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List of abbreviations

ATHP	African Traditional Health Practitioners
ILO	International Labour Organization
MSI	Mass Psychogenic Illness
MOTUs	Mental Observation and Treatment Units
MPI	Mass psychogenic illness
NUL	National University of Lesotho
OPD	Outpatient Department
PHC	Primary Health Care
UNISA	University of South Africa
WHO	World Health Organization

List of annexures

- A. The Ethical Clearance.
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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The phenomenon of mass hysteria has been described for more than six hundred years in a variety of cultures. Mass hysteria, also referred to as psychogenic or sociogenic illness, is a term that is used to describe sudden outbreaks of an apparent illness among groups of people. According to Jones (2000:2649), it is often misdiagnosed as a rapid spreading infection, acute toxic exposure or bio-terrorism. Bartholomew and Wessely (2002:300) describe mass hysteria as a constellation of symptoms suggestive of organic or physical illness with no identifiable cause and little evidence of disease. Bartholomew and Goode (2000)¹, and Verma and Srivastava (2003:357) affirm this description by describing mass hysteria as the rapid spread of a conversion disorder, a condition involving the appearance of bodily complaints for which there is no organic basis. Psychological distress is converted or channeled into physical symptoms in such episodes.

Mass hysteria remains a mysterious or medical anomaly to health workers (Matto, Gupta, Loban & Balraj 2002:643). Different cultures understand and interpret this phenomenon in various ways. These diverse interpretations pose a problem to health workers who have to make a diagnosis that could be against cultural beliefs. According to Jones, Craig, Gunter, Ashley, Barr, Brock and Schaffer (2002:99-100), health professionals pursue extensive investigations even if they have a strong sense that a mass hysteria outbreak is psychogenic, for fear of causing anxiety to the community, or making a mistake in overlooking the possibility of toxic exposure. These authors argue that establishing psychogenic diagnosis involves ruling out a long list of potential causes, such as poisoning, toxic fumes and ants or insects which are sometimes believed to cause such episodes.

¹http://www.csicop.org/si/show/massdelusion_and_hysteria_highlights_from_the_past_millennium/ (accessed 7 May 2008).

The literature shows that outbreaks or epidemics of mass hysteria occur in schools, factories and communities. The symptoms are experienced more often by school children, adolescents and young adults. The condition is observed more in females than in males. Mass hysteria is associated with groups of people who are experiencing stress; people with a hysterical personality; and people who are prone to assuming a sick role and who get gratification when others give them attention (Bartholomew 2005:565; Chen, Yen, Lin & Yang 2003:122; Jones, Craig, Hoy, Gunter, Ashley, Barr, Brock & Schaffner 2000:98; Lawrence & Altman 2000:7; Mkhize & Ndabeni 2002:6971).

Most researchers report that the signs, symptoms, contagion and behaviours of the affected differ according to culture. Flaskerud (2000:9) contends that cultural forces shape symptom formation and expression of distress, which in turn, influence both the diagnosis and the management of mass hysteria. Chen et al (2003:123) point out that folk beliefs play a role in the manifestations of mass hysteria, and emphasise that the cultural belief system of a community serves as a catalyst. In studies carried out in Western countries (USA and Australia), symptoms have been related to gasses whereas in countries in the Far East (Malaysia and Taiwan) they are attributed to supernatural powers (Chen et al 2003:123; Pastel 2001:44).

Episodes of mass hysteria occurring in Lesotho high schools and factories have been widely reported on in the media. Mass hysteria outbreaks occurred at two high schools in the Mokhotlong District in 1995 and 1998 and at two high schools (Catholic schools) in the Leribe District in 2000. In 2005 there was a mass hysteria outbreak in a factory in Maseru and in 2007 two outbreaks of mass hysteria were reported at a high school in an urban and rural area respectively. These reports have been ongoing in Lesotho during the past two decades involving mostly young women as victims of mass hysteria (Mass media reports; radio Lesotho; Moeletsi oa Basotho 2008:June & 2010:September; "Leselinyana" 2007:December; "Moafrika" August:2010).

No studies on mass hysteria in Lesotho could be found in the literature; however, some reports exist in the neighbouring countries such as South Africa. This study explored the phenomenon of mass hysteria in the Basotho context.

1.2 BACKGROUND TO THE PROBLEM

Mass hysteria occurs in groups under stress and tends to involve those with typical hysterical personality and individuals prone to assuming a sick role (Bartholomew & Wessely 2002:180). Social relation appears to play a role in the development of mass hysteria. The affected somehow are either friends or relatives. The victims of this disorder are prone and central to the idea of “contagion”, which suggests that the index cases have an effect on the probability of a person being affected by the disorder repetitively (Bartholomew 2005:565; Dewey & Ries 2002; Jones 2000²). Literature shows that the contagion is related to sight and hearing, meaning that people who see or hear about it may exhibit the symptoms.

Three possible connections between a social position and contagion are indicated by Colligan, Murphy and Pennebaker (1982:11) as follows:

- Girls or women who are social isolates might be stricken because they lack support.
- Those who have social relations would fall prey to attack because the illness would seem closer and the threat would be very real, if a closer associate got sick.
- Contagion might be interpreted as a “crowd response” emphasising emotional solidarity or identification with others.

Mkhize and Ndabeni (2002:697) point out that the illness in an index case spreads rapidly by audio-visual cues and becomes aggravated by the emergency or media response. Several researchers are in agreement with this observation (Herbert 1982:191; Jones et al 2000:96; Rataemane, Rataemane & Mohlahle 2002:63; Verma & Srivastava 2003:359). According to Bartholomew and Goode (2000) many factors, including mass media, rumours, extraordinary fear or excitement, cultural beliefs and stereotypes, and the social and political context (through actions by authorities such as politicians, institutions, the police and military), contribute to the formation and spread of collective delusions and hysterical illnesses.

²<http://www.aafp.org/afp/20001215/2649.html> (accessed 21 February 2008).

According to several researchers, the predominating symptoms of mass hysteria include headache, dizziness or syncope, sore or burning throat, hyperventilation, difficulty in breathing, watery irritated eyes, chest pains, inability to concentrate, trouble in thinking, vomiting, tingling, numbness or paralysis, anxiety or fear, rash and itching (Bynum 2001:1736; Jones et al 2000:98; Mkhize & Ndabeni 2000:698; Rataemane et al 2002:63).

The settings, signs and symptoms and the gender prevalence of mass hysteria have been well documented. However, several researchers identified some gaps in their studies. One of the niche areas of the documented research is the cultural aspect of mass hysteria. Jones et al (2000:1675) emphasise that it is important to understand mass hysteria culturally in order to utilise resources effectively.

The importance and significance of studying this phenomenon, as well as sensitise all health workers to recognise the early signs and symptoms, cannot be over-emphasised in order for the health workers to respond promptly and appropriately to outbreaks (Jones et al 2000:130). Prompt response can save finances that are used during the investigations of the phenomenon, as well as safe-guard a community against the unnecessary anxiety that emanates from a mass hysteria outbreak.

1.2.1 Lesotho

This study was conducted in Lesotho, a country comprising 30,300 km². Lesotho is situated in the southern hemisphere, surrounded by the Republic of South Africa. It has four well-marked seasons, spring, summer, autumn and winter. It lies entirely outside the tropics at 1,500 to 2,000 meters above sea-level. The highest point in the Maluti range (mountains) is estimated at 3500 meters. This results in Lesotho being free from tropical diseases, as well as having an environment that is free from urban pollution that plague other parts of the world. Lesotho is divided into ten administrative districts four of which are in the mountainous areas. These four include Mokhotlong, Thabatseka, Quthing and Qacha's Nek which have a lower population than the other districts in Lesotho. The overall population of Lesotho is 1.88 million (National Reproductive Policy 2009:7).

1.2.1.1 *Lesotho health care system*

According to the new Lesotho Infrastructure Plan Document (2004:1), health facilities have been reclassified in relation to “service packages” and “technological sophistication”. They have been categorised at primary level as health posts and health centres; at secondary level as hospitals and filter clinics; and at the tertiary level as the referral hospitals. There are three referral hospitals, namely the National Referral, the National Mental Referral and the Leprosy Hospital.

The catchment population varies according to the location of the hospital and the ability to access the facility, for example Paray Hospital which is located in the mountainous area of the country and caters for 12,000 clients, while Berea Hospital situated in the urban lowlands, provides care for 42,000 consumers of health care.

Mental health

Mental health is one element of primary health care (PHC) which caters for prevention of mental health disorders and the possible chaos that may be caused by untreated mental illness in the communities. The focus of mental health care is to rehabilitate clients into the community. Lesotho has one referral hospital (Mohlomi hospital), situated ten kilometres outside Maseru city. The hospital has 120 beds, 60 beds for female and 60 for male adult clients whereas children are treated as outpatients. In August 2011, a children’s wing, geriatric and forensic units were added.

Eight Mental Observation and Treatment Units (MOTUs) exist in all the districts, except Thaba Tseka which runs community services only, manned by one psychiatric nurse and a nursing assistant. The Maseru MOTU was closed down due to administrative and manpower problems (Mental Health Quarterly Report 2010: March-June).

The MOTUs can admit 20 adult patients (10 males and 10 females) for observation and treatment for a period of 6-8 weeks. If the patients do not respond to treatment, they are transferred to the referral hospital under section 7 of the Mental Health Act no.7 of 1964 (presently under review). All district MOTUs are run by mental health nurses who

are answerable to the district hospital administration authority. Mental health relies on mental health nurses to provide services. They, however, operate in isolation of the general health team. This poses problems, because the Mental Health Act (1964) does not allow nurses to prescribe medication for patients or to admit or discharge patients. Psychiatric nurses rely on the medical officers to carry out what they are not allowed to do according to the legislation as some of the medical practitioners review in-patients once a week. Table 1.1 presents the staff profile for the Lesotho Mental Health Section, for the year 2010 to 2011.

Lesotho presently has one expatriate psychiatrist. The status-quo brings problems of translation and cultural interpretations. Mental health is culturally based as affirmed by Flaskerud (2000:9) who indicates that language differences between a client and a health worker may lead to an incorrect diagnosis, because the medical officer/psychiatrist may miss the client's non-verbal cues due to cultural differences and only rely on the interpreter's impressions. Flaskerud (2000:9) cautions that non-English speaking clients may be given severe diagnoses by English speaking therapists.

Table 1.1 Lesotho mental health staff profile

Staff designation	Referral hospital	7 MOTUs
Director of Mental Health	1	0
Consultant Psychiatrist	1	0
Psychologists	2	0
Social Workers	2	0
Psychiatric Nurses	18	12

Mental Health Profile (2004)

According to the Mental Health Profile (2004:7), the staff numbers are far below the International Labour Organization's (ILO) recommended 1:5 nurse/patient ratio. To this day, nurses' attrition rate from Lesotho to the developed countries is on the rise. This is a big challenge faced by the Ministry of Health in Lesotho and other developing countries.

Historically, mental illness has been viewed as a demonic possession, the influence of the ancestral spirits, the result of violating a taboo or neglecting a cultural ritual, and a spiritual condemnation worldwide (Freedman, Kaplan & Saddock 1972 in Johnson 1992:6). In Lesotho the mentally ill and their families experience stigma and discrimination from the communities where they live and the stigmatisation extends even to the nurses who work in mental health settings. Mental health nurses in Lesotho are ridiculed as “being mad or insane like their patients” (the researcher’s own experience as a psychiatric nurse). The researcher has observed relatives of the mentally ill becoming uncomfortable when a doctor recommends admission to the mental hospital. Some of the community members would rather consult a private practitioner, who is not a psychiatrist, in order to avoid seeking help from the mental health facilities, and to dissociate themselves from a mental disorder and its stigma.

To this day, mental illness has not progressed from ridicule, neglect, blame and persecution of the mentally ill. This observation is supported by Flagg (1983:246-251) who contends that such approaches are determined by the political and social climate.

Most health workers who work in the health centers and clinics do not understand the treatment for the mentally ill and as a result, clients are given the wrong prescriptions, the common practice being prescribing diazepam to induce sleep and ease tension, per se. As a result many patients become drug dependent, especially to anxiolytics (researcher’s observations).

It is difficult to retain mental health professionals like all other health workers, in Lesotho. Most professionals leave for greener pastures to the Republic of South Africa, the United Kingdom, Australia, New Zealand, the United States of America, and the Middle East (Makoa, Biesma, Tsekoa, Mpemi, Odonkor, Ralejoana & Tlali 2009:44). The problem is escalated by the fact that the post-basic diploma programme in Psychiatric Mental Health Nursing, the only training programme for mental health nurses in Lesotho, has been experiencing low admission numbers in the last 5 years. Statistics of the National Health Training College show that enrolment in the mental health nursing programme has been declining from 16 candidates since the program’s inception in 1989, to 11 candidates in 1991; 5 in 1993; 6 in 1995; 6 in 1997 and 4 in 2001. After 2001 the program has been indefinitely suspended, which means that there is no training for mental health nurses presently in the country (Mental Health Policy

Draft 2 2005:9). Most mass hysteria victims go unnoticed and untreated due to the low numbers of the mental health practitioners. Thus, myths about the condition remain unchallenged and mysterious, hence the chaos and widespread panic amongst the community members and the victims during the occurrence of mass hysteria episodes. As previously mentioned, the MOTU's are run by psychiatric nurses who function beyond their scope of practice. Sometimes they prescribe and change medication, relying on their own discretion, because some of the medical officers refer patients to the nurse in the MOTU. There is a general lack technical know-how about mental health issues, despite the fact that medical officers are responsible for such patients as indicated in the Mental Health Act no. 7 of 1964 (Mental Health Policy 2nd Draft 2005:7).

1.2.2 International situation

There is considerable classic literature on the phenomenon of mass hysteria from the 17th to the 21st centuries (Madden 1857; Hirsch 1883; Small 1896; Markush 1973; Sirois 1974 in Bartholomew 1990:467; Boss 1997:234 in Bartholomew & Goode 2001; Bartholomew & Wessely 2002:300). These authors and researchers examined the historical evolution of the mass hysteria phenomenon, from evil spirits to chemical and biological warfare and terrorism according to the beliefs of various communities. Cheng-Sheng, Cheng-Fang, Hsiu-Fen and Ping-chen (2003:122) report on a mass hysteria episode among adolescent girl students in Taiwan which were believed to be caused by evil spirits according to their belief system. Bartholomew (2005:564) reports on an incident in Australia where 57 people at Melbourne airport experienced breathing problems, headache, dizziness, nausea and vomiting after an alert that a terrorism attack maybe under way. The mass media attributed the symptoms experienced by the 57 people to mysterious leaking gas. Bartholomew analysed the events and concluded that this episode was possibly psychogenic in nature as its characteristics met the description of psychogenic illness.

Bower (2000:37) contends that physicians fear to diagnose mass hysteria in patients. The fear emanates from causing shame and anger in those affected and in their families. Jones et al (2000:99,100) state that health professionals often pursue extensive and expensive investigations, even if they have a strong sense that the outbreak is psychogenic, for fear of causing anxiety in the community, and of making a

mistake for example overlooking a toxic exposure to the affected people. They argue that establishing psychogenic diagnosis involves ruling out a long list of potential causes such as food poisoning, environmental toxicity, and low levels of ozone and carbon monoxide. These authors purport that in their study it was fairly difficult to make a decision on how much investigation was enough. They emphasise that no extent of testing can eliminate the possibility that evidence of transient exposures may have been missed (Jones et al 2000:1675).

The aforementioned observations illustrate the difficulties faced by health care professionals when they have to make a diagnosis with regard to mass hysteria. Wessely (2000:130) states that health workers feel that their credibility is challenged and they are afraid to be caught in a social debate and become subjects of controversy, media attention and special-interest groups. Some researchers conclude that the medical authorities are defensive and determined to implicate an organic etiology to mass hysteria, in order to escape the stigmatic label of epidemic hysteria. They point out that mass anxiety hysteria is more prevalent in western developed countries, while mass motor hysteria is found mostly in underdeveloped, traditional societies such as Malaya, and Central, Southern and Eastern Africa, where male and adult-dominated power structures foster strict disciplinary routines among pupils especially females (Bartholomew & Sirois 2000:498-499, 502).

This position poses a problem for the victims of mass hysteria, families and the community they live in. It causes tremendous anxiety and worry due to the unknown phenomenon which may be culturally-bound. Miranda and Fraser (2002:423) describe culture-bound syndromes as disorders whose description and phenomenology are specific to a cultural group.

1.2.3 Regional situation

The literature indicates that it may be difficult to link the mass hysteria phenomenon to a specific label regionally and internationally except in the cultural context, which makes it attractive to investigations. A typical example of such a culture bound phenomenon is “Amafufunyane”, which is reported to occur commonly among Zulus and Xhosas in the Eastern Cape (Louw & Edwards 2000:707). In the report by Louw and Edwards, four hundred school children were affected, and the incident was attributed to witchcraft. The

victims displayed swollen and painful stomachs, the school children ran about out of control, rolling eyes, hitting people and wildly breaking chairs and desks. The researchers observed that during such incidences, victims may go into a state of extreme agitation and run about aimlessly. Such incidences lead to social instability in the community. Some people from the community were accused of bewitching children and were attacked by angry crowds, who wanted to kill them.

In April and November 2007, the same phenomenon occurred at Itsekeng High School (a catholic school), located in the urban area south of the capital city, Maseru, and at Peka High school in the Leribe district, in the rural northern region of Lesotho. (Media Reports, September 2007). Newspapers such as "Moeletsi oa Basotho" (2008:June, 2010:September), "Leselinyana" (2007:December) and "Moafrika" (August:2010) reported mass hysteria episodes in Lesotho high schools. These episodes are wide spread in both rural and urban locations showing that mass hysteria often occurs in Lesotho.

An outbreak of mass hysteria was reported at Mapholaneng High School, in the rural area of Mokhotlong District (a protestant school) in 1995, and at St. James High School (a catholic school in the same district) in 1998. Other reports included occurrences of mass hysteria in the Leribe district in 2000 at two catholic schools in the rural area of Lesotho (Radio Lesotho News:2000), and at some factories and in a village in the north of the capital city, Maseru, in 2005 (Radio report). An outbreak of mass hysteria at the factories was triggered by the death of a famous unionist, who was gunned down after working hours, on his way home. He died over night in hospital. During the visiting hour, many factory workers gathered at the hospital and on receiving the news of his death, fainted and cried uncontrollably. This resulted in some of them being admitted to the hospital for a few hours for observation. The situation turned out into a mass hysteria episode (Radio Report 2005).

There were more reports from two factories, owned by the Chinese in the industrial area of Maseru. These outbreaks were reported to affect mostly women. One of the reports came from a village named Mokhethoaneng north of the capital city. The mass hysteria occurred in young married women in April, 2004. The national television showed great interest and televised these women while having an attack; the public was allowed to phone-in and make comments. The audience attributed the mentioned episode to

witchcraft and spirit-possession, while some considered it as a form of mental illness, without ruling out super-natural forces. This concurs with the historical background of the mass hysteria phenomenon named “Amafufunyana” reported in the literature, as occurring among the Zulus and Xhosas in the Republic of South Africa (Louw & Edwards 2000:701).

The Basotho nation holds special beliefs about illness. In particular, unexplained illnesses are attributed to witchcraft, which is a deliberate manipulation of the supernatural forces and spirit possession, anger of gods or ancestors (Louw & Edwards 2000:699-670). The phenomenon of mass hysteria in Lesotho is unexplained; there could be many possible undocumented explanations for its occurrence in this country. It has, therefore, left an area open for study by researchers, to investigate it in the context of the Basotho culture in Lesotho.

1.3 STATEMENT OF THE PROBLEM

Mass hysteria reports are on the increase in Lesotho and these outbreaks involve mostly young women. Norman and Ryrie (2008:543) report that mass hysteria is a dissociative disorder that affects young people, particularly girls and it presents as an epidemic that involves a sensory loss of sight or hearing as well as consciousness. Often, when such outbreaks occur, the traditional healers, faith healers, pastors and priests are deployed to treat the affected. The western health care providers are only engaged as the last resort.

A survey was carried out by Moji and Rojas (1993), who interviewed health workers, international partners (donors), and ordinary citizens from various social strata to explore their perceptions of health and disease. In addition, the belief systems with regard to which diseases are important to the Basotho nation were explored. The authors found that group anxiety disorders and conversion disorders are psychological difficulties which are of priority importance to the Basotho nation. Hysteria is classified as a conversion disorder by Brooker (2005:122). Moji and Rojas (1993:7) purport that “seizure by spirit” is ranked second on the list of diseases of importance to the Basotho while possession by a small animal spirit called “thokolosi” is ranked 6th on the list. This explains why traditional and religious leaders become first line role players in the treatment of the mass hysteria disorder, as they are believed to exorcise the evil spirits

and thokolosi. According to Louw and Edwards (1993:690), the Basotho nation holds special beliefs about illness. Unexplained illnesses are attributed to witchcraft and to spirit possession. It therefore appears that Basotho beliefs regarding psychogenic illness or mass hysteria could be attributed to the supernatural and grounded in the culture and religious inclinations.

The phenomenon of mass hysteria is not well documented in Lesotho. According to the reports over the media during mass hysteria outbreaks, chaos is created among community members and different explanations are given for the occurrence of mass hysteria episodes. During the incidents of mass hysteria in Lesotho, the community members become insecure due to anxiety provoked by this unknown phenomenon (Radio Lesotho and Radio Moafrika Reports). This leads to the research question: what are the Basotho's views and experiences of mass hysteria and how can this phenomenon be better managed to prevent mass anxiety and chaos during mass hysteria outbreaks?

1.4 PURPOSE OF THE STUDY

The purpose of this study was to explore the phenomenon of mass hysteria among the Basotho people in Lesotho and to propose guidelines which may facilitate early intervention and better management and control of mass hysteria outbreaks.

1.5 OBJECTIVES OF STUDY

The objectives of the study were to

- describe the experiences of young Basotho women who were victims of mass hysteria
- establish the causes of mass hysteria in Lesotho, inclusive of the predisposing conditions
- determine the effect of mass hysteria on the community
- identify the strategies used by the Basotho to manage mass hysteria
- propose guidelines for appropriate management of mass hysteria

1.6 SIGNIFICANCE OF THE STUDY

The findings of the study may guide health workers in Lesotho to manage victims of mass hysteria appropriately and to diagnose the episodes timely. If mass hysteria in the Basotho context is better understood, teachers can be empowered through health education to enable them to identify mass hysteria outbreaks in schools early, manage victims and observers more effectively and refer victims to health workers for treatment. The Basotho people can be taught about the condition, in so doing unnecessary anxiety may be prevented and social stability could be maintained, in turn myths may be resolved. The data generated by this study will hopefully lead to a better understanding of the phenomenon and contribute to a greater awareness of mass hysteria among the Basotho.

1.7 DEFINITION OF KEY CONCEPTS

Hysteria is defined as a term previously used for conversion disorder, which is a state of tension or excitement ... that may result in loss of emotional control (Brooker 2005:122). Aromando (1989:49) describes hysterical neurosis or conversion disorder as an expression of psychological conflict which manifests into loss of physical functioning without an organic basis.

Mass hysteria is defined by Bartholomew and Radford (2007)³ as the rapid spread of illness signs and symptoms without any biological basis. Wilson (2005:1) defines mass hysteria as the spontaneous, rapid spread of false or exaggerated beliefs within a population at large, temporarily affecting a particular region, culture or country.

According to Verma and Srivastava (2003:357), mass hysteria is the rapid spread of a conversion disorder, a condition involving the appearance of bodily complaints for which there is no organic basis. Psychological distress is converted or channeled into physical symptoms in such episodes.

³ www.csicop.org/si/archives/P36/ (accessed 23 Aug 2008).

In this study, **mass hysteria** is regarded as a condition in which a group of people exhibit similar physical or emotional symptoms such as anxiety, extreme excitement, convulsions, bouts of crying, running away, aggression and nausea; it starts when a group witnesses an individual, who becomes hysterical during a traumatic or stressful event.

Sociogenic illness (another term used by some authors for mass hysteria) is described by The American Academy of Family Physicians (2002) as being: when groups of people (such as a class in a school or workers in an office) start feeling sick at the same time even though there is no physical or environmental reason for them to be sick.

Psychogenic is defined as a condition caused by psychological factors, in the absence of organic pathology (Lego 1996:628).

Organic illness is defined as a disorder in which mental changes are caused by a specific structural or chemical central nervous lesion (Gary & Kavanagh 1991:1029).

Anxiety is described as an unpleasant feeling of tension resulting from a physical or emotional threat to self (Lego 1996:614).

Rumour is defined as a story spread among a number of people, which is unconfirmed or likely to be false (Oxford South African Pocket Dictionary 2011:786).

Experience is described as a practical contact with and observation of facts or events (Oxford South African Pocket Dictionary 2011:310).

Manifestation is defined as a sign or evidence of something (Oxford South African Pocket Dictionary 2011:547).

Young women refer to women in their youth. The Concise Oxford Dictionary (1964:1518, 1519), defines youth as adolescence, the period between childhood and full womanhood. Young is defined as immature, youthful, and in-experienced. In this study young women means adolescent girls in high schools in Lesotho, also referred to as students, in this study.

1.8 PARADIGMATIC PERSPECTIVE

Belief statements and assumptions about research shape the way the researcher interacts with the world from a paradigmatic perspective. The researcher's assumptions, values and judgments have to be stated explicitly to facilitate valid, reliable research.

A paradigm is defined as “a world view”, a set of beliefs, concepts, assumptions, values and practices that constitutes a way of viewing reality. Paradigms direct scientific inquiry and enable researchers to structure their research and make the philosophical assumptions underlying their methodological choices explicit. Paradigms are characterised by ontological, epistemological and methodological differences in their approach to research and contribution to knowledge (Denzin & Lincoln 2003:4; Weaver & Olson 2006:460; Welford, Murphy & Casey 2011:38).

The researcher followed a qualitative approach, adopting the Naturalistic Paradigm, whose beliefs include that reality is not a fixed unit it depends on the participant's interpretation and within the background the participant lives in. This paradigm stipulates that there are many interpretations of reality and such realities cannot be readily established. The voices and interpretations of participants are equally important and need to be heard and reflected in the report (Polit & Beck 2004:13). According to Denzin and Lincoln (2003:4), qualitative research implies interpretive research involving a naturalistic approach to the world.

For the purpose of this research the following ontological, epistemological and methodological assumptions apply. Assumptions are statements that are believed to be true without proof or verification (Polit & Beck 2008:14).

Ontological assumptions

Ontological means the study of being or reality, it is derived from the Greek word, *ontos*, which is translated as “being” or “reality”. Ontological assumptions concerns human nature and observable phenomena and ask what the real world is and what can be known about it (Mouton 2002:8,124; Welford et al 2011:38).

The researcher assumes that:

- Mass hysteria outbreaks cause anxiety to the community.
- Mass hysteria among the Basotho is enforced by cultural beliefs.
- Mass hysteria outbreaks are aggravated by the Media.
- Mass hysteria often involves young women.

Epistemological assumptions

Epistemological assumptions focus on the nature of knowledge and science, what is authentic, what is true knowledge, what is the relationship between the inquirer and that being studied (Mouton 2002:9,124; Welford et al 2011:38). The researcher believes humans create their own experiences and there are multiple realities, therefore truth is a composite of many realities. Reality, in this case mass hysteria, exists within a context and can be interpreted in many ways. It is important to understand mass hysteria as it is experienced in the naturalistic setting. The researcher is subjectively involved, intersubjectivity (mutual recognition) between researcher and research participant is fostered and valued and the researcher is the primary instrument for data collection and analysis. The truth about the nature of mass hysteria in Lesotho can only be known through the voices and interpretations of those who experienced the phenomenon.

Methodological assumptions

Methodological assumptions are concerned with the nature of the research process and the most appropriate methods to be used, it questions how the researcher can go about finding what he believes can be known (Mouton 2002:39; Welford et al 2011:38). The researcher believes that mass hysteria in the Basotho can best be investigated by using individual interviews and focus group interviews with those who experienced and witnessed mass hysteria episodes. By listening to the participants' experiences, meaning and understanding can be gained about the phenomenon of mass hysteria.

1.9 RESEARCH DESIGN AND METHODOLOGY

A brief description of the research design and methodology used in the study follows.

1.9.1 Research design

A qualitative approach was adopted in this study. Qualitative research is defined by Polit, Beck and Hungler (2001:469) as the investigation of phenomena in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design. The focus in qualitative research is on descriptions and meaning, which involves interpreting non-numerical data.

Qualitative researchers “focus on the dynamic, holistic, and individual aspects of phenomena and attempt to capture those aspects, in their entirety, within the context of those experiencing them” (Polit et al 2001:15). This approach has the advantage of allowing for more diversity in responses as well as the capacity to adapt to new developments or issues during the research.

The design was explorative, descriptive, and contextual. Polit and Beck (2004:192) describe descriptive research as a non-experimental study whose purposes are observation, description and documentation of a situation as it occurs in a natural setting. In this study mass hysteria was described as it appears among the Basotho in Lesotho. Rubin and Babbie (1997:82) contend that explorative studies are valuable in social scientific research, especially if the topic is understudied, which is the case with mass hysteria in Lesotho. Explorative research was regarded as practical and essential in breaking new ground, with the possibility to yield new insights into the phenomenon of mass hysteria as it presents among the Basotho people in Lesotho.

1.9.2 Population and sample

The population for this study comprised of young women (school girls in high schools in Lesotho) who experienced mass hysteria and those who witnessed and were involved

during the mass hysteria incidents including teachers, traditional healers, religious leaders and parents.

1.9.2.1 Sample

The sample comprised the identification of information rich participants from four affected schools in Lesotho where mass hysteria episodes occurred and were reported by the media from 2005 to 2010. The key informants included the affected school girls (victims of mass hysteria) in schools A, B and E. They came from urban areas and a rural school. The sample included the principals and teachers who were present during the mass hysteria incidents and traditional healers and priests who assisted the victims of mass hysteria and a parent of one of the affected school girls.

The researcher proceeded to sample until satisfied that the richness of the data was meaningful to report, and until the data saturation point was achieved when no more new data emerged (De Vos, Strydom, Fouche & Delport 2005:294; Munhall & Boyd 1993:256).

In this study non-probability, purposive sampling was used; this is purposely selecting the specific participants that will provide the rich data needed to gain insights and discover new meaning in the area of study as purported by Munhall (Burns & Grove 2007:348).

The selection of participants was based on the assumption that the participants knew more about the phenomenon under study, by having experienced mass hysteria (being victims) or having observed and/or assisted the victims of mass hysteria.

1.9.3 Data collection instruments

The researcher used focus group and semi-structured individual interviews to collect data. The individual interviews were held with 1 victim of mass hysteria from a rural area, 4 school principals from schools A, B, C and D, 1 parent from school E, 5 traditional healers, 1 priest and 1 pastor. The focus groups were conducted with 10 affected school girls from school A, 10 victims from school B, 10 teachers from school E and 10 teachers from school A as well as 10 victims from school E.

Bowling (2000:352) argues that focus groups, specifically, elicit group dynamics. These underlying forces aid discussion stimulation, insight development and in-depth idea generation from participants. They persistently assail the phenomenon on hand. Moule and Goodman (2009:298) add that focus group interviews are time efficient, as group views are obtained at once. They have the potential to encourage a rich dialogue from participants.

An individual interview was held with one student from the rural part of Lesotho because she was the only one that could be tracked by the researcher in that area. Interviews are flexible and allow deeper exploration of the phenomenon at hand. All interviews were audio-recorded.

A checklist (Alberstein's Histrionic Vampire Checklist⁴) was completed by 14 victims of mass hysteria from school A and 10 unaffected school girls from school E as a comparison group to evaluate whether the victims have histrionic personality traits.

1.9.4 Data analysis

Burns and Grove (2007:586) state that data analysis reduces, organises and gives meaning to data. There are no systematic set of rules for analysing and presenting qualitative data. Moule and Goodman (2009: 344) indicate that various methods can be utilised when analysing qualitative data.

The researcher used content analysis which Moule and Goodman (2009 349) describe as a process involving the labeling of data. During content analysis data chunks are labeled (coded) and similar codes are grouped into categories. Themes emerge from categories which are linked together. The data were derived from the verbatim transcriptions from a voice recorder. The voice recorded interviews were transcribed word for word as prescribed by Morse and Field (1995) in Burns and Grove (2007:81). The main task was a search for themes and categories, which revealed commonalities across and within the data. Burns and Grove (2007:79) contend that qualitative data analysis occurs in three stages: description, analysis, and interpretation. The

⁴Psy.rin.ru/eng/article/140-101.html (accessed 21October 2007).

descriptive phase is the stage whereby the researcher needs to become more familiar with the data. This may involve reading notes and transcripts, recalling observations and experiences, and listening to audiotapes, a process whereby the researcher becomes immersed in the data.

The quantitative analysis of the data from the check list was carried out with the use of computer software. The analysis was done by utilizing the “Stat Pac Program Package”. The age distribution, social problems and religious denominations of the affected students, parents’ occupation as well as cause of death (where applicable) were identified. The distribution of the checklist scores was analysed separately for the affected students and the unaffected girl classmates.

1.10 ETHICAL CONSIDERATIONS

Ethics is defined as the study of the code of moral principles which derive from a system of values and beliefs and is concerned with rights and obligations (Brooker 2005:86). Ethical considerations in research studies ensure that the specific study meets prescribed ethical standards. The researcher obtained ethical clearance from the Department of Health Studies Higher Degrees Committee at the University of South Africa (UNISA) (Annexure A). The approval to conduct the study at the study sites was obtained from the Ministry of Education and Training (Annexure E) and the Ministry of Health (Annexure D). The letters requesting permission to conduct the study are attached as Annexures B and C. The researcher respected the participants’ right to voluntary participation and self-determination, fair treatment and protection from harm, and the right to privacy. The ethical considerations are discussed in detail in chapter 3.

1.11 CONCLUSION

An overview of the topic and context of the study was given indicating the lack of literature on mass hysteria in the Basotho context. The background and problem statement illustrated the continuous reports of mass hysteria outbreaks in Lesotho mainly in the secondary schools and to a lesser extent in factories, highlighting the need for a thorough investigation into the nature and consequences of the phenomenon of mass hysteria as it manifests in the Basotho. The research design and methods were indicated briefly. The next chapter discusses available literature on mass

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses relevant and recent literature on mass hysteria and Sesotho culture. A literature review serves many purposes as it identifies research problems. It orientates researchers towards what is known about the area of inquiry, and towards what is left unknown, thus providing a clearer perspective on the best contribution towards the generation of new knowledge in the area of the research topic. It assists the researcher in identifying gaps and inconsistencies in the existing body of knowledge, as well as the appropriate theoretical frameworks, applicable to the current study. It further assists in the identification of suitable research designs, data collection and data analyses methods (Polit et al 2001:121).

This literature review presents a discussion of mass hysteria as a phenomenon, different definitions and theories of mass hysteria and contributing factors. An overview of the Basotho culture is included.

2.2 THE PHENOMENON, MASS HYSTERIA

Hysteria has been a controversial phenomenon from its inception; there have been many debates about this phenomenon. According to Micale (1995:5), hysteria conjures up from its historical past, where it evoked flamboyant and melodramatic images. Hysteria dates as far back as Greek medicine, which ascribed it to the “mischievous wandering womb”, which was believed to move through the female’s body, causing physical and behavioral abnormalities. The Columbia Electronic Encyclopedia (2007⁵) defines hysteria as “a disorder ... in which a psychological conflict is converted into a bodily disturbance”. This disorder is found in clients with immature, histrionic personalities who are under stress. Several Austrian and French health workers including Breuer, Freud, Charcot and Pierre, initiated research on hysteria and drew the

⁵ <http://encyclopedia2.freedic.com/hysteria+definition/>. [Accessed 30 October 2013]

conclusion that hysteria symbolises repressed emotions and that it could be treated by hypnosis (Illis 2002:311).

Bartholomew and Sirois (1996:286) explain that several researchers have recommended the abandonment of terms such as mass or epidemic hysteria, which are believed to be prejudicial towards females.

Various authors and researchers use different terms to describe mass hysteria. These authors however, agree on the description of mass hysteria as a rapid spread of illness, which affects a group of people collectively. The affected show the same emotional symptoms and bodily complaints, for which there is no organic basis. A mass hysteria episode is characterised by epidemic malaise, emotional lability, depression, gastrointestinal upset, muscle aches and headaches. These symptoms change quickly and easily between outbreaks and the symptoms occur in closed, socially cohesive populations. Wilson (2005⁶) describes mass hysteria as a spontaneous, rapid spread of false or exaggerated beliefs within a population at large, temporarily affecting a particular region, culture or country. He adds that this problem is triggered by a person's perception of a threatening force.

It is important to understand the views of different authors who have studied mass hysteria in order to comprehend the difficulties that face the communities involved in mass hysteria outbreaks.

2.2.1 Terminologies and definitions of mass hysteria

The reasons provided as rationale for the many terminologies and definitions for mass hysteria vary, according to perception. According to Balaratnasingam and Janca (2006:171), the different terms used are likely to be the result of the pejorative nature of mass hysteria. Bartholomew and Wessely (2007:657) affirm that most community members dislike diagnosing mass hysteria. They have an opinion that mass hysteria is far-fetched as a concept and that it happens to those outside their community. Most consumers of healthcare are afraid to diagnose mass hysteria and acknowledge it as an acceptable disorder (Jones 2000⁷). The diagnosis of mass hysteria remains debatable,

⁶ <http://im1.jou.ufl.edu/projects/Spring05/Wilson/hysteria.html> . [Accessed 8 August 2007]

⁷ http://www.aafp.org/2000/12_15p2649.html (accessed 20 July 2004).

and is regarded as a prohibited diagnosis. It is likewise an expensive diagnosis, as practitioners run many costly tests to rule out other diagnoses.

This view is supported by Wessely (2000)⁸, who states that mass hysteria, as described by Freud, is a “destructive phrase”, because it stresses the fact that its symptoms are all in the mind, while psychogenic symptoms are experienced as physiological and are based on physiologic processes that cause pain and suffering. The problem emanates from the fact that the client experiences pain, which may not be treated.

The following diverse terms for mass hysteria are found in the literature.

Conversion disorder

According to Brooker (2005:122), mental health professionals have moved away from the use of the word mass hysteria, and have renamed this condition “conversion disorder.” Their understanding being that repressed emotions are diverted into wrong somatic channels (conversion) and result into physical symptoms (The Columbia Electronic Encyclopedia 2007)⁹.

