needed to be taken to his place of origin. The village-head said he felt the old man needed to be united with his people after the long period of separation. It was also according to the traditional Shona customs that a visitor should not be neglected when ill and that should they die among people who were not related to them their spirit would torment the villagers in one way or another. The researcher discussed the treatment procedures with the village-head and a traditional healer who was regarded as an expert in treating dissociative fugue-related behaviours. Reuniting the individual with his people was one of the therapeutic methods that the traditional Shona people used to treat dissociative fugue-related disorders. The re-

researcher's notes and the information gathered by the village-head from the participant were used to reconstruct the participant's place of origin. A traditional healer, village elders and the village-head went to the places mentioned by the participant. The problem that made the search difficult was that the participant had no identity documents. The team finally located the chief and the village-head of the area that the man had come from. The place was about three hundred kilometres away from the village.

The researcher collected information on how the traditional treatment was conducted from the traditional healer and the villagers. A welcome-home ceremony was held and the man was finally placed among his people. The welcome-home ceremony involved beer, and feasting. The treatment took place in the evenings. The village-heads, village elders and relatives of the participant would sit on a mat without shoes. The traditional healer led the therapeutic proceedings and was directive in approach. The traditional healer would talk to the participant with dissociative fugue-related disorders and then communicate the responses to the ancestors. Sometimes the traditional healer would use drummers to provide music needed in the therapy. The client, relatives and other participants were supposed to indicate their agreement with the traditional healer in a chorus that was sung in unison about the man's mental health. The traditional healer would narrate the life of the client during the dissociative fugue state and how his ancestors managed to call him back to be united with his people. The traditional healer would prescribe what the relatives would be required to do to appease the ancestors in welcoming their lost son from the forest or foreign land. The supervision of progress of the recovery process was done by the traditional healer and relatives were expected to comply with the traditional healer's recommendations.

The treatment of dissociative fugue-related disorders like **kutetereka nesango** could take a less elaborate form due to the influence of modernization. The treatment sessions could involve fewer people but the intensity of the treatment could rigidly adhere to the methods of treatment that were handed down from one generation to another. In fact, some traditional Shona clients could prefer more comprehensive approaches as that could be considered as more effective than the brief therapies.

The researcher's last assessment of the participant after the ceremony did not find the presence of clinical features of dissociative fugue on the Dissociative Experiences Scale as was the case in the initial interviews. The participant seemed to have greatly recovered from the dissociative experiences or episodes of amnesia. He could follow events and the participant seemed to be integrating smoothly among his people. He was now living with his people in a community and his relatives were expecting him to get married as the traditional Shona customs expected him to have a family despite that he was now an old man.

Case Example 2

A man called Choto (not his real name) often quarreled with his mother about paternity. There was a family dispute, but Choto's sisters were not interested in the matter. Choto started to be violent as he wanted the mother to disclose his father's name. He burnt down his mother's hut and ordered

her to leave the family home. He would beat her or abuse her emotionally. His mother's relatives complained about it to the family elders and the villagers branded Choto as a social misfit because the traditional Shona customs do not allow children to abuse their parents. Choto later left home to look for work. Despite the relocation of Choto to town, each time he returned home he would quarrel with his mother. He also started accusing her of bewitching him at work since he could not keep jobs [21]. There was tension between him and his mother's relatives such that Choto was not allowed to come home again. His mother eventually died and the misunderstanding between her and Choto was not resolved.

Choto lost his job but instead of going home, he was reported to be sleeping in open places in a different town away from the town he used to work. He had wandered from place to place and could not remember details of his identity or home. His sisters got to know about their brother's situation a year after he left work. When his relatives contacted the researcher for the rehabilitation of their brother, a visit was made to Choto's new residential place. The researcher and Choto's sisters found him living in a dirty place in a disused building. The participant could hardly recognize his sisters. When the sisters called him by name he responded without enthusiasm and it appeared as if he had not recognized them. The people in that area regarded him as a destitute and he received food rations from social welfare and non-governmental organisations. He was known by nickname but Choto could hardly remember his real name.

The initial assessment results using the Dissociative Experiences Scale showed that Choto's mental health met the diagnostic criteria of dissociative fugue. The participant was observed over a period exceeding twelve months. The researcher explained the assessment results and asked the family members what they thought would be the best remedy for their brother. The family members suggested that they conduct a traditional remedy first before asking their brother to go for rehabilitation in modern facilities. The family members insisted that the cause of the dissociative fugue was the family conflict. The spirit of their deceased mother was viewed to be behind the dissociative fugue disorders. They suggested **kutanda botso** ceremony as a cultural remedy for the treatment of dissociative fugue.

