‘Some words just come out of my mouth’

An exploration into the construction of explanatory models among psychiatric patients in Tanzania

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Abstract

Explanatory models of illness (EM) refer to causal attributions of illness and healing that are employed by patients, their families, and practitioners. Despite the growing emphasis on EMs of patients in clinical research and practice, little is known about the way these beliefs are produced, represented, and transformed in the social context of treatment, and the extent to which they may affect treatment satisfaction. In an attempt to explore these issues, in-depth interviews were repeatedly conducted with patients and their therapist in a psychiatric ward in Tanzania. Furthermore, therapy sessions were observed to explore diverse aspects of the treatments and therapist-patient relationship. Patients appeared to hold multiple EMs, consisting of superficial, uncertain, and at times inconsistent ideas, which they alternately presented as most valid during the interviews. While EMs transformed substantially over time, changes did not occur in a specific direction. Although patients were reportedly satisfied with the treatment in general terms, the lack of a clear understanding their diagnoses appeared to be a major concern. Remarkably, several instances of secrecy and deception were detected in the clinical and interview encounters, which had particularly to do with supernatural beliefs. Results point to the ambiguous and fluid nature of EMs that tend to shift in accordance with varying contexts, in which they are produced. Secrecy and deception are discussed in the hierarchical treatment setting of the hospital.

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Introduction

Interviewer: Your doctor says that your pains are psychological. Sometimes, people have physical problems that cause them pain. Other times, there is no physical problem, but people still have pain. In these cases, the doctors say that the pain does not have a physical cause, but a psychological one. So there is nothing wrong with the body, but the mind creates the pain that you feel in your body. What do you think of that explanation?

Patient: So it's the mind…. It's not true, because I don't direct my mind to hurt my eyes. I don't intend to hurt my eyes…."

Patient's father: It's not consciously done. The working of the mind is not clear to us. You won't consciously be injuring your eyes, but subconsciously….

Interviewer: What do you think of that?

Patient: As I said, it could be allergy…. I think my problems are caused by allergy and unemployment. Now, I'm struggling to find a job. So it is the [unemployment] that is disturbing me, nothing else… no, it's not psychological.

Interviewer: Can I ask how come you think it's not psychological?

Patient: Because, ... my problem is finding a job. I don't know... can it disturb eyes [laughter]? That's why I'm not concerned with psychology.

Explanatory models (EMs) refer to causal attributions of illness and healing that are held by patients, their family and practitioners. Predominantly culturally shaped, these models project personal and social meaning on the illness experience, and may affect the treatment choice (Kleinman, 1980).

The *EM approach* was originally introduced in clinical practice in order to draw attention to the patient's perspective of illness. It was assumed that focus on these subjective illness beliefs would facilitate communication and understanding between patients and practitioners in negotiating a specific problem definition (clinical reality) and an appropriate therapeutic action (Kleinman, 1980). In recent years, clinical practice has increasingly strived to recognize patients' EMs, as well as the processes through which they affect health behavior and outcome. However, the clinical application of the EM approach has not been materialized as intended (Kleinman & Benson, 2006). Often, patients' EMs are conceptualized as specific, technical items that can be "measured" in the same way as "hemoglobin" or "blood pressure" (p. 1674). It is assumed that patients' EMs consist of a simple, concrete and static set of cognitions that affects coping (Dein, 2007) and treatment compliance in a mechanical way. The present study is a modest attempt to examine these premises by exploring the nature of, and changes in EMs of illness within a social and therapeutic context of a psychiatric hospital in Tanzania. Furthermore, the study aimed to gain a better understanding of the ways in which patient's EMs and the perceived rationale behind the treatment may affect treatment satisfaction.

Nature of EMs. Kleinman (1980) conceptualized EMs as multi-faceted entities, incorporating ideas regarding the origins of the symptoms, their mode of onset, and pathophysiology, as well as the course of illness, and its treatment. Kleinman argued that patients' EMs could be fragmentary, failing to include all the above-mentioned components. He suggested, further, that EMs are produced in specific contexts to interpret specific symptoms. Due to their context-dependent properties, they are often prone to change over time. Moreover, in a study among patients with depression, Williams and Healy (2001) found EMs to be uncertain and highly dynamic cognitions; on each occasion, patients seemed to hold, and to switch between multiple, contrasting beliefs without any apparent problems. Although these findings provide a more complex and thorough notion of patient's EMs, it remains unclear how these beliefs are represented, and produced, in specific clinical (doctor-patient), and ethnographic (interviewer-informant) encounters.

In the present study, I have chosen to explore patients' EMs also in relation to their treatment choice and other knowledge structures patients may present in addition to formal EMs. Kleinman (1980) considered treatment preference as a formal component of EMs. Although he recognized that EMs do not determine the eventual treatment choice automatically, he predicted a certain level of correlation between ideas on illness causation and the actual help-seeking behavior. That is to say, patients' EMs may determine the type of treatment they eventually consume, alongside other factors, such as the availability, affordability, and quality of care. Exploring EMs in relation to patients' treatment choice is likely to be productive, as it may, to some extent, clarify the practical significance of EMs. As a result, the nature of EMs may be exposed more comprehensively, not only as mere cognitions, but also as possible determinants of behaviors, choices, and strategies.

Previously, Kleinman's EM framework has been criticized for its exclusive focus on formal EMs, ignoring other important types of knowledge, which may equally affect the illness experience (Young, 1981, 1982a, 1982b). Young (1981) introduced the notions of *prototypes* and *chain complexes* in order to call attention to these processes. Prototypes can be defined as salient past episodes or events, which serve as exemplars of a particular type of illness experience. A person may use a prototype as an analogy to his current condition to better determine its meaning and consequences. Chain complexes, on the other hand, refer to a sequence of events, which has led to the current illness (Groleau, Young, & Kirmayer, 2006). In this view, both prototypes and chain complexes can influence the illness experience, similar to EMs, but they do not imply a causal link between various events (Groleau et al., 2006; Kirmayer & Young, 1998). An additional focus on chain complexes and prototypes makes it possible to investigate patients' EMs in the total context of their knowledge regarding their specific illness episode and possibly shed light on how these different knowledge structures are interrelated.

Belief change. During the past decades, a large body of anthropological literature has been dealing with changes in popular understandings of illness and healing following contact with biomedical knowledge and practices. Whereas the majority of the studies had a general, and retrospective focus (e.g., Haram, 1991; Opala & Boillot, 1996), a few incorporated a longitudinal approach, allowing direct observation of changes across time. For instance, Hunt, Jordan, and Irwin (1989) studied belief change among American diabetes patients, following consultation with medical professionals. Although patients seemed to have accepted the professional EMs of their symptoms, or had integrated them in their previously held beliefs, none had entirely dropped his/her original assessment. Similar results have been reported in studies among Swedish and Turkish-born women with medically unexplained symptoms (Bäärnhielm, 2000, 2004). Thus far, little attention has been given to changes in EMs of *mental* distress. The only study in this area found that patients' EMs of depression did not significantly change following an educational intervention (Jacob, Bhugra, & Mann, 2002). However, this study lacked sufficient analytic power to assess subtle belief changes, due to its exclusively quantitative, and reductionistic approach. In sum, a direct and thorough documentation of changes in EMs of mental illness is still lacking, especially in the context of developing countries where great discrepancies may exist between popular and professional understandings of health and illness.

EMs and treatment satisfaction. Quality is an important determinant of health demand (Sahn, Younger, & Genicot, 2003) and treatment compliance. This concept has been defined as a two-dimensional entity, referring to the availability of the structure with which care is provided (structural quality), such as the availability of appropriate equipment and pharmaceuticals, and to the process by which care is provided (process quality), such as practitioners' attitudes and curative skills. Although patient satisfaction is increasingly recognized as an important factor in developing countries, studies into the nature of the patient evaluation are rare (Gilson, Alilio, & Heggenhougen, 1994).

