Zar Culture and Psychopathology

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Abstract

Zar is a culture-bound syndrome of possession and a folk healing practice still prevailing among women in Sudan. The study attempts to delineate the main socio-demographic and clinical characteristics of female psychiatric patients who practice Zar. The design is that of a Case-Control. The study involved 819 women aged 40-54 years consecutively reporting for treatment at the Clinic for Nervous Disorders in Khartoum North, Sudan between 1973 and 1983. The patients who had attended Zar were assigned to the Zar Group, the others - to the Control Group. Inter-group comparisons included a wide range of demographic and clinical variables, using bi-variate and multi-variate statistical methods. The variance of therapeutic response to Zar with the clinical diagnosis was also tested. Zar Attendance was reported by 287 (35%) of all patients. Zar was most common among patients of rural origin, low education, poor occupation, singleness or divorce, family history of Zar, and enduring stressful life events, including marital dissatisfaction, infertility, child loss, inter-personal conflicts and chronic somatic ailments. Both Zar attendance and favorable response to it were most typical of patients with Conversion/Dissociative Disorders, and to a lesser extent Anxiety Disorders. Conclusions: Zar in Sudan is mostly prescribed for psychogenic reactions to prolonged psychosocial stressors, particularly in individuals prone to Conversion/Dissociative Disorders. The phenomenological parallels between personality switches during Zar trance and Dissociative Identity Disorder need further studies

Introduction

Zar is an ancient healing practice based on a folk belief in possession by alien spirits as a cause of disease, and in the possibility of curing such a disease by ceremonial placation of the possessing spirits (Lewis, 1986; Boddy, 1989).

The word "Zar" itself is variably used to denote a type of spirit, the illness that such a spirit can cause by possessing humans, and the rituals necessary for pacification of these spirits (Sargant, 1957; Opler, 1959; American Psychiatric Association, 1994). Most Zar attendants develop a long-term relationship with the possessing spirits (Leff, 1988; Lewis, 1986), for management of possession is usually an on-going process of spirit socialization and human accommodation (Boddy, 1989). The cult is found in many countries of Africa and Middle East, including Sudan (Greenberg, 1946; Zenkovsky, 1950; Barclay, 1964; Cloudsley, 1983; Constantinides, 1985; Boddy, 1989), Egypt (Okasha, 1966; Kennedy, 1967; Fakhouri, 1968; Nelson, 1971; Al-Masri, 1975), Ethiopia (Plowden, 1868; Trimingham, 1952; Messing, 1958; Giel et al., 1968; Young, 1975), Somalia (Lewis, 1986), Algeria, (Cloudsley, 1983), Morroco (Crapanzo, 1973), Arabia (Trimingham, 1968) and Iran (Modarressi, 1968). Variants of essentially the same cult under somewhat different names are found in many other countries of the

neighbourhood, including Nigeria (Tremearne, 1914; Smith, 1954; Onwuejeogwu, 1968;Besmer, 1983), Kenya (Gomm, 1980), Tanzania (Gray, 1969), and Zambia (Colson, 1969).

Other forms of culture-bound possession states have been reported from other parts of the globe (Kiev, 1961; Yap, 1967 and Wijesinghe et al., 1976). Lewis (1986), Boddy (1989), Constantinides (1985), Kennedy (1967), and Al-Masri (1975) have made detailed descriptions of Zar ceremonies and rituals. In all these studies Zar clients were reported to be predominantly females of middle age, with enduring socio-economic, psychosocial and interpersonal problems.

This female preponderance is not peculiar to Zar; it is common to virtually all known forms of spirit possession worldwide (Ivens, 1927; Hogbin, 1934; Fortune, 1953; Elliot, 1958).

Interest in the subject has been ignited by the writings of early Western explorers, travellers and colonial staff (Plowden, 1868; Tremearne, 1914; Greenberg, 1946; Trimingham, 1949; Messing, 1958 and others).

Most serious works on Zar were written from anthropological and socio-cultural perspectives, while the contributions of mental health professionals were scanty and limited to uncontrolled descriptive case series and speculative over-views.

An epidemiological survey of a newly urbanized part of Khartoum in Sudan found that 32 percent of the interviewed mothers of 3-15 years old children considered Zar a beneficial form of treatment (Rahim and Cederblad, 1986).

