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Conjuring Madness: Self/Non Self and Mental Illness in Post-Apartheid Namibia

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Il convient plutot de s'attacher à ce que signifie ?tre un homme, avant de problématiser la folie en terms de santé et maladie, Ludwig Binswanger, Le R?ve et l'Existence (1954)

On a cold winter morning I walked on Independence Avenue, Windhoek's main thoroughfare in the heart of the capital's central business district, with M. a young man whom I had known for some months. I felt slightly under dressed for the occasion. Partly because I wasn't prepared for the cold, and partly because M. was as always dressed very elegantly. On that chilly and windy morning, he was wearing a stylish blue velvet jacket, a nice red shirt, a pair of matching corduroy trousers, and some fine leather shoes. Wearing his sunglasses and his long dread locks, he stood out from the crowd and made, with his combination of vibrant colours, for a very visible and distinguished figure among the Windhoek morning crowd. As we walked along the street, M. greeted several people with his warm smile and strong handshake. This was sometimes accompanied with a joke that made people laugh. Sometimes he would also add a significant hand gesture. He would touch his chest with his fist and then reach out to his interlocutor with his hand, 'peace my brother', before departing. I asked him if the people he greeted along the way knew about his condition, and he said 'no, they don't'. I found this to be strange in light of what he had told me previously, but I decided not to question him further. We turned off Independence Avenue, and made our way to his office, located in a new commercial building where we sat down for a while. M. was diagnosed with bi-polar disorder, or manic depression, in the early 2000s. M. had told me how at the onset of the illness, he was taken to Angola by his mother, an Oshiwambo speaker who lives in the north of Namibia, to see an *onganga*, a traditional healer.[i] He recalled in graphic detail the way the *onganga* had attempted to treat him by administering a potent herbal brew. The brew, aimed to drive away the demons that possessed him, but as he told me 'just made me vomit and shit the whole day.' Shackled to a tree for most of the time he felt increasingly powerless and exhausted. He did not feel any improvement in his condition, but felt his body wasting away. So, after four weeks he told his family and the

onganga that he felt much better, 'I lied to them. I could not take it any longer'. The *onganga* smiled and told him he was free to go. As soon as he returned to his mother's village just across the border in Namibia, he jumped on a *combi* (a small twenty-seater bus) and travelled back to Windhoek. 'As soon as I got to Windhoek I was running wild again, taking my clothes off', he chuckled. He was apprehended by the police and taken to the Windhoek psychiatric ward- one of the only two psychiatric wards in the country- where he spent some time. After a few weeks he was sent back home. When he got home, he felt depressed and ashamed. He locked himself up in his room avoiding any contacts with friends and even family, 'I wanted to avoid everyone. I was afraid of the stigma. I was too ashamed'. He would only leave the house to collect his disability pension and the prescription drugs he had been given by the state psychiatrist to manage his condition. Then after some time, 'almost two years' he said, M. decided to get his life back on track. With the help of his elder sister he decided to send out his CVs to several companies in Windhoek. M. is a trained accountant with a University degree and he was soon hired by a local financial institution. M. has been working for this company for over a decade now. He told me that he manages his condition by taking his 'tablets' regularly and also by cultivating his passion for photography and art for which he has acquired a large following in the capital as a local emerging artist. M. appears regularly at all the openings of local exhibitions as the official photographer and also has held several exhibitions of his own. Most recently he has published a book. M. is a Rastafarian and attends a church in Katutura, Windhoek's largest and historical township. Moreover, M. has come out openly about his illness, giving interviews to local newspapers and appearing recently on television in the course of the celebration for mental health day held at Windhoek central Hospital.

In many respects, M.'s story is no different from that of many other people who live with mental illness and who go to great lengths to manage their condition. M.'s is undoubtedly a story of pain and hardship, of fear and exclusion, of living and successfully coping with the illness, of survival and resilience in the face of a life changing condition and in a context where the treatment of mental illness for the great majority of Namibians remains woefully inadequate (WHO 2005). M. has only had one therapy session with a clinical psychologist over the last fifteen years. Nearly three decades after Independence in 1990, mental health provisions in Namibia remain at the bottom of the national health budget, despite the call from local practitioners to address the soaring statistics on suicide and alcohol abuse and the legacies of the violent and traumatic colonial past that impinge on postcolonial Namibia (Fenwick 2002; Whittaker 2015).