Earlier reports, dealing with the issues of quality and patient satisfaction in Tanzania, have predominantly focused on the availability of health services and pharmaceuticals (structural quality; e.g., Gilson et al., 1994; Sahn et al., 2003). Hence, little attention has been given to determinants of process quality. Focusing on this type of quality, satisfaction may be considered to exist when an individual's expectations, beliefs, and responses regarding the treatment match conditions of care provided (Fox & Storm 1981). Similarly, Kleinman (1980) has proposed that congruence between the patient's and practitioner's EMs of illness may generate better treatment outcome and higher satisfaction. However, this hypothesis has been only marginally tested in western countries (i.e., Callan & Littlewood 1998), and is not empirically investigated in the context of developing countries. There are rather conceivable arguments to assume that the available data may not necessarily be applicable to low and middle income countries, as structural quality standards in these settings are not entirely met, so that patients' EMs and the perceived treatment rationale may have a marginal effect on satisfaction.

The present study aimed to shed light on (1) the nature of EMs of illness among individuals seeking psychiatric treatment, (2) the way these ideas were produced, and changed within the social context of treatment, and (3) how patients' EMs and their understanding of the treatment rationale were related to therapy satisfaction.

Method

Setting

The study was conducted during a five-month period in a regional government hospital in Northern Tanzania. In this section, I shall present some background information on (mental) health care in Tanzania, and specifically on the hospital in which the study was conducted.

(Mental) health care in Tanzania. Tanzania is located on the eastern part of the sub-Saharan African. With an average per capita consumption expenditure of 10120 Tanzanian Shillings[1] per month (National Bureau of Statistics Tanzania, 2002), it ranks among the most disadvantaged counties of the world. The recent history of the country is marked by profound transformations, such as "villagization", the creation of communal villages, urbanization, and industrialization, all of which have caused significant changes in the social fabric (Kilonzo & Simmons, 1998).

Following independence in 1961, great priority has been given to free primary health care, especially in rural areas, which resulted in significant public health improvement

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[1] 1 USD ≈ 1000 TShs

(Shiner, 2003). However, Faced with an economical crisis in 1980's, Tanzania was forced to approach the International Monetary Fund for financial assistance and to accept the conditions of structural adjustment policies, such as partial privatization of health care services and the introduction of user fees (Benson, 2001). However, the social costs of reforms are not shared equally among the population; urban population continues to receive the bulk of health subsidies, particularly for hospital care (Green, 2000). This seems in line with the growing accessibility of public health services in large cities, whereas the quality (Green, 2000) as well as the accessibility of these services seem to have been declined in rural areas (Benson, 2001).

Tanzania has a well defined pyramidical health care structure, rising from the primary level (village health posts, dispensaries and health centers) to district hospitals, regional hospitals and, finally, consultant hospitals (Gilson, 1995). The prevalence of mental disorders at the primary level has been estimated at 10 to 20 percent (Kilonzo & Simmons, 1998). A recent study of patients with *common mental disorders*, consulting primary health care in the largest city, Dar-es-Salaam, found a point prevalence of 24 percent (Ngoma, Prince, & Mann, 2003). Treatment of mental disorders takes place in different settings, such as community mental health services, psychiatric rehabilitation villages, and psychiatric units in large hospitals (Kilonzo & Simmons, 1998), and typically involves pharmacotherapy and counseling. In addition, Tanzania has numerous types of traditional healing practices, which are consulted by a large proportion of individuals with mental health problems (Ngoma et al., 2003; Schulsinger & Jablenski, 1991).

The hospital. As a regional center, the research site serves a vast geographical area. Patients who seek treatment at this center are predominantly referred by smaller health posts and clinics. The hospital has the only specialized psychiatric service in the region, which consists of a small outpatient unit and a slightly larger clinical ward, particularly reserved for patients with severe mental disturbances (e.g., psychotic disorders). The staff consists of a few psychiatric nurses and assistants.

Participants

A sample of seven informants was drawn from patients who sought psychiatric treatment at the hospital. Children and adolescents, as well as patients with a presumed delusional condition, and those who were otherwise considered as unable to communicate about their illness beliefs and condition, were not approached for participation.

Interviews were carried out with a psychiatric nurse who was responsible for all intakes at the psychiatric ward, as well as for the treatment of most patients at the outpatient unit. As all informants eventually received an outpatient treatment, this psychiatric nurse was the only therapist at the hospital who, as an informant, took part in the study.

Data collection techniques

Semi-structured interviews. Patients were interviewed prior or directly following their intake or first treatment session. Whenever possible, subsequent sessions were held with a two or three week interval up to a maximum of three months. In total, one informant was interviewed four times, three informants for three times, two informants twice, and one informant only once.

The guiding themes during the first interview were complaints for which the informant has sought treatment, his/her explanations of the condition, beliefs of significant others, the rationale behind his/her hospital visit, and expectations regarding the efficacy of treatment. Following interviews, in the course of the treatment, focused in addition on the informant's, health improvement, and their explanations of the healing process. Unless informants preferred otherwise, interviews were tape recorded and transcribed later. All interviews were conducted in a consulting room within the hospital. When necessary (11 out of 18 interviews), an interpreter facilitated the communication. Two of these interviews were interpreted by a bilingual assistant. Due to the limited resources available for this study, the psychiatric nurse assisted the communication in the remaining nine interviews. The transcriptions of these interviews were subsequently reviewed by the bilingual assistant to control the accuracy of the translations. In a number of cases, inaccuracies were found. These data were not used in following analyses. Only three informants were exclusively interviewed with the assistance of the psychiatric nurse; others were interviewed at least once in his absence.

Considering the study's focus on treatment context, the psychiatric nurse was interviewed to elicit his EMs, and therapeutic strategy following each intake. During treatments, one or two interviews were carried out with him, which in addition, focused on his understanding of patients' illness beliefs, and explanation of healing process.

Observations. In all but one case, the intake and follow-up treatment sessions were observed. In some instances, the sessions were held in English. The conversations were, otherwise, carried out in Swahili, in which case the psychiatric nurse summarized the exchanged accounts regularly during each session.

Results

Patients' EMs

In this section, I shall present data regarding the patients' EMs, which were reported during the interviews. I will first focus on the nature of these beliefs, that is, types of EMs that informants presented, and significant features of EMs, such as vagueness, fluidity, and multiplicity. Second, I will describe the relation between EMs and patients' treatment choice, in order to further explore the nature of EMs, and to investigate their practical meaning and significance. The section concludes with a discussion of EMs in relation to chain complexes and prototypes, which also sheds light on the way EMs may occasionally be acquired.

Nature of EMs. Informants presented a large body of complaints. Physical problems, such as bodily pain and weakness were most prevalent. Also, episodic loss of consciousness and psychological problems, such as depression, as well as memory and concentration problems were frequently reported.

EMs that were presented by informants can be classified into three general categories, i.e., supernatural, physical, and social/psychological. Supernatural causes were widely reported; four informants mentioned witchcraft at least once in the course of the interviews. In most cases another female in the family was considered as the source of the problem. These types of illness attributions also appeared to be mostly supported by the informants' social network.

Another group of EMs consisted of physical causes. These explanations referred predominantly to the malaria condition. Other factors such as epilepsy, allergy, medications, and diet were reported as well.