The family carried out the ceremony to appease the spirit of their deceased mother. Choto was assisted by his family to complete the ceremony. They engaged a traditional healer and the mother's relatives in the ritual. The **kutanda botso** ritual among the traditional Shona people may not be as elaborate as it used to be in the past due to modernization.

The researcher visited the village after the traditional ceremony. Choto was now functioning almost like any other villager in his community. He had mended relations with his mother's relatives and was now more interested in community work than employment in urban areas. The second assessment of Choto using the the Dissociative Experiences Scale did not show clinical features that indicated the presence of dissociative fugue.

DISCUSSION

The existence of dissociative fugue among the traditional Shona people could be likened to the description of cultur-

ally relevant behaviours that are described in DSM-IV [1]. The indicators of dissociative fugue-related disorders among the traditional Shona culture are characterized by dissociative experiences, moving away from one's family, relatives and the immediate community. The Shona people have names that they give to such disorders and they tend to attribute it to the retributive powers of ancestral spirits.

The cause of dissociative fugue-related behaviours among the traditional Shona people could be related to traumatic life events as is described in DSM-IV [1]. In this study, **kutetereka nesango** was related to traumatic events that are associated with military combat while **kutanda botso** was associated with family violence. The participant who was presented as Case Example 1 had been involved in military combat when he was a teenager and this could have contributed to the development of dissociative fugue [2, 19, 8,]. The family violence in which the participant who was presented as Case Example 2 was involved in could have led to the later development of sanctuary trauma [19]. He could not possibly come home to face sanctuary hostility as he reported that his mother and her relatives did not want to see him. When the family which could be regarded as the place of safety, support and protection turns out to be hostile and the home becomes the centre of conflict, affected individuals tend to face social isolation or alienation and this could lead to the later development of dissociative fugue-related disorders [19]. Furthermore, perpetrators of violence could develop dissociative disorders such as posttraumatic stress disorder and dissociative fugue [28, 29]. The participant who was presented as Case Example 2 could have developed dissociative fugue-related disorders or generalized dissociative experiences that are associated with the perpetration of violence [29].

Dissociative fugue was diagnosed and treated among the traditional Shona in a way that did not use traditional medicine in this study. The healers did not give traditional medicine to their clients instead they provided therapeutic ceremonies that were deemed to treat dissociative fugue-related disorders. It could also be noted that modern methods of psychotherapy do not use medicine to treat dissociative fugue. It could be said that there tends to be some similarity between traditional Shona methods of treating dissociative fugue and modern psychotherapy in that both approaches do not use organic medicine to treat dissociative fugue.

Psychotherapeutic methods in which participants engage in psycho-drama could play a curative role in the treatment of dissociative fugue in modern interventions. The home-coming ceremonies that were used to treat dissociative fugue-related disorders in western societies after the two world wars could resemble **kutetereka nesango** and **kutanda botso** ceremonies of the traditional Shona culture [20, 19, 21]. In the USA home-coming ceremonies were used to welcome war veterans of the Vietnam [19, 20]. The ceremonies drew upon the cultural experiences learnt from American native rituals of welcoming war veterans. The ceremonies emphasized the affirmation of the worth of the worrier, societal participation, reintegration of the war veteran in society, spiritual and existential support [19]. In this study, the two case examples used traditional ceremonies that could have played a curative role in the treatment of dissociative fugue-related disorders like **kutetereka nesango** and **ku-**

tanda botso. The rituals did not involve the use of medicine and the treatment methods recognized that the dissociative disorders were not caused by alcohol or drugs and that is the same approach that is used in the diagnosis and treatment of dissociative fugue according to DSM-IV [1].

The other important similarity between the Shona traditional method of treating dissociative fugue-related behaviours and modern methods of psychotherapy is that the two approaches would need social support for the therapy to be affective. Family support played an important role in facilitating recovery in the two case examples. The efficacy of a traditional treatment procedure was agreed to by three parties; the traditional healer who was the therapist, the family and the client. The therapist's role in modern psychotherapy and the traditional healer's role among the traditional Shona people could be viewed as that of facilitating the healing and integration processes between the client and their social support system. The client is helped to reintegrate in the family sanctuary [19].

The traditional ceremonies and modern methods of therapy could be said to be efficacious when the patient or client recovers from the dissociative disorders. The two clients who underwent the traditional therapeutic process showed no symptoms of dissociative fugue-related disorders after the treatment. However, no attempt was made to send the participants for further review using laboratory neurological assessments. It could be argued that if the absence of clinical symptoms of dissociative fugue-related behaviours is indicative of cure or therapy then it could be said that the traditional Shona ceremonies could be an alternative intervention in the treatment of dissociative fugue.