But this story is not devoid of its own ambiguities and for this reason it cannot simply be reduced to the effective or ineffective management of

M.'s condition. In a sense we cannot begin to problematize M.'s illness narratives in terms of illness and health, unless we understand first what it means for M. to be human (See Azorin 1984; Binswanger 1954). This because M.'s narrative and practices revealed also a great deal about his efforts to escape dehumanisation and alienation from kin and to establish and maintain social relations. And M. did so through an incredible effort at self-fashioning and self-making, but also, and this was one of the things that had intrigued me the most about him, at what I would call here, (un)self-(un)making. I am here borrowing from David Napier's idea of self/non self (2003), as the ways in which the self makes and unmakes itself through a non-self. It is through this creative process of loss and recovery of the self, argues Napier, that the self is able to manage the dangers that comes with an illness (see also Stoller 2009). I will return to this point later in this paper.

From the conversations and encounters I had with M. I realised that M.'s efforts to remain human required a complex balancing act between self and non-self. It was an acrobatic exercise, between the efforts at carving out a space for distinction and visibility. M. told me repeatedly how he loved dressing up in flamboyant colours and in very fashionable attires, in order to stand out from the crowd: 'to be seen from far. I want people to see me when I approach them'- whilst at the same time anchoring the self firmly within meaningful social relations. His balancing act aimed at reconciling and nurturing the multiple social fields, of self and others that his illness had threatened to sever and thus consign him to an almost inevitable social death (Myers and Ziv 2016).

Whilst stigma and exclusion remain central to the experience of mental illness in most social and cultural contexts, mental illness, *eemwengu*, is directly associated in the context of Oshiwambo sociality with the idea of social death, with exclusion and isolation, and with the term used to describe a person with mental illness, *omunanamwengu*, the mad one, standing metonymically for the other. In this sense mental illness is here the non-self *par excellence*.[ii] As Bartholomew (2017) shows in a recent study on mental illness among Oshiwambo speakers,

> 'Using *omunanamwengu* to describe a person is "offensive because someone [tells] them, like, you are a person of a different group. You are saying [they] are not part of everyone." Members of the focus group and other participants noted that *omunanamwengu* men and women are treated extremely poorly and reiterated the insulting nature of the label. The "whole life of a person is lost" as a result of being mentally ill and isolated, which stems from an ascribed state of otherness to those with *eemwengu,*' (2017: 429)

In a previous conversation M. recalled a story from his childhood that had a lasting impact on him and on his subsequent management of his illness. When M. was a child he lived with his father in the family home in Katutura, Windhoek. This is the house he still lives in with his siblings. M. told me that a paternal relative, 'I called him uncle, but he wasn't a real uncle', used to live with them. But unlike any other member of the family, he lived outside in a shed with the dogs. 'He would eat and live outside… he would go off for days… one day he left and never came back'. Watching his uncle live outside with the dogs, made him very sad. He remembers as a child asking his father about the uncle, but his father did not give him a straight answer. 'It is only now that I live with mental illness that I understand. He was also ill. This is what our people do to us. They put us outside, in shacks and huts in the courtyard to live with the dogs. I don't want that for people with mental illness. It is very bad'.

Managing one's illness and escaping stigma are central to the experience of mental illness (Goffman 1963; Holmes and River 1998). This requires on the parts of patients, the management of a complex process of denial, silence, isolation and self-exclusion. Certainly this was the case among most of the people I worked with in the course of my project, some of whom guarded and protected their diagnosis from as many people as possible, even their significant others. As M.'s biography illustrates, denial, silence, isolation, and self-exclusion also characterised his experience in the past, as they do in the present. M. guarded his condition from others and was very reluctant, at first, to speak to me about his illness and take part in my project. However, unlike the other people I met in Windhoek, M. had publicly acknowledged his condition; he had given interviews and spoke on national television about his illness. The fact that he had been diagnosed with mental illness was widely known among friends and acquaintances in Windhoek. M. also campaigned actively for the Namibia Mental Health Association, a voluntary organisation led by patients and mental health practitioners. So in M.'s experience was not marked by denial and silence, but by the opposite strategy. M. undertook a creative process, a difficult balancing act between self and non-self, through which his illness became confined to a mythical place.