The last category was social/psychological explanations, which consisted of factors, such as unemployment, lack of (financial) support, relationship problems and "too much thinking". Social explanation, and specifically problems in social relations, appeared to be strongly intertwined with supernatural explanations (i.e., witchcraft). In all cases, the act of witchcraft was thought to have stemmed from distorted social and family relationships. Specifically, jealousy and hostile relationships were repeatedly assumed to be the reasons behind witchcraft. Thus, supernatural explanations seem to possess a strong social dimension, pertaining to the nature and quality of social relations.

Generally, informants reported multiple, concurrently held EMs during each interview. These models were quite vague, superficial, uncertain, and consistently lacked ideas on the 'pathophysiology' (see Kleinman, 1980). In each specific interview context, a different illness attribution could be revealed and stressed as referring to a significant causal agent. Occasionally, the relative importance of different EMs shifted within the same interview. For instance, Joseph (23) held two different explanations for his painful eyes and reduced vision. Firstly, he used a previously given professional diagnosis (i.e., allergy) as an explanation of his problems. Simultaneously, however, he mentioned “invisible computer rays” as a causal factor, since he has been recently working with a computer. He mentioned repeatedly that he was not sure which explanation was more valid, and considered both possible. However, depending on the questions posed during the interview, and the flow of the conversation, he would stress either one of these explanations as more important. Another informant attributed her depressive complaints and bodily weakness to her sister-in-law whom she suspected of being involved in witchcraft. Later, in the same interview, she expressed her uncertainty towards this explanation: “I *can’t* know if these problems are [caused] by my sister-in-law”, and reduced her uncertainty in another statement she mentioned later: “I just think the source of all problems [is] that mama [sister-in-law]”.

Beside the “shifting relevance” and uncertainty of EMs, informants’ narratives could also consist of contradictory accounts. One informant, for example, mentioned in one of his interviews that his pain symptoms could have been caused by a medicine that he was taking at the time. In the following interview, however, he denied his earlier account, arguing that pharmaceutical companies conduct enough research into each medicine, hence guaranteeing their products are essentially harmless. Instances of self-contradiction could also emerge within the same interview. One of the informants, who was suffering from depression, viewed his problems as caused by unemployment, mainly because his father failed to support him in finding a suitable job. Later in the interview, he dismissed his father’s lack of support as an explanation, and identified corruption and poor government policies as true causes of unemployment.

In the face of uncertainty, informant’s seemed to be engaged in an ongoing process of searching for meaning. In fact, the very act of help seeking was itself an important component of this process. Help seeking appeared not to be merely a quest to find a *cure*, but also to find *meaning*. Kimario (41) suffered from intense headache and episodic loss of consciousness. He formulated his main objective for visiting the hospital to receive a “check-up” and a “referral letter for a CT scan” at a larger, private hospital in the area. The search for EMs was frequently expressed and emphasized by the informants. In fact, all patients, but one, demanded a professional explanation for their suffering. Of course, the construction of meaning had also a great practical importance; it guided behaviors and strategies to cope with symptoms. Talking about his help seeking history for the treatment of his eye problems, Joseph formulated this point in the following way:

> "I went to hospital [X] to take this medicine to put inside the eyes. The medicine does not function…. After that I went to [another] hospital, they started to treat me. They put a glass [before] my eyes, and they said that there is a… there is problem of allergy…. Also, when I came to [this] hospital in the Eye Department they informed me that I have a problem of allergy…. But they did not say what kind of allergy…. Now, I ask myself and I beg, pray the Lord, if it's a problem of allergy, could the Dr. help me in order to feel [better]? Is there a certain kind of food that [I should not eat]? Because it's a… when I go to [hospitals], they [assure] me that it's an allergy. I do not know if it is a case of wearing spectacles, like my father. That is why… I have not been able to read books… and [work with] the computer."

Relation between EMs and treatment choice. As noted in the introduction to this paper, EMs do not affect the treatment choice in a purely mechanical way (Kleinman, 1980). Thus, whether or not a given treatment is consumed by patients is not merely dependent on its therapeutic rationale or cosmological assumptions, but also on its availability, and quality (e.g., efficacy). Also in the present study, the link between EMs and treatment choice was at times ambiguous or even paradoxal. As I mentioned earlier, supernatural attributions were the most frequently reported type of EMs. Belief in supernatural causes can be viewed as contrasting to consulting hospital treatment, as the supernatural agents and processes are located outside the biomedical cosmology. Alternatively, seeking traditional healing, which may be based on a more compatible worldview could perhaps be a more rational choice. However, none of the informants, who said to believe in a supernatural cause, seemed to have been conflicted by his/her choice for a biomedical treatment. This discrepancy may be explained to some extent by the present data. First, some informants reported that their main reason for visiting the hospital was to receive a “check-up”. Thus, their particular choice for a hospital treatment may not have been determined by a pre-existing EM, but was rather itself a strategy to construct one. Second, the multiplicity of EMs allows for the co-existence of several, possibly inconsistent EMs, some of which may justify seeking hospital treatment. Felomena (27), for example, attributed her symptoms mainly to witchcraft. Simultaneously, she also held a psychological explanation, emphasizing her incapacity to deal with difficult tasks she faced in her daily life. Thus, holding a supernatural EM by no means dismisses other causal possibilities, which may qualify hospital treatment as a logical choice. Finally, some patients may have turned to biomedical treatment, despite their belief in a supernatural explanation, due to the unreliable reputation of some traditional healing practices. This holds, especially, true for some healers, who themselves practice witchcraft as a healing method. Herbalists, on the other hand, seemed to possess a better status among the informants.

In general, some informants were quite reluctant to express their beliefs in supernatural explanations and traditional healings (see the section *talking supernatural in a naturalistic setting*). In sum, it appeared that the link between the nature of EMs and treatment choice was rather weak. I shall elaborate more deeply on this discrepancy in the discussion section.

EMs of illness and other knowledge structures. Focus on prototypes and chain complexes allows for an exploration of EMs in the broader context of illness narratives and knowledge structures, and may reveal the association between these different types of knowledge. In Young’s view (1981), both prototypes and chain complexes can influence the illness experience, similar to the EMs, but they do not imply a causal link between various events. In the present study, however, there appeared to be a strong association between chain complexes and prototypes on the one hand, and EMs on the other. More specifically, prototypes and chain complexes were frequently employed to establish and justify a particular EM. The following examples may illustrate this point.

Juliana (32) came to the hospital for treatment of nightmares and "strange noises" she heard, while resting. She attributed these problems to her sister-in-law whom she accused of bewitching her. When asked why she suspected her sister-in-law, she presented the following sequence of events:

> "In 2000… one night I was suspicious that there was someone outside. All of a sudden my husband went outside and found that mama naked, in the middle of the night. The next day [my sister-in-law] was called [to] discuss the issue [with] neighbors and family: 'what were you doing outside naked at night?'. And she [apologized]. And from that time, I started to have these problems….".

Juliana also remembered an event that led to a further decline of her health:

> "I [believe] that [she] is the one causing my problems. Before I came here, we had the [funeral] of one of the family members, when we shared the same place. I slept [next to] my sister-in-law. Suddenly, without knowing, I had nightmares. And [then] I thought 'I was with my enemy there'. That's the one causing my problems. That's when… people told me I was with my enemy".

In the above case, the informant used chain complexes in order to explain the onset and course of a particular illness episode. This type of reasoning was also utilized by patients' social network to construct their own EMs. For instance, Joseph's father drew a *causal* link between his son's problems and events that preceded its onset (i.e., traveling to town, and receiving treatment for malaria):

> "… when [Joseph] gets proper medication, he is improving. When he goes out of home, let's say to the [town] to try to secure employment… I don't know what happens…. Whenever he goes to town, I don't know what, the pressure of the town, and [trying to find] employment, he gets worse…. [also] in town he gets treatment for malaria. When

> he gets the treatment for malaria with medication, he gets upset…. Whenever he gets treatment for malaria the issue become worse. Then he starts [to] relapse. It's a fresh start for the disease. Then it starts again…."