A noticeable difference between modern therapy and the traditional Shona therapy in the treatment of dissociative fugue-related disorders could be that modern therapy tends to be more preoccupied with the attainment of measurable therapeutic outcomes sometimes within the shortest possible time. The length of the therapy sessions could be determined by the ability of the client to meet the cost of the therapy. On the contrary, the Shona traditional therapeutic methods in this study were slow, elaborate and community-involving. The treatment sessions could take the whole night and end at dawn. The traditional approach was not concerned about the duration of the therapy, rather, emphasis was on following the traditional therapeutic procedures as suggested by oral tradition, the traditional healer and the elders. The healer and the participant were not interested in attaining positive results in the shortest possible time. The healer, client and relatives in this study were positive and had the belief that recovery would be spontaneously gained after the ceremony. If the treatment methods failed to attain full remission, it could then mean that the ancestors had not accepted the client's request [27].

Hypnosis is widely used to treat dissociative fugue in modern methods of psychotherapy [2]. The Shona traditional therapeutic approach could, to some extent, be hypnotic in approach. The drum therapy that is usually used by traditional healers in the treatment sessions involves intense rhythmic musical sounds that could be accompanied by the healers' incantation. The sessions could be long and hypnotic to the client. The traditional healer could become mys-

tical, transcendental, authoritative and directive such that the client could be left confused or hypnotized. The sessions could be hypnotic in that the healer could ask their client a series of repeated questions, rhetoric questions and some of the questions are directed to the client's ancestral spirits. The healer could give answers and suggestions that a client has to comply with throughout the therapeutic sessions. Sometimes the client has to answer a series of "yes" or "no" questions quickly as directed by the traditional healer and the healer could challenge the client to tell the healer if the healer was lying [24, 25]. The spiritual possession of the healer, their bodily movements, rapid eye movement and staring, arousal and agitation, voice undulation, voice change due to the gender of the spirit, use of gestures, and the use of strange tools of his/her trade could be hypnotic to the patient. This hypnotic approach could be comparable to Western hypnotherapy in the treatment of dissociative fugue [2]. Hypnotherapy involves long sessions in western societies and directive behaviour of the hypnotherapist who might lead the patient into a mental state of confusion. The difference could be that in the western approach, the hypnotherapist could be directive and manipulative in a dual relationship between the patient and the therapist whereas in an African approach the healer would be directive and manipulative to a group of clients, that is, the patient and the accompanying relatives. The client would normally bring their relatives to the treatment room. The traditional healer would adopt a community-based therapeutic approach as the health of an individual is considered to be a communal concern among the traditional Shona people.

LIMITATIONS OF THE STUDY

The limitations of this study could be that there were no neurological investigations to further corroborate evidence that the two cases were correctly diagnosed as dissociative fugue. Some researchers could prefer a molecular or neurological assessment of individual functions of the brain to determine the presence of dissociative fugue in participants [30]. However, the focus of this study was to screen for dissociative fugue-related disorders that were observable and recognizable in the traditional Shona culture and how the traditional Shona people would treat such conditions in a non-western manner [6, 31].

CONCLUSION

Although there were more similarities than differences in the identification of dissociative fugue between western and the traditional Shona methods of diagnosing and treating dissociative fugue-related disorders, there is still paucity in research that attempts to assess the efficacy of African rituals and ceremonies that are used to treat dissociative disorders. An ethnopsychological perspective was adopted in this study to prompt researchers to have a deeper understanding of the African concept of illness and what cure, therapy or treatment could mean in a traditional Shona cultural context. An African perspective of dissociative fugue could be utilized by mental healthcare practitioners working among the Shona traditional communities in the diagnosis and treatment of dissociative fugue by recognizing it as an alternative cultural remedy for treating dissociative fugue.