Collective delusion

Dewey and Ries (2006)¹⁰ and Bartholomew and Goode (2000)¹¹ define mass hysteria as a form of “*collective delusion*”. They denote collective delusion as the spontaneous, rapid spread of false or exaggerated beliefs within a population at large, temporarily affecting a particular region, culture and country. These authors point out that this condition is a false belief, inconsistent with the person’s culture and level of intelligence, and that it cannot be altered by argument or reasoning. There is the suggestion of labeling the person as being mentally ill. According to Bartholomew (1997)¹², delusions are persistent pathological beliefs associated with serious mental disturbance, as defined by psychiatrists. However, sociologists describe “collective delusion” as the spontaneous, temporary spread of false beliefs that occur in a given population. Jones

⁸<http://www.aafp.org/2000/1215p2649.html> (accessed 21 July 2005).

⁹<http://www.factmonster.com/encyclopedia.html> (accessed 14 February 2013).

¹⁰http://www.amazon.com/exec/obidos/ASIN/1933665025/the_anomalist (accessed 21 August 2007).

¹¹<http://www.csicop.org/2000-05/delusion.html> (accessed 23 August 2007).

¹²<http://ergotism.info/en/hysteria/mass-hysteria-epidemic-rev-1997.pdf> (accessed 20 November 2008).

(2000) adds that mass psychogenic illness (MSI) involves people with real symptoms, which are often triggered by misunderstood or false information.

Pastel (2001:44) refers to mass hysteria as “collective behaviours” and mass panic and outbreaks of multiple unexplained symptoms. He contends that they occur in situations that are characterised by obvious physical danger and limited escape routes, a phenomenon which is common in combat. Pastel describes mass panic as an acute fear reaction, marked by a loss of self-control, followed by a social and non-rational flight. This description denotes shared group behaviour associated with panic and other mysterious symptoms.

Mass psychogenic illness

Bartholomew (1994¹³), reports that Stahl (1982:185-198), prefers the term “*mass psychogenic illness*” (MPI) to mass or epidemic hysteria, because MPI has a psychological explanation, while mass or epidemic hysteria is judged to be a sickness that is psychosomatic in origin and viewed as abnormal behavior. It therefore carries a stigma endured by mental illness. This stigma signifies a mark or sign of disgrace or discredit to the victims.

Mass sociogenic illness

Feldman (1994¹⁴) refers to the term “*mass sociogenic illness*” (MSI) which he describes as a form of mass hysteria, whereby sight and sound can cause many people to start feeling sick. He adds that the cause of mass hysteria is a baseless belief that begins small, but becomes devastating when picking up speed. He compares its speed to a tornado. The American Academy of Family Physicians (2002)¹⁵ agrees with Feldman’s description of MSI by adding that these groups of people are associates, such as a class in a school or workers in an office. They feel ill at the same time, even though there is no physical or environmental reason for them to be ill.

¹³ <http://www.ergotism.info/en/hysteria-epidemic-rev-1997.pdf>. [Accessed 20 November 2008]

¹⁴ <http://www.selfhelpmagazine.com/article/masshysteria>. [Accessed 23 October 2007]

¹⁵ <http://www.healthyplace.com/Communities/Anxiety/mass-psychogenic-illness.asp> (accessed 23 August 2008).

Bartholomew and Wessely (2002:300) and Harris (2012)¹⁶ report that mass sociogenic illness is a rapid spread of illness, with symptoms affecting members of a cohesive group. It originates from a nervous system disturbance involving excitation, loss or alteration of function, whereby physical complaints are exhibited unconsciously with no corresponding organic etiology.

Mass phenomena

Wittstock and Rozental (1991:851) refer to “*mass phenomena*”. According to them, mass phenomena are outbreaks of unusual behaviour including epidemic spread of somatic complaints with no organic etiology. They too avoid the term hysteria.

Psychosomatic illness

Mackenzie (1997:5) uses the term “*psychosomatic illness*”. He attributes its origin to the rising ethnic tensions in a region where there is an element of fear or panic, and where the symptoms have a combination of physical and mental origin.

Koro

Chowdhury (1998:180), Dzokoto and Adams (2005:53) and Garlipp (2009:21) refer to an incidence of mass hysteria as “*Koro*” which has been described a culture-bound phenomenon. Koro has been reported in several countries including Malay, China, India and some countries in West Africa namely: Ghana, Cameroon and Nigeria. These researchers describe the syndrome as an epidemic characterised by an imagination or fear of shrinking, retracting or vanishing organs, such as the penis in males and breasts in females.

These authors report that there were accusations that were triggered by incidental body contact with a stranger in a public place, after which the victim would feel strange scrotal sensations. The accused would be confronted, often threatened, and in extreme cases beaten to death. This supports the false information as a cause of the incidence (Bartholomew & Goode 2000¹⁷; Chowdhury 1998:180). Some researchers use the term

¹⁶<http://www.orange-paper.org/forum/node/1328> (accessed 30 October 2012).

¹⁷[http:// www.csicop.org/2000-05/delusion.html](http://www.csicop.org/2000-05/delusion.html) (accessed 7 May 2008).

mass hysteria to describe the same phenomenon that has been addressed as Koro. Ntouros, Ntoumanis, Bozikas, Donias, Giouzepas and Garyfalos (2010)¹⁸ contend that Koro syndrome may be viewed as rare among caucasians living in the western countries, but, an increasing number of cases are nonetheless being reported.

The above discussion illuminates a variety of terminologies and definitions for the phenomenon of mass hysteria. However, the use of terms like mass psychogenic illness or mass sociogenic illness or collective exaggerated emotions never gained acceptance, because researchers view these as stigmatising victims of mass hysteria by linking the psychic to the diagnosis. Micklem (1996:120) asserts that the term hysteria must not be given up, but its existence be appropriately recognised as reality and be addressed appropriately.

2.2.2 Theories of mass hysteria

Most researchers agree that mass hysteria is a physical, social and psychological problem (Bartholomew & Wessely 2002:300; Micklem 1996:4; Smelser 1962:6). In the literature it is possible to explain the etiology of this disorder in the biological, psychoanalytic, sociological dimensions. In this study the biological, psychological and sociological theories are acknowledged.

2.2.2.1 *Biological theory*

As pointed out earlier in the discussion of the controversies that surround hysteria, it is perhaps wise to dwell a little on the historical perspective. Micklem (1996:9) reports that hysteria was previously described as a female gynecological disorder, which presented with different symptoms and signs. It emerged in healthy young women, as well as spinsters or widows, who presented with shallow breathing, a sensation of suffocation, palpitations, weak pulse, pallor, cold clammy skin, vomiting, headache, contractures, convulsions or loss of consciousness, and loss of sight, speech or memory.

According to Micklem (1996:3), Micale (1995:16) and Gilman, King, Porter, Rousseau and Showalter (1993:9), hysteria has been a form of organic disorder from its historical

¹⁸[doi:10.1136/bcr.08.2008.0679](https://doi.org/10.1136/bcr.08.2008.0679) (accessed 27 January 2012).

inception. However, Muller (1996:2) argues that although priority is given to the biological substrate of understanding behaviour, it is actually culture that is the proper cause of human action or behaviour.

The medical fraternity had been treating the phenomenon of mass hysteria as a biological disorder throughout centuries. Bartholomew and Sirois (1996:290) and Gilman et al (1993:viii) point out that the biological theorists suggest that females are born with a susceptibility to epidemic hysteria syndrome. The authors hold that females possess weak mental constitutions and are prone to emotional instability, which predispose them to this type of epidemic outbreak.

During medieval times (around the 5th Century AD) disease was attributed to supernatural forces, emphasis was placed on evil spirits, demons and sorcerers, and hence hysteria was assigned to witches, who were then punished by being burned alive or stoned to death. Hysteria was perceived as a crime, instead of a disorder requiring treatment and care (Perko & Kreigh 1988:3; WiseGeek 2009¹⁹).

Bartholomew and Sirois (1996:290) argue that proponents of a biological basis for the disorder do not take into account the influence of gender socialisation, which dictates emotional expressiveness and the submissive character traits of females. Lee and Ackerman (1980:85) support this observation by indicating that in Malayan culture, women are socialised to perceive women's souls as being by nature, weaker than men's. This is said to expose them to the vulnerability of spirit possession. Mass hysteria is further believed to be a type of spirit possession in Malayan culture. These women are socially prohibited to voice their grievances, anger or dissatisfactions openly in public. Throughout the world, despite the feminism movement, women have been placed in a low-status position in the social power hierarchy, which one could reasonably argue predisposes them to long-term withheld emotional frustration.

Gilman et al (1993:286) elaborate on the views of Tilt (1881:85), who links women's biology to hysteria. He states that women sustain something fundamental in their nature which is inborn, fixed or given, that obviously require interaction with the environmental forces to manifest, and the author claims that it is irreversible. Gilman et al (1993:187)

¹⁹ <http://www.wisegeek.com/what-is-mass-hysteria.htm> (accessed 8 April 2009).

add that all women are hysterical and every woman carries the seeds of hysteria. Biological theorists are adamant that hysteria is directly linked to womanhood.

Most researchers attribute mass hysteria to be a preponderance of females (Halvorson et al 2008²⁰; Kokota 2011:74; Smeehuijzen 2012²¹). However, Waller (2008)²² and Wedel (2012:4) report male involvement in mass hysteria. Other researchers report “Koro” episodes that involve both genders (Garlipp 2008:21; Sinawi, Adawi & Guenedi 2008²³). Goh (1979:265) found equal numbers of male and female students involved in an epidemic of mass hysteria. Furthermore, Bartholomew and Wessely (2002:302) support Goh (1979:265), showing that males can experience mass hysteria. These authors studied male military recruits in 1988 in California, USA, who were involved in an outbreak of a psychogenic illness.

According to Medscape (2012)²⁴, neurobiologists have various explanations for the biological origin of mass hysteria (conversion disorder). The neurologists purport that because the mind is a structure of the brain, unbearable memories are transformed into somatic symptoms, and are depicted as mass hysteria (Illis 2002:311). In addition, another biological theory stipulates that conversional states are protective strategies that arise from pre-learned behaviours (Wilner 2012²⁵).

This hypothesis points to several anatomical structures of the brain, in which a circuit dysfunction can be found that contains the cingulate cortex, insula, thalamus, brainstem nuclei, amygdala, ventromedial prefrontal centers, supplemental motor area and other key areas (Medscape 2012²⁶). Another theory points to a dysfunction of striathalamacortical pathways, which control both the sensori-motor function and voluntary motor behavior (Medscape 2012²⁷). Owens and Dein (2005)²⁸ contend that conversion disorder is the result of an impaired cortical and subcortical dysfunction.

²⁰ <mhtml:file:G:\An Outbreak of itching in an elementary School - A Case of Mass Psychogenic Response> (accessed 27 August 2012).

²¹ <http://www.united-academics.org/magazine/723/723/> (accessed 30 October 2012).

²² <mhtml:file://John Waller-Looking Back Dancing plaques and mass hysteria.mht> (accessed 27 August 2012).

²³ <http://www.ijmhs.com/content/3/1/22> (accessed 24 January 2011).

²⁴ <http://www.medscape.com/veiwaarticle/766971> (accessed on 8 April 2009).

²⁵ <http://www.medscape.com/veiwaarticle/766971> (accessed on 8 April 2009).

²⁶ <http://www.medscape.com/veiwaarticle/766971> (accessed on 8 April 2009).

²⁷ <http://www.medscape.com/veiwaarticle/766971> (accessed on 8 April 2009).

²⁸ <http://apt.rcpsych.org/content/12/2/152.full> (accessed 23 January 2013).

One of the biological theories is entrenched in the concept of 'neo-dissociation', a concept derived from Hilgard's hypnosis theory. According to Whalley (2012)²⁹, Hilgard's theory proposes that hypnosis is produced through detachment (dissociation) within high level control, by splitting the functioning of the executive control systems (ECS) into different divisions. He adds that the part of the ECS is essentially functioning normally, but it is unable to represent itself in a conscious state due to an amnesic barrier. However, through the concept of the 'hidden observer' introduced within the theory, this means that part of the mind (one division) is conscious of the hypnosis process, while the other division is unconscious. Hilgard therefore assumes that the hidden part of the mind experiences hypnotic pain relief. Proponents of this theory assume that a hysterical client with visual loss still processes visual stimuli, which influence her/his behaviour, yet she/he is unaware of the visual input. From these deductions, psychosomatic symptoms are endorsed as being representations of sensory data that is integrated into the consciousness in an erroneous way.

Feinstein (2011)³⁰, on the other hand, explains that conversion disorder clients have an abnormal form of cerebral activation, whereby the limbic system overrides the activation of motor and sensory cortices, a mechanism referred to as 'reciprocal inhibition', which permits regions to close up each other during data processing. The caudal segment deactivates the anterior cingulate cortex when processing strong emotion in conversion disorder. These are the contemporary explanations of biological theorists.

2.2.2.2 Psychological theory (psychoanalytic)

According to Marcel (2005:64), Sigmund Freud had an idea that hysteria may develop due to a physical traumatic injury, as well as a severe fright or other psychical trauma. Freud divorces himself from the biological basis of disease, but elaborates on a new theory that hysteria is psychological in origin. He emphasises the origins of neuroses as being both physical and mental. Gilman et al (1993:vii) agree that hysteria is a result of a mind-body association. Mickel (1996:13) views hysteria as being a psychological structure, which causes distress and requiring psychotherapy. Pienaar (2005)³¹ and Allin, Streeuwitz and Curtis (2005:207) assume that victims of mass hysteria react to a

²⁹ www.hypnosisandsuggestion.org/theories-of-hypnosis.html (accessed 7 March 2013).

³⁰ [doi:10.1503/cmaj.110490](https://doi.org/10.1503/cmaj.110490) Epub 2011 April 18 (accessed 23 January 2013).

³¹ <http://blogs.sun.ac.za/mhic/files/2011/09/somatic-complaints-in-Psychiatry.pdf> (accessed 23 January 2013).

state of extreme unconscious psychic conflict, which is converted into psychosomatic symptoms. This theory is used to explain the histrionic personality associated with mass hysteria.

Psychoanalysts believe that the conscious, subconscious and partly conscious use of the 'sick role' is to get sympathy, attention and to manipulate a situation, with the unconscious secondary gains contributing to mass hysteria (Lee et al 1996:248; The Royal College of Psychiatrists 2013³²). However, the American Psychiatric Association (1994:457) argue that histrionic people do not consciously assume the sick role to obtain secondary benefits, but, considerable simulation might occur in order to convince a given authority to take immediate action to stop the perceived threat (Bartholomew & Sirois 1996:288). Milhado (2011)³³ purports that hysterical people are generally depressed and introverted. They are overly dramatic, dependent and susceptible. These theorists contend that mass hysteria originates from the mind in response to psychological conflict.

2.2.2.3 Sociological theory (value-added theory of collective behaviour)

This theory operates on an assumption that hysteria is a social problem, that it emanates from society and it is cultural in origin. The theory was developed by Neil Smelser in 1962. His aim was to reduce the unknown occurrence of collective outbursts (Kotler 2012³⁴; Smelser 1962:1). Collective behavior refers to the expression of strong, inappropriate emotional or physical responses such as irrational fears or hopes, or sickness by groups of people whose beliefs are based on suggestions, misunderstood facts, imagined stimuli, communal reinforcement, or blindly following a false authority (Skeptical Dictionary³⁵).

Smelser (1962:1) stipulates that the collective behaviour episodes occur in dysfunctional social orders, because rapid social and cultural changes produce disequilibrium within the normal state of society. Robin (1981:153) indicates that, for example, "new moral codes" associated with religious revival in New Guinea, resulted in

³² www.rcpsych.ac.uk/ (accessed 23 January 2013).

³³ <http://ojaiandventuraveiw.com/ovvtaArt/veiwvol3Issue37Juneonline.pdf> (accessed 26 January 2013).

³⁴ <http://www.forbes.com/sites/stevenkotler/2012/11/23> (accessed 23 January 2013).

³⁵ www.skeptdic.com/mass_hysteria.html (accessed 19 February 2013).

hysteria, while Chowdhury (1998:184) reports that Koro epidemics are a result of geopolitical stress and cultural transformation.

Bartholomew (1990:455) contends that mass hysteria is viewed as a deviant, irrational or abnormal behaviour, due to its contagious nature. Contagion is a rapidly spreading infection, which moves quickly from person to person. It is now used as a metaphor for anything that spreads rapidly. It is, therefore, befitting to examine the contagion theory, in order to understand this phenomenon more broadly in a wider cultural context.

Contagion theory maintains that a crowd exercises a hypnotic effect on the members of the given crowd; members lose identity and responsibility to a shared mind. Proponents of contagion theory are of the opinion that it is important to examine social forces that arise from the interactions of large numbers of people in a group which form the cultural and social orders (Monnier 2011³⁶).

Macionis and Gerber (2010)³⁷ explain that for the contagion to occur the crowd members must focus their attention on the same event and influence each other, thus, excitement grows within them. This results in loss of self-consciousness, which leads to a frenzied state. The situation inhibits decision-making in the crowd members. The group members act before they can analyse the situation, and agree to any idea or behavior by any group member. In so doing, they move to the level of the lowest member. This explains why people do what they normally would not do when within their rational status.

Smelser's theory identifies the significant features of collective behaviour as being directed by beliefs which comprise extraordinary forces. These beliefs are divided into:

- Generalised beliefs which entail an assessment of the strange consequences, which will follow if the collective attempt to re-form social action is successful.
- Collective behaviour is not established behaviour, rather, it is shaped or copied to meet vague or unstructured circumstances (Smelser 1962:8-9).

³⁶<https://globalsociology.pbworks.com/w/page/147111> (accessed 23 January 2013).

³⁷[Wps.prenhall.com/ca-ph-Macionis-sociology-5/23/6034/1544830.cw/index.html](http://wps.prenhall.com/ca-ph-Macionis-sociology-5/23/6034/1544830.cw/index.html) (accessed 20 February 2013)

He further describes collective behavior as a product of interaction between the following five elements:

- Structural conduciveness is the pre-existing social circumstances that permit the occurrence of collective behaviour.
- Structural strain concerning the encounters of societal norms and values which results in panic.
- Growth and spread of a generalised belief, occurring when people view the strain in a similar context.
- Mobilisation for action, which entails the communication by the leadership, which is viewed as very important in organising collective action.
- Social Control, which inhibits the formation of hysterical belief. It is intended to minimise structural conduciveness and strain, in order to prevent and affect the speediness, magnitude and the trend of the episode (Bartholomew 1989:297).

These elements are all needed to assist the existence of mass hysteria (collective behaviours). This theory guides the researcher to identify the beliefs and elements in Basotho culture that would promote mass hysteria.

2.2.3 Manifestations of mass hysteria

Mass hysteria outbreaks manifest in different patterns and types, although common characteristics of epidemic mass hysteria have been identified. During these outbreaks victims display a variety of symptoms, as described in the literature.

2.2.3.1 *Patterns and types of mass hysteria*

The Oxford South African Pocket Dictionary (2011:654) defines “pattern” as a regular form or order in which a series of things occur. This section examines the types of mass hysteria in different world regions, with the purpose of identifying the patterns that the Basotho victims experience during mass hysteria incidents.

Bartholomew and Sirois (1996:291) conducted a literature review to examine the characteristic features of epidemic hysteria in school settings. From the review they identified three distinct symptomatic patterns, namely:

- Mass motor hysteria, which is predominant in non-western traditional cultures.
- Mass anxiety hysteria, which is prevalent in western or developed countries.
- Mass pseudo hysteria, which involves the re-labeling of ordinary symptoms by authorities.

Furthermore, some literature shows that according to the locations and cultures, victims of mass hysteria experience different signs and symptoms. Bartholomew and Wessely (2002:300) for example identify two types of mass sociogenic illness as:

- *Mass anxiety hysteria*, which involves sudden, extreme anxiety, following the perception of a false threat and it is of short duration of one day.
- *Mass motor hysteria*, which is typified by slow accumulation of pent-up stress, and it is confined to an intolerable social setting and characterised by dissociation and alterations in psychomotor activity (such as shaking or tremors, twitching and contractures). It lasts for weeks to months.

Phoon in Colligan et al (1982:28) describes the two main modes of presentation of mass hysteria as:

- *The violently hysterical* victims presenting by screaming, crying and struggling. They illustrate that in these cases violence is aggravated by any attempts to restrain the victims.

They add a sub group to this type; a trance state, whereby the victim acts as though she is somebody with a spirit speaking through her, which lasts for a few minutes and they label it as:

- *The frightened* presenting with explained feelings of fear, numbness, coldness and giddiness.

Roach and Langley (2004:1269), the Ugandan Media (2011)³⁸ and Govender (2010:320) define mass hysteria as the immediate manifestation of related signs or symptoms with a psychogenic basis in many individuals in a group, which means that

³⁸ Wps.prenhall.com/ca-ph-Macionis-sociology-5/23/6034/1544830.cw/index.html (accessed 20 February 2013).

the symptoms are not organic in origin and that they occur suddenly, without warning and affect many healthy people within a group. These people display the same behaviours which may include fainting, seizures, screaming, anxiety and physical strength. Verma and Srivastava (2003:357) identify mass hysteria as being characterised by the rapid spread of conversion disorder, a condition involving the appearance of bodily complaints, for which there is no organic basis. They agree with the afore-mentioned authors and add that it is a type of somatoform disorder, namely conversion disorder (DSM-IV-TR Classification 2000: 300:11). They therefore classify this condition as a mental disorder.

Wessely (1987:109), Kokota (2011:74) and the Ugandan Media (2011)³⁹ describe the general pattern of a mass hysteria outbreak as a sudden onset (without warning), with a high degree of contagion from person to person, school to school or factory to another. They report that there is a high rate of repeated tendency for a victim to experience an attack after the initial one, as well as likelihood for the victim to be involved in other attacks on the second and subsequent days. Such outbreaks subside within a week or so without any intervention. This pattern seems to occur worldwide.

Bartholomew and Sirois (1996:291; 2002:497) agree with Wesley on the general pattern but add a rare third episode-type named “*mass pseudo-hysteria* or *re-labeling of endemic symptoms*” that is fostered, maintained and reinforced by a hyper-vigilant medical community, and/or authority figures. On the other hand, Govender (2010:318) classifies mass hysteria into the *Explosive type* and *Diffused Type*. He describes the *explosive type* as occurring in small “entrenched” social relations, while the *diffuse type* affects people in one institution as a result of false beliefs and rumours that devastate the community. From the above observations it is clear that distinct patterns of mass hysteria occur in different regions of the world. One outstanding factor is the country’s developmental position, which verifies the significance of the socio-cultural factors in the phenomenon’s prevalence.

³⁹[http://freethoughtkampala.wordpress.com/2011/04/04/woo-takedown-03-demonic-attack in Ugandan-primary-schools](http://freethoughtkampala.wordpress.com/2011/04/04/woo-takedown-03-demonic-attack-in-ugandan-primary-schools) (accessed 30 October 2012).

2.2.3.2 *Characteristics of epidemic mass hysteria*

Epidemic mass hysteria episodes are described in the Literature indicating a variety of signs and symptoms.

Goh (1979:268) describes the common features of an outbreak as:

- Sudden onset
- High degree of “infectiousness”
- Rapid spread

Lee et al (1996:248), The Daily Omnivore (2005)⁴⁰ and Smeehuijzen (2012)⁴¹ outline the characteristics of mass hysteria as:

- Absence of laboratory and physical test findings
- Preponderance of females
- Transmission of illness by sight or sound or both
- No illness among other group sharing the environment
- The presence of hyperventilation or syncope
- Spread and rapid remission of symptoms
- Potential relapse in the setting of original outbreak
- Evidence of physical and or psychological stresses

Bartholomew and Wessely (2002:303) disagree with this by arguing that there is no consistent pattern for mass hysteria. Knight et al (1965:859), Moss and McEvery (1966:1300), Roach and Langley (2004:1271) and Vaknin (2009)⁴² contend that people with hysterical traits and histrionic personality disorder who are paranoid and neurotic are prone to mass hysteria outbreaks, whereas Bartholomew and Wessely (2002:303) find no relationship between psychogenic illness and personality traits. They therefore conclude that there is no particular predisposition to personality traits and mass sociogenic illness. They point out that since mass hysteria is a behavioral reaction,

⁴⁰<http://thedailyomnivore.net/2012/09/05/mass-psychogenic-illness/> (accessed 30 October 2012)

⁴¹<http://www.united-academics.org/magazine/mind-brain/mass-psychogenic-illness> (accessed 5 November 2012).

⁴²<http://www.healthyplace.com/personality-disorder/malignant-selflove/histrionic-personality-disorder/> (accessed 23 January 2010).

anybody can exhibit it under favorable circumstances. Bartholomew and Wessely (2002:303) and Lee and Tsai (2009)⁴³ further advise that because human beings continually construct certainty and perceive danger, no person is immune to a mass hysteria epidemic. Health workers therefore need to be on the look-out for new forms of outbreaks, which may change due to different situations.

2.2.3.3 Symptoms displayed by victims of mass hysteria

The literature reveals that there are differences in the symptoms of mass hysteria in developed and underdeveloped countries, as well as the type of mass hysteria, as purported by Phoon in Colligan et al (1982:28), and Bartholomew and Wessely (2002:300). Mass anxiety hysteria appear to be evident in developed countries whereas mass motor hysteria occur in underdeveloped countries as illustrated in table 2.1 and table 2.2 respectively. The researcher believes that the cultural belief system may have a role in the development of symptomatology experienced by victims.

Jones (2000)⁴⁴ identified the predominant symptoms in nine outbreaks of mass psychogenic illness from *developed countries* as follows:

Table 2.1 Common symptoms of mass hysteria in developed countries

Symptoms	Patients reporting (%)
Headache	67
Dizziness	46
Nausea	41
Abdominal cramps/pain	39
Cough	31
Fatigue, drowsiness or weakness	31
Sore or burning throat	30
Hyperventilation or difficulty in breathing	19
Watery or irritated eyes	13
Chest tightness/ chest pains	12
Inability to concentrate/trouble thinking	11
Vomiting	10
Tingling, numbness/ paralysis	10
Anxiety/ nervousness	8
Diarrhea	7
Trouble with vision	7
Rash	4
Loss of consciousness/syncope	4
Itching	3

⁴³<http://www.elsevier.com/locate/mehy> (accessed 30 November 2010).

⁴⁴<http://www.afp/20001215/2649.html> (accessed 21 February 2008).

Mkhize and Ndabeni (2002:6971) list the following symptoms as reported by teachers in the Umtata outbreak in *underdeveloped* traditional settings:

Table 2.2 the common symptoms of mass hysteria in underdeveloped countries

Symptoms	Number of times	Reported (%)
Screaming	20	95
Collapsing	19	90
Fearfulness	18	86
Rolling on the ground	17	86
Headache	17	81
Loss of consciousness	17	81
Dizziness	16	76
Visual hallucinations	15	71
Tiredness	14	67
Jerking	13	62
Head banging	12	62
Sweating	12	57
Palpitation	11	52
Stiffness	12	57
Tongue biting	1	5
Urinary incontinence	1	5
Fecal incontinence	1	5

2.2.4 Predisposing factors to mass hysteria

The Concise Oxford Dictionary (1964:959) defines predisposition as subject or inclined to disease or a feeling. The *Daily Omnivore Net* (2012)⁴⁵ point out that due to the lack of empirical evidence, the etiology of mass hysteria is poorly understood, and therefore, a number of speculations are made regarding the causation of mass hysteria.

However, a variety of predisposing factors that may contribute to mass hysteria are described in the literature. Bartholomew and Goode (2000)⁴⁶ report on factors that contribute to the formation and spread of collective delusions and hysterical illness as:

⁴⁵<http://thedailyomnivore.net/2012/09/05/mass-psychogenic-illness/> (accessed 30 October 2012).

⁴⁶<http://www.afp/20001215/2649.html> (accessed 21 February 2008).

mass media; rumours; extraordinary anxiety or excitement; cultural beliefs and stereotypes; the social and political context; as well as reinforcing actions by authorities such as politicians, or institutions of social control such as the police or the military.

2.2.4.1 Stress

Stress is commonly mentioned as a contributing cause of mass hysteria (Bartholomew & Wessely 2007:657; Lee & Tsai 2009⁴⁷; Smeehuijzen 2012⁴⁸). Some researchers argue that mass hysteria or psychogenic illness is caused by pent-up stress at schools and factories, as well as fear of environmental intoxication (Goh 1987:269; Jones 2000⁴⁹; Nair 2009⁵⁰; Ross 2001:44; Sharma, Jha & Lamsal 2010⁵¹; Small & Nicholl 1979:721). Some researchers contend that stress related to examinations can cause mass psychogenic illness episodes (Halverson et al 2008⁵²; Nair 2009⁵³). Nair (2009)⁵⁴ states that outbreaks of mass hysteria which were reported in three Gauteng, three KwaZulu-Natal schools and one Eastern Cape school in South Africa were described by a child and adolescent psychiatrist as stress-related.

News 24 (2001)⁵⁵ reported on an outbreak of mass hysteria in Kuala Lumpur, Malaysia. Thirty school girls experienced screaming and fainting episodes. The educational officials attributed the encounter as psychological and psychosomatic. The girls were due to sit for a nation-wide end of year examination. Some authors relate mass hysteria to the psychological stress as a result of inhibited emotional ventilation (Sharma et al 2010)⁵⁶. Bartholomew and Sirois (2000:502) purport that Islamic Malaysian females lack channels of communication with the employees, despite their dissatisfaction and long working hours. The cultural and religious mores prohibit direct confrontation with their male superiors. They therefore repress their emotions.

⁴⁷ www.elsevier.com/locate/meny (accessed 20 February 2011).

⁴⁸ <http://www.united-academics.org/magazine/mind-brain/mass-psychogenic-illness> (accessed 8 April 2009).

⁴⁹ <http://www.afp/20001215/2649.html> (accessed 21 February 2008).

⁵⁰ <http://www.thetimes.co.za/News/Article.aspx?id=972384> (accessed 21 March 2010)

⁵¹ <http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012).

⁵² <http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012)

⁵³ <http://www.thetimes.co.za/News/Article.aspx?id=972384> (accessed 21 March 2010).

⁵⁴ <http://www.thetimes.co.za/News/Article.aspx?id=972384> (accessed 21 March 2010).

⁵⁵ <http://www.news24.com/News24/Archive/0,,2-1659-1050043,00.html> (accessed 17 October 2006).

⁵⁶ <http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012).

Goh (1987:265) conducted an epidemiological study during a school outbreak of unusual illness, where a total of sixty five students and one teacher experienced symptoms of nausea; dizziness; chills; headache; difficulty in breathing; and faintness after alleged inhalation of a “gas”, in the school premises in Singapore. He concludes that those students had undergone psychological or emotional stress, and that they were more likely to be affected by the mass epidemics. He adds that the rapid socio economic changes and cultural conflicts seem to be the underlying factors in some epidemics. He fears that rapid socio economic changes are a source of anxiety, as they bring uncertainties to people experiencing the changes. Several researchers have reported that psychological factors play a role in the development of mass hysteria outbreaks (Balaratnasingam 2006:172; Lee & Tsai 2009⁵⁷; Smeehuijzen 2012⁵⁸). Jones (2000)⁵⁹ contends that outbreaks of psychogenic illness occur in groups that are experiencing physical or emotional stress.

From the above discussion it appears that stress is amongst the factors which lead to mass hysteria.

2.2.4.2 *Extraordinary anxiety and fear*

Several researchers report extreme anxiety, fear or panic in victims of mass hysteria (Bartholomew 1989:288; Jones 2000⁶⁰; Kokota 2011:74; Sharma et al 2010⁶¹). The Concise Oxford Dictionary (1964: 51, 441) defines anxiety as an uneasiness, a troubled concern, whereas fear refers to a painful emotion caused by impending danger or evil, it is a state of alarm. Bartholomew (1989:291) points out that the anxiety occurs when ambiguity prevails due to a panic-stricken belief amongst a group of people. Dzokoto and Adams (2005:53) report on a scare of genital shrinkage (Koro) in Western African countries, which resulted in an epidemic. Bartholomew and Wessely (2007:658) and Smeehuijzen (2012)⁶² mention an incident where nineteen bus passengers and a driver, in Canada, became sick. This was after a young suspect, believed to have come from the Middle East, remarked that the driver’s day would not be good for long. The

⁵⁷ www.elsevier.com/locate/mehy (accessed 20 February 2011).

⁵⁸ [http://www.united-academics.org/magazine/mind-brain/mass psychogenic illness](http://www.united-academics.org/magazine/mind-brain/mass%20psychogenic%20illness) (accessed 8 April 2009).

⁵⁹ <http://www.afp/20001215/2649.html> (accessed 21 February 2008).

paramedics who were summoned to help the sick people also became sick. This incidence was related to fear of a chemical or biological attack.

Hosken (2009)⁶³ reports on episodes of mass hysteria in Pretoria schools in South Africa. At one of the schools the incident was followed by a suicide of a student. Clearly, people experience initial panic as a reaction to a particular exterior environment which causes uncertainty and cultivates anxiety.

According to the Sunday Tribune (2002)⁶⁴ and Lee and Tsai (2009)⁶⁵, mass hysteria occurs when a group of people collectively show physical symptoms that do not correspond with the organic aetiology. These symptoms are experienced when people face stress and anxiety. Bartholomew (2005:564) emphasises that mass hysteria outbreaks will continue to be a major public health challenge, due to the widespread anxieties over the threat of chemical and biological weapons and the fear of environmental intoxications and contamination in developed countries. This is affirmed by Bower (2000:37) who states that anxiety and fear were possibly predispositions that lead to the outbreak of mass illness at McMinnville High School, in Tennessee, USA.

2.2.4.3 Culture

According to several authors, culture is a way of life for a given society; it involves shared beliefs, values, traditions and morals (Callaghan & Waddock 2006:276; Richter & Whittington 2006:280). Brooker (2006:62) defines culture as the attitudes, beliefs, ideas, knowledge, practices and values which members of different groups hold, and which inform the total behaviour of a group. Culture is learned through a socialisation process and is thus deeply rooted (University of Minnesota 2012⁶⁶).

⁶⁰<http://www.afp/20001215/2649.html> (accessed 21 February 2008).

⁶¹<http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012).

⁶²<http://www.united-academics.org/magazine/mind-brain/mass-psychogenic-illness> (accessed 8 April 2009).

⁶³<http://www.iol.co.za/news/south-africa/teachers-scared-as-mass-hysteria-hits-school-1.438427> (accessed 23 September 2012).

⁶⁴<http://www.tribuneindia.com/2002/20020922/spectrum/main1.htm> (accessed 19 June 2006).

⁶⁵www.elsevier.com/locate/mehy (accessed 20 February 2011).

⁶⁶www.cliffnotes.com/studyguide/Culture-and-Society-Defined.topic ArticleId-26957-26848.htm (accessed 12 January 2013).

Brooker (2006:62) states that culture encompasses the attitudes, beliefs, ideas, knowledge, practices and values which members of different groups hold about self, and they inform the total behaviour of a group. The Daily News (2009)⁶⁷ quotes a clinical psychologist who specifies that mass hysteria is rooted in the belief systems and culture, implying that culture is an important factor in the study of mass hysteria. Thus there is a need to examine these factors in relation to the group behaviour that is exhibited by participants in mass hysteria outbreaks.

Researchers have shown in a number of studies that culture has an impact on mass hysteria outbreaks (Bartholomew & Victor 2004:229; Garlipp 2008:21; Lee & Ackerman 2005:79; Pushpa, Ajaha & Anish 2010⁶⁸; The Daily Omnivore 2012⁶⁹; Waller 2009⁷⁰). Cultural belief systems which revolve around witchcraft, evil spirits or demons and spirit possession, are commonly mentioned as causing mass hysteria (*The Star* 2008:2; Wedel 2012:1).

Bartholomew and Wessely (2002:300) point out that during the Middle Ages, popular beliefs in witches and demons that came from cultural systems of beliefs, triggered mass hysteria outbreaks. Tseng, Mo, Chen, Ow and Zheng (1992:117) contend that a cultural belief system served as a catalyst in the Koro epidemic in China, due to the sexual taboos in this southern area of China. McLaren and Ringe (2001)⁷¹ affirm that culture-bound syndromes are linked to a particular culture; some researchers refer to mass hysteria as a culture-bound syndrome (Mkize 1998:329; Neihaus, Oosthuizen, Emsley, Jordaan, Mbanqa, Keyter, Deleuse & Stein 2004⁷²). According to Ugandan Media (2011), the features of mass hysteria are the illustrations of popular social and cultural preoccupations, reflecting unique social beliefs about the nature of the world.

Rataemane et al (2002:63) point out that mass hysteria is a social phenomenon occurring in healthy people, who suddenly feel that they have been made ill by some external factors; and any illness that cannot be explained is attributed to witchcraft and

⁶⁷<http://www.dailynews.co.za/index.php?fSectionID=3532&fArticleID=nw200901231820527> (accessed 4 August 2009).

⁶⁸<Mhtml:file:///IriGtnecselodAdnaairetyHs saMydutSlanoitn> (accessed 27 August 2012).

⁶⁹<http://thedailyomnivore.net/2012/09/05/mass-psychogenic-illness/> (accessed 30 October 2012).

⁷⁰<html:file:///G:\John Waller- Looking back dancing plaques and mass hysteria .mht> (accessed 27 August 2012)

⁷¹<http://www.stayfreemagazine.org/archives/21/mental-illness.html> (accessed 23 August 2006).

⁷²<http://www.ncbi.nlm.nih.gov/pubmed/15057028> (accessed 22 February 2013).

evil spirits in most African cultures, a belief that is shared by the majority of the society (*Daily News* 2009⁷³; Govender 2010:318; Hosken 2009⁷⁴; Thakali 2008⁷⁵; Ugandan Media 2011⁷⁶).

Mkhize and Ndabeni (2002:698) ascribe an outbreak that occurred in Umtata in the Eastern Cape Province, South Africa, to the demonic or evil possession of learners based on a popular belief that a nearby church was practicing Satanism. Bartholomew (1990:456) purports that mass hysteria can be filtered through a culturally-ascribed symbol system, which affirms the fact that mass hysteria is related to cultural factors.

Lee and Ackerman (1980:85) postulate that the assignment of blame to the spirits allows the victims to vent their emotions without suffering any consequences. The victims of mass hysteria are able to express their frustration, without being responsible for their actions. The blaming of spirits is more culturally acceptable.