Although prototypes were not observed as frequently as chain complexes, their contribution to the construction of EMs was, nonetheless, equally significant[1]. For example, Juliana attributed her hearing difficulties to side effects of Quinine, an anti-malaria drug. She mentioned that she has been treated with this medicine several times in the past, in addition to the doses she took recently, prior to the onset of her symptoms. In her experience, she suffered from the same "deafness" she used to have during her previous experiences with this drug. In another instance, one informant failed to generate an explanatory account, due to the lack of a prototype: "I don't know what's wrong with me, because I have never had such a serious problem in my life".

Overall, these data support Young's (1981) observation that informants' accounts are occasionally a combination of several EMs, prototypical experiences and chain complexes. These latter entities seemed to play a significant role in the construction of formal EMs.

Professional EMs

The therapist's views on complaints that informants presented during the first sessions were extremely biomedically oriented. Whereas social factors were frequently investigated, they were never reflected in the diagnoses, and only marginally targeted in the treatment plan. The following case may clarify this issue.

Mary (25), mother of two children, was brought to the hospital by her husband. She complained of multiple bodily pains and depression. In her view, these problems were caused by her husband's lack of responsibility. The family faced financial problems, and she did not receive any support in her "difficult" task of taking care of her family. In addition, she suffered from "bad thoughts", because her husband did not come home regularly. A few weeks before my first interview with her, Mary had run away to her parental home. In the second interview, she also reported that she was physically abused by her husband, and that it was her primary reason for leaving her family. After his first contact with Mary, the therapist described her as “confused”, and “a typical case of depression”. The treatment consisted mainly of tranquilizers and anti-depressants. Psychosocial intervention was limited to a number of minor recommendations to the husband. In general, the therapist believed that stabilization of patient’s mental state, using pharmacotherapy, should precede any form of psychotherapy or psychosocial counseling. “Changing symptoms”, he once cited a Tanzanian psychiatrist, “cannot be achieved without changing the context”. However, no structural form of counseling was provided for Mary or any other one of the informants.

This paradox also existed between the therapist’s cultural insights and diagnostic choices. Specifically, he repeatedly stated that belief in witchcraft was part of the local culture. In one instance, discussing one of the informants, he mentioned that the patient attributed his symptoms to witchcraft. When I inquired whether he had asked the informant regarding his EMs, he denied: “he didn’t mention it, but as far as I know it’s in our culture”. Yet, all patients who identified witchcraft as a causal factor were, consistently diagnosed as “deluded”, “paranoid”, and “schizophrenic”.

The medicalization of supernatural beliefs is perhaps, partially, caused by the staff’s general, negative attitude towards this type of beliefs and traditional healing, which they viewed as ineffective. The therapist described his strategy in dealing with supernatural explanations as follow:

> “Of course, when [a patient] tells me that he's bewitched, I have a small talk with him: ‘listen, they [healers] are trying to get some money from you…. Please, keep on coming to see us for medication, and [don’t] go the local healers, because the local healers take care of your money, and [in the end] you [will] become poor.’ Most patients, they agree with us.”

Therapist-patient interaction

In order to appreciate changes in informants' EMs, it is first necessary to explore the therapist-patient interaction in this specific setting. The interaction was characterized by a strong hierarchy. Patients and their family members assumed a submissive role during the encounters. Mostly, they spoke, only when they were asked a question. Each session would last less than 10 minutes and end typically with a prescription.

The therapist did not discuss his EMs in any of the sessions, but one. Moreover, none of the patients said to have ever received an explanation for their illness from the hospital staff, despite their (expressed) interest in such information. In the therapist's view, "education" would be given, once the active phase of the disease was over. Yet, this occurred only in one session (see also the section on changes in EMs), even though the patients were generally stabilized or improving. The therapist's secrecy regarding his EMs was not well understood by patients and their families. Joseph's father presented his dilemma in the following way:

> "Because… his problems this naggings and complaints, and unexplained, unverified pains, doctors have not been able to explain him exactly how it has originated. So he has just been receiving medication. I don't know if withdrawing the information from him is helpful or not, I don't know. Or being explicit to him would be more painful to him… make the problem worse. It may not help, I don't know. So up to the professionals, to decide, is it helpful to tell him exactly what is wrong or not."

In the hierarchical treatment context, and in the absence of an explicit interaction concerning possible causal factors, there seemed to be a perfect understanding between patients and the care provider. This seeming agreement is remarkable, as a comparison between their views revealed that they diverged from one another in most cases. Patients seemed extremely reluctant to express any form of disagreement openly during the treatment.

The following excerpt is an illustration of this attitude. It is derived from my second interview with Chora (18), in which the therapist also acted as an interpreter. Chora had already mentioned his belief in a supernatural explanation of his illness. All patient's statements (P), as well as his exchanges with the therapist (T) were originally in Swahili, and have been translated later by the bilingual assistant.

INT: I was wondering, do you think, that this treatment that you receive here, has an effect on the witchcraft that has caused your problem?

P: No… I was given malaria medicine.

T: So the belief [in witchcraft] is still there.

INT: The reason I asked it is that, on the one hand, witchcraft has caused your problems, and on the other hand, you take medicine to get better. So I was wondering if taking the medicines could also do something about the witchcraft. How do you see that?

P: For other diseases you can use the hospital medicine, but for [learning and concentration problems]... I cannot understand anything at school. I cannot cope with anything at school.

T: He thinks that the other diseases can be treated by hospital drugs, but the loss of memory… is not something that can be treated by our hospital treatment. And he says he doesn't have the interest of studying.

INT : Ok. What kind of diseases do you think is treatable by the hospital?

P: All diseases, I can't name them, but malaria is one of them.

T: One is malaria, which is treatable in the hospital.

INT: So as I understand, correct me if I'm wrong, part of your problem that could be treated by the hospital is better now, but other problems still exist because the hospital is not suitable for the treatment of those diseases.

P: It can be treated.

T: Which diseases?

P: The one I mentioned about.

T: All of them?

P: Maybe my loss of consciousness and chest pain.

T: Yes, these diseases like chest pain and malaria can be treated in the hospital. What about other diseases that you have?

P: It can be treated.

T: He says that they can be treated in the hospital, the loss of memory…

INT: Umm, yet you say that there are problems that are not easily treatable by the hospital. Is it true?

P: It can be treated in the hospital.

T: He is agreeing now that these conditions of mental problems can be treated in the hospital.

INT: Why did you change your mind all of a sudden? ... I appreciate that you give answers you really *think*. Don't feel pressured that I would like to hear certain answers. The answers I would like to hear are your real thoughts. Ok?

P: Some words just come out of my mouth, and I don't know what I have said.

T: I think his insight is somehow partial.

In this excerpt the informant initially questions the efficacy of the hospital treatment in dealing with his psychological complaints (i.e., concentration problems), but seems to be pressured to revise his comment. It is likely that my questions, aimed at clarifying his original comment, may have appeared critical to him. In the later part of this excerpt, the therapist takes over the conversation and asks the informant which specific types of diseases he thinks are treatable in the hospital. The patient refers to his own physical symptoms (i.e., loss of consciousness and chest pain). As he receives further questions regarding his other symptoms, he reports that hospital treatment is suitable for *all* kinds of diseases, disqualifying his earlier statement.