REFERENCES

- [1] American Psychiatric Association (1994). Diagnostic and statistical manual for mental disorders (Fourth Edition), Washington, DC: Author.
- [2] Coons PM. Psychogenic or dissociative fugue: A clinical intervention of five cases. *Psychol reports* 1999; 84: 881 - 886.
- [3] Aschwanden H. Symbols of life: An analysis of the consciousness of the Karanga. Gweru: Mambo Press 1982.
- [4] Levi-Strauss C. Structural Anthropology. London: Allen Lane 1978.
- [5] Jasper FJ. Working with dissociative fugue in a general psychotherapy practice: A cautionary tale. *Am J Clin hyp* 2003; 45: 311 - 322.
- [6] Akhtar S, Bremner, I. Differential diagnosis of fugue-like states. *J Clin Psychiat* 1979; 40: 381-385.
- [7] Kapur N. Amnesia in relation to fugue states - distinguishing a neurological from a psychogenic basis. *Br J Psychiat* 1991; 159: 872 - 877.
- [8] van der Kolk BA, Fislser R. Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *J Traum Str* 1992; 8: 505 - 526.
- [9] Brewin CR, Andrew B, Rose S. Fear, helplessness, and horror in posttraumatic stress disorder: Investigating DSM-IV Criterion A2 in victims of violent crime. *Journal of Traumatic Stress* 2000; 13: 499-509.
- [10] Herman JL. The mental health of crime victims: Impact of Legal Intervention. *Journal of Traumatic Stress* 2003; 16: 159-166.
- [11] Maercker A, Herrie, J. Longterm effects of the Dresden Bombing: Relationships to control beliefs, religious belief and personal growth. *J Traum Str* 2003; 16: 579-587.
- [12] Kilpatrick DG, Ruggiero KJ, Acierno R, Saunders BE, Resnick HS, Best CL. Violence and risk of PTSD, major depression, substance abuse/dependency and co morbidity: Results from the national survey of adolescents. *J Con Clin Psychol* 2003; 71: 692-700.
- [13] Ai AL, Peterson C, Ubelhor D. War-related trauma and symptoms of posttraumatic stress disorder among adult Kosovar refugees. *J Traum Str* 2002; 15: 157 -160.
- [14] Najarian LM, Goenjian AK, Pelcovitz D, Mandel F, Najarian B. The effect of relocation after a natural disaster. *J Traum Str* 2001; 14: 511- 526.
- [15] Bremner JD, Brett E. Trauma-related dissociative states and long-term psychopathology in posttraumatic stress disorder. *J Traum Str* 1997; 10: 37 -54.
- [16] Putman FW, Carlson E, Ross CA, Anderson GRPN, Clark PRN, Torem M, Bowman ES, Coons PM, Chu JA, Dill DL, Loewenstein RJ, Braun BG. Patterns of dissociation in clinical and non clinical samples. *J Nerv Men dis* 1996; 184: 673 - 679.
- [17] Kopelman MD, Panayiotopoulos CP, Lewis P. Transient epileptic amnesia differentiated from psychogenic "fugue": Neurological, EEG, and PET findings. *J Neurol Neurosurg Psychiat* 1994; 57: 1002 - 1004.
- [18] Kilstrom JF. Dissociative disorder. *Ann Rev clini Psychol* 2005; 1: 227 -253.
- [19] Obenchain JV, Silver SM. Symbolic recognition: Ceremony in a treatment of posttraumatic stress disorder. *J Traum Str* 1992; 5: 37 - 44.
- [20] Johnson DR, Lubin H, Rosenheck R, Fontana A, Southwick S, Charney, D. The impact of the homecoming reception on the development of posttraumatic stress disorder: The West Haven homecoming Stress Scale (WHHSS). *J Traum Str* 1997; 10: 259 - 277.
- [21] Aschwanden H. Symbols of death: An analysis of the consciousness of the Karanga. Gweru: Mambo Press 1987.
- [22] Gelfand M. Growing up in Shona society: From birth to marriage. Gweru: Mambo Press 1979.
- [23] Aschwanden H. Karanga mythology: An analysis of the consciousness of the Karanga. Gweru: Mambo Press 1989.
- [24] Peltzer K. Traditional healing and psychosocial healthcare in Malawi. Heidelberg: Asanger 1987.
- [25] Peltzer K. Psychology and health in African cultures: Examples of ethnopsychotherapeutic practice. Frankfurt: Iko Verlag 1995.
- [26] Bernstein EM, Putnam FW. Development, reliability, and validity of a dissociation scale. *J Nerv Men Dis* 1986; 174: 727-735.

- [27] Bourdillon MFC. The Shona peoples: An ethnography of the contemporary Shona, with special reference to their religion. Gweru: Mambo Press 1982.
- [28] Kopel H, Friedman M. Posttraumatic symptoms in South African police exposed to violence. *J Traum Str* 1997; 10: 307-317.
- [29] Rogers P, Gray NS, Williams T, Kitchiner N. Behavioural treatment of PTSD in a perpetrator of manslaughter: A single case study. *J Traum Str* 2000; 13: 511-519.
- [30] Phaterpekar H. Amnesia in fugue states- neurological or psychogenic basis. *Br J Psychiat* 1992; 161: 133 – 133.
- [31] Salama AA. Psychotherapy in non-Western cultures. *Br J Psychiat* 1992; 161: 127 – 128.

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