Freeman, Petzer, Flemming and Simon (1990:851) describe a culture-bound syndrome known as 'amafufunyane' as a serious disorder occurring among Zulu and Xhosa cultures in Southern Africa. They assert that this disorder is believed to be an invasion and possession of evil spirits resulting from sorcery or witchcraft. They conclude that cultural customs disguise this syndrome, so that the diagnosis becomes very difficult because witchcraft is part of cultural beliefs. Mkize (1998:330) affirms that the syndrome affects Tsonga, Tswana and Sotho groups as well. He contends that 'amafufunyane' is culturally believed to be associated with "possession by thousands of evil spirits".

Robin (2001:153) attributes the cause of mass hysteria to the presence of the evil spirits in the affected, whereas Phoon (in Colligan et al 1987:23), believes that certain cultural factors such as "spirit possession" might contribute to the advent of mass hysteria. He cites the Malay's belief in 'Semangatt'; a vital force that prevents evil spirits or 'hantus' from attacking the body. This 'Semangatt' is described as a vital force within the 'living

⁷⁴<http://www.iol.co.za/news/south-africa/teachers-scared-as-mass-hysteria-hits-school-1.438427> (accessed 23 September 2010).

⁷⁵Saturday Star, SA Media. University of Free State 27-Sept-2008. Ref No-5219

⁷⁶<http://freethoughtkampala.wordpress.com/2011/04/04/wootakedown-03-demonic-attack-in-ugandan-primary-schools> (accessed 30 October 2012).

things', which is an important part that maintains health. It is believed to be invisible, but its presence exerts an external force which prevents evil spirits from acting on the body. It is characterised by convulsions; when eyes roll during a fit, it is believed that the affected is seeing the evil spirit. Convulsions have been found to be one of the symptoms for mass hysterical episodes. As can be seen in table 2.2 illustrating the general signs and symptoms of mass hysteria in underdeveloped countries, the rolling of the eyes and jerking concur with convulsions.

In conclusion, it appears that culture plays a role in mass hysteria occurrences in a variety of cultural groups.

2.2.4.4 *Socio-economic and political context*

Some researchers indicate that the prevailing political status quo can be associated with epidemics of mass hysteria. Bartholomew (1989:289) reported an outbreak of mass hysteria among South African native soldiers. This was due to the political tension between Britain and Germany at the outbreak of World War I, when meteorites were interpreted by natives as German monoplanes about to drop bombs. The outbreak occurred as a result of perceptions and reactions of a portion of a native population to misinformation that filtered through by the wildly circulating respected newspapers.

Another common threat lately in the developed countries is the chemical and biological warfare where strange odours and the presumed presence of toxic gases are blamed for the outbreaks of mass hysteria (Bartholomew & Wessley 2007:665; Bartholomew 2005⁷⁷; Bartholomew & Wessely 2002:302; Halvorson et al 2008⁷⁸). Several outbreaks, such as that which took place at an Australian airport, where airplanes were grounded due to people reporting that they smelt poisonous fumes, are examples of fear of chemical warfare (Bartholomew 2005⁷⁹). Various other reports that happened in the USA related to anthrax poisoning after 11th September 2001, the attack of the Trade Center's twin-towers in New York City, as well as Canada's "Toxic Bus" incident, where a bus driver, 19 bus passengers and paramedics became nauseated and vomited after one of the passengers insisted that the driver would not feel good for long (Bartholomew

⁷⁷<http://www.mja.com.au/public/issues/183-051205/bar10320-fm.html> (accessed 20 February 2006).

⁷⁸[Doi:10.1111/j.1746-1561.2008.00303.x](http://dx.doi.org/10.1111/j.1746-1561.2008.00303.x) (accessed 24 November 2012).

⁷⁹<http://www.mja.com.au/public/issues/183-051205/bar10320-fm.html> (accessed 20 February 2006).

& Wessley 2007:665; Bartholomew 2005⁸⁰). This incident was referred to as a possible terrorist attack by the citizens.

Moscrop (2001:1023) links biological weapons with mass destruction. He stresses that these weapons can, on the other hand, cause mass hysteria. He purports that even when these weapons do not cause death or destruction, they may cause public panic, and loss of confidence in the authorities, manifesting in mass hysteria.

Repeated reports about lack of food for the population, as a result of prolonged drought in Malawi, could have led to unfounded rumours that people were being attacked by vampires for their blood. These people claimed that the Malawian government was colluding with international aid agencies in order to supply the agencies with human blood in exchange for food aid (Swarms 2003⁸¹). This led to terrified villagers leaving their fields unattended, scared of becoming the next victims of these mysterious blood-suckers.

Research studies show that socio-economic status may contribute to outbreaks of mass hysteria. Knight, Friedman and Sulianti (1965:859) and Thakali (2008)⁸² indicate in their studies in India and South Africa respectively, that the affected students in the mass hysteria episodes were in slow learners' classes and engaged in part-time employment. This implies a low-socio economic status if students have to work part-time while still at school. Additionally, low school performance (below average IQ) by learners has been associated with mass hysteria episodes (Balaratnasingam 2006:172; Goh 1987:269, Sharma et al 2010⁸³).

Bartholomew (1989:293) contends that poor economic conditions may contribute towards the presence of anxiety in victims. He maintains that there is a direct relationship between low socio-economic status and the perceived likelihood of participation in a mass hysteria outbreak. However, some researchers report from their studies that academic performance is not a contributing factor per se; mass hysteria victims were able to cope with their school work equally well as the control group

⁸⁰<http://www.mja.com.au/public/issues/183-051205/bar10320-fm.html> (accessed 20 February 2006).

⁸¹<http://www.alertnet.org/thenews/newsdesk/L09222202> (accessed 23 August 2007).

⁸²Saturday Star, SA Media. University of Free State 27-Sept-2008. Ref No-5219.

⁸³<http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012).

(Bartholomew & Wessely 2002:303; Goh 1987:267). These findings propose some contradictions which need further investigation. However, there is proof that the socio-economic and political milieu exposes people to mass hysteria.

2.2.4.5 Mass media

Media coverage has been one of the factors which the literature reports, blows mass hysteria outbreaks out of proportion and causes increased anxiety to the communities where the incidences occur. According to Jones (2000)⁸⁴, and several other researchers, media coverage escalates mass psychogenic illness (Govender 2010:318; Halvorson et al 2008⁸⁵; The Current Science 2002:14).

Govender (2010:318) refers to several incidences of mass hysteria in different provinces of South Africa namely, KwaZulu-Natal, the Free State and Gauteng. Pastel (2001:44) adds that the presence of mass media at the scene of an incidence of mass hysteria aggravates and perpetuates the outbreak. However, the Sunday Tribune⁸⁶ argues that mass media has a role to play during the outbreaks, in order to shoulder its social responsibility during crisis.

The Ugandan Media (2011)⁸⁷ reports that “prominent emergency or media response” aggravate the incidence of mass psychogenic illness (mass hysteria). This was observed in the Kitebi Nursery and Primary Boarding School in Uganda. There had been media coverage of outbreaks of mass hysteria in several schools in Uganda, namely: Bisika Primary School located in Butemba, Sir Tito Winyi Primary School in Kiziranfumbi and Nakasongola Junior Academy in Migeera town. The reporter (Corner 2011)⁸⁸ concludes that the media coverage of the first outbreak and the declaration of a state of emergency aggravated the situation. Halverson et al (2008)⁸⁹ suggest that

⁸⁴<http://www.afp/20001215/2649.html> (accessed 21 February 2008)

⁸⁵<http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012).

⁸⁶<http://www.tribuneindia.com/2002/20020922/spetrum/main1.htm> (accessed 19 June 2006).

⁸⁷<http://freethoughtkampala.wordpress.com/2011/04/04/woo-takedown-03-demonic-attack> in [Ugandan-primary-schools](#) (accessed 30 October 2012).

⁸⁸<http://freethoughtkampala.wordpress.com/2011/04/04/woo-takedown-03-demonic-attack> in [Ugandan-primary-schools](#) (accessed 30 October 2012).

⁸⁹<http://www.nepjol.info/index.php/NJOG/article/view/5055/4170> (accessed 27 August 2012).

restricting the media and parking of emergency vehicles out of sight could be some of the possible management interventions in order to curb mass psychogenic illness.

Dewey and Ries (2006:3) refer to the reported sighting of an unidentified flying object (UFO), which occurred in Warminster in August 1985, and was published in The Warminster Journal. The fact that a reputable journal reported this rumour encouraged faith in its veracity. The people experienced anxiety and fear, which led to the mass hysteria outbreak in Warminster City.

From the above mentioned reports, the assumption is that mass media in the form of radio, television or newspaper reports play a significant role in the development of mass hysteria outbreaks.

2.2.4.6 Rumours

The Oxford Thesaurus Dictionary (2001) defines a rumour as “a story spread among a number of people which is unconfirmed or likely to be false”. Researchers have found that rumour is one of the contributing factors to mass hysteria (Bartholomew & Goode 2000⁹⁰; Lisa 2009⁹¹). These rumours are believed to start and spread quickly like fire, and similarly, may just as quickly die a natural death. Goh (1987:269), in his epidemiological enquiries into a school outbreak of an unusual illness, concludes that such outbreak is triggered by general fear, anxiety or rumours.

Colligan and Murphy (1982:77) contend that rumours played a big role in the spread of mass hysteria outbreaks in Malayan factories, where oppressed factory women employees experienced mass hysteria. Small and Nicholl (1979:721) affirm this observation in a study carried out in a Boston suburb. During a mass hysteria outbreak 34 of 224 pupils were hospitalised, because they experienced severe dizziness, weakness, hyperventilation, headache, nausea and abdominal pains during the school assembly. These researchers found rumours circulated that 12 pupils had died of food poisoning. The index person who fell from the stage and sustained a laceration of the chin was alleged to have undergone an open heart surgery. These rumours spread rapidly throughout the school and in the community near the school. These researchers observed that when the epidemic faded the exaggerated rumours subsided as well.

⁹⁰[http:// www.csicop.org/si/2000-05/delusions.html](http://www.csicop.org/si/2000-05/delusions.html) (accessed 23 August 2007).

⁹¹www.nytimes.com/GlobalEdition (accessed 18 April 2013).

Bartholomew (1989:293) analysed a rumour of the British and South African soldiers who historically claimed to have observed a German monoplane in the night hours, some distance away, spying on these soldiers, in 1914. He argues that the uneducated illiterate black soldiers were more vulnerable to rumours than their white counterparts, due to their past experiences with the white South African soldiers. They became prone to participating in mass hysteria episodes. These rumours were circulated by ignorant alarmists, who were found to have misinterpreted a shooting star for the light of a monoplane.

Bartholomew and Wesley (2002:300) note that during the twentieth century, outbreaks of mass hysteria were triggered by food poisoning rumours. Wilson (2005)⁹² affirms that rumors are but one of the factors that contribute to mass hysteria and collective delusion. Bartholomew and Wesley conducted a Literature Survey in order to identify historical trends in transcultural understanding of the protean nature of Mass sociogenic illness from the Middle Ages to the twenty-first century. They found that mass sociogenic illness demonstrated prominent social concerns, which changed according to the context and circumstances. Tension, panic and anxiety triggered by factors such as odor, exposure to chemicals or biological chemicals, or food poisoning, are mostly affected by rumours, which in relation to the different cultures lead to misinformation. The form of hysteria is said to be dictated by the culture of the group in question. Rumors appear to have an impact on the advancement of mass hysteria.

2.2.5 Settings for mass hysteria

Literature shows that mass hysteria episodes occur in schools, factories, convents and orphanages (Bartholomew & Goode 2000; Colligan et al 1982:24; Jones et al 2000; Govender 2010:320; Lee & Ackerman 1980:78; Mkhize & Ndabeni 2002:6971; Nemery, Fischler, Boogaerts & Lison 1999:96; Pastel 2001:44; Yasamy et al 1999:710). However, Matto, Gupta, Loban & Bedi (2002:643) report a family setting case, of a thirty

⁹²<http://im1.jou.ufl.edu/projects/Spring05/Wilson/hysteria.html> (accessed 8 August 2007).

one member family displaying mass hysteria in ten members at one time, for two decades, in India. This case is the only one reported in all the literature reviewed, whereby the whole family was affected.

Lee and Ackerman (1980:78) discuss an episode of mass hysteria in a Malay college in West Malaysia. They elaborate on four outbreaks of mass hysteria occurring in schools. Colligan et al (1982:23) stipulate that outbreaks of mass hysteria were previously described to occur in schools in 1973-1978; but, the authors also describe six episodes of mass hysteria outbreaks which occurred at factories in the Republic of Singapore Island.

Nemery et al (2002:140) report an outbreak of an epidemic of mass sociogenic illness that occurred in five schools in Belgium after pupils consumed Coca-Cola beverage. The students reported symptoms of headache, nausea, and vomiting, abdominal pain and trembling; potentially related to the consumption of Coca-Cola. However, literature shows that those symptoms were related to mass sociogenic illness (Gally, Van Loock, Van Heyden & Van Oyen 2001⁹³). In addition Kokota (2011:74) conducted a literature review of documented episodes of mass hysteria in African schools. He reports that many African students are placed under extreme pressure, which fuel outbreaks of mass hysteria. He cited documented episodes which occurred in the following countries: South Africa, Malawi, Zimbabwe, Zambia and Uganda and concluded that mass hysteria occurs in schools in the African continent.

Yasamy et al (1999:710) on the other hand, report an outbreak of psychomotor syndrome occurring in a village in Iran after 26 schoolgirls were inoculated with tetanus vaccine. Bartholomew and Goode (2000)⁹⁴ and Govender (2011:320) found that episodes of mass hysteria occur in small, tightly knit groups in enclosed settings such as schools, factories, convents and orphanages. They emphasise that motor hysteria appear to be prevalent in intolerable social situations, such as strict school and religious settings where discipline is excessive.

Jones et al (2000:96) report on a high school episode where eighty students, nineteen staff members and a family member who was picking up a pupil, went to the emergency

⁹³<http://aje.oxfordjournals.org/content/155/2/140.long> (accessed 18 April 2013).

⁹⁴<http://www.csicop.org/si/2000-05/delusions.html> (accessed 23 August 2007).

room in McMinnville, Tennessee, USA, complaining of headache, nausea, shortness of breath and dizziness related to toxic exposure. Kokota (2011:74) reports on several school outbreaks of mass hysteria in Africa, including in South Africa, Tanzania, Malawi, Zimbabwe, Zambia and Uganda. He observes that African schools apply extreme pressure during examinations, which expose students to the potential for mass hysteria.

According to Jones (2000)⁹⁵ and Pastel (2001:44), for the period 1973 to 1993, fifty percent of mass hysteria outbreaks occurred in schools. However, Godish (2000) reports that seventy five percent of cases in the USA and Europe for the past forty years occurred in schools. On the other hand, Pastel (2001:44) indicates that the scenario from 1973 to 1993 is different from that of 1872 to 1972, whereby fifty percent of the outbreaks were in schools. He shows that outbreaks in towns have declined from 24 percent to ten percent, while the factory incidences have risen from eight percent to 29 percent. The reason behind this is the fact that many people now work in factories with the advent of industrialism. The employer's target-setting, which pertains to high production expectations in the industries, is associated with a stressful atmosphere, which results in mass hysteria episodes.

The above scenario illustrates that schools, factories, orphanages and convents have been found to be prevalent places for mass hysteria outbreaks. In Lesotho, the episodes have been reported in schools (mostly boarding schools), factories and communities.

2.3 BASOTHO CULTURE

It is necessary to examine the Basotho culture in this section, as it sheds light on their beliefs, practices and values. The Basotho Archives (2009)⁹⁶ and Molapo (2005:4) reveal that the Basotho nation was a unity of tribes under King Moshoeshoe during the early 1800's. These tribes originated from the Sub-Saharan region of Africa. They moved to the south from what was known as the Transvaal Province, and settled in the Orange Free State Province now known as the Free State. They moved into the Kingdom of Lesotho after the tribal wars in Southern Africa.

⁹⁵<http://www.csicop.org/si/2000-05/delusions.html> (accessed 23 August 2007).

⁹⁶<http://www.basotho.org/Basotho/Basotho.htm> (accessed 28 November 2012).

The Basotho comprises different clans which are associated with certain animals, for example the Bafokeng (hare/rabbit), the Bakuena (crocodile), the Bataung (lion), and the Basia (cat). Other clans include the Batlokoa, the Baphuthi, the Makhoakhoa and the Makholokoe (Molapo 2005:4; South African History Online⁹⁷). The Basotho's source of wealth is livestock.

According to the Basotho Archives (2009) and Molapo (2005:13), the Basotho have a patriarchal society. A man is the head of the family. He pays a price for his bride (lobola), which amounts to 20 herds of cattle. Preston-Whyte (1974:187) notes that the bride price legalises the marriage. It gives the woman and her children the rights into the man's family. Molapo (2005:13) points out that the wife moves out of her natal home to live with the husband's kin, and that in addition, she is given a new name and adopts her husband's surname. A sheep is slaughtered to welcome her into the new family, and she is adorned with new clothing (a long dress and a new blanket). Polygamous marriages are noted to be common among the elite (South African History Online 2012⁹⁸).

Molapo (2005:12) emphasises that in these marriages the husband controls all his wives. The author describes that they are enslaved in various customs and rituals that uphold the patriarchal system. Men are given a higher status than women within the social stratification. According to Molapo (2005:19), even the legal system of Lesotho discriminates against women. These practices put women in an awkward position. They are treated as second-class citizens in comparison to their male counterparts.

According to The South African History (2012)⁹⁹, Basotho women are traditionally considered as farmers and bearer of children. Males are considered to be heads of families by virtue of their gender. This situation affects women negatively, as they are considered as not being important (Molapo 2005:19).

The Basotho also still exercise chieftainship. The King is the Head of the Kingdom and he is considered as the reigning monarch. The Principal Chiefs are his right hand and the chieftainship extends to the chiefs, headmen and the sub-headman (Ramotse) at

⁹⁷ <http://www.sahistory.org.za> (accessed 23 January 2013).

⁹⁸ <http://www.sahistory.org.za> (accessed 23 January 2013).

⁹⁹ <http://www.sahistory.org.za> (accessed 23 January 2013).

the local level. The villages usually crowd together around the chief, who is usually at the centre of the village (Basotho Archives 2009¹⁰⁰).

According to the South African History (2012)¹⁰¹, the traditional religion of Basotho revolves around the Supreme Being (God/Molimo) who is believed to come within reach of the spirits of one's ancestors (balimo). These ancestors' spirits are believed to bring sickness or misfortune to relatives who forget them or who do not respect them. The Basotho Archives (2009), on the other hand, show that Basotho worship the "balimo", because they hold the belief that the ancestors can afflict hardship on their descendants for violating societal laws and customs. This illustrates that the Basotho believe in both God, "The Almighty" and in "balimo", or ancestors.

According to Panos London (2004)¹⁰², there are two forms of healthcare in Lesotho. One is the traditional system, in which traditional healers use medicinal herbs and plants. This system is believed to be effective in treating social, psychological or spiritual dimensions of illnesses. This type of healthcare has been with the Basotho since the pre-historic period, much trust is instilled in it by a majority of the Basotho people. The reason given for the popularity of traditional medicine includes the accessibility, affordability, adaptability and culturally familiarity (Masupha, Thamae & Phaqane 2012:5).

The other health care system is Western medicine, which is sometimes not feasible due to the long distances travelled to health facilities as a result of the Lesotho terrain, the unfriendly winter (snowfall) or flooded rivers during the rainy summers (Makoa et al 2009:60-61). It is apparent that the two systems are used simultaneously, as indicated by Masupha et al (2012:7), who contend that although the modern (western-trained) doctors do not recognise the healing capabilities of the traditional healers publicly, they, doctors, nurses and pharmacists, consult the traditional healers at awkward hours when confronted with witchcraft or bad luck.

¹⁰⁰<http://www.basotho.org/Basotho/Basotho.htm> (accessed 28 November 2012).

¹⁰¹<http://www.sahistory.org.za> (accessed 23 January 2013).

¹⁰²<http://www.panos.co.uk> (accessed 20 January 2013).

According to Sechefo [S.a.]¹⁰³ and Van Wyk (2004)¹⁰⁴, the Basotho and other Africans believe in witchcraft and spirits. These beliefs are not peculiar to the uneducated or to non-Christians only; they are seen as culturally acceptable. The Basotho cultural beliefs of supernatural forces (like evil spirits ascribed to witchcraft and thokolosi) reinforce the occurrence of mass hysteria. As pointed out by some authors that belief systems impact on mass hysteria episodes (The Star 2008:2; Wedel 2012:1).

2.4 CONCLUSION

Mass hysteria is defined by different researchers who use diverse terms to describe this phenomenon. The biological, psychological and sociological theories of mass hysteria were explored in order to gain a better understanding of the phenomenon under study. The discussion of Basotho culture guides the perspective of this study. The patterns of mass hysteria and symptoms differ in non-Western, traditional cultures and in developed countries and both genders can be affected. The literature points to the fact that various factors may lead to the manifestation of mass hysteria and that mass hysteria outbreaks tend to happen repeatedly in specific, identified settings.

In the next chapter the research design and methodology are discussed.

¹⁰³ www.malealea.co.ls/basotho-culture/basotho-beliefs.html (accessed 21 March 2013).

¹⁰⁴ Hts.org.za/index.php/HTS/article/download/63536 (accessed 21 March 2013).

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the research method and design for the study. A complete account of the way in which the study was planned, structured and carried out is discussed, further more the chapter describes the population, sampling procedures, data collection, data analysis, and the ethical considerations taken into account for the study.

Purpose of the study

The purpose of this study was to explore the phenomenon of mass hysteria among the Basotho people in Lesotho and to develop guidelines which may facilitate early intervention and better management and control of mass hysteria outbreaks.

Study objectives

The objectives of the study were to

- describe the experiences of young Basotho women who were victims of mass hysteria
- establish the causes of mass hysteria in Lesotho, inclusive of the predisposing conditions
- determine the effect of mass hysteria outbreaks on the community
- identify the strategies used by the Basotho to manage mass hysteria
- develop guidelines for appropriate management of mass hysteria

3.2 STUDY SETTING

The study was conducted in the Maseru, Berea, Thabatseka, Mafeteng and Mohale's hoek districts in Lesotho. Figure 3.1 presents a map of Lesotho indicating the areas where mass hysteria was reported in Maseru, Berea, Leribe, Mokhotlong and Thabatseka districts, however, the study participants (victims) came from Maseru and Thabatseka. Traditional healers who were interviewed came from Mafeteng and Mohale's Hoek, while school principals were from the Maseru and Berea districts. Three districts, namely Buthabuthe, Qacha'snek and Quthing had no outbreaks of mass hysteria during the study period.

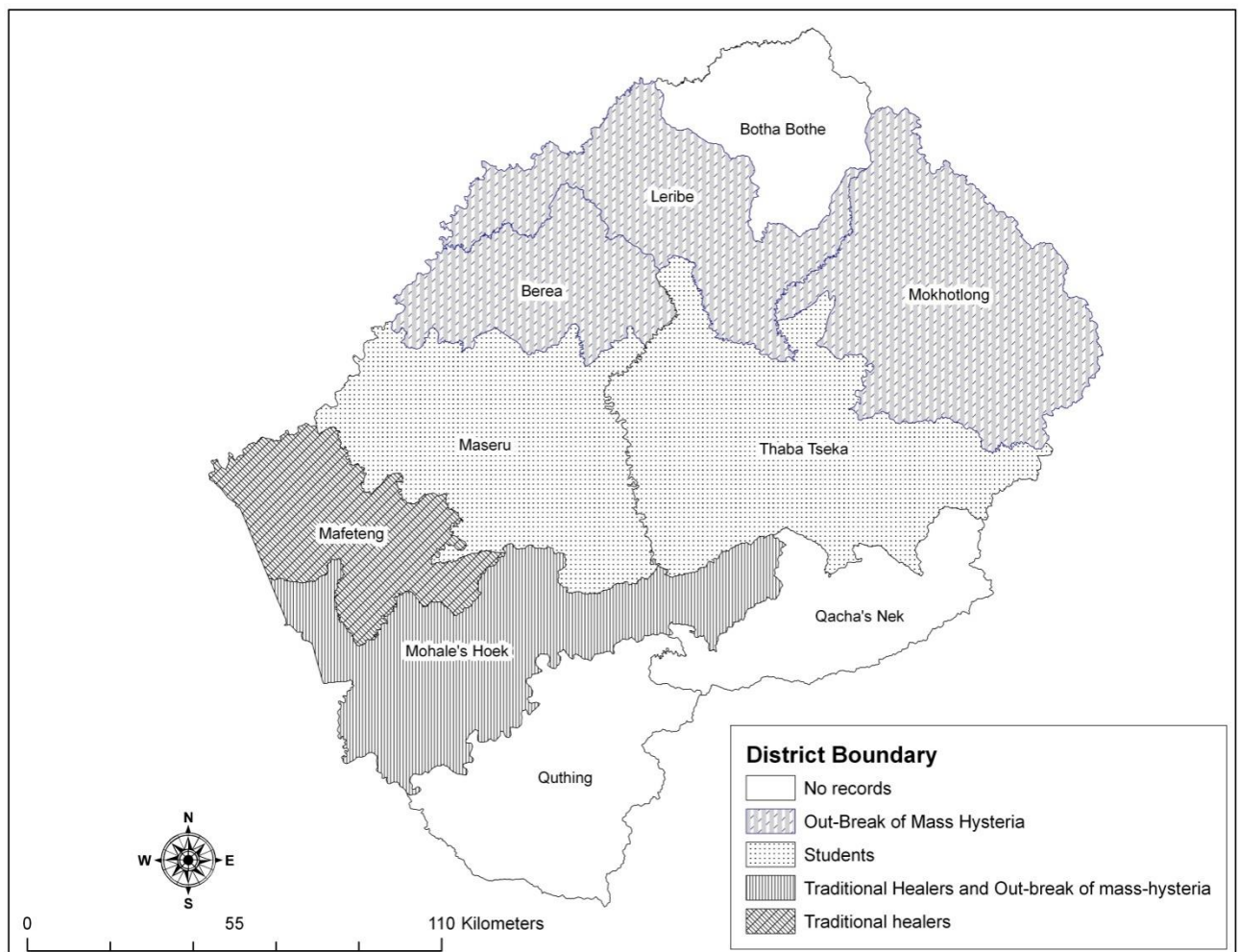


Figure 3.1 Map of Lesotho illustrating the districts, mass hysteria outbreaks and study participants' destinations
(Source: NUL Geography department)

3.3 RESEARCH DESIGN

A qualitative, descriptive, explorative and contextual design was selected as an appropriate design to explore the phenomenon of mass hysteria among the Basotho people in Lesotho.

According to Burns and Grove (2007:237) and LoBiondo-Wood and Haber (2010:577), research design is defined as a blue print for conducting a study. Its purpose is stipulated as maximising control over the factors that may interfere with the validity of the findings; the control, thus, increases the probability that the study results are accurately reflecting reality. Polit, Beck and Hungler (2001:40,470) describe the research design as the overall plan for addressing a research question, including specifications for enhancing the integrity of the study.

Research designs are the plans that affirm the accuracy and truthfulness of the study findings by ascertaining that the instrument used in data collection, measures what it is intended to measure (Polit & Beck 2006:512). Moule and Goodman (2009:68) describe design as a map of the way in which the researcher will engage with the participants in order to achieve the outcomes needed to address the research aims and objectives. The design specifies the various approaches to be adopted in the study, in order to implement controls that will enhance the interpretability of the results.

The study sought to explore and understand the phenomenon of mass hysteria in the Basotho context, focusing mainly on the experiences of young women in Lesotho who have been affected by mass hysteria. The researcher explored the feelings, attitudes and views of the victims to gain a better understanding of mass hysteria in the Basotho's context. The emphasis of this study was on the experiences of young women (victims of mass hysteria) in high schools in Lesotho. It is hoped that the insight gained into these experiences would be utilised for improving the care rendered to individuals who experience mass hysteria. The study also investigated the views of those who witnessed mass hysteria episodes in the high schools and those who rendered care to the victims.

3.3.1 Qualitative research

Qualitative research is a systematic and subjective approach used to describe life experiences and giving meaning to such experiences, as unique to the individual who undergoes the event.

Qualitative research is grounded in the Naturalistic paradigm. Polit and Beck (2004:13) define paradigm as “a world view, a perspective on the complexities of the real world”. Naturalistic paradigm is on the other hand, that world viewpoint whereby reality is not fixed, but it exists within a context. The naturalistic researchers’ assumptions include that reality can be interpreted in many ways in an individual’s mind. It is therefore important to listen to the voices and interpretations of the study participants in order to understand the phenomenon which is being studied (Polit & Beck 2004:15). Naturalistic inquiry helps to describe, understand or interpret life experiences. According to Burns and Grove (2007:6), a qualitative approach involves systematic collection and analysis of narrative, subjective material with minimum researcher-imposed control.

Qualitative research focuses on the qualities of human experiences. It emphasises the qualitative aspects rather than the quantitative and measurable entity of human behaviour as supported by Brink and Woods (1998:335). According to Munhull (1989:20), qualitative research is an inquiry oriented towards understanding the unique nature of human thoughts, behaviours, life experiences and personal views about the world.

Each participant is viewed as a holistic individual, and two informants cannot generate the same or duplicate data of the same lived experience (Hopkinson 1999:203). Since this research is concerned with the analysis of concepts and words rather than numbers, it became a choice for this study to facilitate the systematic collection and analysis of subjective narrative data without compromising the researcher’s unbiased position.

According to Polit and Hungler (1999:239) and Polit et al (2001:207), qualitative research is an “*emergent*” *method*, because direction emerges as the researcher makes

on-going decisions reflecting on what has already been learned in the available data. The qualitative approach is not permanent; it is easily bent according to how participants respond. There is interaction between the responses and the findings throughout the research process (Ulin, Robinson & Tolley 2005:22).

Lincoln and Guba (1985) propose that an emergent strategy in qualitative studies does not result from the researcher's laziness or sloppiness. Instead, the researcher bases his/her investigation on the realities and views of the participants. These are not known at the onset of the study. In so doing, patterns of shared views and variability can be identified, while new leads may feature.

Burns and Grove (2005:23) assert that qualitative research describes participants' life experiences and gives meaning to them. This is affirmed by Streubert-Speziale and Carpenter (2003:341) who state that the aim of qualitative research studies is to gain knowledge about people or participants by emphasising their lived experience as they define it.

A qualitative approach was regarded as appropriate to explore and describe the phenomenon of "Mass Hysteria" as it occurs frequently among young women in Lesotho high schools. The researcher specifically collected data from young women in Lesotho who experienced mass hysteria and from those who witnessed these episodes. Streubert and Carpenter (2011:20) note that qualitative researchers emphasise the fact that realities are numerous and are committed to the participant's perspective. Qualitative researchers operate in a natural setting, and, therefore, they do not disturb the phenomenon in which they are interested in and the data report is rich with participants' annotations.

Qualitative research draws its strength from its approach, which focuses on specific people or situations, emphasising words more than numbers. In addition, it has an ability to gain greater understanding of experience as lived by the individual (Burns & Grove 2007:19).

3.3.2 Descriptive research

Polit and Beck (2004:192) explain descriptive research as a non-experimental study, with the purpose to observe, describe and document situations as they occur in a natural setting. Descriptive research obtains complete and accurate information about a phenomenon through observation, description and classification. It provides new information on the phenomenon under study. In this study participants described their experiences as victims of mass hysteria; teachers and parents elaborated on their observations of the victims; and priests and traditional healers provided their understanding of mass hysteria.

3.3.3 Explorative research

This study explores dimensions of the phenomenon of mass hysteria and the manner in which it manifests, as well as factors with which it relates therefore, it provides insight about the nature of the phenomenon. The method is explorative because its objective is to gain insight and a better understanding of mass hysteria.

Explorative research identifies and describes an unknown problem area. It further explores in depth, in a loose unattached way, and finally arrives at a description of an experience that has little or no literature (Brink & Woods 1998:309). Cairns (2002:799) state that explorative studies help in areas in which very little information is available. The researcher chose the explorative method in order to gain in-depth knowledge and a better understanding of the phenomenon of mass hysteria as it manifests among the Basotho in Lesotho.

According to Brink and Woods (1998:312), the exploratory researcher looks for new knowledge, new insights, new understanding and new meanings. They further point out that exploratory research is actually “discovery research”. An exploratory study increases knowledge in the study field (Burns & Grove 2005:395).

Apart from radio and other media reports on mass hysteria outbreaks in Lesotho, no evidence-based information on this phenomenon in Lesotho could be found in the literature, therefore an explorative design became applicable to this study. Mass hysteria incidences occur repeatedly in schools and communities in Lesotho resulting in

chaos, uncertainty and anxiety among community members. Rubin and Babbie (1997:82) indicate that explorative studies are valuable in social scientific research, especially if the topic is understudied.

3.3.4 Contextual research

The purpose of qualitative research is to understand the context within which the participants act, as well as the influence of the context on participants' actions. Qualitative research captures the context entirely without controlling it. Thus, the collected data preserves the spontaneity of the participants' lived experiences and the individuality of each of them.

The study is contextual because the information obtained was a narrative dialogue and assessment of victims of mass hysteria among the Basotho culture in Lesotho (Pee & Poggenpoel 2001:42). The study considered the context of the Sesotho culture and the perceptions held by the Basotho towards this phenomenon. Babbie and Mouton (2002:89) affirm that meaning is always within the background and that contexts incorporate meaning.

3.4 POPULATION AND SAMPLING

3.4.1 Population

Population is defined by Parahoo (2006:256) as a total number of units from which data can potentially be collected. These units may be individuals, organisations, events or artefacts. Burns and Grove (2009:714) describe population as all elements, that is, individuals, objects, events or substances that meet inclusion criteria for a study. The site population comprised four high schools in Lesotho where mass hysteria episodes were reported.

The target population included young women (school girls) who experienced mass hysteria in high schools in Lesotho; the teachers, including the head teachers (school principals) who witnessed the episodes; the parents who observed the occurrences; the

traditional healers who treated the affected girls; and the priests and pastors who prayed for the affected school girls.

3.4.2 Sampling

According to LoBiondo-Wood and Haber (2010:224), sampling is a process of selecting a portion or subset of the designated population to represent the entire population. The aim of sampling is to maximise the proficiency of the study, by providing accurate data from a portion or subset of the phenomenon of study interest, so that the findings can be generalised to the entire population.

In qualitative studies generalisation is not important as pointed out by Streubert and Carpenter (2011:28). Qualitative researchers select the participants for the purpose of description of the experience in which they participated. Hence, Polit and Beck (2006:269) state that small non-random samples are used in qualitative research.

This study employed a non-probability sampling approach, whereby not every element of the population had an opportunity to be included in the sample (Burns & Grove 2005:350). Non-probability sampling is the non-random selection of elements for a sample. Qualitative research requires a small, purposive sample for completeness; the sample is therefore not predetermined but depends on data saturation (LoBiondo-Wood & Haber 2010:225; Streubert & Carpenter 1999:302).

Burns and Groove (1999:22) purport that such a sample is not representative. It provides the means to reach these unique subjects with the rare experiences. Tjale and De Villiers (2004:242) argue that large samples, when used in qualitative research, yield and generate an amount of data that becomes difficult to manage and analyse in a meaningful way. Therefore, qualitative research advocates for small samples. In qualitative research, the focus is more on the quality of the data. According to Burns and Grove (2009:361), when the data's quality and richness are high only a few participants saturate the data meaning when no new information emerges.

Purposive sampling

The sampling method used in this study was purposive sampling. According to Parahoo (2006:472), during purposive sampling researchers utilise their knowledge of

potential participants to be recruited for the study. They use their judgment or others' judgment about the participants who have knowledge about the phenomenon of interest because they were either involved in the event or were familiar with the incident. Burns and Grove (2005:352) state that purposive sampling yields *information-rich cases*.

The criteria for selection were that the young women had to be high school girls who have experienced mass hysteria themselves, or be a class mate who was present during and who witnessed the mass hysteria episode. Teachers or school principals who observed the mass hysteria episodes were selected. Traditional healers who treated the young women (victims of mass hysteria) and church leaders who prayed for the victims were also included in the sample.

Sample size

A total of 29 participants were included in the sample for the victims. The school girls who experienced mass hysteria from schools A (8), B (10), E (10) and one school girl from the rural area were included in the sample to represent the victims of mass hysteria. After inclusion of school girls from school E, data saturation was reached.

Seventeen teachers, four school principals, five traditional healers, two church leaders and one parent were included in the sample. Altogether, there were sixty eight participants.

Purposive sampling can be supplemented with snowball sampling, during which early informants are requested to make referrals to other study participants. Snowball or network sampling takes advantage of social networks and the fact that friends tend to have the same or common experiences (Burns & Grove (2007:346; Polit & Beck 2004:306). In this study, some school girls were recruited by their classmates into the study, because they had experienced mass hysteria. Table 3.1 shows the data collection instruments and the sample used in this study.

Table 3.1 Data collection instruments and sample

Focus groups x 5	<ul style="list-style-type: none">• (8) Victims, schoolgirls from school A• (10) Victims, school girls from school B• (10) Teachers from school A• (7) Teachers school E• (10) Victims in school E
Semi-structured Interviews x 13	<ul style="list-style-type: none">• Victim schoolgirl from rural school x 1• Principals from schools, A, B, C & D x 4• Parent from school E x 1• Traditional healers x 5• Church leaders 1 x Priest (Roman Catholic Church)• 1 x Pastor (Apostolic Faith Church)

3.5 DATA COLLECTION INSTRUMENTS

An instrument is defined as a device used to carry out a particular function (Oxford South African Pocket Dictionary 2011:961). A research instrument is a device or tool that is used to collect data. This study utilised *semi-structured individual interviews* and *focus group interviews*.

According to LoBiondo-Wood and Haber (2010:274), an **interview** is a data collection method whereby a researcher asks questions that participants respond to. This method becomes productive in obtaining personal information. Moule and Goodman (2009:295) add that interviews are used to address exploration of personal experiences, perceptions, beliefs and attitudes. A semi-structured interview comprises a verbal questioning of study participants and the use of probing when necessary, that is if the researcher needs more elaboration or does not know terms used by the participant or feels that the participant is hiding or withholding some information. Some of the questions maybe predetermined. The pre-set questions allow the participants to elaborate and magnify their answers (Sechrist and Pravikoff in Parahoo 2006:329).

Polit and Hungler (1993:278) argue that self-report approaches such as interviews yield information that would be difficult, if not impossible, to gather using any other method. Burns and Grove (2005:388) further affirm that self-report measures may even enable

the researchers to ask questions that were not previously considered, thus, build knowledge in unexplored areas.