Despite their confirmative attitude, many informants attempted to defy the professional authority and hierarchy in a variety of ways, which were never visible to the hospital staff. Some applied self-medication, as they observed insignificant improvement after taking their prescribed medicine, which one person even stopped using. Likewise, Mary had secretly, as her husband reported later, consulted a traditional healer. Chora also considered going to a healer if his symptoms would not disappear soon. However, the most striking instances of defiance were, perhaps, patients' rejection of their diagnoses, which I shall elaborate in the next section.

Changes in EMs

As noted previously, informants' EMs were highly dynamic; patients navigated between different possibilities throughout the interviews. Additionally, a number of informants manifested, what may be called "solid" changes, which marked a clear departure from their previously held beliefs. Notably, four out of the six informants, who have been repeatedly interviewed, provided five explanatory accounts, which were profoundly different than their previous ones. In two instances, the changes can be dismissed as due to social desirable responding, as informants deliberately concealed their supernatural EMs initially (see the section *talking supernatural in a naturalistic setting*). The following case illustrates how patients reconstructed their illness meaning in the course of the study.

Kimario suffered from headache and episodic loss of consciousness. In the first interview, he stated that he did not actually know what had caused his illness. He *assumed*, however, that the malaria parasite had affected his brain functioning. Reportedly, his family did not have any idea on the illness causation either. In the following interview, approximately two weeks later, he said he had absolutely no idea what might have caused his symptoms. He had been to the hospital laboratory for a malaria test. The test results had come back that morning, showing that there was no parasite in his body. He believed that it was obviously not a case of malaria. For him, it was then even more important to have a CT scan to find out the correct diagnosis. During the third interview, he mentioned that his condition had worsened significantly. He still lacked any certainty regarding his illness etiology. When I discussed the fact that he may suffer from epilepsy according to the therapist, he denied it, rationalizing his view by restating his original EM even after I reminded him of the test results:

> "I think when you have malaria for a long time, without treatment… it can make problems, like [epilepsy]…. I feel head pains and back pains like malaria is in my body…. They checked the blood, and [found] nothing…. [But] the microscope can't see all of it….I think there [are still] a few parasites inside my body, which cannot be seen using the microscope".

In this example, the informant alters his EM drastically during the three interviews. This case also illustrates that profound changes in patients' explanatory accounts are products of internal or external demands. In the second interview, for instance, the patient drops his initial assumption when facing the new *clinical reality*, test results that deconstructed his malaria theory. The patient proceeds to once more revise his account in the third interview, when he is confronted with an internal pressure, resulting from the lack of information and control. Having a highly stigmatized alternative diagnosis, such as epilepsy, has perhaps been an additional reason to cling back to his initial EM. Equally remarkable is the fact that none of the available professional information (i.e., test results and diagnosis) had eventually any effect on the EM the patient held valid.

This display of persistence was more widely observed among the informants. In fact, three of four patients, whom I informed about their diagnoses at some point during the interviews, discarded the diagnosis completely, and only one considered it possible. In one of the most interesting instances, one informant (Joseph) seemingly adjusted his view on his complaints, when the therapist, in an exceptional instance, provided him with his professional EM (i.e., schizophrenia). In the following interview, however, Joseph expressed doubt towards this diagnosis, and eventually recounted his original EMs (i.e., unemployment and malaria).

Thus, patients' EMs appeared to be fairly transformable. The belief changes were, however, unrelated to the therapist's views and diagnoses. As for possible causes of these changes, at least two factors could be identified. First, the *treatment efficacy* or the degree of improvement seemed to affect the informant's causal beliefs. Notably, most informants who manifested little or no changes in their EMs seemed to report only insignificant improvement of their complaints. Chora, the young man suffering from multiple bodily pains and concentration problems, reinforced his initial explanation of witchcraft, when the treatment failed to produce an effect.

> “Now, these days, I start to trust [healers]. But in the past, I had no way to trust them…. When this problem started, it started in a way I didn’t expect it to. When it started, I [could] study for half an hour and not understand anything. I wonder why. Because in the past my performance [at school] was good…. And this problem, it can be a normal, common problem. But apart from that, there is something else. They took some measures for malaria, and I’m better. But this problem is still there.”

In contrast, the perceived efficacy of the treatment in another case was associated with an adjustment of the original EMs. This informant who reported significant improvement, said to have revised her initial model concerning witchcraft as a result:

> “I’m better because of the medicine… Some people in the family still think that it’s bewitchment. But I’m progressing, so it’s not bewitchment”.

Notably, none of the informants could offer an explanation for the treatment efficacy or failure.

Another factor that may have affected informants’ initial models is exposure to EMs of their social network. In two instances, this seemed to be the case, as informants changed their original views to encompass their family’s EMs as well. For example, Eliminata’s (31) family viewed her symptoms as responses to her stressful life circumstances, which partly consisted of taking care of her severely ill mother. Whereas she initially did not endorse this explanation, she spontaneously reported stress and rumination as important causal factors during the second interview.

In sum, in addition to inherent fluctuations of EMs, these ideas were also subject to a reasonable amount of change. Overall, the changes did not take place in a specific direction, and could not be attributed to an exposure to professional EMs. Perceived efficacy of the treatment, as well as beliefs of one's social network seemed to be relatively more influential in altering the patients' views.

Talking supernatural in a naturalistic setting

In this section, I shall elaborate on the way patients applied secrecy and deception in their encounters with the therapist, and perhaps more interestingly in their contacts with me. Remarkably, all these instances had to do with visits to traditional healers or beliefs in a supernatural etiology.

In my first interview with Mary, she denied having consulted a healer for her current problems. Taking this account at face value, I was rather surprised when her husband returned to the hospital the next day, claiming that she had lied about her treatment history. He had brought a bag full of herbal medicines, which he opened before me and the therapist to see. In the second interview, I asked Mary once more whether she had been to a healer. This time she confirmed, and added that she had forgot to mention this fact in the previous occasion. She also mentioned that the traditional medicines were not effective, and that she had "thrown them away".

In a similar fashion, a number of informants showed great reluctance to report supernatural EMs. When inquired about their illness attributions, some patients commented that they had "no idea". Interestingly, a supernatural explanation would emerge cautiously afterwards. In two instances, informants continued to deny a supernatural cause until the second interview. Felomena was suffering from a recurrent episode of fainting. She first developed this symptom when she was seven years old. At the time, her family believed that she was bewitched, and brought her to a traditional healer who prescribed her herbal medicines. Subsequently, she felt great improvement, which she ascribed to these medicines. When asked why she had not consulted a healer this time, she recounted that she was now mature enough to make her own decision, and, thus, came to the hospital for a check-up. She said that she had no idea what had caused her problems, and actually, had not thought about it yet. Her family had advised her to visit a traditional healer again, although they, too, had reportedly no particular EM. In the second interview, Felomena gradually changed her initial account. She said that she had been advised to consult a healer, because her family believed that she was bewitched by her stepmother. Later during the same interview, she mentioned that she, too, believed that her symptoms were caused by witchcraft. She explained the discrepancy between her accounts as follows.

> "I couldn't tell you [about the witchcraft] the first time, when I was here. I feared something.… I couldn't… I didn't remember to tell you about the problems that were caused by my step mom…. I was afraid to tell you directly… I was afraid to tell you, because I didn't believe that you could keep it as a secret. But now I do."

Juliana, another patient who did not disclose, and even denied her supernatural attribution initially, commented similarly by pointing to issues of acceptance and trust: "… I didn't know if you believed me. That's why I didn't say anything".

The therapist seemed to be quite aware of these deceptions:

> "It's not easy for the patients to disclose that issue [witchcraft] early to you and me. Not so easy. They think that we would not be happy, and would ask: 'why do you believe in this?'"