Here I want to draw again on the work of David Napier. In the *Age of Immunology (2003)*, Napier demonstrated how the self/non-self opposition is foundational to our understanding of the relationship between self and other. In particular, in building largely on his observation on ritual healing practices in Indonesia, Napier suggests that it is possible to create a safe self that is immune from the dangers of otherness, only if the dangerous non self, is either marginalized or destroyed. In M.'s case the dangerous non-self—his madness—is not simply contained through medication, but through a creative process of self-making that confines the non-self to the margins of a mythical world. M. does not deny the existence of his illness,

but he rather confines it within what it means to be human in local Oshiwambo idioms of sociality.

Sitting in his office, I spent time with M. going through the photographs I asked him to take as part of a photo elicitation project I conducted with him and other patients. Among his pictures there were a number of photographs he had taken with friends and neighbours. I asked him who they were and if they knew about his illness.

> ‘No they do not know. They can’t believe it. If you tell them M. is mad they would not believe you. They see me doing so many things. I work, I take pictures, I do my art, and I also have children. For them my illness is the stuff of dreams.’

In this sense M. mediated and managed his illness through a very complex process of individuation and socialisation. Whilst stigma excludes the ill, and medicalisation pushes an individual to the personal daily management of the illness through medication, M. escaped exclusion by anchoring his illness and its negation within social relations. In the context of Oshiwambo sociality, the rupture caused by mental illness, must be avoided with an effort at preserving ones social fields turning madness into something so unique and visible, that it almost becomes mythical. One could think of this process as the reverse of delusion, one of the symptoms often associated with bi-polar disorder. M.’s words and actions are not those of a delusional subject. His visibility and efforts at standing out are not driven by grandeur, detachment from reality and the denial of one’s illness. On the contrary they are the product of a combined effort at *autopoiesis*, the making of the self (Toren 2012), and what I call here *auto-mytho-poiesis*, the making of a mythical self that helps confines the non-self in the realm of dreams. M. acknowledges his illness, he speaks about it publicly, and yet his efforts at standing out and being visible are what make his audience doubt his illness. M. is a conjurer of madness. He confounds his audience through revelation, and yet his process of self-making, leave the audience dazzled and incapable to believe that who they see is someone affected with mental illness.

I here want to argue that this process is akin to what Napier refers to in *Foreign Bodies* (1992) as selective dissociation. In starting from the recognition that illness is a negotiated event, ‘getting better’, especially he argues in non-Western context, ‘is itself a creative, even artistic, process, in which new categories are created’ (1992:196). This process of change, the dynamic and transformative engagement with illness, Napier argues, is possible through a creative, constructive loss of self, or what Napier calls selective dissociation. But rather than seeing selective dissociation, as another form of pathology, as the complete damnation of

the self, as it is understood in much of Western psychoanalytic thought, selective dissociation is the ways in which the individual overcomes uncertainty through a deliberate letting go:

> 'since illness can be defined only as an absence of a condition of well-being, this goal such dissociative states is not the self-conscious reflection of one's disability-it is not, in other words, always to be found in the 'support group', in which aberration has a certain normality- but the goal is to find the strength to place one's illnesses in the context of that condition of well-being, whatever it may be in a particular social context.' (1992: 198).

Faced with the uncertainty that comes with the diagnosis of mental illness, M. has worked hard to locate his illness in the context of the condition of wellbeing, of what it means to be human in contemporary Namibia. And this process must require daily efforts at the process of self-making and (un)-self (un)-making, as the ultimate balancing act between self and non-self.

Since I left Windhoek in August 2017 I have remained in contact with M. We exchange daily messages on WhatsApp. He sends me regular updates and pictures of his latest achievements: the video and photographs of his latest exhibition and book launch; his public speech at the mental health day; and the pictures of M. donating copies of his book to local libraries and of his art works hanging on the walls of governmental offices. I send him congratulatory messages and he responds almost invariably, with the following line, 'It is hard…but I must carry on'.

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Notes

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[i] I here use the term Oshiwambo as a general ethnic identifier of various ethnic groups whose dialects can be grouped under this term. Most notably among these ethnic groups are the Ova-Kwanyama, Aa-Ndonga, Aa-Mbalanhu, Aa-Ngandjera and Aa-Kwambi.

[ii] Among Oshiwambo speakers, and most widely in Namibia, mental illness is understood as a social illness and as such it requires treatments that are aimed at restoring the social issues underlying the illness.

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