An interview has the ability to access events that occurred in the past and to cover all the content within a phenomenon. However, it has some weaknesses in relation to accuracy and validity. Participants sometimes provide information that is not true, when they have to reveal an unpopular stand on a controversial issue or admit a socially unacceptable behaviour (social desirability). The researcher had to be alert to personal biases, to avoid being judgmental in order to put aside and ignore preconceived ideas and beliefs about the phenomenon.

A **focus group** is described as a group of about six to ten people gathered together to discuss a focused issue of concern. Morrison and Peoples (1999:62) state that a focus group is a group interview that gathers data on feelings, perceptions and experiences. Krueger in De Vos et al (2001:300) adds that a focus group is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. Burns and Grove (2005:542) affirm that the setting for focus groups allows for a non-threatening atmosphere to allow participants to freely express their views within their group dynamics.

The attention of the researcher during a focus group interview is more on the interaction between participants in the group (Rice & Ezzy 2000:76). The researcher listens, not only to the content of the focus group discussions, but, is also able to illicit emotions, ironies, contradictions and any tensions that may exist within the group (Kreuger & Casey 2000:70).

The advantages of a focus group interview are that it is efficient and can generate dialogue (Polit et al 2001:465). De Vos (2005:300) adds that a focus group interview facilitates “multitudes of perceptions in a defined area of interest, promotes “self-disclosure among participants” and creates “a process of sharing and comparing among participants” (Annexure I).

An **interview guide** was used during the individual and focus group interviews. Questions were directed on how the participants felt physically and emotionally during the mass hysteria episodes; what they thought triggered or caused the episodes and

what the after effects were; and whether they believed in supernatural forces (Annexure G).

An additional data collection instrument used in this study was a **checklist**, adopted from Alberstein (Histrionic Vampire Checklist¹⁰⁵) and the researcher adapted it for use on 14 victims (school girls) from school A who experienced mass hysteria and 10 school girls from school E who witnessed a mass hysteria episode. It is attached as Annexure H.

The participants were individually interviewed to collect biographical data, after which the checklist was filled in by each participant. The checklist assessed the participants' histrionic personality traits, as advocated by psychoanalytic theorists who state that victims of mass hysteria have a histrionic personality. Burns and Grove (2005:395) assert that a checklist can be used as a self-report tool in obtaining data.

3.6 DATA COLLECTION PROCESS

Burns and Grove (2007:536) describe data collection as a systematic gathering of information that is pertinent to the research purpose, objectives and research questions from the participants who have lived the experience or observed the phenomenon under study. During qualitative research data collection is ongoing until saturation of data is reached and data collection and analysis occur at the same time.

The researcher selected the participants in relation to the phenomenon under study, that is, the victims of mass hysteria. In order to get diverse perspectives, a parent, teachers and school principals who witnessed mass hysteria episodes and religious leaders and traditional healers who were involved with treatment or praying for victims of mass hysteria, were included as a source of data as affirmed by Burns and Grove (2007:76).

An informed consent for participating in the study was obtained from participants who had to sign a consent form before the data collection process commenced. This form explains the purpose of the study, that participation is voluntary and participants can

¹⁰⁵ psy.rin.ru/eng/article/140-101.html. [Accessed 26 October 2007]

withdraw from the study at any time if they so wish. It also addressed the confidentiality and anonymity of the participants. Appointments were set for the focus groups and individual interviews and administration of the checklist.

A voice recorder was used with the participants' permission before the start of the individual interviews and focus group interviews. This helped the researcher to be free from writing notes. Therefore, the researcher was able to concentrate on the participants' non-verbal and verbal cues and could probe when necessary. Field notes were kept during the discussions.

It was initially decided to collect data through individual interviews with the victims who experienced mass hysteria. However, during the first individual interview conducted with a mass hysteria victim the participant became dramatic and the researcher got the impression that she exaggerated a lot. This behaviour discouraged the researcher from continuing with individual interviews as data collection method. It was decided to rather continue with focus group interviews with the victims of mass hysteria.

Participants who took part in the research met the inclusion criteria for sampling by either having experienced mass hysteria themselves or having witnessed mass hysteria episodes in high schools in Lesotho. The teachers and school principals were present during mass hysteria episodes in high schools, while the traditional healers had treated the victims of mass hysteria and church leaders had prayed for the victims.

Focus group interviews

Focus group interviews were held with victims of mass hysteria in schools A, B and E to explore their experiences and with teachers (observers) in schools A and E, to get their views, perceptions and observations with regard to the mass hysteria episodes. The questions for the focus groups included the triggering factors of the incidence, descriptions of the occurrence, as to how it started, whether the index person could be identified and how it was stopped. The beliefs about the cause of the phenomenon as well as the aftermaths of mass hysteria were sought (Annexure G).

The focus group interviews were flexible. They allowed both the researcher and the participants to talk freely, while, directing the flow of information. This approach

provided the researcher with knowledge and insight as well as the meaning of the phenomenon in the context of the Basotho. The researcher had time to establish a trusting relationship with the participants and to build on the already existing relationships, which are necessary in qualitative research, in order to establish rapport. Another gain was that participants raised issues that the researcher was unfamiliar with and had not considered beforehand.

Polit et al (2001:265) caution that the disadvantage of a focus group interview is that some people may feel uncomfortable to express their views or to describe their experiences in front of a group despite the environment created by the researcher. Fortunately, this did not happen during data collection. Parahoo (2006:333) adds that participants reflect on and react to other group members' opinions by either disagreeing or learn ideas that they were unaware of. During the focus group interviews participants disagreed on some of the supernatural and/or cultural issues.

Individual interviews (semi-structured)

Individual interviews using an interview guide (Annexure G) were conducted with a victim from the Lesotho highlands (rural); the relative of one of the victims (mother) in school E; four school principals who were present during mass hysteria outbreaks in their schools; five traditional healers (two sangomas, a herbalist, a traditional generalist and the president of the traditional healer's association); a priest and a faith healer.

Questions asked to the parent and the school principals inquired about their observations and beliefs on the causes of mass hysteria. The church leaders and traditional healers were asked on their treatment of the victims and their beliefs regarding the phenomenon.

Checklist

The checklist on Histrionic personality type (Annexure H) was administered to 14 school girls from school A who experienced mass hysteria, and 10 school girls from school E who did not experience the phenomenon of mass hysteria themselves, but were present during mass hysteria episodes. This was done to determine if there were differences in

their personality traits. Literature shows that histrionic personality traits predispose individuals to mass hysteria (Rataemane et al 2002:61; Roach & Langley 2004:1271).

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3.7 DATA ANALYSIS

Data analysis is defined as a technique used to reduce, organise and give meaning to data (Grove & Burns 2007:536). Polit and Hungler (1993:329) point out that data analysis imposes order on a large body of information, so that conclusions are drawn and communicated in a research report. In the case of qualitative research, content and narrative analysis is performed (Burns & Grove 2005:554-556).

Data analysis occurs simultaneously with the data collection in a qualitative design. According to Parahoo (2006:376), qualitative data analysis is simultaneous with data collection, because the researcher processes the data during its collection and looks for patterns and identifies themes to follow so that the analysis continues between interviews and after all data were collected. Qualitative data analysis is a search for general statements about relationships among categories of data.

According to Brink and Woods (1998:324), the analysis of qualitative data requires a flexible intuitive interaction between the investigator and the data. They emphasise that it is important for the researcher to read and reread the transcripts of the interviews on a daily basis, be able to elucidate what has been learned, what is puzzling, what has not been answered, as well as what does not fit into the data, these authors named this process memoing. In qualitative research the researcher must give a voice to the participants and the use of self as primary instrument for collecting and analysing data is an important factor in the process of giving voice. This implies an openness of the researcher to possibilities and to examine new ideas. **Bracketing**, by which the researcher put aside knowledge and preconceived ideas about the phenomenon and experience of participants, and instead focus on awareness of the participants' experience and the research process, is required (De Vos 2005:337). The researcher had to bracket her own preconceived ideas about mass hysteria and prior knowledge during data collection and interpretation.

Data chunks were prepared from the verbatim transcripts. **Open coding** was applied by breaking down data into distinct parts, examining the data closely and comparing similarities and differences while asking questions about the phenomena revealed by the data (De Vos 2005:271). Codes were developed which were then grouped into

categories and sub-categories. **Axial coding** followed during which the researcher made connections between categories and subcategories to put data back together in a new way in order to explain the phenomenon of mass hysteria in the Basotho.

In this study the researcher carried out a content analysis. She manually transcribed and coded the textual data. By reading through the transcripts she identified key words and verified them with a colleague in the Social Science Department, National University of Lesotho and the Promoter (UNISA). The researcher noted the key issues and then developed codes into categories and sub-categories which eventually lead to the emergence of four themes (Moule & Goodman 2009:349).

The numerical data gathered through the checklist were analysed by utilising the descriptive statistical procedures in a computer package of Stat Pac and Excel was used to draw graphs (Polit et al 2001:14). The checklist was used to answer the question of whether victims of mass hysteria in the Basotho context possess a histrionic personality. The researcher gathered the empirical evidence, which was rooted in objective reality, by using an existing checklist as a data collecting tool that had undergone validity and reliability testing.

3.8 TRUSTWORTHINESS

Qualitative research is trustworthy when it accurately represents the experiences of the participants (Streubert & Carpenter 1999:333). Trustworthiness establishes how confident the researcher is with the truth of the findings based on the context, the participants and the research design. According to LoBiondo-Wood and Haber (1994:276), the strongest point of qualitative methodology is measured against credibility, fittingness and confirmability criteria. Lincoln and Guba (1985) refined the criteria for trustworthiness to include credibility, dependability, transferability and confirmability. Due to critical comments on developing criteria which were parallel to positivist criteria (internal validity, reliability, external validity, objectivity), Guba and Lincoln (1994) and Christians (2000) introduced authenticity as a fifth criterion (Tobin & Begley 2004:391, 392).

Credibility is defined as the extent to which the findings of a study reflect the experience and perceptions of those who provided the data (Parahoo 2006:466). It

involves the activities that increase the probability that credible findings are produced. It is believed that credibility will be established through long engagement with the data or by engaging participants to validate that the findings represent their experiences (Krefting 1990:214; Lincon & Guba 1985:290). According to De Vos et al (2003:346), credibility is an alternative to internal validity, which ensures that participants are accurately identified and described; this places boundaries around the study and so makes the study credible. Credibility refers to confidence in the truth of the data.

In this study credibility was ensured by using triangulation in data collection (utilising the checklist and conducting both individual interviews and focus group interviews as data collection techniques). Multiple populations were included, the participants included young women who had experienced mass hysteria as well as various others who witnessed the mass hysteria episodes and/or were involved by assisting the victims. The researcher prolonged her stay in the field by establishing rapport with participants through spending time with them before the interviews, explaining about the research and building trust through honouring their anonymity and being honest and open. Data collection continued until saturation of data was reached and no new data emerged. Facilitative communication was established during interviews by using probing, clarifying, reflecting, summarising, minimal verbal responses and silences.

The researcher went back to the participants to verify the accuracy of data and the findings (after the data analysis and the interpretation) as representative of their experiences. This is referred to as member checking (Moule & Goodman 2009:188). Two co-coders, the researcher's supervisor and an experienced qualitative researcher in the Faculty of Social Sciences at the National University of Lesotho were involved in the data analysis phase especially in the verification of the themes, codes and categories. Referential adequacy was achieved by consulting relevant and current sources.

Confirmability refers to a measure of the objectivity of the data (Moule & Goodman 2009:190). The rigor in qualitative methodology, data analysis as well as an extensive literature review provide for confirmability enhancement. These were enriched with different data sources, thus leaving a trail for an independent researcher to follow the procedures used in this study. Tobin and Begley (2004:392) point out that the findings do not come from the researcher's imagination but derive from the data; this has been

done by leaving an audit trail (Annexure J) in this study, as supported by Streubert-Speziale and Carpenter (2011:49).

Dependability refers to the stability of data over time and with replication, as purported by Polit and Hungler (1999:430). The audit trail assists in establishing dependability of research, whereby the research process is clearly documented and is rational and traceable, so that others can examine the researcher's documentation of data, methods of analysis, decisions and end product (Tobin & Begley 2004:392). The methodology, characteristics of the sample and data collection process were described in detail and the content analysis was discussed with experts in qualitative research, namely the supervisor and a member of the Faculty of Social Sciences at the University of Lesotho and thus subjected to peer review and quality checks. Krefting (1990:216) states that qualitative researchers learn from informants rather than by controlling them. They emphasise the uniqueness of humans, so that variation in experience rather than identical repetition is sought. Researchers are held responsible to ensure that the research process is logical, clearly documented and can be traced to its source. Leaving an audit trail allows for authentication of data through auditing (Tobin & Begley 2004:392).

Transferability is the degree to which findings can be applied to other contexts, settings and groups (Streubert-Speziale & Carpenter 2011:49). The study findings must have meaning to other investigators. This is because most researchers may not agree that only a few participants would represent a population's viewpoint or experiences. One of the strategies to utilise in transferability is to replicate the same study in another population as affirmed by Ulin et al (2005:27).

In this study, the research process has been detailed fully, to allow another researcher to replicate the study despite the fact that the study specifically addressed the Basotho context. The sampling technique (purposive) used in this study promotes transferability, because the researcher consciously selected participants who experienced mass hysteria and observers who witnessed the episodes of mass hysteria and those who helped the victims. The rationale for the choice was that these participants knew more about the mass hysteria phenomenon.

The participants' demographics (profiles) are well described in the study, in addition, the findings are described in-depth with participants' verbatim quotations from the transcriptions, furthermore the results have been re-contextualised in the literature.

Authenticity is a criterion for determining the goodness and rigor in qualitative research and implies fairness. According to Tobin and Begley (2004:392), authenticity is demonstrated when a researcher shows a range of realities, reflecting all participants' views, concerns and voices in the text.

Guba and Lincoln in Denzin and Lincoln (2005:207) affirm that authenticity refers to deliberate attempts by the researcher to prevent marginalisation, to act affirmatively with respect to inclusion by ensuring that all voices in the inquiry have the chance to be represented in the text and to treat participants' stories fairly and with balance.

Denzin and Lincoln (2008:8) contend that an interpretive researcher identifies and conveys tensions represented by contradictory structures of stakeholders because tensions reflect diversity in knowledge, experiences and value systems. These contradictions revolve around concerns, allegations, issues and problems of stakeholders and are conquered by including all voices of participants. The researcher ensured that all stakeholders' voices were heard in the presentation of the data, the victims of mass hysteria as well as those who witnessed the episodes. An audit trail is left which honours authenticity.

3.9 ETHICAL CONSIDERATIONS

Brooker (2005:86) defines ethics as the study of the code of moral principles which derives from a system of values and beliefs and concerned with rights and obligations. When human beings are used as participants, the investigator must exercise great care in ensuring that the rights of those informants are protected. However, scientific demands and these rights may conflict in some situations (Polit & Hungler 1993:354). It becomes mandatory to balance the protection of rights and the fundamental ethical considerations.

A code of ethics was adopted in 1978 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (Belmont Report), which

serves as a model or guidelines for the Biomedical and Behavioural disciplines. The primary ethical principles on which this study was based are voluntary participation and the right to self-determination, fair treatment, and protection from harm, as well as the right to privacy (Polit & Hungler 1993:355; Streubert-Speziale & Carpenter 2011:60).

- **Voluntary participation and the right to self-determination**

The right to self-determination means that individuals are free to live their lives as they choose without being controlled by others. The implication, for the researcher is that participants have the freedom to voluntarily participate in research or to withdraw from the study at any time without penalty (Burns & Grove 2005:194). The researcher informed the participants about the purpose, aim of the study and voluntary involvement in the study. Participants were asked to sign an **informed consent** form (Annexure F) which explained the principle of voluntary participation and the right to self-determination and the fact that they had the right to withdraw from the study at any time, without fear of censure or penalty. Informed consent means that participants understand the possible risks and benefits of the particular study, the purpose of the study, how they were chosen to participate and whom to contact with questions and concerns (McNeill 2002:61; Ulin et al 2005:59).

- **Fair treatment and protection from harm**

The right to fair treatment is based on the principle of justice and implies that each participant must be treated fairly and should receive what he/she is entitled to. Fair treatment includes selecting participants according to research requirements (Polit & Beck 2008:173). The researcher chose participants on the basis of their experience and knowledge of the phenomenon of mass hysteria, the young women who experienced the symptoms and those schools girls, teachers and traditional healers who witnessed and were involved during the episodes. The researcher demonstrated respect for the culture of the participants as she herself is a Basotho and appointments for interviews were honoured.

Inherent to the right to fair treatment and protection from harm, is the ethical principle of **beneficence**, which states that one should do well and do no harm (Burns & Grove 2007:189). The researcher ensured that participants encountered no physical, social or

economic harm in participating in this study; the participants did not have to travel as interviews were held at the schools in a private venue arranged with the principal of the school. The other participants (traditional healers) were visited in the privacy of their homes for the interviews. The researcher guarded against potential emotional harm by pausing when a participant showed emotional distress during an interview and arrangements were made with a counselor to be available for referral purposes. However, it was not necessary for the researcher to terminate any one of the individual or focus group interviews due to emotional distress demonstrated by a participant (Ulin et al 2002:61). Participants were respected and received courteous treatment at all times during the research process. The researcher was friendly, greeted all participants, avoided deception, and asked for permission to use the voice recorder and to take notes during the interviews.

- **Right to privacy**

Privacy refers to the right of an individual to determine the time and circumstances under which personal information will be shared with others or withheld (Burns & Grove 2005:198). According to Polit and Beck (2008:174), a research study must not be more intrusive than it needs to be. The researcher ensured that the study was not unnecessarily too intrusive by only asking questions about how the participants experienced mass hysteria and what participants observed during the episodes and participants shared information openly and voluntarily.

Violation of the privacy of a participant occurs when private information about the participant is published without his/her consent or knowledge (Burns & Grove 2005:198). The right to privacy also includes anonymity and confidentiality. The information collected from the participants was kept in strictest confidence. That is, the participants could not be linked to the data they provided in the report. They were asked not to fill-in their names on the biographical form and the checklist. Instead numbers were randomly assigned to the forms during data analysis. Numbers were allocated to different participants in the focus group interviews during data analysis and data transcription phases, so that true identities of participants could not be identified in the data. **Anonymity** was thereby ensured.

In order to adhere to the principle of **confidentiality**, the researcher ensured that information provided by participants was not publicly reported or made accessible to unauthorised persons (Burns & Grove 2005:190). The data was locked away and only the researcher, co-coder and the promoter had access to the transcribed data. The participants were ensured that the data will be destroyed after the study.

- **Scientific integrity of the research**

Scientific honesty is of crucial importance in research. The researcher acknowledged all sources consulted in the references and bibliography. Data collected were transcribed and analysed with the assistance of two co-coders and verbatim quotes of participants were recorded in the text without falsification and all participants' voices were acknowledged. Misconduct in research occurs through fabrication and falsification of data by using inappropriate techniques for data analysis, dishonest manipulation of the design and methods and plagiarism (Pera & Van Tonder 2011:340).

3.10 CONCLUSION

This chapter discussed the research design and methodology, population, method of sampling, the sample and the data collection process. The method of data analysis was described and trustworthiness and ethical considerations were discussed in detail.

CHAPTER 4

DATA PRESENTATION AND LITERATURE CONTROL

4.1 INTRODUCTION

This chapter presents data that have been collected from the participants included in the sample. The data were collected by using focus groups and semi-structured interviews. The qualitative analysis section addresses the data and findings from the focus groups and semi-structured interviews held with participants, namely young women (high school girls), a parent, teachers, traditional healers and church leaders.

A checklist was adopted from Alberstein (Histrionic Vampire Checklist) and adapted for use with a number of participants (14 school girls who experienced mass hysteria and 10 school girls who witnessed the mass hysteria episodes), in order to assess whether the participant had histrionic personality traits or not. The last section covers the biographical data of the female students who completed the checklist. The biographical data includes age; religion; academic class; and the background of each student (focusing on parental occupation in order to assess family financial status, which includes ascertaining whether the parent is alive or deceased). If the parent/s is/are deceased, the cause of death is identified and the various social problems encountered by students are listed.

The data used in this research study on the incidence of mass hysteria in Lesotho covers the ten year period between 1995 and 2005.

4.2 DATA PRESENTATION: QUALITATIVE ANALYSIS

This section presents the narrative data collected through focus group discussions and individual semi-structured interviews held with various individuals and groups: victims of mass hysteria, teachers, school principals, parents, traditional healers and church

leaders. The researcher reviewed the field notes, listened to the audio recordings, transcribed, read and re-read the verbatim transcripts in order to familiarise herself with the data and to develop a general impression of the interviews. After that, the researcher worked on each verbatim transcript sequentially, according to the order of data collection. The next step was the analysis of every individual transcript. All similar ideas or topics were grouped together into categories. Four themes derived from the data. Member checking was done to validate the data.

Four themes, 14 categories and 22 sub-categories emerged, as illustrated in table 4.1.

Table 4.1 Emerging themes, categories and subcategories

Themes	Categories	Sub-categories
Manifestation of mass hysteria among the Basotho	Physical symptoms	Strength Choking Fainting Foaming from the mouth Screaming and crying Muscle weakness and rigidity Fatigue
	Psychological reactions	Anxiety Hallucinations Confusion
	Contagious effect	-
Interventions used by the Basotho to alleviate mass hysteria	Herbal remedies Water splashing Pain infliction Prayer Exorcism Mental health team interventions	-
The Basotho's views on mass hysteria	Natural illness	-
	Supernatural illness	Evil spirits and witchcraft Blasphemy Satanism
Effect of mass hysteria on the Basotho	Negative effects on the victims	Discrimination/stigma Performance decline Fear
	Positive effects on the victims	Friendship Pride Christianity Improvement
	Effects on others	Effects on family Effects on teachers Effects on community

A Moeletsi oa Basotho newspaper report describes a mass hysteria episode in a high school in Lesotho (July, 2009):

Mass hysteria is often experienced at schools, factories and occasionally in the villages in Lesotho. It strikes when one least expects it. For example, it is a normal school day all is well; it is assembly time, just before classes start; it is time for the morning prayer and the head teacher is leading the prayer. He has a paper in his hand with announcements. Suddenly, one of the girls screams loudly, uncontrollably. For some time, all is quiet, and then all hell breaks loose!

Some students, especially boys next to the screaming girl hold on to her because she falls down, as if she were losing consciousness. A few teachers run to assist the girl!! She becomes violent; she fights who ever touches her!

Other students run away for their safety. They do not know why they are running away. They have not even seen what was happening. They hear the screams. There is a stampede. Some students fall on top of each other. Some get injured in the process; they get cuts, bruises and abrasions. Everybody is confused. Suddenly a number of girls from the same class, from the same age group, and others from other classes display the same symptoms. They are friends or relatives of the affected girl.

Teachers are totally amazed, they do not know what is happening, they order the boys to carry all affected girls to the staff room for care, while the principal calms the unaffected students and assures them that all will be well. He then dismisses them to their classes. He assigns them some work while the teachers are busy helping the affected girls in the staff room. The students who show serious symptoms are accompanied to the outpatient department (OPD) of a local hospital for treatment, while parents are summoned to the school.

Within a very short time, word gets around that “there is a mysterious illness” in Mazenod High school (school B). Reporters go rushing. They start reporting live on air; parents quickly go to the school to make sure that their children are safe, or to take them either to consult a traditional healer, a medical officer, a priest or a born-again pastor (who has healing powers). All radio stations and the national television report the incident; it becomes the headline of the day. Most of the students spend a few hours at OPD; they are treated and sent home. While a few girls spent one night in the hospital, and are well the following day. Even those who were released at the OPD are back in class. Some of the previously affected girls, exhibit some of the symptoms for two to three days. However, the episode dies out as quickly as it occurred. There are reports of such episodes in two other schools around the region [sic].

This is a story of what took place in one of the schools in Lesotho, (Mazenod high school) and from this scenario there are many lessons to be learned that are relevant to the study at hand. It is important to hear how the affected students describe both the physical and psychological manifestations and symptoms that they experienced. Manifestation is defined as “a sign or evidence of something” (Oxford South African Pocket Dictionary 2011:547). Theme 1, the manifestation of mass hysteria among the Basotho, includes physical and psychological manifestations and the contagious effect of mass hysteria.

4.2.1 Theme 1: Manifestation of mass hysteria among the Basotho

The themes and categories are shown at the beginning of each section. They are discussed individually. Below each theme, related categories are described. The verbatim quotations from the subjects are cited without attempts to correct grammatical errors that may have been made. The data is classified, in order to facilitate the audit trail.

Table 4.2 Manifestation of mass hysteria among the Basotho

Theme	Categories	Sub-categories
4.2.1 Manifestation of mass hysteria among the Basotho	4.2.1.1 Physical symptoms	Strength Choking Fainting Foaming from the mouth Screaming and crying Muscle weakness and rigidity Fatigue
	4.2.1.2 Psychological reactions	Anxiety Hallucinations Confusion
	4.2.1.3 Contagious effect	-

4.2.1.1 Physical symptoms

Brooker (2005:185) defines “physical” as anything that is related to the body, while Semple et al (2005:80) defines “symptom” as “an abnormality reported by the patient”. Seidel, Ball, Dains and Benedict (1991:756) state that symptoms are the subjective indication of disease as perceived by the patient. Therefore, physical symptoms are the somatic abnormalities reported by the victims of a disorder.

The affected students or victims of mass hysteria in this study exhibited some somatic or corporeal symptoms during the incidents. When victims were asked about the symptoms experienced during the mass hysteria episode, they reported that physically they felt strong and even powerful, but at the same time experienced rigidity and

weakness of muscles, especially in the their knee joints. They had the urge to run away. They experienced nausea and dizziness, had difficulty with breathing and felt like they were suffocating. They felt hot and were perspiring. They cried out, had tremors and became unaware of their surroundings.

The observers (teachers and parent) of the mass hysteria incidents reported that victims fainted during the incidents and became unconscious. These symptoms have been reported in several schools in South Africa including Nompumelo Junior Secondary School in the Eastern Cape; 90 Windsor Secondary School in Ladysmith, as well as Mahlenga High School in KwaZulu-Natal (Daily News, 23 March, 2009).

Strength

The victims of mass hysteria reported that they experienced extraordinary physical strength during the incident. They said that they suddenly became very powerful and would fight whoever was trying to hold them down.

The observers confirmed the victims as being extraordinarily strong and displaying aggressive behaviour towards those who intervened and tried to stop them from running away, as most of the victims did. Boys were, in the main, helping to prevent the victims from running away. The victims were so powerful that the boys reported that they were compelled to handle them harder than a man should handle a woman. One of the victims reported her extraordinary strength as follows:

I was really fighting; I was very powerful (Data: 7) [sic].

The victim's comments on the experience of exceptional strength and power were affirmed by the observers, who added that victims demonstrated violent behaviour towards those who tried to restrain them.

The teachers who observed the incidences commented:

She was powerful, trying to fight the boys (Data: 112).

... She was powerful and overpowered several boys ... (Data: 129).

... I tell you, those girls displayed such power, you could not imagine! They overpowered a bunch of men, as if they were small boys; it was unbelievable! (Data: 154) [sic].

... "Fought with all they had"; literally did not care if you were a man ... (Data: 16) [sic].

... They kept their eyes closed, screamed as if they were in pain, fought furiously, some of them tried to get up and run away while others sobbed quietly and tears ran down their faces; others made choking sounds, rolled down on the floor as if in pain (Data: 181) [sic].

The physical strength was displayed by the victims of Basotho and Zulu cultures as reported in the *Daily News* (2009:3)¹⁰⁶, where the school principal reported that "pupils ... were screaming hysterically and behaved aggressively towards anyone who tried to subdue them".

The Times Educational Supplement (2004:16) cites Bartholomew (1993:180) who reported on East African women's outbreak of psychogenic symptoms, which included destructiveness, violence, running, disobedience to authority and laughing. Rataemane et al (2002:65) reiterates that abnormal motor behaviours associated with motor mass hysteria always occur prior to tension in any given group. This indicates that the group has some stressors. The study concludes that these symptoms may accompany "mass motor hysteria" as reported by Bartholomew and Sirois (2000:498).

Choking

Choking is defined as "preventing someone from breathing by squeezing or blocking the throat or depriving him or her of air (Oxford South African Pocket Dictionary 2011:149). Choking is one of the physical manifestations reported by both victims and observers of mass hysteria. Victims showed signs of being suffocated. They displayed obstructed breathing.

The observers described the choking as follows:

... they made choking sounds (Data: 120) [sic].

¹⁰⁶<http://www.dailynews.co.za/index.php?fSectionId=3532&faArticleId=vn200903251055210> (accessed 04 August 2009).

... like choking, unable to swallow ... (Data: 142) [sic].

... Others made choking sounds ... (Data: 181) [sic].

... Some actually presented [as if] being choked ... (Data: 192).

... They looked like they were being strangled (Data: 269) [sic].

Two of the victims reported that they experienced choking symptoms:

I became suffocated ... though we shook, we did not lose consciousness (Data: 34) [sic].

I suffocated, and then I shook (Data: 35) [sic].

I also felt weak and I felt like I was choking, I was unable to swallow, even my own saliva was difficult to swallow (Data: 230) [sic].

Not all of the victims reported this reaction. This may be because most victims were reported to have lost consciousness and were therefore not able to recall the encounter. Choking as a symptom, according to Nair in Daily News (2009)¹⁰⁷ and Rataemane et al (2002:65), is associated with witchcraft. In Lesotho, witchcraft is related to a 'thokolosi', which strangles or chokes its victims. This creature is described as an 'African brownie' because it is described as a brown, hairy dwarf (Van Hunks 2000). Thokolosi is a widespread belief in the Southern African region; there are reports about it from countries such as Botswana, Lesotho, Swaziland, the Republic of South Africa and Zimbabwe (Van Hunks 2000).

In Basotho culture illnesses that cannot be explained are attributed to evil and witchcraft and its characters, such as the 'thokolosi'. It is believed that thokolosi strangles its victims. Such symptoms of choking and epileptic fits are often associated with this creature (Moji & Rojas 1993:27; Daily News 2009¹⁰⁸; Rataemane et al 2002:65). As illustrated by an observer's remark:

... she looked like someone being choked; a thakhinya (kicking aimlessly) (Data: 81) [sic].

¹⁰⁷ <http://www.dailynews.co.za/index.php?fSectionId=3532&faArticleId=vn200903251055210> (accessed 04 August 2009).

¹⁰⁸ Daily News 25 March 2009 <http://www.dailynews.co.za/index.php?fSectionId=3532&faArticleId=vn200903251055210> (accessed on 04/08/2009).

Chen et al (2003:122) emphasise that it is important to identify the root cause of a mass hysteria episode, as cultural beliefs serve as the main factor in the intervention phase. Bartholomew and Benjamin (2003) add that culture-bound syndromes are determined by ethnic and cultural beliefs.

Fainting

Fainting is described as a “sudden loss of strength caused by reduced cerebral circulation often following fear, when vasodilation is responsible” (Brooker 2005:236). This description indicates that the victims of mass hysteria are somehow exposed to fear. Fainting is one of the common reactions during mass hysteria. The *BBC News* (11th September, 2008) reported the experience of 20 girls, who fainted in a school in Tabora in Tanzania while taking a final examination. This mass fainting was linked to witchcraft by local people.

Some of the victims reported as follows:

... On the first day, many students fainted, many, many, many students (Data: 33) [sic].

When I am angry I will not speak. Instead, I will faint at your feet (Data: 39) [sic].

Although participants (teachers, parent, church leaders and traditional healers) who observed the episodes described that the affected students fainted, there is some confusion between fainting (which could be described as a black out for a few seconds) or it could be linked to loss of consciousness and/or having a convulsion. Hosken (2009:4)¹⁰⁹ points out that it was not clear whether learners from the Pretoria High school collapsed from unexplained convulsions or fainting. Convulsions (seizures) are defined as sudden temporary changes in physical movement, sensation, or behaviour caused by abnormal electrical impulses in the brain (American Academy of Paediatrics 2009¹¹⁰). They are believed to cause sudden stiffness of the body or relaxation of the muscles, while loss of consciousness is described as loss of one’s awareness and response to surroundings (Longman Dictionary of Contemporary English 2003:329).

¹⁰⁹Pretoria News 27 March 2009 Ref No:1705 SA Media - The University of The Free State

¹¹⁰<http://www2.aap.org/> (accessed 23 January 2008).

Teachers commented as follows with regard to fainting among the victims:

They fainted, they lost consciousness for some time, and they fell on the ground
(Data: 192) [sic].

... They have convulsion-like signs, they faint, fall down, choke, froth at the mouth, some may even lose consciousness (Data: 250) [sic].

The fainting episodes are described as symptoms of mass hysteria in both developed and developing countries, despite the observations in the literature that Bartholomew and Sirois (1996:291) identified different types of mass hysteria that occur in diverse regions. Illustrating that “mass motor hysteria” is more protuberant in non-western traditional cultures while “mass anxiety hysteria” is prominent in western, developed countries (Altman 2000:7; Bartholomew & Sirois 2000:500; Chen et al 2003:122; Clements 2003:600; Nair 2009:4; News 24 2000¹¹¹). Mbuyazi (2009:3) in The Daily News, maintains that the victims of mass hysteria lose consciousness. One victim reported that “it was like I had a long dream, but couldn’t remember what I had dreamed about”. Geddes (2009)¹¹² affirms that victims seem to be in a trance, look as if they are dazed and often lose sense of their whereabouts.

Foaming from the mouth

The mass hysteria victims reported that they foamed from their mouths during the incidents. Foaming posed questions as to whether they were experiencing convulsions (grand mal epilepsy) or not. Some observers associated the foaming with choking. The observers (teachers and the traditional healers) reported:

... They were being choked by an animal (thokolosi); they made choking sounds; some rolled eyes, some even formed froth around their mouths! (Data: 120) [sic].

... Like they had a seizure and were foaming from their mouths; looked like they were being strangled (Data: 269) [sic].

¹¹¹<http://www.medicalnews today.com> (accessed 27 January 2013).

¹¹²<http://www.medicalnews today.com> (accessed 27 January 2013).

The act of kicking aimlessly (ho tharinya) (Data: 81), indicates that the affected could be strangled; culturally this means that an unforeseen animal (Thokolosi) is the cause of the suffocation. From the researcher's experience, during early school days, learners who had epileptic fits were described as being strangled by the thokolosi (dwarf). This cultural belief seems to still exist in the Basotho culture, despite attempts to correct this myth by the Ministry of Health, Department of Mental Health.

Yasamy and Zaaddini (1999:710) affirm that the cause of mass hysteria is often associated with the victims' cultural background. News 24 (2006)¹¹³ reports an incident in Nepal within a Hindu community, where 67 learners were described as having experienced "fainting fits" because school authorities had killed a sacred snake. This indicates that mass hysteria may be culturally-based, and that it is important to understand the cultural beliefs in order to effectively deal with these episodes. Bartholomew (1993:178) asserts that mass hysteria has effectively been masked by cultural custom.

Screaming and crying

Screaming was evident in all the incidents of the Lesotho mass hysteria episodes. All the index people, in this study screamed at the onset of the incidence. Crying was associated with pain according to the observers who commented as follows:

They ... cry uncontrollably (Data: 67) [sic].

... She screamed like she was in pain... (Data: 112) [sic].

She was screaming (Data: 81) [sic].

... Others were also screaming (Data: 109) [sic].

However, the pain was not experienced by all victims, as evidenced in this statement by one of them:

It does not hurt (Data: 52) [sic].

¹¹³http://news24.com/News24/Archive/0,,2-1659_-1050043,00.html (accessed 17 October 2006).

According to the literature, screaming by the victims is observed during a mass hysteria incident, but it is not associated with pain, the screaming is viewed as part of the dramatic side of mass hysteria. Such exhibitionism is elaborated on by News 24 (2001); a victim in Nepal is quoted as having said:

I only remember staggering a distance after hearing the screams of my schoolmates who were collapsing [sic].

The same view was conveyed by another victim in an outbreak in a Pretoria high school in South Africa, who stated:

I remember hearing people scream and seeing a friend faint in the passage outside my classroom (Pretoria News 2009:4¹¹⁴) [sic].

Nair (2009) in The Times reported mass hysteria outbreaks in seven high schools in three provinces of the Republic of South Africa, namely: Gauteng (3), KwaZulu-Natal (3) as well as in one Eastern Cape school, where some learners fainted, screamed and cried uncontrollably. These incidents show that most victims of mass hysteria displayed symptoms of “screaming and crying”.

Muscle weakness and rigidity

Victims have expressed that their muscles were affected during their experience of mass hysteria. They either experienced muscular weakness or muscular rigidity. Victims expressed their awareness of muscle weakness and rigidity as follows:

I felt weak and my knees tremble (Data: 37) [sic].

... I 'm very rigid and my fingers are rigid, clasped together ... (Data: 38) [sic].

Observers commented:

A bonts'a hore o shoa bohatsu (complaining of numbness in her extremities) (Data: 81).

¹¹⁴ Pretoria News 27-Mar-2009 Ref No1705 SA Media- The University of Free State

... *Their body twitches, they complain of weakness of the limbs* ... (Data: 64)
[sic].

Fatigue

Tiredness or fatigue refers to a physical state of weariness or inertia. According to Brooker (2005:91), it is a term used in physiological experiments on muscles to denote diminished reaction to stimuli applied. It is related to the muscle manifestation, where after a stressful event, such as the episodes described above, it is normal that victims go into a stage of exhaustion and feel fatigued. The victims of mass hysteria in this study expressed their feelings of tiredness and fatigue.

I was tired (Data: 8). [sic].

I felt tired (Data: 51) [sic].

... *I felt fatigued* (Data: 234) [sic].

According to the literature the symptom of fatigue is experienced in both developed and developing countries, according to the literature. McCarthy (2004)¹¹⁵ in The Guardian Newspaper reports fatigue as occurring in victims of mass hysteria. Jones et al (2000:2650) found from their study that in the nine outbreaks they investigated, fatigue was ranked sixth out of twenty symptoms for 1,571 mass hysteria victims.

4.2.1.2 Psychological reactions

Apart from the physical symptoms, the victims of mass hysteria endured specific psychological reactions. The majority of the victims (participants) reported that they experienced emotional reactions such as anxiety, fear, hyperactivity, sadness and anger (directed to nobody in particular) during the mass hysteria episodes. On further investigation, the participants explained that anxiety and fear were mostly the result of the then-existing political unrest in Lesotho, at the time. The cause of the sadness and anger they reported experiencing remained unaccounted for. Rataemane et al (2002:62) report that victims of mass hysteria experience psychological dysfunction.