This fear of rejection had a true and realistic basis. In fact as noted earlier, the traditional healing and supernatural EMs *were* indeed rejected, and viewed as fallacious in the hospital, and even by some authority figures outside. Chora, who suspected his classmate of making him ill through witchcraft, discussed his view with the head teacher at school. The teacher rejected his account, and instructed him not to think and talk about these issues at the school. Chora's reaction was a silent struggle. He held on to his belief, but stopped talking about the issue: "if the teacher commands, then you can't say anything".

Thus, informants could have been engaged in acts of lying and deception in order to avoid an undesirable consequence in their interactions at the hospital. It is, however, difficult to determine whom they viewed as the main audience of their deceptive performance: the therapist, the interviewer or perhaps both. Given I could not detect deceptions in my direct interviews, it becomes impossible to accurately assess my own contribution in provoking deceptive accounts. It is, on the one hand, plausible to assume that the presence of the therapist was a significant contributory factor to the emergence of lies and secrecies. After all, patients may have been exposed to health professional's negative attitude towards witchcraft and traditional healing during their previously direct or indirect encounters with the biomedical ideology. This seems to be in line with my observation that some informants talked more openly in the interviews during which the therapist was not present. On the other hand, it would be naive to trivialize my own role in this regard. Facing a foreign person with an ambiguous role in a biomedical setting may have equally caused some informants to conceal or lie about their EMs. Indeed, my role in the hospital was not well understood initially by both patients and the staff. During the first two weeks of the study, some patients considered me as a doctor. In two occasions, patients even asked me to diagnose or to treat them. These attitudes were quite surprising, as I had never introduced myself as a physician, and had explicitly denied any connection with the hospital. Even more surprising was the role that I have been initially ascribed to by the staff. Obviously, they were aware of my clinical training and addressed me as "doctor" in our greetings and conversations. The therapist, with whom I worked with in this study, even asked me to comment on his diagnoses and prescriptions on the first day we met. As pleasing as these attitudes were, I repeatedly needed to redefine my role to the patients, the staff and myself. Introducing myself as a student with no medical training appeared quite rewarding, as it led to a more open and desirable relationship with all my informants, that is the patients and the therapist.

EM and treatment satisfaction

In general, patients reported a high degree of satisfaction with the treatment, regardless of the therapist's views and his treatment rationale, which remained undisclosed throughout the entire treatment. I shall elaborate on the consequences of the therapeutic secrecy further in this section.

Informants' narratives on satisfaction can be divided into two different components. The first component includes utterances of general views on the hospital treatment, elicited using direct questions. When informed about their evaluation of the treatment, all informants but one reported a high degree of satisfaction. Patients, however, seemed to hold a rather restrictive conception of treatment. In fact, treatment was consistently defined as "medicine" (*dawa*) by informants and interpreters. Such a narrow view of treatment did not allow any reflections on staff attitudes or therapeutic advices. In general, treatment evaluation was largely informed by efficacy of prescribed pharmaceuticals, which were regarded as highly positive. Symptom improvement was predominately ascribed to the medicinal effect, although none of the informants could explain its healing mechanism.

The second component of informants' narratives were those views on satisfaction, which were provided only after careful probing, or reported/implied, while discussing other issues during the interviews. Notably, all these statements were produced in the absence of the therapist. These narratives pertained to three interrelated areas of hospital services that will be discussed below.

Lack of understanding regarding the illness etiology. Earlier in this paper, I have described some informants' predicaments in assessing the "true" nature of their symptoms. Uncertainties regarding the causes of their illness, made it difficult for them to determine an appropriate course of action. Consequently, the majority of informants repeatedly demanded a professional explanation of their problems, which was not provided by the hospital staff. This might have led to attitudes that can be qualified as dissatisfaction. Joseph noted in this regard:

> “It is important for me to know the cause of my problem, because it helps me [cope with it]…. If they [the staff] had told me, I would be happier. Because when I understand a certain kind of problem, after investigation, I will know what kind of food I must eat or keep away, in order my eyes to be good. And I think then my problems will be better.”

Kimario posed a similar point in the following way:

INT: If you were in the position to change the treatment the way you wanted, how would you change it?

P: Maybe looking deeper inside, having tests, because my main problem is headache. So maybe they can go more inside and test more nicely. It would be better.... It will be better if they check me and see how this thing started. By having test, a good nice test, and medicines, and advice from the doctor... Just advice, it would be better.

Narrow focus of the treatment. Another area of concern was the selective focus of the treatments. Some informants believed that the pharmaceuticals, prescribed by the therapist, targeted only a few problems, while leaving other symptoms untreated. Joseph’s complaints of reduced vision and painful eyes are examples of symptoms that remained outside the focus of the therapy. Relevant in this regard is also Chora’s belief in the inefficacy of hospital treatment to counter certain psychological symptoms (see the section on therapist-patient interaction).

Lack of expertise or facilities. This domain of hospital treatment seemed to be only occasionally criticized. Disqualifying statements about these aspects of the hospital were reported by only two informants, who felt that the hospital might not have been the best place for their symptoms to be treated. The following excerpt from my interview with Kimario may illustrate this point.

INT: ... if I was a patient, and you were a doctor. I had the same problem as you mentioned. And I came to you for help, how would you help me?

P: [Pause] I would do anything I can in my... power. In my power to see that you have got well. I'd give you medicine, and I would order tests.

INT: Yes.... Do you think that the hospital here has done anything in its power to help you? Honestly. I don't work here, so you can say everything.

P: This hospital? I think that it has no power. It is … this is a regional hospital, and [the private hospital in the area] is consultant. They have doctors who are specialists… specialists for many diseases. And here, there are no specialist doctors.

Dosage of prescribed medicine. Complains regarding the dosage of the medications (being either too high or too low), and their side effects were more frequently reported by the informants than any other aspect of the treatment. These narratives were also the only reflections on the treatment that were openly discussed in the presence of the therapist.

In sum, informants' narratives on treatment satisfaction were largely based on views regarding the efficacy of pharmaceuticals. Only after probing or in response to questions posed on different themes, other aspects of the treatment were included in informants' evaluation. These aspect could roughly be divided into areas of hospital care relating to the communication of professional EMs to patients, the focus of the treatment, lack of expertise or facilities, and the dosage of the prescribed medications. The latter category was more freely discussed during the interviews, even in the presence of the therapist. More fundamental issues, related to the functioning of the hospital as an institution, were however, subject to self-censorship. Only two patients expressed doubts towards the capabilities of the hospital in light of its lack of medical facilities.

Discussion and conclusion

This study explored the nature of EMs of illness among patients in a psychiatric ward in Tanzania, and the way they produced, and altered their accounts within the treatment context. EMs appeared to consist of multiple, superficial and uncertain ideas, which tended to shift according to varying internal or external demands, and interview contexts. Patients provided at times even conflicting accounts, although they did not seem to be troubled by these contradictions. This also applies to a certain extent to the discrepancy between EMs and the actual choice for the hospital treatment. Patients' EMs appeared to be strongly related to other knowledge structures. Specifically, chain complexes, and to a lesser extent, prototypes were occasionally used to construct or justify a certain EM. Whereas EMs were characterized by a great degree of change over time, transformations did not occur in a specific direction; changes represented both a shift towards, as well as away from a bio-psychological perspective, mostly endorsed by the hospital staff. The therapist's EMs or diagnoses were almost never communicated with the patients, and hence had no direct effect on their views. On the other hand, the perceived efficacy of treatment and exposure to EMs of one's own social network appeared to be important factors in causing changes. These findings need to be viewed in the context of a therapeutic relationship, marked by distance and hierarchy, in which medically deviant beliefs (e.g., supernatural EMs) were not easily discussed, or even concealed. The fieldwork shows that self-censorship and deception were also occasionally applied in interactions with me.

Nature of EMs. These data seem to be supportive of Williams and Healy's (2001) concept of "explanatory maps", which was introduced as an alternative to "explanatory *models"*. In their view, patients' ideas on illness causation are not sufficiently coherent to be qualified as 'models', but rather form a map of possibilities, according to which patients search for possible illness explanations. Also, in the present study patients' EMs were primarily a representation of their ongoing process of searching for meaning (Bäärnhielm, 2000). This process is inherently marked by uncertainty, and may give rise to a range of tentative, causal beliefs. However, contrary to what Williams and Healy suggested, the uncertainty regarding the illness etiology was clearly problematic for most patients. The uncertain nature of their illness meanings prevented them from planning an appropriate coping strategy to regain control of their minds and bodies. However, once healing took place, it was of no importance *how* it had occurred. Thus, as far as it concerns the healing mechanism (Kleinman, 1980), patients' EMs were consistently incomplete. Last (1981) arrived at a similar conclusion, in his classic study of patients and healers in Nigeria. He found it remarkable how little patients (and healers) need or care to know about various aspects of illness and healing (e.g., origins and mechanism). The present study, however, suggests that the disinterest in medical information is mainly related to the domain of healing, and not to illness etiology. Indeed, patients are not systematic theorists of their illnesses, but rather pragmatic thinkers who merely search for practical knowledge that can contribute to their coping repertoire.

A remarkable feature of patients' narratives was the continuous shift between multiple, at times, inconsistent explanations. These shifts and inconsistencies may appear illogical to an outside observer, but could be said to result from specific interview contexts in which they occurred. The very questions posed to elicit the informant's EMs, and specific themes that are discussed during the interview can profoundly shape the accounts that are subsequently produced. Ewing (1990) raised a similar problem in her discussion of multiple self-presentations (i.e., identities) that individuals reveal in ethnographic encounters. Although the subject of her analysis is beyond the scope of the present study, its insights can be generalized to the domain of EMs. Ewing argued that people in all cultures can produce multiple, inconsistent, and context-dependent self-presentations that may change rapidly in time:

> "In effect, [informants] often keep only one frame of reference in mind at any particular moment…. Though in certain contexts individuals may identify themselves in terms of clearly defined, labeled categories…, such categories may be relevant only in certain social situations or only for certain purposes. The same individual may shift frames of reference from one context to another, even from one moment to the next, and may tolerate considerable inconsistency in his or her own beliefs and opinions, often without realizing it…. We may hypothesize that a person fails to notice inconsistency because, with the change in frame of reference, the environmental cues triggering memory also shift, leading to a 'forgetting' of one's previous point of view." (p. 268)

Similarly, with respect to illness beliefs, the interview questions and the flow of conversation may activate certain memories, illness cognitions, and information that are more likely to trigger a particular EM, while suppressing others. As the interview context shifts, other perhaps contrasting EMs may be brought to attention. Under normal circumstances, and insofar as various EMs are not reviewed, and contrasted systematically, individuals do not tend to notice possible inconsistencies. However, when they are forced to do so, for instance when facing a counter-argument (e.g., in the case of Kimario), they are likely to either (a) integrate or accommodate various EMs in order to construct a slightly alternative account, in which these elements can co-exist, or (b) drop either one of the EMs to avoid dissonance.

To make matters "worse", the interview context may even distort the representation of existing EMs, or generate new ones. This has, particularly, to do with the ambiguous, and implicit cognitions, underlying EMs (Young, 1981). Adopting the notion of *performative ethnography* (Fabian, 1990), one can argue that interview questions, meant to elicit existing knowledge, in fact force informants, perhaps for the first time, to act, perform, intellectually process, and eventually verbalize a "rational" account in order to meet a particular interview demand (see also Van der Geest, 1991). Insofar as informants lack a firm, clear and "presentable" EM, they need to invest more effort in this performance, gaining new "insights" in the process. In this way, EMs are not only *re*produced during interviews, they may also be constructed *spontaneously*. The interviewer's "role, then, is no longer that of questioner; he or she is but a provider of occasions, a catalyst in the weakest sense, and a producer in the strongest" (Fabian, 1990, p. 7).

The presented data point to a certain degree of discrepancy between patient's EMs and their treatment choice. Before discussing a number of possible explanations, some words of caution seem appropriate. The study did not adequately focus on informants' treatment choice or their help-seeking behavior. Hence, there are no comprehensive data on their past and present help-seeking strategies, other than those they volunteered to mention in their interviews. As I have mentioned earlier, certain types of help seeking, namely those related to visits to traditional healers, were particularly susceptible to self-censorship. Nonetheless, it seems quite puzzling why supernatural EMs are so wide-spread among patients who consult a biomedical hospital for the treatment of their symptoms. I have already suggested two explanations for this inconsistency that could be supported by my findings, namely the quest to find an EM, and not only a cure, and the multiplicity of EMs, which allows several beliefs to co-exist. In addition, there are a number of plausible explanations that are partly supported by the literature. First, some informants may have consulted the hospital treatment initially to get a faster relief, following which they would seek treatment from a healer to remove the cause of their illness (Lam, 2001). The cheaper admission fees at the government hospital may have also been a contributing factor. Second, it is possible that some informants may have sought traditional healing, but turned to modern medicine, as traditional treatment failed to produce an effect. Third, some may have sought both types of treatments simultaneously (Kleinman, 1980), but decided not to report it during the study. Finally, the lack of congruence between EMs and the actual treatment choice may point to the uncertainties the informants faced in detecting their illness etiology. They may have sought help for their symptoms in advance of evidence about their nature or causes. As Bierlich (1995) argued, people can seek different types of treatments (traditional or biomedical) "without knowing or being committed to the technical or philosophical premises of one or another medical system"

(p. 507). It seems likely that patients tend more to do, in face of severe and chronic symptoms.

Findings regarding other knowledge structures (i.e., prototypes and chain complexes) support Young's (1981) assertion that informants' narratives consist of a combination of these structures and formal EMs. The presented data, however, not only suggest that these cognitions may co-exist in individuals' illness narratives, but that they also may be interconnected. Indeed, prototypes and chain complexes were occasionally utilized to construct or justify a specific EM. This observation is in line with the finding that prototypes and chain complexes may transform into formal EMs, even within the interview context (Groleau et al., 2006).

Belief change. In addition to the inherent shifts in EMs, patients also manifested rather drastic changes between the interviews. Earlier studies into patients' EM point to transformation of original models *towards* professional views (e.g., Bäärnhielm, 2000, 2004; Hunt et al., 1989). This was only occasionally the case in the present study. In fact, in most cases the divergence between the patients' and therapist's EMs remained until the end of treatments. One reason for this could be the lack of explicit communication regarding the illness etiology during the treatment. The therapist transmitted his EM only implicitly and vaguely through the prescription of medicines. Consequently, patients were not offered an opportunity to evaluate their own EMs in light of an alternative, professional perspective. Interestingly, in cases in which patients were confronted with their diagnoses during the interviews, all eventually rejected them. Generally, this may occur due to a number of factors. First, the diagnosis can be so much in contrast with the existing EMs that integration or accommodation is not easily possible. Second, diagnosis of mental illness is, particularly, stigmatizing. Its acceptance can have negative consequences for one's self-image, and status among one's social milieu (Leventhal & Nerenz, 1985). Finally, rejecting the professional diagnosis represents the patient's implicit defiance of the professional authority in a blatantly hierarchical power relationship. This, and other deviant behaviors, such as visits to traditional healers, and covert replacement of prescribed medicines, highlight the patients' status as independent actors, and not mere recipients of medical treatments within the hospital context.