¹¹⁵ www.guardian.co.uk/world/2004/mass-hysteria (accessed 25 January 2012).

The Daily News (2009)¹¹⁶, reported that learners suffered from hysteria after losing control; this manifestation of losing control is psychological in nature.

Anxiety

Anxiety is described as a general term for several disorders which cause nervousness, fear, apprehension, and worrying which may manifest in physical symptoms. The physical symptoms may include an increased heart beat and blood pressure, palpitations and sweating. Mild anxiety is vague and unsettling, while severe anxiety can be extremely debilitating (Medical News Today, March, 2012¹¹⁷). Anxiety is considered as normal when it precedes some challenging events such as an interview, but it becomes a problem if its symptoms interfere with one's functioning, such as the inability to sleep (Medical News Today, March, 2012¹¹⁸).

Most participants (victims) reported that they experienced anxiety attacks during the episodes. Rataemane et al (2002:12) purport that anxiety is always present and that it is a collective feeling experienced by the victims of "mass anxiety hysteria". It is collective because it is an emotion shared amongst many individuals at the same time.

The mass hysteria victims indicated their feelings of anxiety:

I was overwhelmed by fear I have never experienced (Data: 131) [sic].

I had an urge to get away from the school premises and the atmosphere was "spooky" (Data: 220) [sic].

I had a splitting headache and lots of anxiety. My heart beat was fast and I felt fatigued (Data: 234) [sic].

While only a few of the victims reported to have experienced anxiety, observers reported seeing anxiety in the victims and one observer reported that a victim complained of it.

¹¹⁶ <http://www.dailynews.co.za/index.php?fSectionId=3532&fArticleId=nw200901211722272> (accessed 8 April 2009).

¹¹⁷ www.medicalnewstoday.com (accessed 27 January 2013).

¹¹⁸ www.medicalnewstoday.com (accessed 27 January 2013).

I think they displayed anxiety because they wanted to run away, maybe fear too
(Data: 95) [sic].

Most of them appeared to experience fear ... anxiety, hostility and ... excitement
(Data: 106) [sic].

They displayed anxiety because they wanted to run away, maybe fear too. Felt fatigued (Data: 182) [sic].

Bartholomew and Sirois (2000:513) assert that mass hysteria presents in three patterns: mass anxiety hysteria; mass motor hysteria; and relabeling of the endemic symptoms. They add that a pattern of mass anxiety hysteria is precipitated by a stimulus that generates anxiety as a result of a threat; while mass motor hysteria emanates from an internal conflict such as employee dissatisfaction with management's restrictive practices.

Relabeling of endemic symptoms involves the conversional reactions, which are reinforced by the medical fraternity as well as by social factors. The presence of anxiety and other motor symptoms in these findings show that the Basotho experience all types of mass hysteria; that is mass anxiety, mass motor hysteria and the relabeling symptoms of mass hysteria. However, Bartholomew and Sirois (2000:497) point out that mass anxiety hysteria is almost exclusive to Western or developed countries. This study affirms that the Basotho victims experience all three patterns of mass hysteria, despite the fact that they are part of a group in developing countries that do not otherwise exhibit the same trend.

Participants (victims) said they experienced symptoms including dizziness, tremors (shaking of the whole body), difficult breathing, breathing very fast (hyperventilation) and an urge to run away. These symptoms can be related to anxiety, as they are the physical manifestations of anxiety. They were mentioned sporadically, but are worth citing here because they point to the type or pattern experienced by the Basotho victims. Bartholomew and Victor (2004:241) refer to all symptoms as "somatic reaction", as a result of a threat rumour that accompanies a mass hysteria episode, which is an "unconscious imitation of a model of the act".

Hallucinations

Hallucinations are defined as false perceptions in so far that there is no adequate external stimulus for the experience (Norman & Rylie 2008:26). Each of the five human senses can be affected by hallucinations. Thus, hallucinations are typically referred to as auditory (hearing), visual (sight), olfactory (smell), tactile (touch) and gustatory (taste). Mass hysteria victims in this study experienced visual and auditory hallucinations.

One of the victims said that on the day of the mass hysteria incident, she felt different, that life had changed:

... everybody did not care about me. They just passed me by, no one wanted to talk to me. I just felt confused, wondering why these people were like this. This particular day; why they looked different ... They seemed like they had turned against me; everybody went about his business and did not pay attention to me" (Data: 49) [sic].

Another victim experienced auditory and visual hallucinations. She commented:

... I think I heard a person calling me by my name...I looked around...then I saw someone peeking by the head ... (Data: 43) [sic].

Sometimes I saw people who did not have skins, they looked like skeletons. Sometimes I would see snakes that are scary things ... (Data: 44) [sic].

Some victims reported seeing either frightening animals or witches, and one referred to a bright light she believed she saw, they said:

Sometimes he became a lion, terrifying things. He became many things that are terrifying and they would make you feel that you needed to run away from this person (Data: 11) [sic].

(Granny ... so and so ... let go of me) ... (Data: 164) [sic].

One of the victims said she was aware that she could have imagined what she thought she saw, due to her confused state of mind:

I am not sure this happened or if it was an imagination. I think I saw a very bright light, like lightening, mind you, it was not raining, and this is what threw me to the ground (Data: 214) [sic].

The magnitude of this phenomenon is escalated by the belief system within a given society, as affirmed by Bartholomew and Victor (2004:231), who contend that the social dynamics of collective behaviours can expose victims to all types of hallucinations.

Confusion

Confusion is a state of the mind, whereby the individual loses touch with reality and displays both misunderstanding and misperception. Confusion is associated with the clouding of consciousness, disorientation and poor decision making (Brooker 2005:57). Most of those involved in mass hysteria, the victims reported that they were confused, as well as some of the observers (teachers and parents), reported that the episodes of mass hysteria caused confusion.

The victims expressed themselves as being confused:

I just felt confused. That is like I was where I had never been before (Data: 48) [sic].

We were really confused (Data: 114) [sic].

... I personally felt numb and unable to explain how I felt (Data: 216) [sic].

Another victim indicated:

I just felt confused. That is, I felt like I was where I had never been before so the people there lived like ... oh, they didn't live the kind of life that I lived every day. It was as if they lived their own life that I wasn't yet used to (Data: 48) [sic].

The observers (teachers and parent) were devastated and overwhelmed during a mass hysteria incident; they did not know what to do or how to assist the victims involved in the episode. A teacher said:

I was now panicky, I felt helpless and worried that those girls would die in our hands" (Data: 189) [sic].

A parent expressed her dismay in the following statement:

There was confusion everywhere, parents stood watching (Data: 266) [sic].

The existence of confusion during mass hysteria episodes is frequently mentioned throughout the literature. Mass hysteria appears to be a confusing phenomenon, as indicated by various references in the literature. Authors have referred to this phenomenon as “mysterious” (Altman 2000:7); “multiple unexplained symptoms” (Pastel 2001:44); “contagion of fear that goes far beyond germs” (Szegedy-Maszak 2001); and “mystery illness” (Bartholomew 2005:564). This indicates that people are perplexed and get confused, things seem to be in disorder and they are unable to comprehend this phenomenon, they tend to refer to it as something that baffles the mind.

4.2.1.3 Contagious effect

Contagion refers to the capability for the transmission of a disease or infection (Brooker 2005:58). Several authors have reported that mass hysteria is highly contagious. It is transmittable from the index person to others around him/her. They assert that the contagion is transmitted by sight, sound or both (Engs, McKaig & Jacobs 1996:195; Feldman 2000; Geddes 2009; Jones 2000; Rataemane et al 2002:11; Szegedy-Maszak 2001). The explanations in the literature for the contagious nature of mass hysteria vary from personality suggestibility (mob psychology), sympathetic induction of emotions, to environmental triggers such as odour (Rataemane et al 2002:11; Sunday Tribune 2002).

In this study, the victims of mass hysteria referred to the contagious nature of mass hysteria as follows:

... but the second day was not the same as the first day. On the first day, many students fainted, many, many, many students (Data: 33) [sic].

When I saw others run away, I also ran away (Data: 32) [sic].

The teachers commented on the magnitude of the affected students:

They increased at an alarming rate; at one point they were more than twenty four (Data: 82) [sic].

I must have counted about eight or nine of them. This was getting out of hand (Data: 91) [sic].

I found a number of students, all girls, lying on the ground, some teachers and students, mostly boys were trying to help. I must have counted twelve or so girls (Data: 185) [sic].

It must have been twenty girls; mostly from the Form D class, only two girls came from different classes, one was in Form A while the other was in Form C (Data: 188) [sic].

A parent remarked:

It must have been about 15 to 18 of them; I could not believe it! Indeed, my daughter was among them (Data: 268) [sic].

Many victims indicated that they underwent the attacks after seeing either friends or classmates experiencing the attack. According to Bartholomew (2005:567), it is believed that the contagion in these episodes occurs by line of sight and sound. The following statement by one of the school principals verifies the fact that even hearing about a mass hysteria outbreak can contribute to an epidemic of outbreaks demonstrating its contagious nature:

At the time two schools around our area had experiences of the event; it was given a high coverage by the media ... (Data: 122) [sic].

Rataemane et al (2002:11) explain that contagion is the transmission of emotions from one member of the crowd to other members, because of the vulnerability of members in a crowd. They add that this apparently happens when other members witness the facial expressions of the affected member. The group member affected is described as possessing a specific personality that cannot resist the contagion. Bartholomew and Victor (2004:240) consider that such people are highly anxious and are often affected, while the sceptic and analytic individual will remain unmoved by the incident. They contend that when there is a connection to a social network such as friendship or

kinship, the relationship plays a role in a personal anxiety transmission, by endorsing a sense of shared meaning and solidarity.

4.2.2 Theme 2: Interventions used by the Basotho to alleviate mass hysteria

According to the Medical Dictionary Online¹¹⁹, intervention is defined as “any measure whose purpose is to improve health or alter the course of disease”. Theme 2 comprises the interventions used by the Basotho to alleviate mass hysteria during the epidemics of mass hysteria in Lesotho. Most interventions are rooted in a set of beliefs perceived to be the cause of such episodes. Religious leaders use prayer and exorcism to treat the affected whereas traditional healers use herbal remedies, pain infliction and other means as discussed below.

Table 4.3 Interventions used by the Basotho to alleviate mass hysteria

Theme	Categories
4.2.2 Interventions used by the Basotho to alleviate mass hysteria	4.2.2.1 Herbal remedies 4.2.2.2 Water splashing 4.2.2.3 Pain infliction 4.2.2.4 Prayer 4.2.2.5 Exorcism 4.2.2.6 Mental health team interventions

There are different kinds of traditional healers, including amongst others, herbalists, faith healers and *sangomas*. To become a sangoma is considered a calling from one’s deceased ancestors. The candidate for this calling either gets very sick, or dreams about a specific spring or well, where the water is used for healing people’s ailments (traditional healer’s interview).

The novice may even dream about the lethuela (traditional healer), who has to train him/her (ho mo fehlella) and initiate him into becoming a traditional healer. There are several steps and traditional practices the trainee has to undergo and perform during and after training (Truter 2007:57¹²⁰).

¹¹⁹ www.online-medical-dictionary.org/ (accessed 24 April 2013)

¹²⁰ (Interview date: 11/07/2009)

The sangomas or maqhekha (mathuela – in Sesotho, plural for leqhekha/ mathuela) are identified by wearing beads in different colors (Annexure K). A Sangoma is considered to be born a Sangoma and can be called to practice at any time during the course of her/his life, either willingly or unwillingly. Some recognise the calling and go through the initiations (becoming a [ho thoasa] or apprentice). At other times, Sangoma illness goes undetected and shows up as bipolar disorder, schizophrenia, depression and mental illness. They throw bones (litaola) when diagnosing the illnesses of their clients (Truter 2007:57).

Sangomas assert that they cannot harm nor do evil to anybody, because this would anger the ancestors. The ancestors can desert them and take away the talent or even make them sick or kill them (traditional healer's interview). The herbalists formally studied different types of herbs and their medicinal usage in the treatment and prevention of diseases. They then spend few years as trainee (Truter 2007:58).

Ngaka-chitja (general traditional healers) can repay evil by evil; that is, if one person bewitches another, an ngaka-chitja can retaliate by using muti (medicine) or thokolosi (spirit) the owner of the spirit. The ngaka-chitja learns the art of healing from his parents. One such traditional healer was interviewed for this study. Such healers use herbs and animal fat and organs for example a gall bladder, in their practices.

The World Health Organization (WHO) defines the traditional healers as African Traditional Health Practitioners (ATHP), who specialises in divination, psychology, counseling, social spiritual work, mediation and ministering.

Four traditional healers were interviewed in the two southern districts of Lesotho; Mafeteng and Mohale's Hoek. Two "Sangomas" (mathuela) were interviewed together because they worked as a team. A herbalist and a generalist were also interviewed. The generalist illustrated his supremacy of healing by reiterating:

... When I and the patient agree that I get rid of "thokolosi" and sent it back to its owner, I send it back via the very patient; she/he will take it to its owner. Then, it will be very angry, maybe even angrier than when it attacked the patient (Data: 167) [sic].

A devil is fought with another devil; so I have my own means of fighting or counteracting the devil; we either use herbal medication or animal fat mixed with

some concoction; that will sent back whatever “muti or thokolosi” that is causing trouble for children. This takes a very experienced healer to do, not a novice healer! (Data: 167) [sic].

4.2.2.1 Herbal remedies

Herbal remedies are often used by the traditional healers to treat victims of mass hysteria. The herbalist explained:

This can be treated by a mixture of special herbs; the three herbs have healing properties, which fight the heat and the symptoms of anxiety and the symptoms of mental illness that the affected people display (Data: 65) [sic].

This participant believes that mass hysteria is caused by “heat”, which is generated when people live in a small hut; and he further attributed the incident to new information, that the symptoms displayed by the affected are a result of ingesting a poisonous worm that hibernates in a cabbage plant. If vegetables are undercooked, the same symptoms can be experienced by those who eat the vegetables and the worm. According to him, special herbs can alleviate the anxiety and other symptoms of mental illness emanating from the condition.

It is argued here that most perceptions about mass hysteria display some form of superstitious belief. Other sectors of traditional healers stipulated that they use both herbs and animal products, such as fat or body organs and that these body parts are revealed to them in dreams by their ancestors (Balimo). They explained:

They [balimo] talk to you as you sleep or while you are having litaola [bone divination, used for diagnosing a patient] (Data: 79) [sic].

... Use herbal medication or animal fat mixture ... (Data: 103) [sic].

This takes a very experienced healer ... (Data: 104) [sic].

The Traditional Healers said the following when asked about the remedy given to mass hysteria victims, though they were reluctant to share information:

We gave them some mixture of the intestines of squirrels and the porcupine's feathers; all [ground] together. It is a good, strong mixture. You dry up the intestines in the sunlight, without washing them (Data: 77) [sic].

We have shared quite a bit with you; the rest we will give to you as treatment, if you are ill, you see these are special gifts from the ancestors, they guide you along, when a patient is in your care (Data: 78) [sic].

... These were given to me by my late ancestors (Balimo), it cannot be disclosed for free source of healing powers, hence the secrecy (Data: 105) [sic].

4.2.2.2 Water splashing

During the interview with a parent it was disclosed that water splashing is frequently used as a home remedy; it is believed to bring back “sense” to anybody that has lost their sense. When cold water drops on her face, she regains consciousness. PDR (2011) indicates that sprinkling cold water on the face of someone who faints is helpful.

When an individual faints, the Basotho believe that she lacks oxygen (Masupha’s interview). This is the rationale behind fanning a patient. The researcher has not been able to understand the reason for giving water to drink, but, has seen it done, even during funeral services when a funeral attendant cries and is overwhelmed by emotion.

The observers reported as follows:

(Interview date: 11/07/2009)

When one of the teachers threw water on her face... she regained her consciousness (Data: 90) [sic].

Some employed home remedies of splashing water onto the affected student’s faces and this worked wonderfully (Data: 116) [sic].

She paid no attention to anybody ... fighting; until one of the teachers threw cold water on her face, she gave a sighing sound that is when she regained consciousness (Data: 179) [sic].

Some were “fanning” fresh air for them; others were trying to give them water to drink (Data: 18) [sic].

There is not much mention of water as an intervention in mass hysteria episodes beyond a report from Nepal, where a sacred snake had been killed; the journalist

reported that the priests sprinkled holy water in the classroom to drive away the “spirit” (News 24:2006¹²¹).

4.2.2.3 Pain infliction

According to Brooker (2005:174), pain is described as a distressing sensation felt by an individual when his nerve endings react to a stimulus. Pain can be either physical or emotional. The physical pain can be a result of injury or illness (Oxford South African Pocket Dictionary 2011:641). An inflicted pain is that type of pain that can be deliberately imposed.

Some of the observers believe that inflicting pain to the affected relieves the symptoms. This is an old intervention, which was used for the mentally ill during prehistoric times, when people believed that mental illness was demonic (Perko & Kreigh 1988:4). It is thus not uncommon for a community to beat up a mentally ill person in the hope of driving away the demons. This approach is evident in the Basotho proverb ‘lehlanya le phekoloa ka phafa’ (a madman is cured by thrashing). In the case of mass hysteria the participants mentioned this intervention of inflicting pain. In another instance of mass hysteria, a participant was hurt because she was seen to have brought shame on her family. This intervention was minimally used but, it is worth mentioning because of its effect on the individual who receives the treatment in order for health workers to address the topic of pain infliction during health education on mass hysteria.

This is how it was expressed by the participant (victim) who encountered pain:

My stepmother gave me a good hiding ... that I brought the family name into shame... (Data: 138) [sic].

The traditional healer acknowledged that they utilise this method. He said:

Oh, sometimes we resort to inflicting pain, maybe giving them “a good hiding” (Data: 171) [sic].

¹²¹<http://www.news24.com/news24/AnanziArticle/0,,2-10-1462-19955155,00.html> (accessed 17 October 2006).

4.2.2.4 Prayer

Prayer is described as speaking to God to ask for help or to give thanks (Longman Dictionary of Contemporary English 2003:329). Most of the participants mentioned it as being one of the interventions frequently used during mass hysteria episodes. This is how the victims expressed themselves:

People from all churches came to my home and prayed for me; the priest came and prayed for me at home (Data: 12) [sic].

They gave holy water and oils and told me to use those things (some churches use these in prayer) (Data: 17) [sic].

... So the priest prayed ... (Data: 4) [sic].

The teachers explained:

We ended up with five or six priests, who arrived at different times to pray for them ... (Data: 84) [sic].

Some religious groups prayed for them, one of them ... (Data: 97) [sic].

Some religious group prayed for them (Data: 184) [sic].

A priest was asked to come and pray for the students. He conducted a special Holy Mass for them, used some holy water and oil and asked all of us to pray for them (Data: 200) [sic].

I think prayers helped her; we prayed a lot. We used holy water and oil (Data: 276) [sic].

The traditional healers never mentioned prayer as an intervention strategy. They used and trusted their own remedies such as herbs and animal product concoctions or brews.

4.2.2.5 Exorcism

The priest consulted for this study pointed out that:

Evil spirits and earnest prayer are not friends at all, prayer always supersedes; calling upon the names of the Virgin Mary and her son, Jesus, is all that will drive away the demonic power. In our church we have many things that we use in

prayer; such as holy water, rosary, miraculous metal, holy oil and special prayers such as the Novena. I tell you they do miracles! (Data: 160) [sic].

In this study exorcism emerged as one of the management strategies for mass hysteria, because certain victims are believed by some people to be possessed by the evil spirits.

Two participants, the priest and the faith healer, specified that they were able to exorcise evil spirits from victims of mass hysteria. This is how they articulated it:

We faith healers have special talents or gifts from the Almighty that enable us to drive these spirits back to their owners through faith and prayer. It is during such times that you lose your earthly being and you become a real servant of God. Even what you say does not come from you, but from Him. You know, we all have the potential but we do not use it fully. I tell you faith can move a mountain; remember we were created in His image. Prayer is our only weapon. We are also given powers by the church to exorcise the evil spirit (Data: 252) [sic].

The researcher asked a victim who experienced exorcism how she felt during the exercise; and she explained the experience:

While praying I felt my body going into shock, like I had been dipped into cold water (Data: 15) [sic].

The priest described the exorcism procedure as successful if the affected person attains calmness. In his own words:

They fell down and you could see that they were busy fighting with the spirits. But, when they [spirits] left the child, you could see the calmness and the relief in the child's face. However, the children needed to be followed up either at home or in church; because, once a victim, you are prone to be a victim once more (Data: 255) [sic].

He emphasised the importance of follow up by observing the fact that the episodes could re-occur. Yazamy et al (1999:711) point out that the “index case” always has a history of similar attacks. They found in their study, that three students had repeated episodes after the interventions. This is affirmed by Jones (2001), who indicates that symptoms can recur in the setting of the initial outbreak. The observations are important for follow-up. It is apparent that the episodes re-occur from one of the teacher's statements:

It lasted three days ... the same girls who started were always among the group
(Data: 113) [sic].

4.2.2.6 Mental health team interventions

The Mental health team intervened in some incidents and gave health education to both the students and teachers, as verified by the participants:

Professional people from the department of Mental Health also visited and talked to both students and staff (Data: 184) [sic].

A mental health team from Mohlomi Hospital and the National University of Lesotho, comprising nurses, social workers and psychologists, visited the school (Data: 238) [sic].

According to Rataemane et al (2002:67), it is important for the health authority to intervene as “public health statements can help terminate these epidemics”. They emphasise that such statements must deny the role of agents such as evil spirits or sorcery, as they are frequently implicated.

According to Jones (2000)¹²², the health authority’s role is important during the response to an outbreak, and it needs to be prompt in order to restore normal functioning of victims and communities. Its role may include separating the victim from the unaffected students; monitoring those who are adversely affected; notifying the public health authorities; opening communication pertaining to laboratory results; not exposing clients to too many tests; and reminding victims and communities that rumor reports are exaggerating facts. According to Feldman (2004), early intervention of a calm authority figure is mandated during outbreaks of mass hysteria. The authority gives clear and accurate information repeatedly and remains visible and available to provide updates. This person is deemed a powerful tool in mass hysteria episodes.

¹²² <http://www.aafp.org/aafp/20001215/2649.html> [Accessed 14August 2007]

4.2.3 Theme 3: The Basotho's views on mass hysteria

Views and values go hand in hand, with values shaping views. Stuart and Laraia (2005:18) indicate that values are formed from life experiences associated with culture, which includes the family and society in which an individual lives. They emphasise that value systems provide the framework for daily decisions and actions. Helman (1994) cited in Swartz (2005:6) views culture as “a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to the supernatural forces or gods ...”

This view intertwines the concepts of culture, views and values. It is therefore important in this study to examine and get the viewpoint of the Basotho nation regarding their perceptions or opinions as it emerged as a theme. Table 4.4 illustrates that participants ascribed the cause of mass hysteria to either natural or supernatural causes. The supernatural were blamed on evil spirits, witchcraft or Satanism. This section examines Basotho perceptions. The categories of the natural and the supernatural are discussed separately.

Table 4.4 The Basotho's views on mass hysteria

Theme		Categories	Sub-categories
4.4	The Basotho's views on mass hysteria	4.4.1 Natural illness	-
		4.4.2 Supernatural illness	Evil spirits and witchcraft Blasphemy Satanism

4.4.1 *Natural illness*

Natural illness emerged from the data as a category. Some participants endorsed the perception of mass hysteria as a natural illness. A natural illness is a type of illness that exists in nature and it is not caused or made or controlled by people (Longman Dictionary of Contemporary English 2003:1094).

One of the participants explained that the cause of the episode was of natural occurrence, because it was of natural origin. The participant ascribed mass hysteria to different natural causes, inclusive of heat (energy), the food people eat, a poisonous worm, or a natural illness from God. The participant stated his views in this manner:

It is attributed to the “heat” of the household generated by individuals ... it is due to the “heat” (Data: 60) [sic].

I can conclude that it happens in schools because students eat the same food, and generate a lot of heat as they share one big place (Data: 66) [sic].

The participant elaborated that the energy (heat) produced by the people living in a household results in mass hysteria.

We discovered that it can also come from the food that people eat, especially from the cabbage vegetables. Cabbage plants can be invested by some poisonous worm (Data: 62) [sic].

According to him, the two factors that cause mass hysteria episodes are “heat” and a poisonous worm found on the cabbage plant (the Basotho eat cabbage more than any other kind of vegetable). He indicated mass hysteria to be a natural illness from God. Thus:

At other times it is a natural illness from God. It is a type of “Lehabea” (conversion disorder) (Data: 71) [sic].

Some participants hold the belief that mass hysteria is a psychological illness (conversion disorder) rather than a supernatural condition. Semple et al (2005:85), describe conversion disorder as a condition of the unconscious, psychological anguish that manifests as a physical illness, such as seizures or paralysis.

The teachers speculated that mass hysteria may be a psychological illness which could be due to problems at home, while some victims attributed it to stress as a result of different factors, such as lack of funds to meet basic needs, drug abuse, expectations for good performance, and pretending illness with other ulterior motives. According to

Kokota (2011:76) and Sharma et al (2010)¹²³, extreme situations of stress expose students to mass hysteria. They mention that inhibited emotional ventilation, poor academic performance, unresolved grief and failing family communication, result in stress.

The victims commented:

Our teachers thought that maybe we have problems ... at home (Data: 41) [sic].

I am sure that the stress we are under and the demands, especially economic ones, have attributed to the illness. This witchcraft business, I do not believe in [it] ... (Data: 149) [sic].

Another victim suspected that her stepmother expressed that she was malingering; this is how she put it in her own words:

My stepmom thought I was faking illness, because I wanted to dodge work at home and deceive people that she was a witch (Data: 235) [sic].

One teacher validated that it could have resulted in the pressure they exerted on the students for high performance, by saying:

They were due to write examination ... teachers put pressure ... on [students to achieve a] good performance (Data: 121) [sic].

Another teacher regarded it as related to drug abuse:

There is so much drug abuse in our school, these students abuse matekoane marijuana, glue, name it ... this could be the result of drug abuse (Data: 124) [sic].

It is certainly the case that drug abusers sometimes display bizarre behavior that people do not understand. The National Institute of Drug Abuse (2010)¹²⁴ explains that marijuana affects the brain negatively, where initially it produces behaviors such as euphoria, heightened sensory perception, altered time perception, inappropriate laugh and increased appetite. However, when the euphoria subsides, users may feel drowsy

¹²³<http://www.nepjol.info/index.php/njog/article/view/5055/4170> (accessed 27 August 2012).

¹²⁴www.drugabuse.gov/publications/drugfacts/marijuana (accessed 12 February 2013).

or depressed. Occasionally, marijuana users may experience anxiety or panic attacks, fear and distrust of other people.

The Daily News (2009¹²⁵) reported a series of schools in the Republic of South Africa, where “pupils became crazy”. This happened in Nompumelelo Junior Secondary School in Lusikisiki, 90 Windsor Secondary School, Ladysmith and Mehlela High School, northern KwaZulu-Natal. An Eastern Cape police spokesperson commented that if such an incident is reported, police would check the school for illegal drugs that could lead to a child’s ‘uncanny behavior’. The researcher concludes that the teacher may be right in his observation, because drug abusers behave abnormally, due to the drug action on the brain. Discipline issues that were not fully explained were cited in Pretoria high schools as contributing to the outbreaks of mass hysteria. One of the principal teachers was quoted as referring to the episode, saying that it was “clear that this is a sign of moral degeneration occurring in our society” (Pretoria News 2009:4).

4.4.2 Supernatural illness

“Supernatural” is a factor regarded as being caused by some agency beyond the forces of nature (The Concise Oxford Dictionary 1964:1296), it is often associated with superstition. In order to dissociate the self from the irrational belief, the researcher uses supernatural factors in this study.

Evil spirits and witchcraft

Some of the participants reiterated that mass hysteria episodes are supernatural in nature. They assumed that mass hysteria episodes were caused by “evil spirits or witchcraft”. These two causes are, rather, entwined from the explanations given by the participants.

One participant commented:

The devil is the root of evil spirits and that the witches belong with him; so definitely these things are there ... (Data: 161) [sic].

¹²⁵ <http://www.dailynews.co.za/index.php?fSectionId=3532&fArticle=nw20091211722272>. [Accessed 8 April 2009].

You will see newspaper headlines like: 'Thokolosi e patela bana sekolong' (A dwarf troubles school children); you also see some of the sick students being choked by something that you cannot see, you definitely say, this could have been [the] thokolosi referred to in the papers; I am not sure if you have any other explanation. Surely, I personally believe that some supernatural force maybe ... [laughs] the dwarf is at play here (Data: 242) [sic].

The victims expressed their beliefs as follows:

I take it that this sickness was caused by the evil spirits. I take it as evil spirits (Data: 24) [sic].

I heard that when a student is out-competed by another student, she tells her grandmother "who rides a broom (a witch's practice) sends a "thokolosi". These witches can target anybody and send muti to him (Data: 73) [sic].

Most people thought it could be bewitchment by jealous people ... One of my mom's friend used muti to cause the illness (Data: 144) [sic].

I have never believed in sorcery but I could now imagine, yes, it is it, when I saw so many girls, me included, in such a state; I started believing that it was witchcraft, I had no other explanation (Data: 217) [sic].

My mom consulted a traditional healer, who said that one of my mom's friend used muti to cause the illness, because her daughter dropped out of the school, while I am doing well in my studies (Data: 236) [sic].

The Draft Witchcraft Suppression Bill of 2007¹²⁶ defines "Muti" as any mixture of herbs, water, woolen cuffs etc., used by wizards, igedla, inyanga, African churches, foreign traditional healers etc. for the purposes of curing diseases, helping others who come to consult them for whatever purposes, including causing harm to others or their property. The bill (2007) defines a witch as "any person who secretly solicits or uses muti, zombies, spells, spirits, magic powders, water, mixtures, baboons, etc. for the purposes of causing harm, or damage, or suffering to another." This information supports the fact that muti and witchcraft are linked. Muti is defined in the Draft as "African medicine or magic charms that are prepared from plants, animals, etc." (The Draft Witchcraft Suppression Bill for South Africa 2007)¹²⁷. Both the traditional healer and the herbalist expressed that:

¹²⁶ <http://www.pagancouncil.co.za/node/66> (accessed 12 February 2013).

¹²⁷ <http://www.pagancouncil.co.za/node/66> (accessed 12 February 2013).

Witches sen[d] muti and people around you see you acting like you are mad (Data: 74) [sic].

They must have sent an animal, that is a thokolosi It is the one that makes children run and faint (Data: 80) [sic].

“Thokolosi” is here... (Data: 99) [sic].

Teachers on the other hand believed that witchcraft played a role in the episodes as expressed:

... It was witchcraft; others believed it was a curse to the parents ... (Data: 119) [sic].

... They were being choked by an animal [thokolosi]; they made choking sounds; some rolled eyes, some even formed froth around their mouths (Data: 120) [sic].

Surely, I personally believe that some supernatural force ... is at play here (Data: 148) [sic].

Yes, it could have been a result of something supernatural (Data: 194) [sic].

Some teachers learned from other sources, such as priests and religious groups, that evil spirits were the cause of the incident. This is how they expressed what they had heard:

We ended up with five or six priests, who arrived at different times to pray for them ... they actually said that the kids were filled with evil spirits (Data: 84) [sic].

The religious group was suspecting “some bad/evil spirit” (Data: 123) [sic].

A faith healer, who said the illness, is due to the “evil spirit” ... (Data: 145) [sic].

The church leaders viewed this differently, as the following statements indicate:
These are the devil’s work; these people are mean ... (Data: 101) [sic].

... Evil spirits and sorcery are mentioned in the Bible ... you definitely will know that culturally those beliefs are acceptable; they are part of Basotho culture (Data: 147) [sic].

... The devil is the root of evil spirits and that the witches belong with him; so definitely these things exist ... (Data: 161) [sic].

Blasphemy

In one of the schools (school A) an abnormal incidence had taken place as narrated by the principal:

The boys had made a big cross ... this could have been blasphemy. Surely, one can play around but must not mess around with sacred things, such as heavenly entities. I have a feeling they stepped over-board, I think the evil spirit does exist; indeed, this could have overpowered them to have committed such an act. Somebody must have been jealous of the good performance we displayed and decided to bewitch us (Data 201) [sic].

The school principal actually referred to this as blasphemy as it is explained in the Christian bible. The Holy Bible of Christianity reads as: “You shall not misuse the name of the Lord, your God, for the Lord will not hold any one guiltless, who misuses His Name” (New International Version, Exodus 20:7). From this verse it is clear that religion teaches those that claim to be Christians to be vigilant of this commandment.

It is not surprising that one of the school principals picked up what she termed “blasphemous behavior” from the boys when they assembled a cross and imitated the Son of God, carrying the Cross to Golgotha (NIV, John 19:17).

An episode of “fainting fits, screaming and crying” of 67 learners aged between nine and sixteen was reported in Nepal in Laxmi Secondary School, after school authorities killed a snake that was considered sacred by many Hindu communities. People explained the outbreak as revenge from killed sacred snake’s spirit (Sarkar 2006¹²⁸)

One of the parents commented:

There were lots of rumours. One of them was that one woman who worked on the school grounds, confessed that she caused it through witchcraft (Data: 270) [sic].

This belief is supported in the literature by Thakali (2008:7), who reported in the *Saturday Star* about an outbreak of mass hysteria at a school in Soweto, South Africa,

¹²⁸ <http://www.india-forum.com/>. [Accessed 23 August 2008].

where the episode was ascribed to evil spirits by the pastors who were called in to pray for the learners. The *Daily News* (2009)¹²⁹ reported about *sangomas* who planted *muti* in one of the schools' yards in the North West Province of South Africa; this demanded a cleansing ceremony by some traditional administration. Benjamin (2003) report on culture-bound syndromes such as *amafufunyane* in the Gauteng, KwaZulu-Natal and Eastern Cape provinces in South Africa, and ascribe it to witchcraft. He contends that most African regions' cultural and religious beliefs fuel mass hysterical episodes. Close living arrangements expose every member of a family living in a small hut to the observation of hysteric behaviour. In September 2008, a similar phenomenon was reported in Tanzania, and it was linked to witchcraft (BBC News 2008).

Satanism

Some participants proposed that mass hysteria could be caused by "Satanism". This new religion is posing a problem in most countries, as illustrated by this statement from one church leader in this study:

... Here a small girl that was born and bred in the Catholic faith, suddenly, is confronted by "Satanism" [...] through peer pressure; definitely the evil spirit and the Holy Spirit are in conflict; that is the reason they display such behaviours (Data: 261) [sic].

Several studies have implicated Satanism as a cause of mass hysteria episodes; Rataemane et al (2002:11) reports that in Mangaung and Heidedal in the Free State province of South Africa, students experienced an epidemic of skin itching. Satanism and white powder which was found in the environment were identified as causative sources of the epidemic. The Pretoria News (2009:4) also bore a heading: *Mysterious wave of mass hysteria hits city school: Satanism suspected as 25 gripped by seizures*. In these outbreaks, several schools were involved, namely: Pretoria High, Daspoort Secondary and some schools in Sunnyside and Laudium. It was believed that the episodes were caused by Satanism, because Satanism items were discovered around the school premises.

In this study some victims mentioned "Satanism" as a cause of the outbreaks:

¹²⁹<http://www.dailynews.co.za/index.php?fSectionId=3532&fArticle=nw200901211722272>... (accessed 8 April 2009).

She's Satan's person; she's that one who had Satan's sickness (Data: 20) [sic].

I personally, believe that the evil spirit exist, I have had many stories and seen people involved in "Satanism", may be someone was trying to expose us to that, because I heard that a lot of what we, involved girls, did is what they also do (Data: 244) [sic].

While one of the church leaders alluded to the same idea in this way:

Some of these religions that are mushrooming are big problems; can you imagine a religion that will teach its members to kill, to drink human blood? That in itself is "sickness", I mean madness; there is so much brainwashing that such members can do anything! My personal stand is that most of these religious beliefs have a great impact to these occurrences in our schools. Here is a small girl that was born and bred in a Catholic faith suddenly, is confronted by "Satanism" faith, through peer pressure; definitely the evil spirit and the Holy Spirit are in conflict; that is the reason they display such behaviours (Data 261) [sic].

From the above statements, the researcher concludes that episodes of mass hysteria touch the fabrics of "social order" within societies and causes dismay and confusion, which result in anxiety and uncertainty, as well as unpredictable behaviors of blame towards other citizens, that may result in hatred. Literature in the Southern African region shows that people become confused during these episodes and describe them as a "bizarre drama", "quite strange" (Daily News 2008:2); "evil spirit" (Daily News 2009:3); "outbreak of a mysterious illness" (Saturday Star 2009:7¹³⁰). It is therefore not surprising that the Basotho experience chaos and crises during mass hysteria outbreaks.

4.5 Theme 5: Effect of mass hysteria on the Basotho

Theme 5 deals with the outcome (effect) of a mass hysteria outbreak on the victims of mass hysteria as well as the effects on other people such as the family and community.

According to Kokota (2011:74), mass hysteria produces anxiety amongst community members, such as parents and victims of mass hysteria, including medical practitioners and priests, because it is an unknown mysterious occurrence. He observes that the

¹³⁰Saturday Star 27-sep-2008 Ref No: 5219 SA Media - The University of Free State

anxiety is fueled by the media coverage. Rataemane et al (2002:62) elaborates that those victims of mass hysteria experience social rejection by family and society.

Table 4.5 Effect of mass hysteria on the Basotho

Theme	Categories	Sub-categories
4.5 Effect of mass hysteria on the Basotho	4.5.1 Negative effects on the victims	Discrimination/stigma Performance decline Fear
	4.5.2 Positive effects on the victims	Friendship Pride Christianity Improvement
	4.5.3 Effects on others	Effects on family Effects on teachers Effects on community

4.5.1 Negative effects on the victims

The victims said that they were affected negatively by being stigmatised and hated, and they became shy and ashamed of themselves. Rataemane et al (2002:63) point out that victims of mass hysteria are rejected and ostracized by family, teachers, the public and other students. They were given scornful names by other students, they lacked concentration, their school performance declined and they lost their self-esteem as well.

Discrimination/stigma

The victims voiced the impact of a mass hysteria incident as bringing a negative impact upon them, thus:

After I got better, I was afraid to walk in public (Data: 19) [sic].

She's Satan's person; she's that one who had Satan's sickness (Data: 20) [sic].

When I went to church after I was sick; I sat next to one lady who moved away from me (Data: 21) [sic].

... Some students called us names and mocked us (Data: 137) [sic].