Secrecy and deception. Interestingly, the disobedient behavior was consistently concealed by acts of secrecy and deception. In fact, secrecy and lies were characteristic features of many encounters, which this study is based on. Observing these interactions, one can distinguish different forms of deception: secrecy as a therapeutic style of the care provider, and patients' secrecy and lies in relation to their therapist and the interviewer. Concerning the first form of deception, the therapist consistently refused to provide patients with his EM, despite their occasional requests. A number of authors have already observed that professional EMs are frequently not transmitted to patients (e.g., Kleinman, 1980; Bäärnhielm, 2004). In many cases, this form of secrecy is justified by a moral or a therapeutic judgment: "the truth will harm the patient", or "it will complicate things for the patient" (Fainzang, 2005). In the psychiatric context of the present study, secrecy was justified in a similar fashion, but was also accompanied by downgrading patients as incapable individuals who, at least temporarily, were unable to comprehend the truth. Such decisions not only serve as justifications of secrecy, but also uncover the hierarchical structure in the hospital, which governed all clinical encounters. Moreover, the therapeutic secrecy seemed to have a number of additional, interrelated outcomes. First, through secrecy, the therapist maintained, and enhanced his dominant power position within the therapeutic relationship (Fainzang, 2005). Knowledge is power. By concealing the diagnostic information, the therapist could be the only one in the privileged position to know the "true" nature of the patients' problem, and how it was to be treated. Second, secrecy deprived patients from necessary information that they could employ to evaluate the therapeutic choices and treatment efficacy. Consequently, possible therapeutic mistakes, and misjudgments could be effectively concealed. Finally, secrecy ensured the therapist that his treatment rationale would remain uncontested, and the therapy would progress harmoniously. Our findings underscore Sachs's (1989) observation that, when EMs are not clearly communicated, doctors and patients could both construct differing, but at the same time undisputed treatment rationales, which resulted in patients' compliance with the treatment.

Patients' deceptions, similar to therapeutic secrecy, have much to do with power dynamics within the therapist-patient relationship. However, whereas secrecy on the part of therapists may enhance their power position, patients' deceptions are more paradoxical in nature. On the one hand, their deceptions confirms their *dominated* position in the therapeutic dyad. Patients may lie about their true beliefs and treatment history, because they fear negative reactions from the therapist. Hence, one may argue that their lies have, mainly, a conflict-preventive function. In so doing, patients reinforce their submissive role in the treatment. On the other hand, the very same lies underscore patients' defiance of hierarchy (Fainzang, 2005). Disobedience, and holding psychiatrically deviant beliefs are evident instances of defiance. Both indirectly, but vividly, question the competence, and authority of the medical establishment in general, and those of individual therapists in particular. Concealing them allows patients to exercise power through deceiving, and manipulating their therapists. As a result, patients direct the treatment towards a desirable outcome (i.e., receiving medication, and recovery) without having to critically review their own beliefs and behaviors.

These arguments may equally apply to deceptions in relation between informants and myself. Insofar as I was perceived as an embodiment of the medical institution, patients may have been engaged in a similar power struggle during the interviews. Issues of power and deception are, however, more fundamental to interview situations than this argument may suggest. In fact, the term "interview" is itself misleading. Only rarely, interviews consist of an equal exchange of "views". The interviewer has no interest in revealing his own views on a particular subject. He may find such disclosures even counterproductive. This introduces a power inequality in the interview situation, in which the interviewer claims the right to intrude the most private aspects of the informant's life for his own agenda, while the latter is merely supposed to grant him the access. That is precisely what many informants refuse to do, despite their initial willingness. Lying is their attempt to restore the power imbalance in relation to the interviewer; the interviewer has the power to intrude, while they have the power to lie without him noticing it (Pool, 1994).

EM and treatment satisfaction. Generally, the notion of satisfaction is a problematic issue in research and practice. The growing emphasis on patient and community satisfaction, as a mean to evaluate the quality of health care, ignores a number fundamental pitfalls in the assessment of satisfaction. First, satisfaction seems to be quite sensitive to individuals' social desirable responding (Sabourin, Laferrittre, et al., 1989; Sabourin, Bourgeois, Gendreau, & Morval, 1989). Second, satisfaction with a given treatment makes little sense, if patients do not know much about other alternatives (Ruggeri, 1994). Keeping these problems in mind, I believe the present study did clarify some aspects of the relation between EMs and treatment satisfaction. Although the research setting did not provide an opportunity to assess patients' satisfaction in relation to their understanding of the treatment rationale, the lack of this very understanding was itself an interesting phenomenon that affected satisfaction. Specifically, the absence of a clear communication on the part of the staff regarding the etiology of the symptoms was obviously distressing to some informants. This observation points to the significance of process quality in the provision of health care in the context of a developing country. That is to say, not only patients seemed to include the structural quality of services (e.g., the availability of medical facilities) in their overall evaluation of the treatment, but they also tended to value clear communication and fulfillment of their needs other than those for effective pharmaceuticals. Hence, efforts in the field of (mental) health care should not only focus on the provision of effective drugs, but also aim to enhance the communicative and interpersonal aspects of the treatment, in order to satisfy *all* patients' needs, especially those for diagnostic information, and therapeutic advices. This study failed to examine how professional EMs, specially their interplay with patients' views may affect treatment satisfaction. Future research can accomplish this in setting where patients' and therapists' EMs are explicitly exchanged.

This study suffers from a number of limitations. First, the short period of data collection provided only an incomplete understanding of patients' EMs in the treatment context. Possibly, their assessment during a longer timeframe could have been more productive in detecting their transformations in interaction with symptom improvement and beliefs held by social network. It would have also created the opportunity to establish a deeper relationship with informants, which could result in a deeper understanding of their views and choices, and my own role in provoking deceptive accounts. Second, my perceived link with the medical establishment has, undoubtedly, affected what informants were willing to share. This is, particularly, the case in the beginning of the fieldwork, before these issues were even more explicitly addressed during the interviews. Conducting home interviews would have perhaps been more productive in bridging the gap between the informants and myself. This gap may also have been existed in my interaction with the hospital staff who viewed me as a foreign, perhaps more expert professional. Unfortunately, the study does not make it clear to what extent this may have affected the staff accounts and behaviors. Finally, the occasional involvement of the therapist as an interpreter during the interviews was another complicating factor. Although attempts were made to remove his interpretations in the translation process, his mere presence during some interviews has evidently influenced the patients' statements. This obvious shortcoming, however, produced two unexpected advantages. First, it clarified the role that the therapist played in patient's concealment of certain EMs, by allowing a comparison between accounts generated in his presence, and those produced in his absence. Second, it provided more opportunities to observe the therapist-patient interaction and hierarchy, which proved to be invaluable for further analyses.

Despite these limitations, the results demonstrate the dynamic, and uncertain nature of patients' EMs, and the way they were generated an altered within the social contexts of the clinical and ethnographic encounters. It is suggested that patients' statements on illness causation cannot be viewed outside the very specific context in which they are produced. The findings raise serious questions regarding the clinical perspectives on EMs as a static set of coherent ideas, and patients' accounts as mirror representations of these beliefs.

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Notes

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[1] The significance of prototypes has also partially to do with the definition of the concept. Whereas this notion has been usually defined as significant episodes/exemplars of illness in the past (e.g., Kirmayer & Young, 1998), it also has been generalized to include *cultural* exemplars (see Kirmayer, Galbaud du Fort, Young, Weinfeld & Lasry, 1996). The latter definition would imply that nearly all instances of lay medical knowledge can serve as a prototype for the interpretation of a certain illness episode. This makes the link between prototypes and EMs far more prevalent.