We also felt ashamed (Data: 151) [sic].

They are embarrassed by the whole situation, so I preferred not to ask them (Data: 156) [sic].

Both teachers and students hated me for partaking in the incident... after what happened I could see hatred ... (Data: 136) [sic].

The victims reported negative effects of ridicule, hate from teachers and discrimination from some community members; which resulted into embarrassment for them and loss of self-esteem. Their feelings are captured in the following statements:

Names such as “the possessed”, they gave us horrible looks and when I passed a group of people, I could see that they were talking about me (Data: 225) [sic].

I remember one of the Form E students moved away from me in the school hall, all her classmates laughed (Data: 226) [sic].

Mass hysteria has been associated with possession of evil spirits, demons and witchcraft, because victims exhibit psychotic behaviours such as uncontrolled behaviour, aggression, speaking in tongues, hallucinations and delusions (Bartholomew & Radford 2003¹³¹; Corner 2011¹³²; Mkize 1998:330). People are afraid of being “possessed”. On the other hand, Ackerman and Lee (1978:33) report that possessive behaviour was gratifying to the victims of mass hysteria, because they displayed “unusual physical power” that overpowered men. The behaviour overwhelmed and impressed these men.

Performance decline

The mass hysteria episodes appear to have influenced the victims’ academic performance negatively.

The observer participants reported:

¹³¹<http://benjaminradford.com/books-by-ben-radford/hoaxes-myths-and-manias/> (accessed 23 August 2008).

¹³²<http://freethoughtkampala.wordpress.com/2011/04/04/woo-tadown-03-demonic-attacks...> (accessed 30 October 2012).

Their performance declined...lacked attentions ... shy since the occurrence...most students and teaching staff seem to shun them. I am busy trying to rebuild their self-esteem (Data: 118) [sic].

The researcher concludes that the academic performance declined because the victims lacked attention in class.

Fear

Some victims cited “fear” as affecting them during the mass hysteria episode:

I ... was very scared because she's my friend (Data: 30) [sic].

... got scared when one class mate fainted (Data: 128) [sic].

I was overwhelmed by a fear I never experienced (Data: 209) [sic].

I had an urge to get away from the school premises, and the atmosphere was “spooky” (Data: 220) [sic].

Some participants, teachers and a parent stated “fear” as one of the symptoms they experienced:

They were actually doing something frightening (Data: 2) [sic].

It is very scary for people watching them (Data: 76) [sic].

It was scary to watch those (Data: 94) [sic].

In all the reported cases of mass hysteria an element of fear is reported either by the victims or the observers. The researchers have reported that fear dominates in all episodes of mass hysteria (Feldman 2004¹³³; Lawrence & Altman 2000:7).

4.5.2 Positive effects on the victims

On a positive note, the episodes resulted in friendship for the victims and the victims felt a sense of pride because of the experience they shared. One of the participants said that she has become a better Christian as a result.

¹³³<http://www.selfhelpmagazine.com/articles/mass-hysteria> (accessed 23 October 2008).

Friendship

The victims formed friendship because they felt stigmatised and they formed a support group, in order to support one another.

A teacher commented:

...Most of the students are always together; they formed a friendship (Data: 117) [sic].

The positive effects were expressed by victims as:

This experience has brought us together, we are like a family, and we have become friends (Data: 152) [sic].

The Royal College of Psychiatrists (2011)¹³⁴ explains that after a traumatic experience, victims want to understand their feelings, as well as the feelings of those who encountered the same experience, in order to share coping strategies. These psychiatrists advise that it is beneficiary to be involved with other survivors of the experience. The victims discuss the experience and give each other support. Johnson (1989:209) affirms that being in a group helps the victim to feel less isolated and to know that other people have experienced the same trauma. She terms this “universality”.

Pride

Some girls were reported to have been proud of being victims of the incident. Within the literature, Owens and Dein (2006:6) indicate that Freud and Breuer assumed that conversion disorder (another term for hysteria) patients gain a certain benefit when assuming a sick role, during which they gain attention of the people around.

Observers were aware of the victims’ positive gains by pointing out that:

¹³⁴ www.rcpsych.ac.uk (accessed 19 June 2006).

They appeared to be thrilled by the situation they were in and draw other people's attention and enjoyed that (Data: 170) [sic].

I saw that there were people who were so happy to have experienced it that it was like a pride to have tenya-tenya (Data: 25) [sic].

Christianity improved

A victim said:

I am now closer to my God, I pray more often than I used to; I have learned that if I have no answers God provides the answers and makes the impossible, possible (Data: 153) [sic].

4.5.3 Effects on others

Findings of this study show that other people, such as the family of the victims, teachers and other community members are affected by outbreaks of mass hysteria.

Effects on the family

The literature shows that families react differently to the incidences of mass hysteria. In a study conducted in Bloemfontein, South Africa, Rataemane et al (2002:62) conducted a study where an episode of mass itching affected various schools in Grade 8, 9 and 10, with families and society rejecting the affected school girls (Kokota 2011:75).

Govender (2010:318) on the other hand, reports on families that denied the diagnosis of mass hysteria among South African primary school learners in KwaZulu-Natal. Meanwhile, Dominus (2012)¹³⁵ reports an episode in New York where parents wept in response to their daughters' involvement in a mass hysteria episode, among a group of cheerleaders, where they exhibited symptoms of Tourette syndrome. From the above literature, it is possible to conclude that mass hysteria affects families negatively.

¹³⁵ www.nytimes.com/2012/03/11/magazine/teenage-girls-twitching-le-roy.html?pagewanted=all (accessed 21 January 2013).

The victims' families were affected negatively because the communities segregated them and made them feel ashamed of what had taken place. Some members of the community, especially the religious leaders and groups, as well as the traditional healers, offered help.

Families were affected; this is how victims communicated that experiencing mass hysteria brought shame to the family:

My whole family was affected (Data: 22) [sic].

This extended to the village ... my stepmother gave me a good hiding ... that I brought the family name into shame (Data: 138) [sic].

Effects on teachers

The teachers that watched the victims reported experiencing fear, confusion, panic as well as helplessness, as they watched and could not offer any help to the affected.

These are the extracts from them on fear, confusion and not knowing how to help victims:

It is very scary for people watching those (Data: 76) [sic].

It was scary to watch those (Data: 94) [sic].

I was now panicky, I felt helpless and worried that those girls would die in our hands (Data: 189) [sic].

I could not figure out what was happening ... I was trembling with fear... (Data: 132) [sic].

Fear crippled everybody, who was watching, even teachers looked scared (Data: 206) [sic].

There was confusion everywhere, parents stood watching (Data: 266) [sic].

Mass hysteria episodes have adverse effects on teachers. They feel helpless, and do not know how to help the victims. This position shows the need for sensitising and educating teachers on the care and management of such students. Such education

should aim to identify victims early in order to alleviate the fear generated by the incident.

Rataemane et al (2002:62) states that victims of mass hysteria among students at Mangaung schools in Bloemfontein were rejected by other students, their families, teachers and the public (including taxi drivers, who did not allow them to board the taxis after the incident). Students had presented with mass itching and had been treated in different clinics and hospitals but no organic cause was found to be causing the skin irritations. Roach and Langley (2004:1272) carried out a study in a North Carolina high school. A number of students experienced syncope attacks that resembled pseudo-seizure. Several students stated that such episodes are a burden to both the victims and the family. They stressed that the incidents can result in ridicule and can strain interpersonal relationships, leading even to spousal separation or divorce.

Effects on the community

Mass hysteria episodes affect the community unfavourably. It causes **crisis** and **chaos** in the community. The Longman Dictionary of Contemporary English (2003:246) defines chaos as “a situation in which everything is happening in a confused way and nothing is organised or arranged in order, a total lack of organisation or order”. Crisis is defined as “a sudden change in a person’s life situation in which customary methods of coping or problem solving fail or are inadequate, also called *state of disequilibrium*”, which is further described as leading a dangerous situation (Fortinash & Worret 2007:524).

Some participants described the encounter as being catastrophic. Others participants described it as a crisis while others termed it chaos. Victims stated that:

It was a different day altogether. Everybody looked different and felt different. One of us even likened the day to “doomsday”, like it was last day before the end of the world (Data: 215) [sic].

It was a nasty experience for all of us (Data: 228) [sic].

While one of the teachers expressed that:

It was total chaos! (Data: 115) [sic].

A parent reiterated:

Something strange was taking place at the school. He told me that students are behaving weirdly (Data: 265) [sic].

From the above quotations, the researcher concludes that episodes of mass hysteria touches the fabric of “social order” within societies and causes dismay and confusion, which results in anxiety and uncertainty, as well as unpredictable occurrences of blame and hatred. Literature in the Southern African region shows that people become chaotic during these episodes, and describe mass hysteria as “bizarre drama”, “quite strange” (Daily News, 23 September 2008:2); “evil spirit” (Daily News, 25 March, 2009:3); “outbreak of a mysterious illness” (Saturday Star, 27 September, 2008:7). It is thus not surprising that the Basotho also experience chaos and crises during mass hysteria outbreaks.

4.6 CONCLUSION

The themes and categories, as well as the sub-categories clarify the conceptions the Basotho have about mass hysteria, and therefore, indicate the way forward for health workers in identifying misconceptions and developing intervention strategies that are culturally acceptable and attainable.

4.7 QUANTITATIVE ANALYSIS

The quantitative section composes the data collected by using a checklist to establish whether participants in this study possessed histrionic personality traits which would make them prone to hysteria. The subjects who completed the checklist were victims of mass hysteria (14 girl students from School A) and a comparable group from school E (10 girl students) who witnessed a mass hysteria incident but did not experience the symptoms themselves.

The biographical indicators that were assessed included age, religion, academic class, as well as the background of each student focusing on parental occupation, in order to assess family financial status. It was also relevant to discover whether the parents were alive or deceased (if the parent was deceased, the cause of death was pursued and recorded). Different social problems encountered by students were sought and documented.

A checklist was adopted from Alberstein (Histrionic Vampire Checklist) and adapted (by translating some terms that were not familiar to Basotho students and excluding issues that were not applicable to Basotho) for use in this study, to assess if they possessed histrionic personality traits. This assessment was carried out keeping the psychoanalytic theory in mind which stipulates that females are prone to mass hysteria.

The quantitative analysis was carried out using the statistical analysis software, "Statpac Program". Alberstein's "Histrionic Vampire Checklist"¹³⁶ that assesses one's histrionic personality was adapted, for use on the students who experienced attacks of mass hysteria. The literature points out that people who experience mass hysteria are females who exhibit or possess histrionic personality traits (Rataemane et al 2002:61).

Alberstein¹³⁷ has demonstrated that anybody who scores more than 5 points possesses histrionic personality traits. The checklist used consisted of 20 statements that describe the subject, who was required to indicate the statements as true or false in relation to themselves. Each true statement was awarded one point, and all points for true statements were added up to calculate the total score.

¹³⁶ psy.rin.ru/eng/article/140-101.html (accessed 26 October 2007).

¹³⁷ psy.rin.ru/eng/article/140-101.html (accessed 26 October 2007).

The results showed that the scores for the affected students (victims) ranged from 5 to 20 points; 21.4% scored between 0-5 points, the majority (42.85%) scored between 6-11 points, while the minority (14.2%) scored between 18 to 20 points. A comparable group displayed a different trend. The majority (40%) recorded equally between 6 to 11 and 12 to 17 points, none recorded between 0 to 5 points, and the minority (10%) scored between 18 to 20 points (figure 4.1).

Figure 4.1 Checklist scores for affected and unaffected

From the above scores, the affected group shows that all the victims (100%) scored above 6, with the majority (71.4%) scoring between 11 and 20, which shows that all victims possessed histrionic personality traits. In the comparable group (unaffected) 80% (majority) scored within the range of 6 to 20. While 20% (minority) bears no histrionic traits, because they scored under 5. Statistical significance was computed through a t test. The $t=0.389$ is statistically insignificant, at $p=0.05$ with 1df (degree of freedom= $N-1$ ($2-1=1$)). There was no significant difference in the scores between the two groups.

The previous studies have shown no personality differences in the affected and the unaffected groups (Olczak, Donnerstein, Hershberger & Kahn 1971:413; Yazamy et al 1999:713). Bartholomew and Wessely (2002:305) stress that some people can be affected, while others may not; they point out that the predisposition for mass psychogenic illness is not known. The findings in this study support the fact that personality plays no role in causing mass hysteria.

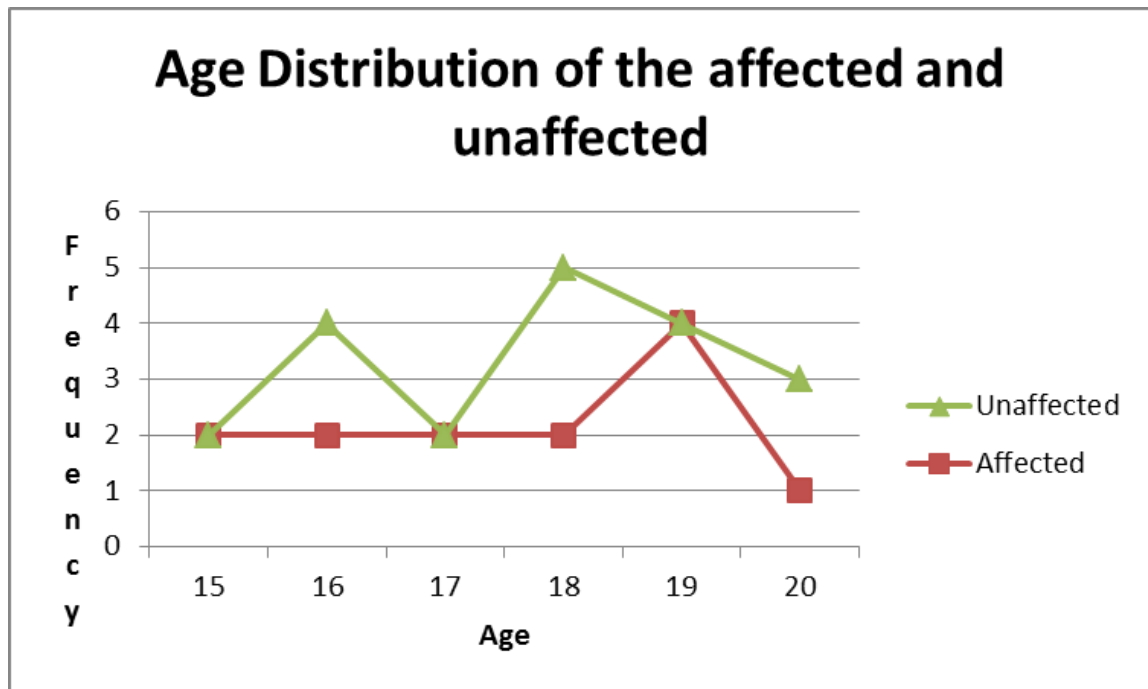


Figure 4.2 Age distribution of the affected and unaffected

The age distribution of students affected by mass hysteria ranged from 15 to 20 years of age. The majority (28.6%) was in the age group 19 years old and the minority (7.1%) was 20 years old. The unaffected group ranged from 16 to 20 years. These results show that teenagers are prone to mass hysteria episodes. According to the literature, this stage of development is highly influenced by peer pressure. Teenagers are not sure of their values, and yearn for a sense of belonging; while they love to be identified with other peers (Gary & Kavanagh 1991:804). Refer to table 4.2.

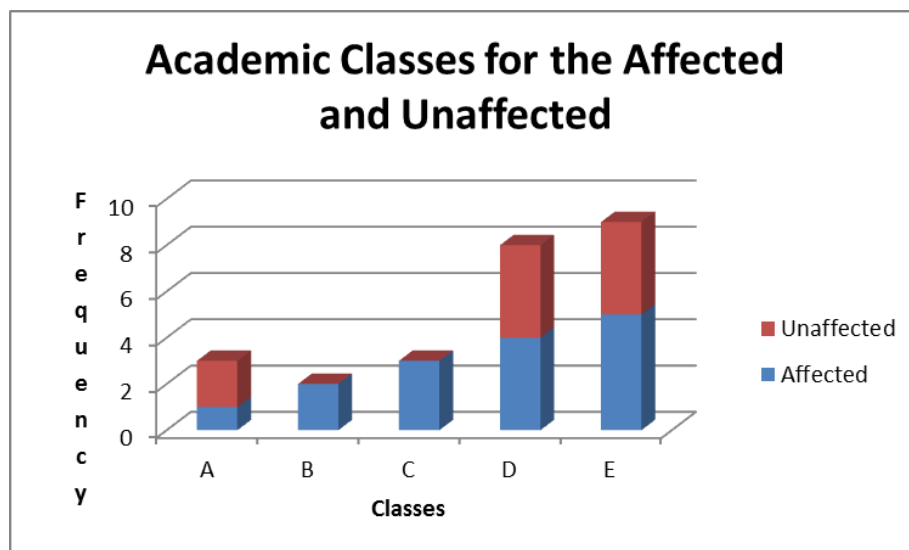


Figure 4.3 Academic classes for the affected and the unaffected

Subjects by academic class showed that 42.9% of the subjects were in Form E (final year in high school), about 28.6% in Form C (third year in high school), while 7.1% was in Form A, (first year in high school) and 21.4% was in Form D. On the group compared, 40 % of the students were in Form E and Form D.

On the group compared, 40 % of the students were in Form E and Form D respectively and 20% was in Form A.

Table 4.6 Religious denomination of the students

Religion	Affected	Unaffected
Apostolic	1	0
Anglican	1	3
Catholic	12	5
LEC	0	2
Total	14	10

The analysis on the religious denomination illustrated that the majority (85.7%) belonged to the Catholic Church, 7.1% belonged to the Church of England, and the other 7.1% to the Apostolic Church. The comparable group demonstrated a 50% majority belonging to the Catholic Church and 30% members of the Anglican Church, while there were no Apostolic; but 20% belonged to the Lesotho Evangelical Church (LEC) (table 4.6).

Table 4.7 Occupation of the students' parents

Occupation	Affected	Unaffected
Cleaner	1	2
Teacher	2	3
Nurse	0	2
Street Vendor	3	0
Unemployed	4	2
Miner	1	0
Contractor	1	0
Soldier	0	1
Total	12	10

The analysis with regard to the occupation of parents of the affected school girls shows that a significant number of parents (28.6%) were unemployed, while 21.4% were street vendors (self-employed). In the comparable group, teachers' children accounted for the majority (30%), while cleaners, nurses and the unemployed each represented 20%, with 10% being soldier's daughters (table 4.7).

Table 4.8 Social problems experienced by affected and unaffected students

Social problems	Affected	Unaffected
Financial constraints	7	4
Orphaned	2	0
Alcohol abuse by parents	1	2
Abandonment	2	2
Neglect	1	0
Cruel Parents	1	2
Total	14	10

The analysis for the different social problems encountered by the affected students in their everyday life showed that 50% of subjects had financial constraints, 14.3% had been abandoned by parents, while 21.4% were orphaned and neglected by parents and/or caregivers. This, coupled with alcohol abuse by the parents, results in the emotional abuse of the children.

The analysis, within the comparable group (unaffected) showed that 40% had financial problems, 20% were abandoned and did not live with their parents, 20% was experiencing emotional abuse as a result of having cruel parents and 20% lived with parents who abused alcohol. In both groups, emotional abuse was cited, resulting from either cruel parents or those who abused alcohol; whereas financial constraints indicated poverty (table 4.8).

In this study, the biographical factors that contribute to vulnerability towards mass hysteria as a phenomenon are observed to be religious denomination, along with social problems escalated by financial constraints and family disorganisation. Catholic students are affected more than those from other churches. Literature shows that the discipline is strict in Catholic schools, with Burton (2013) elaborating that Catholic schools are famous for strict disciplinary policies, which teach the children to take responsibility for their behaviours.

4.8 Conclusion

This chapter discussed the emerging themes, categories and sub categories from the qualitative data. An analysis of the quantitative data generated from the checklist administered to establish whether participants in the study possessed histrionic personality, was presented and discussed.

CHAPTER 5

CONCEPTUALISATION: MASS HYSTERIA IN THE BASOTHO CONTEXT

5.1 INTRODUCTION

The aim of qualitative research is to understand people in terms of how they define their worlds, and to interpret phenomena in context (Babbie & Mouton 2001:271). The presentation of the data in Chapter 4 required de-contextualisation, whereby data was deconstructed by reducing it to categories, sub categories and themes, and thereafter interpreting it. Supporting evidence was provided, through direct quotations from the participants. This chapter presents a re-contextualisation of the data. Data is related to existing theory and synthesised to reveal potential meaning, and to provide a larger consolidated picture of mass hysteria in the Basotho context.

This section discusses the emerging core concepts from the study findings, which basically explain the Basotho's perceptions towards the phenomenon of mass hysteria.

5.2 CORE CONCEPTS OF MASS HYSTERIA IN THE BASOTHO CONTEXT

The core concepts which emerged from the data derived from young women's experiences of mass hysteria in Lesotho and those who witnessed the mass hysteria incidents. These concepts include stress, anxiety, confusion and supernatural beliefs. These core concepts feature in all the identified categories. Each concept will be discussed and related to existing theory.

5.2.1 Stress

Stress is defined as anything that poses a challenge or threat to one's wellbeing (Medical News Today 2009¹³⁸). However, stress can be positive (eustress). It gives passion to life and makes life worthwhile. The negative stress (distress) affects the body if it is prolonged.

When facing a challenge or a threat, the body activates resources which protect it, by either getting away as fast as possible or by fighting the threat; this phase is known as "Fight or Flight response". This is because physiologically, the sympathetic nervous system reacts to a stressful event by producing certain chemicals in large amounts, such as cortisol, adrenaline and noradrenaline (Tortora & Anagnostakos 1984:428).

This production triggers a fast heartbeat, sweating, alertness, rapid respiration, muscle preparedness and increased blood flow; while all other body functions, such as the digestive system and the immune system, slow down. In the cardiovascular system, the blood pressure rises. Persistent stress has negative psychological effects, producing anger, anxiety, and a feeling of insecurity, forgetfulness, irritability, poor concentration, burnout, restlessness, fatigue, confusion, as well as sadness, that may lead to depression (Lackey 2002¹³⁹). The three concepts (stress, anxiety and confusion) that emerged from this study are interrelated, and are grounded in this broad concept of stress as a psychological manifestation.

From the findings, victims experienced stress, which manifests in weakness, fainting, blackout, choking, fatigue, sweating, and dizziness (physically) as illustrated by the data:

I was so weak that I felt like I needed to sit down ... all became dim ... I had a black out (Data: 29) [sic].

I felt weak and my knees tremble (Data: 37) [sic].

¹³⁸<http://www.medicalnewstoday.com/articles/145855.php> (accessed 23 January 2013).

¹³⁹<http://www.unc.edu/~glackey/documents/stress.pdf> (accessed 23 January 2013).

I feel tired ... I'm sweating (Data: 51) [sic].

Psychologically, participants experienced anxiety, poor concentration and confusion. Even the observers experienced psychological effects of helplessness, fear, hostility, excitement and confusion, as reiterated by the following statements:

I am sure that the stress we are under and the demands, especially the economic ones have attributed to the illness ... (Data: 149) [sic].

Most of them appeared to experience fear ... anxiety, hostility and ... excitement (Data: 106) [sic].

Stress theory

The victims of mass hysteria and the observers in this study speculate that mass hysteria results from *stress* or stressful situations. Lackey (2002)¹⁴⁰ elaborates that fundamental concepts in the stress process are external or internal “stressors”, which are factors that challenge the adaptation of an individual to situations. The internal stressors include either the biological or the psychological factors. For example, in chronic illness, such as hypertension, the individual is under stress because he/she has to be taking medication daily and watching his/her diet. The external stressors include environmental and social factors, such as poverty.

In this study, victims were facing both internal and external stressors. Within their biographical data, they faced environmental stressors related to the political situation (stay-away) during the incident. Internal stressors included the social problems that they alluded to, such as financial problems, orphan status, parental neglect and alcohol abuse by parents. The demand from teachers for good performance during examinations also posed as a stressor. This is evident in the following statement from one of the teachers:

The[y] were due to write some examination ... teachers put pressure ... on good performance (Data: 121) [sic]

¹⁴⁰<http://www.unc.edu/~glackey/documents/stress.pdf> (accessed 23 January 2013).

Bartholomew and Sirois (2000:495), Owens and Dein (2006)¹⁴¹ and Wedel (2012:2) agree that some cultures and religions restrict women (including girls) from expressing their dissatisfaction openly, thus, exposing them to mass hysteria when bottling up their emotions. The restrictions imposed on women in Lesotho do not permit emotional expression, as purported by Molapo (2005:13).

Another important concept according to Lackey's theory of stress is the "*moderators/mediators*" concept. He describes a moderators/mediators concept as the social or personal resources that buffer the effects of stressors, which include coping strategies, personal resources and social support. The *coping strategies* focus on changing or managing the stress outcomes; *personal resources* embrace control over one's life and self-mastery; while *social support* comprises a close-knit group that provides emotional support which reduces the severity level and significance of the stressor. Furthermore, intimate relationships encourage confidence. In this study, most of the victims lacked all these mediators. In addition, the orphans and neglected victims did not receive parental and social support. Fifty percent (7) of the fourteen affected school girls experienced financial constraints while the others were subjected to either orphanage status, abandonment by parents, or alcohol abuse by parents, which implies that they probably have to nurture their siblings. They would also be exposed to physical and emotional abuse as a result of their parents being alcoholics (table 4.7).

The "*Stress Outcomes*" as part of the process are described as conditions that result from stress exposure. Lackey (2002)¹⁴² categorises these conditions into psychological, emotional and physiological effects. In this study, mass hysteria manifested itself physically as strength, choking, fatigue and dizziness etc. Psychologically, victims exhibited loss of consciousness, auditory and visual hallucinations, as well as confusion, while emotionally they experienced sadness, anxiety and fear.

Lackey (2002)¹⁴³ further classifies stress into "*event* and *chronic*" stress. He describes *event stress* as a sudden and unexpected phenomenon that results in a stressful outcome. He emphasises that it is important to define the effect of a stressor, as to whether it was anticipated or not, whether it represents closure of another stressor or

¹⁴¹<http://apt.rpsych.org/content/12/2/152.full> (accessed 12 January 2013).

¹⁴²<http://www.unc.edu/~glackey/documents/stress.pdf> (accessed 23 January 2013).

¹⁴³<http://www.unc.edu/~glackey/documents/stress.pdf> (accessed 23 January 2013).

whether it has been sought as a problem-solving strategy to other stressors. In this study an unexpected event of political turmoil may have triggered stress, as verified by an observer participant:

There was political turmoil, the opposition parties had called for a “stay way”, I must say we were all scared about coming to school and the public transport was scarce; you had to be strong to come to work! (Data: 196) [sic].

Chronic stress comprises of numerous strains that include *status*, *role*, *ambient* and *quotidian*. According to this theory, the *status strains* encompass the social position or structure, such as being poor, or holding a generally condemned position by society in relation to gender, sexual orientation or religion Lackey (2002¹⁴⁴). In this study, such strains were reflected in biographical data, where most victims noted that they had financial constraints and could barely met their basic needs.

The *role strain* is focused on stressors that arise from the many demands placed on an individual who holds diverse roles. In this study, some school girls experienced role conflict, because they held a student role but, on the other hand, they were heads of families as orphans. They had to nurture their siblings and carry out house chores, like doing laundry and preparing meals for the family. These applied to the school girls in this study, whose parents abused alcohol, deserted the family or were deceased.

The *ambient strains*' emphasis is on stressors from immediate environmental threats such as violence in the family and inability to access resources like schools and health care facilities. Some of the victims of mass hysteria travelled long distances to the schools, while some faced violence from step parents and abusive parents (table 4.7).

The analysis for the different social problems encountered by the affected students in their everyday life showed that 64.3% of subjects had financial constraints.

Quotidian strains pertain to daily difficulties, such as being caught in traffic. The school principals want students to be punctual for the assemblies and classes, and as such, these demands become stressful. High school performance, expected by both teachers and parents, falls under these strains.

¹⁴⁴<http://www.unc.edu/~glackey/documents/stress.pdf> (accessed on 23 January 2013).

5.2.2 Anxiety

Anxiety is defined as an unpleasant feeling of nervousness, discomfort and dread that heralds that doom is imminent (Fortinash & Worret 2007:523). Vasudevan (2006)¹⁴⁵ adds that this emotion is characterised by nebulousness and unspecified harm. It presents with many physical symptoms such as difficulty in breathing, pounding and fast pulse, sweating, insomnia, nausea, diarrhoea, headache and tightness in the chest. It can easily be diagnosed as a physical illness such as a heart attack. Psychologically, it narrows one's concentration span and perception, as well as distorting the environment, and can produce disorganised behaviour. The victims in the study reported the following symptoms:

I also felt weak ... like choking, unable to swallow ... was hyperventilating and perspiring ... lacked energy ... tearful ... I could not breathe easily ... I had splitting headache, my heart beat was fast and I felt fatigued (Data: 142) [sic].

... they fainted, they lost consciousness for some time, they fell on the ground, some actually presented like being choked, rolling eyes, sweating profusely, some were breathless; saliva was dribbling from their mouth (Data: 192) [sic].

Anxiety theory

According to Vasudevan (2006¹⁴⁶), there are a variety of theories on anxiety as a concept. The *Learning theories* explain anxiety as a motivator, drive of behaviour and a response to learned cues. Owens and Dein (2006¹⁴⁷) on the other hand, contend that symptoms of conversion disorders (or mass hysteria) are maladaptive operant behaviours, which act on the environment and yield secondary gains (sick role) for its victim. Bartholomew (1989:292) views anxiety as constructing vagueness, which results in reducing mental uncertainty in order to regenerate stability during chaotic incidences. The above explanations justify the presence of anxiety experienced by both the victims and observers during the mass hysteria episodes experienced in Lesotho schools.

Psychoanalytic theorists assume that there are two types of anxiety, namely *traumatic* and *signal anxiety*¹⁴⁸. A traumatic form of anxiety results from overstimulation due to a traumatic event, while signal anxiety arises from an individual's need to protect the self

¹⁴⁵<http://www.expertmapper.com/go/anxiety+disorders/-avasudevan+A/-vEmMap> (accessed 1 February 2013).

¹⁴⁶<http://www.expertmapper.com/go/anxiety+disorders/-avasudevan+A/-vEmMap> (accessed 1 February 2013).

¹⁴⁷<http://apt.rpsych.org/content/12/2/152.full> (accessed 12 January 2013).

¹⁴⁸<http://www.accg.net/anxiety.htm> (accessed 6 February 2013).

from traumatic anxiety. According to these theorists, the ego balances the internal drives and the external demands, but if the coping strategies fail, the ego responds with anxiety, which summons the individual to take action in order to avoid more devastating effects.

As pointed out earlier, anxiety is an indication of stress. Most victims reported anxiety as a symptom they experienced during the episodes of mass hysteria, however, the incidences themselves created a chaotic atmosphere that could possibly expose both victims and observers to anxiety. Cognitive theory assumes that anxiety originates from awareness of the environment, meaning what goes on in the setting could affect the people in the vicinity.

The victims of mass hysteria observed the index person exhibiting mass hysteria symptoms; this in turn, affected them negatively and they then experienced the same symptoms because of the environmental effect. In addition, the observers (unaffected school girls, boys and teachers) were affected; they experienced anxiety and fear, as illustrated in the following statements by the teachers:

It was scary to watch them (Data: 94) [sic].

Fear crippled everybody who was watching, even teachers looked scared! (Data: 206) [sic].

5.2.3 Confusion

Confusion is a state of the mind, whereby the individual loses touch with reality and displays both misunderstanding and misperception. Confusion is associated with the clouding of consciousness, disorientation and poor decision-making (Brooker 2005:57). Semple et al (2005:62) contend that confusion exhibits memory impairment and loss of memory clarity as well. Teachers as observers mentioned that they were confused during the episodes. One of teachers expressed his apprehension and confusion in this manner:

I did not know what was happening; it really turned into a crisis. It was chaotic! (Data: 92) [sic].

Misconception and all the accompanying indicators of confusion can be grounded in Uittenbogaard's chaos theory on complex systems.

His assumptions include that:

- Nature is highly composite, exquisite and enigmatic.
- Nature is erratic.
- Theory looks into the unreliability of nature.

Uittenbogaard (2002)¹⁴⁹ indicates that complex systems run in cycles, though circumstances are rarely repetitive or replicated. Therefore, any small difference in the initial parameters of the system results in a completely different behavior of the system. This explains why victims of mass hysteria show different behaviors during the episodes, such as running away aimlessly and displaying extraordinary strength towards people who restrain them. The theory specifies that predictability cannot be accurate because it is prohibited by what the theorist terms the “uncertainty principle”.

The systems strive to attain equilibrium of some sort, by seeking to settle in one specific situation which may be either static (attractor) or dynamic (strange attractor). The state of confusion of the victims and observers somehow directs the society to explain the behaviours of the victims of mass hysteria in the cultural context as a strange attractor. Bartholomew & Sirois (2000:502) point out that cultural beliefs serve as motivators for acceptable supernatural beliefs, such as a curse, spirit possession and witchcraft.

5.2.4 Supernatural beliefs

The supernatural is generally regarded as a difficult matter to explain; it is usually linked to magic or to a given god's powers (Longman Dictionary of contemporary English: The Living Dictionary 2003:1666). Belief in the supernatural relate to failure of the mind to construe the nature of events. Cohen and Barrett (2008)¹⁵⁰ and Kokota (2011:76) contend that supernatural beliefs energise and draw attention to mass hysteria episodes, because traditional societies assign supernatural powers, such as witchcraft, Satanism, spirit possession or any other element which features in the cultural belief system to it. Gaw, Ding, Levine and Gaw (1998)¹⁵¹ reiterate that possession states are

¹⁴⁹<http://www.abarimpublications.com/Arie-Uittenboogard.html> (accessed 24 February 2013).

¹⁵⁰<http://www.academia.edu> (accessed 24 February 2013).

¹⁵¹<http://ps.psychiatryonline.org/articleid=81167> (accessed 24 February 2013).

accepted as such in China, and that the affected individuals are awarded a higher status for owning supernatural powers of healing.

The Basotho people believe in the Supreme Being called Molimo (God). They believe that God is approached through balimo (ancestors), who are honoured at customary feasts. According to South African History Online¹⁵², the ancestral spirits can cause misfortunes if disrespected. Harvey (2011:11) adds that the Basotho believe that the earth is full of evil spirits. These evil spirits were left to wander around, because no rituals were carried out at their deaths. This belief, somehow, shape the behaviours in that people abide by the recommendations of the traditional healers/diviners, who are believed to possess the power to communicate with the ancestors. According to Norenzayan, Garvis and Trzeniewski [S.a.], people treat these gods as mediators, who enter into personal relationships with humans and install supernatural powers to respond to human concerns and monitor social behaviour.

Theories on supernatural beliefs

According to Highfield and Fleming (2006)¹⁵³, people are born with a belief in the supernatural; they either believe in God or other supernatural forces. Norenzayan et al [S.a.] agree that a belief in God and other supernatural agents is historically and culturally wide-spread; though little is known about the intellectual foundations of these sociocultural beliefs. They add that cognitive theorists confirm that the origin of supernatural beliefs emanate from “ordinary human social cognition” and facilitate the conceptualisation of God and supernatural agents (Highfield & Fleming 2006¹⁵⁴).

Legare, Evans, Rosengren and Harris (2012)¹⁵⁵ elaborate that supernatural beliefs are sanctioned across all cultures in both industrialised and developing countries. They contend that supernatural phenomena are important, and are a permanent aspect of human thinking. It is thus not irrational as found in this study, that the Basotho perceive

¹⁵² <http://www.sahistory.org.za> (accessed 23 January 2013).

¹⁵³ <http://www.telegraph.co.uk/news/152805/we're-born-with-beliefs-of-supernatural-says-scientist.html> (accessed 24 February 2013).

¹⁵⁴ <http://www.telegraph.co.uk/news/152805/we're-born-with-beliefs-of-supernatural-says-scientist.html> (accessed 24 February 2013).

¹⁵⁵ <http://www-personal.umich.edu/evansam/Coexistence-Legare-et-al.pdf> (accessed 24 February 2013).

the phenomenon of mass hysteria as due to supernatural agents. They resolve it with prayer, exorcism and traditional healers' interventions.

The Basotho belief system in supernatural beings, as well as in sorcery, muti and thokolosi, pose a good breeding ground for the incidence of mass hysteria. The belief system and the religious beliefs (evil spirits, Satanism and blasphemy) accommodate mass hysteria as a socially and religiously acceptable phenomenon. The acceptability is affirmed by the following participants' responses:

I heard that when a student is out-competed by another student, s/he tells his/her grandmother "who rides a broom (a witch's practice) sends a "thokolosi". These witches can target anybody and send muti to him (Data: 73) [sic].

... evil spirits and sorcery are mentioned in the Bible ... you definitely will know that culturally those beliefs are acceptable; they are part of Basotho culture (Data: 147) [sic].

5.3 THEORIES ON MASS HYSTERIA

The emerging core concepts from this study are grounded in the existing theories, which show that the Basotho people share views with other world nations. There is congruency between the core concepts from this study and the three theories of mass hysteria discussed in chapter two. However, mass hysteria as it manifests in the Basotho fits mainly into the sociological theory.

5.3.1 Sociological theory (value-added theory of collective behaviour)

Within the sociological theory mass hysteria is viewed as a social problem emanating from society and being cultural in origin (Kotler 2012; Smelser 1996:1). The nature of mass hysteria is contagious. Contagion theory maintains that a crowd exercises a hypnotic effect on the members and that they lose identity and responsibility to a shared mind. Their attention is focused on the same event, they influence each other, excitement grows within them and they act before they can analyse the situation (Macionis & Gerber 2010). The contagion effect was acknowledged by participants in this study, victims commented that they started experiencing the same symptoms when they saw their classmates demonstrating the symptoms of hysteria and teachers

reported that between eight to twenty girl students were involved in different mass hysteria episodes.

According to Govender (2010:318) and Halvorson et al (2008)¹⁵⁶, mass media intensifies the outbreaks of mass hysteria, in this study the media gave a good coverage of the outbreaks, which resulted in increasing the contagious effect to neighboring schools as evidenced by a participant's observation:

Just before it occurred here, we heard that it existed in two or three other schools around this district (Data: 204) [sic].

Smelser's theory identifies the significant features of collective behaviour as being steered by kinds of beliefs which involve a belief in unexpected forces, such as threats or intrigues, which are at work in the universe. According to this theory these beliefs are divided into:

- (i) *Generalised beliefs* which entail an appraisal of the extraordinary values, which follows if the collective attempt to reconstruct social action is successful (Bartholomew 1989:291). The findings of this study demonstrate that the Basotho perceive mass hysteria as a supernatural incidence. They link mass hysteria to religion (blasphemy and evil spirits) and illusory cultural beliefs such as witchcraft, thokolosi and muti. This is why the Basotho people (teachers, principals, parents) seek interventions from the church priests and traditional healers who are believed to have the power to exorcise the evil spirits and pray for those who sinned, and to reverse witchcraft and its products.
- (ii) *Collective behavior* is not established behaviour; rather, it is shaped or copied to meet vague situations (Smelser 1962: 8-9). This type of behaviour is clarified by the contagious effect of imitative symptoms of the schoolgirls during the episodes. It is, however, seen as abnormal behaviour.

Smelser in Bartholomew (1989:291-297) further describes collective behavior as a product of interaction between the following five factors:

¹⁵⁶ [Doi:10.1111/j.1746-1561.2008.00303.x](https://doi.org/10.1111/j.1746-1561.2008.00303.x) (accessed 24 November 2012).

- *Structural conduciveness* which is fundamental to the pre-existing social conditions that permits the emergence of collective behaviour. In this study, the belief system of the Basotho cultivates the environment that accepts beliefs in supernatural beings such as God and balimo (ancestors), as well as witchcraft.
- *Structural strain*, which concerns the conflicts of societal norms and values that result in panic. Most incidents of mass hysteria in Lesotho schools were related to some panic-stricken occurrences such as political tension (declaration of a “stay away” by opposition leaders) as in the case of school A; final examinations in other schools; and the murder of a union leader.
- *Growth and spread of a generalised belief* occurs when people view the strain in a similar context. In this study one of the participants, a victim, said: *people from all churches came to my home and prayed for me; the priest came and prayed for me at home* (Data: 12) [sic]. This shows that this strain was understood as such by the church.
- *Mobilisation for action* entails the message by the leadership which is regarded as very important in consolidating collective action. The rumours that the media communicate to people amalgamate the status quo.
- *Social Control* inhibits the formation of a hysterical belief (Bartholomew 1989:297). It is intended to minimise structural conduciveness and strain, in order to prevent and affect the speed, degree and the direction of the episode. In this study, the mental health team served as a social control mechanism. The team explained that the episode was a normal reaction to examination stress and other stressors that the students might have been experiencing. The explanation inhibited the supernatural beliefs about mass hysteria and minimised the structural conduciveness and the strain. This is the reason why the researcher in this study intends to develop guidelines that can be deployed during mass hysteria episodes.

5.3.2 Biological theory

Biological theorists believe that mass hysteria is linked to womanhood. Females are believed to have weak mental constitutions and are therefore prone to emotional instability which predisposes them to mass hysteria (Bartholomew & Sirois 1996:290; Gilman et al 1993: viii). In all the schools in this study where mass hysteria episodes occurred, girls were involved; no single boy was reported, as evident in the following comment:

More girls from her classroom were carried into the room, displaying the same thing; I must have counted about eight or nine of them. I did not know what was happening; it really turned into a crisis (Data: 180) [sic].

In view of the biological theories stipulating that women are weaker in terms of emotional liability, one participant commented:

There is a vast difference in girls and boys; most boys do not attend church like girls do, but the woman folk are also weak in most instances (Data: 159) [sic].

According to Molapo (2005:13), girls are socialised to be submissive to their elders and husbands, hence she emphasises that women are treated as second class, and as “children” by their husbands. There is a set phrase in Sesotho that “Mosali o ngala mots’eo” (literally, this means that even if a woman is hurt by her husband, she is expected to still give him food and show no hurt emotions).

Considering that the limbic system structures are involved in emotions related to survival (Bailey 2013¹⁵⁷), it makes sense the victims of mass hysteria experience strong emotions as reported in this study:

I was scared, irritable ... and [had] lots of anxiety (Data: 143) [sic].

¹⁵⁷<http://biology.about.com/od/anatomy/a/aao42205a.htm> (accessed 6 March 2013).

5.3.3 Psychological theory

Psychological theory postulates that mass hysteria victims react to extreme unconscious conflict which is converted into psychosomatic symptoms. Histrionic personality type is associated with mass hysteria (Allin et al 2005:207; Roach & Langley 2004:1271).

Histrionic personality traits were evident in all the victims of mass hysteria, which affirms the theory, that histrionics are predisposed to mass hysteria. The t-test was statistically significant between the affected and the unaffected groups (figure 4.1).

In this study, victims from the rural area of Lesotho displayed dramatic characteristics of histrionic personality by exaggerating every detail of the incident:

People from all churches came to my home and prayed for me; the priest came and prayed for me at home (Data: 12) [sic].

She pointed out that the priest made remarks about her:

I'm scared of this child; I think I'm going to be in danger (ke tl'o tsoa kotsi). I'm afraid of this child; she has very big issues (Data: 12) [sic].

One of the victims dramatised her experience as follows:

I was overwhelmed by fear I have never experienced; I felt weak and dizzy; it felt like I was walking on air ... I could see anything and I fell to the ground; I must have lost consciousness ... (Data:131) [sic].

It has been advocated by various authors that psychological conflict due to stress, emanating from social problems, plays a part in the development of mass hysteria. All the victims who completed the checklist experienced social problems (table 4.8).

5.4 PATTERNS OF MASS HYSTERIA

The mass hysteria symptoms according to the findings are congruent to *mass motor hysteria*, described by Bartholomew and Sirois (1996:291) who distinguish between symptomatic patterns of epidemic hysteria occurring in schools. They state that mass motor hysteria is predominant in non-Western and traditional cultures. Bartholomew and Sirois (2002:300) affirm that according to the culture, victims of mass hysteria demonstrate different signs and symptoms which culminate in what they identified as either mass anxiety or mass motor hysteria. This concurs with mass hysteria symptoms noted by Mkhize and Ndabeni (2002:6971) in underdeveloped countries, as illustrated in table 2.2. The victims in this study displayed *motor symptoms* such as stiffness of joints, jerking, loss of consciousness, rolling eyes, screaming and collapsing, as evident in the following comments from participants:

They fainted, they lost consciousness for some time, they fell on the ground, some actually presented [as if] being choked, rolling eyes, sweating profusely, some were breathless; saliva was dribbling from their mouths (Data: 192).

She says that I'm very rigid and my fingers are rigid, clasped together ... and my eyes are shut (Data: 38) [sic].

There appear to be a relation between the *diffused type* of mass hysteria and the manifestation of mass hysteria in this study. According to Govender (2010:318), the diffused type affects people in an institution as the result of false beliefs and rumours. One of the participants expressed that rumours fly around and overwhelm the community as evidenced in newspaper headlines.

You will see newspaper headlines like: "Thokolosi e patela bana sekolong" (A mythical dwarf troubles school children); you also see some of the sick students "being choked by something" you cannot see, you definitely say, this could have been the "thokolosi" referred to in the papers; I am not sure if you have any other explanation. Surely, I personally believe that some supernatural force maybe ... [laughs] the [mythical] dwarf is at play here (Data: 242) [sic].

The *explosive type* of mass hysteria, as identified by Govender (2010:318), occurs in schools and there was evidence of this type in the Lesotho schools included in this study. The victims and observers reported the *violent hysterical victims* as follows:

She was powerful, trying to fight the boys; she looked [as if] wild ... foaming from the mouth screamed like she was in pain... (Data: 112) [sic].

She cried out loudly, she was [as if] wild, she was powerful and overpowered several boys...she wanted to run away (Data: 129) [sic].

5.5 CONCLUSION

The experiences of young women in Lesotho reveal that the Basotho's belief in the supernatural, and their culture which regard women as weaker and socialises them to be submissive (allowing for accumulation of pent-up stress), provide a strong breeding ground for mass hysteria. The manifestation of mass hysteria in the Basotho fits mainly into the sociological theory of mass hysteria as supported by their culture, religion, belief systems, norms and values. Their belief in the supernatural potentially exposes them to suggestions, imagined stimuli, misunderstanding, uncertainties and confusion, which may give rise to irrational fears and the contagious effect of mass hysteria. Mass hysteria episodes in Lesotho schools are characterised by the motor mass hysteria pattern as identified by researchers to be typical in underdeveloped traditional countries.

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS, GUIDELINES AND LIMITATIONS.

6.1 INTRODUCTION

This section presents the conclusions and recommendations for this study, as well as the limitations encountered during the study process. The purpose of this study was to explore the phenomenon of mass hysteria among the Basotho people in Lesotho, and to propose guidelines that may facilitate early intervention and better management and control of mass hysteria outbreaks.

The objectives of the study were to

- describe the experiences of young Basotho women who were victims of mass hysteria
- establish the causes of mass hysteria in Lesotho, inclusive of the predisposing conditions
- determine the effect of mass hysteria outbreaks on the community
- identify the strategies used by the Basotho to manage mass hysteria
- propose guidelines for appropriate management of mass hysteria

6.2 CONCLUSIONS

From the insight gleaned in this study, the researcher concludes that the Basotho hold a dual view that mass hysteria is both natural and supernatural in origin. The natural notion is based on the fact that they believe it is a natural disease from God. Some participants believe that mass hysteria originates from supernatural origins of evil spirits, witchcraft, Satanism and blasphemy.

The victims of mass hysteria were able to describe the physical and psychological symptoms that they experienced during the incidents of mass hysteria. The researcher concludes that the Basotho experience mass anxiety hysteria, mass motor hysteria and the violent type or pattern of mass hysteria. The mass hysteria episodes in Lesotho occur frequently in schools and factories and occasionally in the community.

The socio-cultural and religious beliefs of the Basotho play a crucial role in the development of mass hysteria episodes. Stress, due to financial constraints, academic performance demands, gender and personality traits were contributory factors, resulting from the cultural and religious impact.

The victims, families and community reported to have been affected by the mass hysteria events. The victims reported both adverse and positive effects. The adverse effects included stigma, discrimination, fear and poor class performance as a result; while more positively, they reported the formation of friendships amongst the affected students, they became better Christians and some victims were reported to have become more confident as a result of the episodes. Pride served as a secondary gain.

Families and teachers, on the other hand, experienced only antagonistic effects. Families were found to be skeptical about the events, and participants were rejected by the society, while teachers experienced helplessness, fear, panic and confusion during the events. It is therefore concluded that mass hysteria has varying effects on the victims, families and others, such as teachers.

The Basotho use various strategies to resolve episodes of mass hysteria, depending on the perceptions of the causes of the episodes. Those who believe that mass hysteria is a natural illness, involve the mental health team, use water splashing and pain infliction. Those who believe that mass hysteria is supernatural in origin consult traditional healers for herbal remedies; while those who believe in evil spirits will use either prayer or exorcism. The researcher concludes that the strategies are dependent on the belief systems held by the people about the nature or cause of the mass hysteria episodes.

6.3 RECOMMENDATIONS

Recommendations are made with reference to the following:

- Educational programmes.
- A national study needs to be carried out on mass hysteria outbreaks in Lesotho.
- Critical analysis of some cultural beliefs.
- Guidelines for the management of mass hysteria episodes.

6.3.1 Educational programmes

It is recommended that medical practitioners, mental health nurses, general nurses, psychologists, social workers and health workers develop educational programs on the phenomenon of mass hysteria and preventive measures. These programs should be focused on different target groups including students, communities, health workers, traditional healers, church leaders, community leaders, teachers, school inspectors from the Ministry of Education, and the Media. Early identification of this phenomenon has to be mandated in order to protect the community from uncertainties and volatility.

The choice of the target groups is based on the fact that students are culprits of the phenomenon, while they live in the communities who hold different perceptions about mass hysteria. Health workers, traditional healers, church leaders, community leaders and the Ministry of Education need to understand this phenomenon, its causes and the Basotho's perceptions about it, so that the right treatment can be sought timeously. In addition, these stakeholders are authorities, who can give statements of assurance to the community as stipulated in the guidelines.

It has been postulated in the literature that the Media, namely radio broadcasters, newspapers and television, can in/directly escalate the episodes. Consequently, media reporters and presenters need to be educated on what to report and how to report effectively, without distorting facts and expressing their own personal views.

6.3.2 National study on mass hysteria

It is recommended that the Department of Mental Health in Lesotho initiate a national study on mass hysteria that will cover the whole country (urban and rural areas), including a greater number of participants, in order to get more views. Such a study should include outbreaks in other settings such as the factories, communities and orphanages. Reports on mass hysteria outbreaks in these other settings were mentioned in Chapter 1, but were not included in this study. The numbers of mass hysteria outbreaks are not fully reported on, or covered. It is suggested that mass hysteria be added to the list of epidemics in public health, due to its contagious nature.

6.3.3 Critical analysis of some cultural beliefs

This study findings show that Basotho belief system incorporates witchcraft (sorcery), thokolosi and muti; as well as religious beliefs about evil spirits, Satanism and blasphemy, which are socially acceptable. Often people are suspected to be witches. They can be stoned, drowned or burned to death (La Fontaine 2012¹⁵⁸), without tangible evidence. Such issues need to be critically analysed; in order to sensitise Basotho about reality. Some religions highly entertain the existence of the evil spirits that can be a fruit of jealousy. Such a belief can implicate some members of the congregation and result in stigmatising the accused member.

Much as culture and religion are important, it could be beneficial to the Basotho if they re-examine some of their cultural beliefs and the newly-acquired religious beliefs, in order to rule out the detrimental beliefs.

It is recommended that the Department of Mental Health educate all Basotho about the phenomenon of mass hysteria and its contributing factors, as well as its manifestations. The researcher plans to conduct some debriefing sessions with the participants of the study and others. This will include victims, classmates, teachers, parents, community leaders (namely chiefs, priests, traditional healers and pastors), health workers, the Ministry of Education, emergency agents such as the police, ambulance personnel and

¹⁵⁸ <http://www.guardian.curse-africa-kristy-bamu> (accessed 19 June 2013).

the Media representatives, all who will need to attend the sessions. The findings of the study will be discussed fully and questions will be welcomed and answered.

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The team from the Department of Mental Health will chair the session and participate in the debate that may be triggered by the findings, the cultural aspects that contribute to the development of mass hysteria, and how to manage the episodes. The team will represent all the cadres that is, psychiatrist, psychologist, mental health nurse, occupational therapist and the researcher. The Mental Health Team forum will serve as plenary for a way forward, and may further contribute towards the analysis of some detrimental cultural beliefs.

The researcher and the team will visit schools and provide health education and distribute information through brochures and flyers to both students and teachers. The team will address the issue of mass hysteria on the phone-in program allotted to the Department of Mental Health; which is held weekly (every Thursday at 11 a.m) on Radio Thakhube.

6.4 GUIDELINES FOR THE MANAGEMENT OF MASS HYSTERIA

6.4.1 Introduction

The guidelines are part of a process which indicates a system of action during mass hysteria outbreaks in Lesotho. The guidelines document consists of the aim, objectives and sections addressing different role players. The document is structured according to the emergent themes from the study findings.

6.4.2 Rationale for the development of guidelines

According to Govender (210:318), many outbreaks of mass hysteria are not reported. Jones (2000)¹⁵⁹ explains that the diagnosis or recognition of this phenomenon is difficult, because mass hysteria shares features of other illnesses, such as 'sick building syndrome. Mkize (1998:329) adds it is important to delineate cultural and social factors in the diagnosis of mass hysteria.

¹⁵⁹<http://www.aafp/20001215/2649.html> (accessed 21 February 2008).

It is, therefore, important to recognise mass hysteria early, in order to avoid abuse of resources; such as medical services, the fire brigade, police emergency services, laboratory and environmental investigations. Rataemane et al (2002:12) caution that time can be wasted fruitlessly in search of a diagnosis during outbreaks of mass hysteria. They further add that the tedious search reinforces the victims' behavior and prolongs the incident.

Researchers have shown that outbreaks of mass hysteria result in panic and anxiety among the observers (Bartholomew 2005¹⁶⁰; Engs 1996¹⁶¹; Rataemane et al 2002¹⁶²; Rataemane et al 2002:11). Panic and anxiety among community members result in crisis situations. It is important to resolve a crisis as soon as possible to prevent further chaos. The teachers, emergency teams and health workers, in particular, are responsible for intervening during crisis situations caused by mass hysteria (Engs 1996¹⁶³). The following guidelines have been developed to assist the responsible people to manage mass hysteria incidents.

The phenomenon of mass hysteria is poorly understood by the Basotho. It is surrounded by myths and cultural beliefs which are unfavourable to victims, families and community members. Mkize (1998:330) and Rataemane et al (2002:11) indicate that the sudden and dramatic situations created by mass hysteria episodes may result in a variety of suitable explanations such as witchcraft, Satanism or poisoning. The contagious effect of mass hysteria needs prompt interventions and saving of available scarce resources, which are easily abused during the outbreaks of mass hysteria and the follow-up investigations.

Aim

The guidelines aim at streamlining processes to manage mass hysteria in Lesotho and mobilising role players towards responsible action.

¹⁶⁰ <http://www.mja.com.au/public/issues/183-11-051205/bar10320-fm.html> (accessed 20 February 2006).

¹⁶¹ <http://www.indiana.edu/~engs/article/hysteria.htm> (accessed 20 February 2006).

¹⁶² http://psychosocial.com/current-2002/MASS_HYSTERIA.HTML (accessed 20 February 2006).

¹⁶³ <http://www.indiana.edu/~engs/article/hysteria.htm> (accessed 20 February 2006).

Specific objectives

The guidelines have been compiled to

- Assist teachers, parents and health workers to identify mass hysteria promptly.
- Assist health workers and emergency teams to diagnose mass hysteria and handle the outbreaks professionally.
- Guide health workers to teach communities about mass hysteria
- Teach the Media about their role during outbreaks of mass hysteria.

Guideline 1

This guideline addresses Theme 1: *Manifestation of mass hysteria among the Basotho.*

Rationale

Guideline 1 gives direction towards recognising the mass hysteria phenomenon in Lesotho.

Actions

- Health education as a preventive strategy has to be offered to all teachers in training and service. The focus is on the nature of mass hysteria and its management. This can sensitise them to recognise mass hysteria. Health education can be offered by giving lectures, distributing pamphlets, coverage on local television, radio broadcasts and newspaper articles.
- Health workers, teachers and the community members must be adequately informed about mass hysteria to enable them to recognise this phenomenon.

Identifying Characteristics of mass hysteria

The following characteristics occur in mass hysteria outbreaks:

- Sudden onset with dramatic symptoms, rapid spread and recovery.
- Predominately young female population affected.

- There is always an *index* person in all outbreaks.
 - Victims know each other either by friendship or are blood relatives.
 - An auditory or visual triggering stimulus can be identified, such as toxic pollutant, emergency response or rumours.
 - An apparent transmission of symptoms by sight, sound or both .
 - Underlying psychological or physical stress can be identified.
 - Lack of emotional or social support.
 - Symptoms that spread and resolve rapidly.
 - Symptoms inconsistent with biological aetiology.
 - Illness may escalate with vigorous or prolonged emergency or media response.
 - Illness may recur with return to the environment of initial outbreak.
- (Engs 1996¹⁶⁴; Govender 2010:321; Jones 2000¹⁶⁵; Rataemane et al 2002¹⁶⁶; Rataemane et al 2002:12).

Teachers' role

- Separate the affected students from the unaffected, in order to reduce group anxiety.
- Convey the most affected to an outpatient department for treatment if necessary.
- Affected students should be reassured that symptoms will improve with cautious care
- Inform the parents about the condition and ask them to take students home.
- A temporary school closure of the school may be necessary.
- Assume confidentiality about the condition and guide against clients' use of names, and do not discuss what is going on at your school openly.
- Designate one of the reliable and well informed teachers to answer media questions, in order to avoid conflicting statements.
- A firm statement of denying supernatural forces as causing the incident is necessary by the designated teacher to allay community anxiety.
- The school principal must set limits for the affected school girls; not to return to school if they still experience the symptoms.

¹⁶⁴ <http://www.indiana.edu/engs/article/hysteria.htm> (accessed 20 February 2006).

¹⁶⁵ <http://www.aafp.org/afp/20001215/2649.html> (accessed 21 February 2008).

¹⁶⁶ http://psychosocial.com/current_2002_MASS_HYSTERIA>HTML (accessed 20 February 2006).

- Know your students' family background, as well as the social problems they maybe encountering at any given time.
- Familiarise yourself with each student's performance; so that you are able to identify performance changes.
- Inform the emergency personnel such as, public health nurses, medical, police and paramedics, but let them park cars out of sight for other students as seeing the ambulances may expose the unaffected students to panic and may predispose them to the contagious effects of mass hysteria.
- If you suspect that students could be experiencing mass hysteria alert the Ministry of Health and the Ministry of Education about the outbreak (Authorities).

Health workers' role

- Health workers to treat the symptoms in calm, reassuring manner.
- Acknowledge that symptoms which are experienced by the victims are real.
- Perform physical assessment, basic laboratory and environmental tests to rule out other conditions.
- Minimise unnecessary exposure to medical procedures and stimulating situations.
- Assess and provide oxygen if necessary, that is if victim is hyperventilating.
- Assure the victim that the long-term sequelae from the illness are not expected.
- Explain to both the affected students and their families that anxiety, fear and uncertainty potentially increase the symptoms.
- Make a public health statement, regarding the outbreak. This will terminate the epidemic.
- Collaborate with other health workers caring for other victims of mass hysteria for support.
- Promptly communicate laboratory and environmental results.
- Refer the seriously affected victims to other members of the team, such as the psychiatrist and psychologist.
- Involve the victims in psychotherapy.

Guideline 2

The guideline addresses Theme 2: *Interventions used by the Basotho to alleviate mass hysteria.*

Rationale

Users of the guidelines need to know the frequently used interventions in order to assess their effectiveness and actions.

Those who intervene need to identify the safe and detrimental interventions; in order to promote the well-being of the victims of mass hysteria. For instance, some inflict pain as a remedy.

Rataemane et al (2002:12-14) indicate that health practitioners need to consider cultural beliefs and practices when developing successful health education strategies. They, therefore, advocate for the medical model which persuades people to adopt healthy behaviour, due to the psychological nature of mass hysteria.

Actions

- All relevant stakeholders in the study must freely discuss their interventions for information sharing. These are health workers, priests, traditional healers and pastors.
- The herbal remedies need to be tested in the laboratory for properties and dosages.

Health workers' role

- Engage in community discussions, in order to understand the belief systems surrounding mass hysteria's interventions.
- Promote safe interventions and discourage the detrimental practices by giving the rationale.
- Do not confront but, be diplomatic in tackling these sensitive issues.

- Give information, but allow the community to deliberate fully on the topic and seek their conclusion (remember this may take longer than anticipated).
- Allow the community to make suggestions as to how the problem can be solved.

Guideline 3

The guideline addresses Theme 3: *The Basotho's views on mass hysteria*.

Rationale

This guideline addresses the beliefs of the Basotho people and gives them the opportunity to re-examine them, while sharing scientific reasoning. It may help to uproot any misconceptions, myths and superstitions around the phenomenon objectively without undermining the culture and religion.

Actions

- Give the community a platform to re-examine their beliefs regarding mass hysteria.
- Allow them to differentiate myths and superstitions from reality.
- Encourage people who have been identified as witches to make testimonies about their experiences.
- Sensitise the community about negative effects of labeling a community member as a witch. For example, burning of houses, killings and sour community relations.

Health workers' role

- Explain the possible contribution of anxiety and stress to the victims' symptoms.
- Establish predisposing factors.
- Make a public health statement, in regard to the mass hysteria outbreak.
- Organise health education sessions by calling for public gatherings (pitso) for communities and their leaders such as chiefs, church leaders and traditional healers.

- Use the Media to disseminate correct information about mass hysteria outbreaks, such as newspapers (by having press conferences), radio broadcasting and allowing phone-in programs and television appearances.

Guideline 4

This guideline addresses Theme 4: *Effects of Mass Hysteria on the Basotho*

Rationale

The study findings established that victims, families and the community suffer the after effects of mass hysteria, therefore this guideline attempts to guard against any negative consequences.

Actions

Authority's role: Ministries of Health and Education

- Highlighting the untruth in the past rumours that created public scare.
- Quoting experts and people in responsible positions to diffuse and lift the lid of unfounded beliefs and rumours.
- Reassure the public that this is a known medical condition that has been treated successfully and that it is not associated with any supernatural factors.
- The Ministry of Education should employ school-health nurses or collaborate with the Ministry of Health when there is an outbreak, and encourage school visits by a public health nurse and mental health nurse once every fortnight.

Media role

- Giving safe instead of scary headlines.
- Not dramatising or sensationalising unsubstantiated stories by giving them too much space or visibility.
- Portray objectivity and avoid taking sides, or expressing personal beliefs or views.

- Printing facts from reliable named sources.
- Providing a context to rumors, speculations, and alarmist theories.

Health worker's role

- Follow-up victims for at least six months after the episodes.
- Develop health education materials on mass hysteria, in the form of brochures, pamphlets and billboards to disseminate information.

The guidelines will be discussed with key personnel in the Department of Health to get the support of the authorities for the implementation of the guidelines.

6.5 THE SCOPE AND LIMITATIONS OF THE STUDY

This study was limited to schools where mass hysteria outbreaks occurred and whose students were available to participate in the study; in particular the urban, semi-urban and one rural area of Lesotho, because other victims were untraceable during the time of data collection. Some victims of mass hysteria, who worked in the factories, were hard to reach due to the high staff turnover in the factories and were therefore not included in the study. Victims of mass hysteria who came from the community were involved in different chores in the villages, such as weeding and crop harvesting during the data collection phase and could not be reached. In all the schools no boys experienced the mass hysteria episodes; it was only girls. The data were gathered long after the mass hysteria outbreaks. The period could have influenced the study participants' memories of the mass hysteria episodes. Therefore, the findings cannot be generalised to the entire Lesotho as other settings were not included in the study.

Some traditional healers were not very cooperative, because they thought that the researcher was seeking their services; only to find the researcher wanted information which rather de-motivated them. It is also in their nature not to share information about their remedies with others without some means of remuneration.

6.6 REFLECTION

Conducting this study was enriching, the researcher learned a lot from the participants and the Basotho culture, which she as a Mosotho national took for granted and thought she was familiar with. The qualitative methodology was new to the researcher. It posed challenges with regard to finding recent literature on mass hysteria, reading, reflecting, interpreting, writing, re-writing and many frustrations at times.

The researcher faced challenges of role conflict, being a wife, mother, grandmother and professional, it was sometimes very difficult to cope. But above all, the researcher faced the hardest time when her husband passed away after 10 years of illness.

The enriching part was that life had to go on and the researcher resumed her study after being in and out of the study program. The long hours spent on the study somehow, served as deflector from reality.

6.7 CONCLUDING REMARKS

The compiled guidelines are the researcher's intervention attempts to curb mass hysteria in Lesotho schools. Their aim, as reported earlier, is to maintain social stability, uproot myths and misconceptions without necessarily denying the Basotho their cultural and belief systems, but to attain a common ground for all and avoid contravening other citizens' rights by accusing them of 'be-witching' others.

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ANNEXURE A

THE ETHICAL CLEARANCE

ETHICAL APPROVAL

5 June 2013

Student: L Tsekoa
Student number: 3581 224 9
Study title: Mass Hysteria: The experience of young women in Lesotho
Supervisor: Prof E Potgieter

This letter is to confirm that the student received permission in 2006 to conduct the above mentioned study. As evidence, attached please find the permission letters from the following institutions:

1. The Director Mental Health Services in Maseru on 14 March 2006
2. The Ministry of Education and Training in the Kingdom of Lesotho on 30 April 2006

The Chairperson of the Department of Health Studies, Unisa, the Chairperson of the Research and Ethics Committee of the Department as well as the supervisor, Prof E Potgieter approved the research proposal in 2006 according to the processes at that time.

Prof Lizeth Roets



Chairperson:
Higher Degrees Committee
Department of Health Studies
University of South Africa
roetsl@unisa.ac.za

ANNEXURE B

REQUEST LETTER TO MINISTRY OF HEALTH: DEPARTMENT OF MENTAL HEALTH

National University of Lesotho

P.O Roma

Roma.

23rd February, 2006.

The Director

Mental Health Department

Ministry of Health

P.O Box 514

Maseru.

Dear Sir,

Re: Research and Inclusion in Mass Hysteria Intervention Team.

I am a mental health nurse working for the National University of Lesotho and presently a registered student with the University of South Africa for a doctoral degree. I am undertaking research as a fulfilment for the degree. The title of the study is **Mass Hysteria: Experiences of young Women in Lesotho.**

The purpose of this study is to explore the Basotho's understanding of Mass Hysteria as a mental health disorder in order to elicit the cultural, social and political causative factors of Mass Hysteria, so as to help prevent outbreaks and help the affected persons on time. One of my objectives is to develop some guidelines for interventions.

I realize that you recently formed a team that intervenes in the outbreaks. I am requesting your permission to join this team, so that I can participate in helping the victims, teachers and parents as well as collecting data for the study.

I hope to receive a favourable response from you office.

Yours truly,

Lineo Tsekoa (Mrs)

ANNEXURE C

REQUEST LETTER TO MINISTRY OF EDUCATION

National University of Lesotho

P.O Roma

Roma. 180.

20th February, 2008.

The Chief Executive Officer- Secondary

Ministry of Education and Training

P.O Box 47

Maseru.

Dear Sir,

Re: Permission to conduct a Study in schools.

I am a mental health nurse working for the National University of Lesotho and presently a registered student with the University of South Africa for a doctoral degree. I am undertaking research as a fulfilment for the degree. The title of the study is **Mass Hysteria: Experiences of young Women in Lesotho.**

The purpose of this study is to explore the Basotho's understanding of Mass Hysteria as a mental health disorder in order to elicit the cultural, social and political causative factors of Mass Hysteria, so as to help prevent outbreaks and help the affected persons on time. One of my objectives is to develop some guidelines for interventions, that teachers can utilize during outbreaks. I am aware that we presently face such epidemics. I will carry out the study in the following schools: Itsekeng, Mahlabatheng, Thetsane, Mazenod and Rasitemela High schools, because they recently experienced the outbreaks.

Thank you, Sir, in anticipation for a favourable response.

Yours faithfully,

Lineo Tsekoa (Mrs).

ANNEXURE D

PERMISSION FROM MINISTRY OF HEALTH



Mohlomi Hospital
P.O. Box 540
Maseru 100
14TH March, 2006

MH/ADM/23

Mrs L. Tsekoa
National University of Lesotho
Roma 180

Dear Madam,

re: **INCLUSION IN THE MENTAL HEALTH TEAM THAT INTERVENES IN MASS HYSTERIA
OUTBREAKS**

I acknowledge receipt of your letter dated 23rd February, 2006. I hereby grant you permission to be part of the above-mentioned team. As a member of the team you are expected to be involved in the provision of "health education and either individual or group psychotherapy", when necessary, you will also follow-up clients who experienced mass hysteria.

You are also permitted to conduct data collection during this period. As requested, you can carry out the individual interviews and the focus groups with the teachers, students, traditional healers, parents and church leaders while in the field.

I wish you well in your endeavors and look forward to the guidelines you hope to develop for other health workers, teachers and the media personnel. I am glad that you chose this topic: "**Mass hysteria: Experiences of young women in Lesotho**". Mass hysteria seems to be occurring too often and indeed people are often scared and do not know what to do during outbreaks.

Yours faithfully,


M. LEBINA (MR.)

DIRECTOR MENTAL HEALTH SERVICES(i.a)

ANNEXURE E

PERMISSION FROM MINISTRY OF EDUCATION AND TRAINING



THE KINGDOM OF LESOTHO
MINISTRY OF EDUCATION AND TRAINING

30th April 2006

REF: ED/C/16

Ms. Lineo Tsekoa
Maseru
Maseru 100

Dear Madam;

AUTHORITY TO CARRY OUT A RESEARCH STUDY IN LESOTHO SCHOOLS

Receipt of your request in regard to the captioned subject matter refers.

I am aware that you want to undertake a study about mass hysteria in our schools. This is one area where the Ministry is keenly looking forward to its unravelling owing to disruptions to lessons in schools. The incidence normally happens around examination period and you can imagine the havoc it wreaks to the examinations system in our schools. Accordingly, you are granted permission to study this mysterious "illness".

The Ministry will be happy to receive your findings as well as recommendations on how to mitigate the "illness".

Thank you.

Yours sincerely,

R. MAJARA(MR)
CEO-SECONDARY

cc. CIC ai

ANNEXURE F

INTERVIEW GUIDES

The In-depth Interview Guide

1. Describe your experiences during the mass hysteria incident.
2. What did you feel physically?
3. How did you feel emotionally?- Anxiety, Fear, Excitement or joy?
4. Do you believe in supernatural forces?
5. What do you think caused the behavior you displayed?
6. What made you stop?
7. Who brought it to an end?
8. What did the person say or did that brought you back to reality?
9. Have you ever been involved in such an incident previously?

Focus Group Guide.

1. What triggered the incident, what had happened before?
2. How did it start?
3. Who was affected first?
4. How long did it last?
5. How did it stop, who brought it to end?
6. What did you do during the incident?
7. What were the after effects?
8. What do you think caused this?
9. Do you believe in supernatural forces, evil spirit, sorcery?

ANNEXURE G

HISTRIONIC VAMPIRE CHECLIST

CHECKLIST

On describing yourself:

Please, circle the statement below as "True" (T) or "False" (F)

1. I usually stand out in a crowd by virtue of looks, dress or personality. T/F
2. I am a friendly, enthusiastic, entertaining and absolutely wonderful person in social situations. T/F
3. I treat superficial acquaintances as if they were close friends. T/F
4. I can become visibly upset when forced to share attention. T/F
5. I love to talk, gossip and tell stories? T/F
6. Do your stories become more exaggerated and dramatic with each telling? T/F

7. Do you have a good fashion sense, but perhaps a bit too much concern with your appearance? T/F
8. Do you ever become very upset over relatively small social slights? T/F
9. Do you seldom admit to being angry, even when anger is apparent to other people? T/F
10. Do you have very little memory for day to day details? T/F
11. Do you believe in supernatural entities, like the dead ancestors? T/F
12. Do you have one or more ailment that comes and goes to no discernable pattern? T/F
13. Do you have some problems in doing regular chores like paperwork, housecleaning or paying bills? T/F
14. Do you ever get sick to avoid doing something unpleasant? T/F
15. Do you fervently follow several television shows? T/F
16. Is your communication often indirect and vague? T/F
17. Do you believe you are the easiest person to get along with? T/F
18. Do you sometimes become seductive? T/F
19. Are you always in demand and more popular? T/F
20. Do you frequently change your style of dress and overall look? T/F

ANNEXURE H

FOCUS GROUP

Focus Group 10 Students (Mahlabatheng High School) School B

Int: Good after noon students. I want you to answer a few questions. Are you giving me permission to ask you?

Stud: Yes, we do; but what are the questions about?

Int: I presume, you are a group that underwent an attack of illness that swept through your school the last two weeks, am I right?

Stud: Yes, we did.

Int: O.k, the questions we focus on that incident; so are you willing to answer the questions? I will therefore, give you consent forms to sign; that you are willing to participate in the study and that you have not been forced, it is voluntary, also that you have a right to answer questions that you feel comfortable with and you can withdraw from participation any time without facing any censure.

Stud: O.K, we will participate and sign the forms.

(Signing of forms)

Int: Let us then start by answering the following question: **What triggered the incident?**

S1: I really do not know.

S2: I think, were some of us got scared when one of our class mates fainted at the assembly before classes.

Int: Why were you scared; was it the first time she fainted or what?

S10: It was the first time we saw it, she had told me, she faints at home, but it has never occurred in school.

Int: What was scarring you?

S6: The way she looked.

Int: How did she look like? Please, explain?

S7: She cried out loudly

S4: She wanted to run away; this is why boys held her.

Int: So, you think fear triggered this event?

S5: I think it did.

Int: How, then, do you explain how you all underwent the same incident?

S8: This is very difficult for me to explain, but, as we discussed it at home, our parents speculated that since it occurred in our class (form D); when we had just passed our examination so well, somebody, must have been jealous of the good performance we displayed and decided to bewitch us.

Int: So you all passed your exams in flying colors?

S1: We all obtained “merit pass” in the Form C exam.

Int: So, you believed that you were bewitched because of the good exam results?

S: (chorus) yes.

Int: Can you explain **how you felt?**

S4: It is rather difficult for me to explain how I felt, because as I came to the class room, I felt weak and dizzy; it felt like I was walking on air. I held onto the desks for support; my vision changed, I could not see anything and I fell to the ground; I must have lost consciousness because when I came around, I was in the staff room, surrounded by teachers, who threw water on my face. They asked me what the matter was; I told them I did not know.

S8: We share a desk in class, as I entered the classroom I met boys carrying her to the staff room. I became confused, I could not figure out what was happening, before I knew it, I was trembling with fear; I also fell to the ground. I am not sure this happened or if it was an imagination, I think I saw a very bright light, like lightening, mind you it was not raining, and maybe this is what threw me to the ground.

S10: IT was a different day altogether, everybody looked different and felt different, one of us even likened the day to “doomsday”, like it was last day before the end of the world!!

Int: How was this, how different? Please explain.

S7: Indeed, nobody cared for other people; people did not chat as they normally do each morning. It was as if nobody saw other people; it was scary!! I personally felt numb and unable to explain how I felt.

Int: I hear most of you felt confused, so could you **describe your experiences during the incident?**

S1: Yah, lots of things crossed my mind. I have never believed in sorcery but I could now imagine, yes, it is it, when I saw so many girls, me included, in such a state; I started believing it was witchcraft, I had no other explanation, but that. I felt like I was abandoning my religious beliefs, becoming a heathen and I could see people abhorring me

S6: I felt confused, I had an urge to get away from the school premises, and the atmosphere was “spooky”.

Int: what is “spooky”?

S5: Ghost-like, like when you walk in a cemetery and expect to see a ghost, unimaginable! This is how the day dragged on. Both teachers and students hated me for partaking in the incident.

S8: Yah, I somehow felt that we students were carrying a stigma of some sort. Our teachers liked our class but, after what happened I could see hatred instead of the love they had shown.

S3: Even some students called us names and mocked us.

Int: what were some of the names?

S9: Names such as “The possessed”, they gave us horrible looks and as you passed a group you could see that they were talking you.

S7: I remember one of the Form E students moved away from me in the school hall; all her classmates laughed. I felt really hurt.

S2: This extended to the village and my stepmother even gave me a good hiding, saying that I brought the family name into shame and added that I actually said she bewitched me. It was really bad; there was even a family meeting, where I had to defend myself.

S10: It was a nasty experience for all of us.

Int: I can imagine, **can you tell me how you felt physically and emotionally during the illness?** S4 said she felt weak and dizzy, what about others?

S1: For me, the weekend had been very difficult because we had quarreled with my mom (step), she did not give me permission to see my brother, who had promised to give me money to buy books, yet she did not buy the books for me.

So I was already upset and hardly slept or ate any thing. Physically, I felt weak and sleepy. Emotionally I was hurting, angry, frustrated and helpless.

S8: You know, depression is contagious; whenever my class neighbor (S1) is upset and depressed I feel the same. Ma'm this girl has it tough; she is not allowed to talk to her dad nor siblings, that is her married sister and brother, who live in the same village with her. She does all the house chores, while her stepsisters older than her do nothing!

Physically, I also felt weak and I felt like I was choking, I was unable to swallow; even my own saliva was too much.

S7: I felt confused and was hyperventilating and perspiring. .

S4: I was scared, irritable and lacked energy to do anything.

S5: I felt weak and tearful; I could not breathe easily.

S9: I had a splitting headache and lots of anxiety, my heart beat was fast and I felt fatigued

Int: Any body, felt any thing different?

(Head shaking- No)

Int: O.k. **may I see how many of you were involved in such an incident?**

(S1, S4, S6 and S10- had been involved) Thank you.

Int: What do you think caused the behavior you displayed?

S6: Like we said before, there were many speculations; but most people thought it could be bewitchment by jealous people, who heard of the school performance.

S1: My stepmom thought I was faking illness, because I wanted to dodge work at home and deceive people that she was a witch.

S6: Since I had had it before, my mom consulted a traditional healer, who said that one of my mom's friend used "muti" to cause the illness, because her daughter dropped out of the school, while I am doing well in my studies.

S10: I had also consulted a faith healer, who said the illness is due to the "evil spirit", because I am a staunch believer in my church.

Int: Any more views? I see that nobody has something different. **Can you tell what made you stop?**

S5: Three days after the episode, a mental health team from Mohlomi Hospital and the National University of Lesotho, comprising of nurses, social worker and a psychologist visited the school and addressed both the students and the teaching staff.

Int: **What did they do or say that brought you to reality?**

S9: They showed that this is a common incidence that occurs in schools or in the communities; they further explained that it does not emanate from any supernatural forces; but, can be caused by many factors. This explanation brought relieve to us, because were confused and thought that it was as people explained. At least this existed in the medical field and can therefore be cured.

Int: so this is a medical condition; **do you belief in supernatural forces, evil spirit and sorcery?**

S1: I do not know how to answer that because evil spirits and sorcery are mentioned in the holy Bible; every Sunday priests and preachers talk about them, so I can out rightly say yes, I believe in them.

S8: to add to that our culture believes in them, if you listen to some radio stations you hear stories about witchcraft and evil spirits; you will definitely know that culturally those beliefs are acceptable; they are part of Basotho culture.

S7: yes, indeed, most, if not, all Basotho believe in all what you mentioned.

Int: If so, personally, **how do you perceive this incidence?**

S5: This is rather tricky, you get to hear so many stories, you will see newspaper headlines like: "Thokolosi e patela bana sekolong" (A dwarf troubles school children); you also see some of the sick students "being choked by something" you can not see, you definitely say, this could have been the "thokolosi" referred to in the papers; I am not sure if you have any other explanation. Surely, I personally believe that some supernatural force maybe (Laughs) the dwarf is at play here.

S7: I concur with you, my friend, unless somebody explains it better than this.

S9: I thought their explanation was straight forward, it surely sounded factual. I am sure that the stress we are under and the demands, especially the economic ones have attributed to the illness. This witchcraft business, I do n't believe in,

you know people will just pick on you for nothing; they will burn your house and say you bewitched some one, just because they hated you. I actually saw it happening with my grandmother, who was so sweet, she could not hurt even a fly; but she was accused of witchcraft; that's when I knew that it is something fake.

S3: I personally, believe that the evil spirit exists, I have had many stories and seen people involved in "Satanism", may be someone was trying to expose us to that, because I heard that a lot of what we, involved girls, did is what they also do.

Int: What exactly did you do that could be similar to them?

S3: We were crying and screaming, rolling on the ground, running away, choking and very powerful; things like that.

Int: So you belief this illness is somehow related to Satanism, per se.

S3: I really think so.

Int: Any different views?

None (chorus)

Int: I would like to summaries **the after effects**, you previously mentioned earlier and stand to be corrected; I also want you to add more if you have. You mentioned that *people hated you, you experienced fear, stigma and discrimination, you were called names, some of you were beaten by relatives and you felt depressed.*

S1: Yah that is it.

S6: We also felt ashamed of our selves.

S10: this experience has brought us together, we are now like a family, we have become friends; because we have the experiences.

S7: This may sound funny, but, I am now closer to my God, I pray more often than I used to; I have learned that if I have no answers God provides the answers and makes the impossible, possible.

Int: That sounds good, any more contributions? (Pause) I really think we have come to the end of our discussions; I would like to thank you for your time and the contributions you made. This was useful information that will contribute to

the knowledge of this disorder and improvement of care to its victims; unless you have any questions?

S9: A small question; how common is it?

Int: Very common; at the time you people were undergoing it, three more schools in the same district as you; were also having the episodes; it was on the media, maybe you missed it because you were not well too.

Int: Thank you, students and good bye.

ANNEXURE I

AUDIT TRAIL

Audit Trail

Data Chucks

- 1 *I found the sickness called Tenya-tenya already bothering people* (anxiety)
- 2 *They were actually doing something frightening* (fear)
- 3 *They were crying* (physical manifestations)
- 4 *there I was crying, screaming ...running away saying that I want to go with this guy*
(physical manifestation)
- 5 *I would get attacks of hiccups* (physical manifestations)
- 6 *They could n't see him but I could* (Visual hallucinations)
- 7 *I was really fighting; I was very powerful* (physical manifestation)
- 8 *I was tired* (physical manifestation)
- 9 *After I had seen that shadow then I would see this guy live* (Visual hallucination)
- 10 *I became wild sometimes* (psychological reaction)
- 11 *Sometimes he became a lion, terrifying things. He became so many things that terrifying and they would make you feel that you need to run away from this person*
(hallucinations)
- 12 *people from all churches came to my home and prayed for me; the priest came and prayed for me at home* (Intervention)
- 13 *One traditional doctor arrived and said that, "This thing is thokolosi"* (beliefs)
14. *"I'm scared of this child; I think I'm going to be in danger (ke tl'o tsoa kotsi). "I'm afraid of this child; she has very big issues.* (Supernatural belief).
- 15 *While praying I felt my body going into shock, like I had been dipped in cold water!*
(Physical reaction).
- 16 *I felt like someone was standing behind me. Yes, with a heavy shadow*
(psychological reaction)
17. *They gave holy water and oils and told me to use those things* (interventions)
- 18 *Sometimes when I fainted, I foamed from the mouth and kicked around aimlessly*
(physical reaction)
- 19 *After I got better, I was afraid to walk in public* (after effects/ shy)

20 *"She's Satan's person; she's that one who had Satan's sickness."* (After effects/ stigma)

21 *When I went to church after I was sick; I sat next to one lady who moved away from me* (after effect/ stigma).

22 *my whole family was affected.* (After effects to the family)

23 *But, in the end I accepted* (After effect/ acceptance)

24 *I take, this sickness, was caused by the evil spirits. I take it as evil spirits.*

(Cause/perception)

25 *I saw that there people who were so happy to have experienced it that it was like a pride to have tenya-tenya.* (After effects/ pride)

26 *I think it was caused by fear. We were all scared because it happened... every body was saying that they were scared because of that.* (Belief)

27 *when I saw her in a coma. I thought they were going to die... that they were all going to die.* (Psychological reaction)

28 (name).....*is the one who fainted first* (Index person)

29 *I was so weak that I felt like I needed to sit down ...all became dim...I had a black out.* (Physical manifestations)

30 *I...was very scared because she's my friend. I sit next to her in class* (Contagion)

31 *So when I saw her in a coma...I felt sorry for her. When other students fainted after that, I felt sorry for them. I even thought were all going to die.* (Psychological manifestations / confusion).

32 *When I saw others run away, I also ran away* (Psychological manifestation/ confusion)

33 *Two days...but the second day was not the same as the first day, on the first day, many students fainted, many, many, many students.* (Duration).

34 *I became suffocated...though we shook, we did not lose consciousness* (Physical manifestations)

35 *I suffocate, and then I shake* (Physical manifestations)

36 *Like I needed to breathe quickly* (Physical manifestations)

37 *I felt weak and my knees tremble* (Physical manifestations)

38 *She says that I 'm very rigid and my fingers are rigid, clasped together...and my eyes are shut* (Physical manifestations)

39 *When I am angry I will not speak. Instead, I will faint at your feet* (Belief)

40 *...it appeared that as if there was an evil spirit ...present at school. So the priest prayed, chasing it away* (Belief and Intervention).

41 *Our teachers thought that maybe we have problems...at home* (belief)

42 *People were already scared that they had come to school and the "stay away" is coming and we going to get killed.* (Belief)

43 *Well I honestly...I can say that I don't believe in witch crafting but hai! I don't what to say...I think I heard a person calling me by my name...I looked around...then I saw someone peeking by the head...* (Visual hallucination/ Belief)

44 *Some times I saw people who did not have skins, they looked like skeletons. Sometimes I would see snakes that are scary things.....* (Visual hallucination)

45 *So I think it is evil spirits* (Belief)

46 *My family members saw me sitting there like I was no longer breathing...it was like I overpowered them* (physical manifestation/ strength)

47 *She was crying like she was frightened like someone who saw something that frightened her...* (Physical manifestations)

48 *I just felt confused. That is like I was where I have never been before* (Psychological manifestations / confusion).

49 *...everybody looked like they didn't care about me... They looked like they had turned against me; everybody was going about their business and not giving care about me* (after effect)

50 *I had a banging headache* (Physical manifestations)

51 *I feel tired...I'm sweating* (Physical manifestations)

52 *It does not hurt, but I get tired at the joints and muscles...I feel a weak headache* (Physical manifestations)

53 *It's dim at that time...have you ever seen when it is about to rain and the clouds come together and it becomes a bit dark?* (Physical manifestations)

54 *...They tell me it's clear, and I'd be surprised because I would be seeing something different from what they see* (Visual hallucination)

56 ...I agreed with people who said it might have been witchcraft (belief)

57 ...because our school had just produced "merits" at Form C...that they had bewitched...School (Belief)

58 I heard that when a student is out- competed by another student s/he tells his/her grandmother "who rides a broom) (a witch's practice) sends a "thokolosi" (Belief)

59 Some become unconscious, some run away, some fall down, complaining of anxiety and others have diarrhea; they display symptoms of mental illness. (Physical manifestations)

60 It is attributed to the "heat" of the household generated by individuals. Other people think, it is witchcraft, I personally know that it is not witch craft; it is due to the "heat" (Belief /excessive heat/ energy)

61 This affects their mental status (Belief)

62 we discovered that it can also come from the food that people eat, especially from the cabbage vegetables. Cabbage plants can be invested by some poisonous worm (Belief/ some food may cause the episode)

63 if one of the family members asks him/her, what is the matter; s/he gets affected and shows the same symptoms. (Contagion)

64 ... interfere with the breathing patterns of the patient... Their body twitch, complain of weakness of the limbs, fainting, showing signs of mental problems and running away aimless (physical manifestations)

65 This can be treated by a mixture of special herbs; the three herbs have healing properties, which fight the heat and the symptoms of anxiety and the symptoms of mental illness that the affected people display. (Intervention)

66 I can conclude that it happens in schools because students eat the same food, and generate a lot of heat as they share a one big place. (Belief)

67 They normally become unconscious, cry uncontrollably. (Belief)

68 once one student starts, others follow suit. (Contagion)

69 *There are of different types; some are normal, while some are not* (Types)

70 *Basotho can sometimes be very mean, they may be jealous of you and want to make you miserable by bewitching your child* (Belief/ Jealousy)

71 *Other times it is a natural illness from God. It is a type of "Lehabea" (psychosomatic disorder).* (Normal Type)

72 *They displayed malaise, loss of consciousness and showed signs of "bile" symptoms, we also found out that she had problems in her lungs; she had excessive salivation and excreted from the lungs.* (Physical manifestation)

73 *These witches can target any body, sent "muti", to him.* (Belief)

74 *witches, sent muti and people around you see you acting like you are mad;* (Psychological manifestations).

75 *These people with this disease are uncontrollable, they become extra ordinarily strong; look wild and listen to no body, they want to run away and say, they see these witches, calling them to follow them to some place.* (Physical manifestation)

76 *It is very scary for people watching them* (After effects/ to other people).

77 *We gave them, some mixture of the intestines of squirrels and the porcupine's feathers; all grinded together. It is a good, strong mixture. You dry up the intestines, in the sun light, without washing them.* (Intervention)

78 *We have shared quite a bit with you; the rest we will give to you as treatment, if you are ill, you see these are special gifts from the ancestors, they guide you along, when a patient is in your care.* (Traditional healers/ secrecy)

79 *They talk to you as you sleep or while you are having "Litaola" (the bones, used for diagnosing a patient* (Belief)

80 *They must have sent an "animal", that is a "thokolosi". It is the one that makes children run and faint.* (Belief/ supernatural)

81 *she was screaming, she looked like someone being choked; a thakhinya (kicking aimlessly), a bontsa hore o shoa bohatsu (complaining of numbness in her extremities)* (Physical manifestations)

82 *They increased at an alarming rate; at one point they were more than twenty four* (Contagion)

83 *She was rolling her eyes and held her mouth tight, had bitten her tongue because it was bleeding* (Physical manifestations)

84 *We ended up with 5 / 6 priests, who arrived at different times to pray for them... they actually said that the kids were filled with evil spirits* (Belief)

85 *One of priests asked us to separate these children...those affected must not mingle with those that are not.* (Intervention)

86 *She was shouting that she saw "two things"* (Visual hallucinations)

87 *Another said...two women were calling her* (Auditory hallucinations)

88 *In Sesotho when you talk about evil spirit you are talking about witchcraft* (Cultural belief)

89 *One of the students screamed and tried to run away; but the boys tried to restrain her; she was prevailing over the...she paid no attention to any body* (Physical manifestations)

90 *Until one of the teachers threw water on her face... she regained her consciousness* (Intervention)

91 *I must have counted about eight or nine of them. This was getting out of hand!* (Contagion)

92 *I did not know what was happening; it really turned into a crisis. It was chaotic!* (Confusion)

93 *They kept their eyes closed, screamed as if in pain, fought furiously...run away...sobbed quietly...choking sounds, rolled down on the floor.* (Physical manifestations)

94 *It was scary to watch them* (After effects on others).

95 *I think they displayed anxiety because they wanted to run away, maybe fear too.* (Psychological manifestations/ fear and anxiety)

96 *I used to deny their existence, but, after this occasion; I do not know what to think anymore; ...it could have been a result of something supernatural* (Belief).

97 *Some religious groups prayed for them, one of them ...advised us to separate the affected kids from the unaffected...professional people from the department of Mental Health...talked to both students and staff... some of the sick students were taken for traditional treatment by their parents* (Interventions)

- 98 *Most of them fainted, rolled their eyes...choked and...tried to run away. They looked like wild animals, they perspired, breathed heavily* (physical manifestations)
- 99 *"Thokolosi" is here...* (Belief in witchcraft and thokolosi)
- 100 *"If you really want to hurt the family, go after the kid"* (Revenge)
- 101 *These are the devil's works; these people are mean...* (Devil's acts)
- 102 ... *"A devil is fought by another devil"* (Repayment)
- 103 ...*Use herbal medication or animal fat mixture...* (Interventions)
- 104 *This takes a very experienced healer...* (Only experienced traditional healer can treat it)
- 105 ...*That were given to me by my late ancestors (Balimo), it can not be disclosed for free* (Source of healing powers, hence the secrecy).
- 106 *Most of them appeared to experience fear ...anxiety, hostility and...excitement* (Psychological manifestations)
- 107 ...*sometimes we resort to inflicting pain...* (Intervention)
- 108 *One of the students cried out loudly and staggered back and fell on the ground, screaming* (Index person)
- 109 ...*Others were also screaming and running away aimlessly* (Contagion)
- 110 ...*instructed the other students... to take her to the staff room. All other students were dismissed to their class rooms* (Separation of the affected)
- 111 *She has stricken me as a withdrawn student, who keeps to self and has very few if any friends* (Index person)
- 112 *She was powerful, trying to fight the boys; she looked "like wild"...foaming from the mouth, screamed like she was in pain...* (Physical manifestations)
- 113 *It lasted three days...the same girls who started were always among the group* (Duration and repetition by the same girls who started)
- 114 *We were really confused* (confusion/ psychological manifestations)
- 115 *It was total chaos* (Implications)
- 116 *Some employed home remedies of splashing water onto the affected student's faces and this worked wonderfully.* (Intervention)
- 117 ...*most of the students are always together; they formed a friendship...* (After effects/ friendship)

118 *Their performance declined...lacked attentions...shy since the occurrence...most students and teaching staff seem to shun them. I am busy trying to rebuild their self esteem.* (After effects to the affected)

119 *...it was witchcraft; others believed it was a curse to the parents...* (Beliefs/ cause)

120 *...they were being choked by an animal (thokolosi); they made choking sounds; some rolled eyes, some even formed froth around their mouths!* (Belief /supernatural)

121 *There were due to write some examination...teachers put pressure... on good performance.* (Stress)

122 *At the time two schools around our area had experiences of the event; it was given a high coverage by the media...* (Contagion)

123 *The religious group was suspecting "some bad/evil spirit"* (Belief/ evil spirit)

124 *There is so much drug abuse in our school, these abuse "matekoane (marijuana, glue, name it"... this could be the result of drug abuse.* (Belief/ substance abuse).

125 *There is no running away from it, it is part of culture...* (Cultural belief)

126 *The Missionaries...never were able to explain* (Beliefs)

127 *It is Fainting* (Triggered fear)

128 *...got scared when one class mate fainted* (After effect on others/ fear)

129 *She cried out loudly, she was "like wild", she was powerful and overpowered several boys...she wanted to run away.* (Physical manifestations)

130 *Somebody must have been jealous of the good performance we displayed and decided to bewitch us.* (Belief/ jealousy)

131 *I was overwhelmed by fear I have never experienced; I felt weak and dizzy; it felt like I was walking on air...I could see anything and I fell to the ground; I must have lost consciousness...* (Physical manifestations)

132 *I could not figure out what was happening...I was trembling with fear...* (Effect on others)

133 *One of us likened the day to "doomsday"* (Implication/Crisis)

134 *Nobody cared for other people...it was as if nobody saw other people; it was scary...* (Implication/ Confusion)

135 *I started believing in witchcraft...* (Belief)

136 *Both teachers and students hated me for partaking in the incident...after what happened I could see hatred...* (After effects)

137 *...some students called us names and mocked us* (After effects)

138 *This extended to the village...my stepmother gave me a good hiding... that I brought the family name into shame...* (After effects/ Stigma/ hiding; affected & family)

139 *so I was already upset and hardly slept or ate any thing...I felt weak and sleepy.*
(Physical manifestations)

140 *Emotionally I was hurting, angry, frustrated and helpless* (Psychological manifestations)

141 *Depression is contagious; whenever my class neighbor is upset and depressed I feel the same.* (Psychological manifestations)

142 *I also felt weak...like choking, unable to swallow...was hyperventilating and perspiring... lacked energy...tearful...I could not breathe easily... I had splitting headache, my heart beat was fast and I felt fatigued.* (Physical manifestations)

143 *I was scared, irritable...and lots of anxiety* (Psychological manifestations)

144 *Most people thought it could be bewitchment by jealous people... One o my mom's friend used "muti" to cause the illness* (Belief)

145 *...a faith healer, who said the illness is due to the "evil spirit"...* (Belief/ Cause)

146 *The team from the Mental Health department stated that it does not emanate from any supernatural forces.*

147 *...evil spirits and sorcery are mentioned in the Bible...you definitely will know that culturally those beliefs are acceptable; they are part of Basotho culture* (Cultural beliefs)

148 *Surely, I personally believe that some supernatural force...is at play here.* (Belief)

149 *I am sure that the stress we are under and the demands, especially the economic ones have attributed to the illness. This witchcraft business, I do not believe in...* (Belief)

150 *I personally, believe that the evil spirits exists* (Belief)

151 *We also felt ashamed* (After effects/ affected)

152 *this experience has brought us together, we are like a family, we have become friends.* (After effects /Friendship/ cohesion)

153 *I am now closer to my God, I pray more often than I used to; I have learned that if I have no answers God provides the answers and makes the impossible, possible. (After effects/ Strong Faith in God)*

154. *One thing that was common for most girls was that, their symptoms became worse if you prayed, they hated to hear Mary's or Jesus' names mentioned; they became wild, wanted to run away, fought who ever tried to hold them back. I tell you those girls, displayed such power, you could not imagine! They overpowered a bunch of men, like they were small boys; it was unbelievable! (Physical manifestations)*

155. *They spoke in different, strange languages; actually, they said what no one could understand. I do not think there such a language any where in the world, even though I do not claim to know all language (Neologism/ Psychological manifestations)*

156 *they are embarrassed by the whole situation, so I preferred not to ask them. (After effect /Embarrassed)*

157 *Most of them last a few days, say, about 3 to 5 days, in cases where it took longer. (Duration)*

158 ... *definitely the evil spirit and the Holy Spirit are in conflict; that is the reason they display such behaviors. (Belief)*

159 *There is a vast difference in girls and boys; most boys do not attend church like girls do, but, the woman folk are also weak in most instances (Why girls get affected than boys)*

160 *evil spirits and earnest prayer are not friends at all, prayer always supersedes; calling upon the names of Virgin Mary and her Son, Jesus; is all that will drive away the demonic power. In our church we have many things we use in prayer; such as holy water, rosary, miraculous metal, holy oil and special prayers such as the "Novena" just to mention a few. I tell you they do miracles! (Interventions)*

161...*the devil is the root of evil spirits and that the witches belong with him; so definitely these things are there...*

162 *Most of them fainted, rolled their eyes as if they were suffocating/ choking; tried to run away from soothing frightening... (Symptoms).*

163 *They looked like wild animals, they perspired, breathed heavily, “fought with all they had”; literally did not care if you were a man...some of them were calling names of some old women from the community! (Symptoms).*

164 *(granny...so and so...leave me alone). It was a very frightening sight to watch; you could see that they were fighting something ferociously. (Symptoms).*

165 *It is not the pupil they are after but, the families; if you really want to hurt the family go after the kid! (Revenge)*

166 *These people are so mean that they get gratification, when some people are unhappy, it makes them happy. (Revenge)*

167 *“A devil is fought with another devil; so I have my own means of fighting or counteracting the devil; we either use herbal medication or animal fat mixed with some concoction; that will sent back whatever “muti or thokolosi” that is causing trouble for children. This takes a very experienced healer to do, not a novice healer! (Intervention).*

168 *...because that was given to me by my late ancestors (Balimo); it therefore can not be disclosed for free; it is costs, actually, “one cow”...Some of these things can not be openly discussed, unless you are a traditional healer in training! (Reluctance to share information).*

169 *Most of them appeared to experience fear, some complained of anxiety, hostility and some form of excitement. (Emotional reaction)*

170 *They appeared to be thrilled by the situation they were in and draw other people’s attention and enjoyed (After effects).*

171 *Oh, sometimes we resort to inflicting pain, maybe giving them “a good hiding” (Intervention)*

178 *She laid down on the floor with her eyes closed...but the boys held her down, it was, I think five boys; she was she was prevailing over them; she was literally overcoming them.(symptom, extra ordinary physical strength)*

179 *She paid no attention to any body... fighting; until one of the teachers threw cold water on her face, she gave a sighing sound that is when she regained consciousness (Intervention)*

180 *more girls from her class room were carried into the room, displaying the same thing; I must have counted about eight ore nine of them. This was getting out of hand! I*

did not know what was happening; it really turned into a crisis. It was chaotic!
(Contagion and after effect)

181 *They kept their eyes closed, screamed as if they were in pain, fought furiously, some tried to get up and run away; while some sobbed quietly and tears ran down their faces; others made choking sounds, rolled down on the floor as if in pain.* (Symptoms)

182 *they displayed anxiety because they wanted to run away, maybe fear too.*
(Emotional symptoms)

183 *it could have been a result of something supernatural... may be witchcraft or evil spirit*(supernatural beliefs)

184 *some religious group prayed for them, one of them even advised us that we separate the affected kids from the unaffected; that they must not come to school unless they stopped the behavior; professional people from the department of Mental Health also visited and talked to both students and staff. So, I do not know what worked, in addition some of the sick students were taken for traditional treatment by their parents.* (Interventions)

185 *I found a number of students, all girls lying on the ground, some teachers and students, mostly boys were trying to help. I must have counted twelve or so girls.*
(Contagion)

186 *some were “fanning” fresh air for them; some were trying to give them water to drink.* (Interventions)

187 *It was total chaos!!* (Effect)

188 *it must have been twenty girls; mostly from the Form D class, only two girls came from different classes, one was in Form A while the other was in Form C* (Social relationship)

189 *I was now panicky, I felt helpless and worried that those girls would die in our hands* (Reaction)

190 *You see, some looked lifeless as they lay down; while some displayed aggression; they fought the boys that were helping them.* (Physical symptoms)

191 *Most of the girls were treated in the Out patient department; I think four of them were kept overnight. Those were badly affected* (Interventions)

192 *they fainted, they lost consciousness for sometime, they fell on the ground, some actually presented like being choked, rolling eyes, sweating profusely, some were breathless; saliva was dribbling from their mouths.* (Physical symptoms)

193 *there were those that became violent when they came round. They displayed a lot of power to the boys helping them to calm down.* (Physical symptoms)

194 *yes; it could have been a result of something supernatural.* (Supernatural beliefs)

195 *some religious group prayed for them, one of them even advised us that we separate the affected kids from the unaffected* (Intervention)

196 *there was political turmoil, the opposition parties had called for a “stay way”, I must say we were all scared about coming to school and the public transport was scarce; you had to be strong to come to work!* (What happened before the episode?)

197 *she is a very quite girl, she has very few friends, who are in her class. She is an orphan; her mother died two years ago, while she was in Form B; her father had already died when she came to our school. She lives with her aunt, who is not really giving her love* (Index person)

198 *lately her performance has declined* (After effect)

199 *It must have taken three days, as I said the first day was the worst , about twenty girls were sick; the following day it was a few girls, about six of them as some did not come to school, but no the third day, I think only two or three of them . It was short-lived.* (Duration)

200 *a priest was asked to come and pray for the students. He conducted a special Holy Mass for them; used some holy water and oil and asked all of us to pray for them.* (Intervention)

201 *the boys had made a big cross... this could have been “blasphemy”. Surely, one can play around but must not mess around with “Sacred” things, such as Heavenly entities. I have a feeling they stepped over-board I think evil spirit does exist; indeed, this could have overpowered them to have committed such an act* (Cause)

202 *The involved girls, I observed that, they were shy and ashamed unhappy. . It some how affected their grades negatively.* (After effects)

203 *It somehow affected their grades negatively. (After effect)*

204 *just before it occurred here we heard that it existed in two or three other schools around this district. (Contagion)*

205 *I think some of us got scared when one of our class mates fainted at the assembly before classes. (Trigger of event, do not know, may be fear)*

206 *Fear crippled everybody, who was watching, even teachers looked scared! (effect on audience)*

207 *she was like "wild", she was very powerful and overpowered several boys who tried to hold her down. She wanted to run away (Physical symptoms)*

208 *Somebody must have been jealous of the good performance we displayed and decided to bewitch us. (Witchcraft, bewitchment due to jealousy)*

209 *I was overwhelmed by fear I never experienced (Psychological manifestation)*

210 *I felt weak and dizzy; it felt like I was walking on air. (Physical manifestations)*

211 *I held onto the desks for support; my vision changed, I could not see anything and I fell to the ground; I must have lost consciousness because when I came around, I was in the staff room ((Physical manifestations)*

212 *surrounded by teachers, who threw water on my face (Intervention)*

213 *I became confused, I could not figure out what was happening, before I knew it, I was trembling with fear; I also fell to the ground. (Psychological manifestation on others, contagion)*

214 *I am not sure this happened or if it was an imagination, I think I saw a very bright light, like lightening, mind you it was not raining, and maybe this is what threw me to the ground. (Confusion, visual hallucination)*

215 *It was a different day altogether, everybody looked different and felt different, one of us even likened the day to "doomsday", like it was last day before the end of the world!! (Crisis)*

216 *it was scary!! I personally felt numb and unable to explain how I felt. (Confusion/ psychological manifestations)*

217 *I have never believed in sorcery but I could now imagine, yes, it is it, when I saw so many girls, me included, in such a state; I started believing it was witchcraft, I had no other explanation (Perception)*

218 *I felt like I was abandoning my religious beliefs (After effect)*

219 *I could see people abhorring me (After effect)*

220 *I had an urge to get away from the school premises, and the atmosphere was “spooky”. (Psychological manifestations)*

221 *Both teachers and students hated me for partaking in the incident. (After effects)*

222 *we were carrying a stigma of some sort (After effect)*

223 *Our teachers liked our class but, after what happened I could see hatred instead of the love they had shown. (After effect)*

224 *some students called us names and mocked us. (After effect)*

225 *Names such as “The possessed”, they gave us horrible looks and as you passed a group you could see that they were talking you. (After effect)*

226 *I remember one of the Form E students moved away from me in the school hall; all her classmates laughed. I felt really hurt. (After effect)*

227 *This extended to the village and my stepmother even gave me a good hiding, saying that I brought the family name into shame. (After effect)*

228 *It was a nasty experience for all of us. (After effect)*

229 *So I was already upset and hardly slept or ate any thing. Physically, I felt weak and sleepy. (Physical manifestations)*

Emotionally I was hurting, angry, frustrated and helpless. (Psychological manifestations)

230 *I also felt weak and I felt like I was choking, I was unable to swallow, even my own saliva was too much. (Physical manifestations)*

231 *I felt confused and was hyperventilating and perspiring. (Psychological manifestations)*

232 *I was scared, irritable and lacked energy to do anything. (Manifestations)*

233 *I felt weak and tearful; I could not breathe easily. (Physical manifestations)*

234 *I had a splitting headache and lots of anxiety, my heart beat was fast and I felt fatigued (Manifestations)*

235 *My stepmom thought I was faking illness, because I wanted to dodge work at home and deceive people that she was a witch. (Perception)*

236 *my mom consulted a traditional healer, who said that one of my mom's friend used "muti" to cause the illness, because her daughter dropped out of the school, while I am doing well in my studies. (Perception)*

237 *I had also consulted a faith healer, who said the illness is due to the "evil spirit", because I am a staunch believer in my church. (Perception)*

238 *a mental health team from Mohlomi Hospital and the National University of Lesotho, comprising of nurses, social worker and a psychologist visited the school (Who stopped the event)*

239 *they explained that it does not emanate from any supernatural forces; but, can be caused by many factors. This explanation brought relieve to us (Intervention)*

240 *evil spirits and sorcery are mentioned in the holy Bible; every Sunday priests and preachers talk about them, so I can out rightly say yes, I believe in them. (Beliefs)*

241 *you will definitely know that culturally those beliefs are acceptable; they are part of Basotho culture. (Cultural beliefs in supernatural powers)*

242 *you will see newspaper headlines like: "Thokolosi e patela bana sekolong" (A dwarf troubles school children); you also see some of the sick students "being choked by something" you can not see, you definitely say, this could have been the "thokolosi" referred to in the papers; I am not sure if you have any other explanation. Surely, I personally believe that some supernatural force maybe (Laughs) the dwarf is at play here. (Beliefs)*

243 *I am sure that the stress we are under and the demands, especially the economic ones have attributed to the illness. This witchcraft business, I do n't believe in, you know people will just pick on you for nothing; they will burn your house and say you bewitched some one, just because they hate you. I actually saw it happening with my grandmother, who was so sweet, she could not hurt even a fly; but she was accused of witchcraft; that's when I knew that it is something fake. (Belief)*

244 *I personally, believe that the evil spirit exists, I have had many stories and seen people involved in "Satanism", may be someone was trying to expose us to that, because I heard that a lot of what we, involved girls, did is what they also do. (Belief)*

245 *We also felt ashamed of our selves. (After effect)*

246 *this experience has brought us together, we are now like a family, we have become friends; because we have the experiences. (After effect)*

247 *This may sound funny, but, I am now closer to my God, I pray more often than I used to; I have learned that if I have no answers God provides the answers and makes the impossible, possible. (After effect)*

248 *in most if not all experiences, you will find that there is an evil spirit involved in all these incidences. Wherever there is disharmony you know that the evil spirit is involved. (Cause)*

249 *oh, there is competition to outshine each other in performance (Jealousy)*

250 *It is very easy to know such people; they present in a similar manner, for instance, they have convulsion- like signs, they faint, fall down, choke, froth at the mouth, some may even lose consciousness, some become very powerful, they are violent, they some times even speak in "tongues"; like they are possessed by the Holy Ghost in order to confuse the audience, the devil is very clever, you know. They also present with anxiety attacks, irritability, scream and cry persistently. (Evil spirit possession signs)*

251 *when somebody talks in tongues, people that are listening understand the message, even though they do not speak that language. (Speaking in tongues)*

252 *We faith healers have special talents or gifts from the Almighty that enable us to drive these spirits back to their owners; through faith and prayer. It is during such times that you lose your earthly being and you become a really servant of God; even what you say; does not come from you, but, from Him. You know, we all have the potential; but we do not use it fully; I tell you "Faith can move a mountain"; remember we were created in His image. "Prayer is our only weapon". We also are given powers by the church to exorcise the evil spirit. (Faith healers intervention)*

253 *to be honest with you I do not believe in such; I only believe that you are a witch if you are jealous of other people's achievements, you are unhappy and you break all the Ten Commandments. This to me a witch! (Non-believer of witchcraft)*

254 *It is something supernatural as their owner, Satan/ Lucifer; if you remember his is an angel; those are supernatural beings. Most of their actions are beyond a human*

understanding; this is what Catholic call “mysteries”, indeed, it is hard to explain. One thing you have to know is that mysteriously the evil spirit can invade anybody at any given time; how? I cannot explain! But, I can know when one is possessed. (Belief)

255 They fell down and you could see that they were busy fighting with the spirits. But, when they (spirits) left the child, you could see the calmness and the relief in their faces. However, they needed to be followed up either at home or in church; because, once a victim, you are prone to be a victim once more. (Symptoms during exorcism)

256 it occurred in boarding schools in all these missions and that all missions were girls' schools. (Setting)

257 some screamed as if they were in pain, some closed their eyes, and rolled down, some of them made suffocating sounds. One thing that was common for most girls was that, their symptoms become worse if you prayed, they hated to hear Mary's or Jesus' names mentioned; they became wild, wanted to run away, fought who ever tried to hold them back. I tell you those girls, displayed such power, you could not imagine! They overpowered a bunch of 3-5 boys. They had extra ordinary strength. They were like “wild animals. (Physical manifestations)

258 They spoke in a different language; actually, they said what no one could understand. (Psychological manifestation/ Neologism)

259 they are embarrassed by the whole situation, so I preferred not to ask them. (After effect)

260 Most of them last a few days, say, about 3 to 5 days, in cases where it took longer. (Duration)

261 some of these religions that are mushrooming are big problems; can you imagine a religion that will teaches its members to kill, to drink human blood? That in its self is “sickness”, I mean madness; there is so much brainwashing that such members can do anything! My personal stand is that most of these religious beliefs have a great impact to these occurrences in our schools. Here is a small girl that was born and bred in a Catholic faith suddenly, is confronted by “Satanism” faith, through peer pressure; definitely the evil spirit and the Holy Spirit are in conflict; that is the reason they display such behaviors. (Belief about the cause)

262 *There is a vast difference in girls and boys; most boys do not attend church like girls do, but, the woman folk are also weak in most instances.* (Belief about why it affects girls)

263 *calling upon the names of Virgin Mary and her Son, Jesus; is all that will drive away the demonic power. In our church we have many things we use in prayer; such as holy water, rosary, miraculous metal, holy oil and special prayers such as the "Novena" just to mention a few. I tell you they do miracles!* (Interventions)

264 *We all know and preach about it that the devil is evil and he is the root of the evil spirits and that the witches belong with him; so for definite these things are there whether we talk about them or not.* (Supernatural beliefs)

265 *Something strange was taking place at the school. He told me that students are behaving weird* (Episode description)

266 *There was confusion every where, parents stood watching.* (Effects)

267 *The girls were screaming, crying, some lay down, sprawling on the floor.* (Physical manifestations)

268 *It must have been about 15 to 18 of them; I could not believe it! Indeed, my daughter was among them.* (Magnitude)

269 *I heard a lot of noise, screaming, from the class room and some boys were restraining girls who tried to run away. Some girls lay down on the floor, rolling like they were in pain, some had fainted, like they had a seizure and were foaming from their mouths; they looked like they were being strangled.* (Symptoms)

270 *There were lots of rumors. One of them was that one woman who worked on the school grounds, confessed that she caused it through witchcraft.* (Rumors)

271 *Apparently out of jealousy because her daughter had been expelled from the same school for being pregnant; so she felt jealous that her classmates were progressing with their education.* (Cause)

272 *some of the girls in that group called out her name; that (Name) "Please, leave me alone, I do not want to come to you"; so this remained a puzzle to most parents; some wanted to attack her, but the priests advised that she needed prayers more than physical attack, as she was being used by the wicked one.* (After effect)

273 *The two go hand in hand; if you work for the evil one, you possess “his evil spirit, automatically, you are a witch and you practice witchcraft”. There is no doubt about it.*
(Belief in supernatural being)

274 *She became tired, she became mute, rolled eyes and fell down, maybe she was even unconscious for 2 to 3 minutes; she would not recall what had happened in those minutes.* (Daughter's physical symptoms)

275 *She looked sad, anxious and withdrawn.* (Psychological manifestations)

276 *I think prayers helped her; we prayed a lot, we used holy water and oil.*
(Interventions)

ANNEXURE J

SANGOMAS' PICTURE

Appendix J: Sangomas' picture



SANGOMAS' Picture ¹

¹<http://www.google.com/imgres?g=sangoma&safe=actbnh=189&tbnw=136&start=0&ndsp=20&tx=65&ty=139>. Accessed 21 May 2013.