This study hypothesized that Zar clients may have significant differences from their controls, and that these differences would be related, on the one hand, to prevailing socio-cultural attitudes towards Zar, and, on the other hand, to the actual or assumed efficacy of Zar as a treatment for certain psychological problems.

In a preliminary communication (Rahim, 1991) we showed that 287 out of 819 (35 percent) of 40-54 year old female psychiatric patients consecutively presenting for treatment under our supervision at the Clinic for Nervous Disorders in Khartoum North, Sudan, during the ten-years period 1973-1983 had a history of Zar treatment. Comparative bi-variate analyses revealed statistically significant associations between Zar attendance and some socio-demographic and clinical characteristics, namely rural residence, low patient's and husband's education, unemployment, low socioeconomic class, enduring psychosocial stressors, ailing physical health, family history of Zar, as well as suffering from non-psychotic mental disorders. Since then, further follow-up data were collected; psychiatric diagnoses were revised according to ICD-10 criteria; computer-assisted bi-variate and multi-variate analyses were performed. The present paper is comprehensive update of findings.

Aim of the Work

The aim of the present study is to explore the socio-demographic and clinical correlates of Zar attendance among a high-risk group of middle-aged female psychiatric patients as compared to a control group of other patients of the same sex and age simultaneously reporting for treatment at the same facility.

Method

The study design was that of a Case-Control. Zar Attendance was taken as an outcome variable according to the presence or absence of which the study population was divided into two groups - Zar and Control groups. All the female patients in the age range 40 - 54 years who reported for treatment at our psychiatric outpatient unit in Khartoum (North Sudan) during the ten years period 1973-1983 were prospectively enrolled in this study.

A detailed semi-structured questionnaire was used to gather information about various demographic, social, cultural and other aspects of the patient's life.
The psychiatric interview covered the presenting complaints, family and personal history, past medical and psychiatric history, premorbid personality, and physical and mental state examination. Inquiry about participation in Zar included the purpose, occasion, manner, frequency and response. Each patient was followed up for five years after inception; novelties, changes and outcomes were documented.

Operational Definitions:

Zar Attendance:

For the purpose of the present study, "Zar Attendance" is used as a dichotomous variable attesting the categorical presence or absence of resort to Zar as a therapy.

The latter was specifically defined as any involvement in a Zar ceremony with the intention of getting a relief from what the patient or others, usually relatives, perceived as an illness. Visits to Zar out of mere curiosity, for recreation, or simply escorting another person did not count.

Zar Visits:

This term is applied here to denote the total number of occasions in which the subject participated in Zar ceremonies. Participation counted if the subject had attended a whole session or experienced a state of being possessed by a Zar spirit. Mere presence at the site of a Zar activity or catering for participants in a relative's Zar ceremony was not considered.

Response to Zar:

This was operationally categorized as good, moderate, doubtful or absent. The determinant criteria were: subjective feelings, objective observations and "Professional" judgement. *Subjective feelings* were considered positive if the patient herself admitted that Zar had actually helped alleviate the symptoms for which she sought Zar treatment, or if she did identify herself as a Zar patient observing Zar rituals. *Objective observation* was positively scored if key informants in the patient's family circle were convinced that the patient's illness had actually responded to Zar therapy. The *"professional" judgment* was considered positive if the Zar Sheikh (Healer), on the basis of his "diagnostic" tests, formally labeled the patient as Zar possessed, implying that Zar therapy was indicated. If all the three criteria were fulfilled, the patient's response to Zar was considered "good"; if two: "moderate", if one: "doubtful" and if none: "absent".

Socio-economic Standard

For practical purposes, socio-economic standards of families were divided into three levels: low, middle and high. *Low income families* were defined as those, whose income barely covered their basic needs for food, dress and shelter; and where

any unforeseen expenditure or emergency would have critically upset the family budget to an extent that necessitated external help. *Middle income families* were those, whose resources exceeded the immediate requirements of daily living, allowing for modest complementary acquisitions or petit savings, but could yet have become seriously strained on such occasions of excessive financial demands, as wedding festivities, residential moves, unpaid leaves, expensive medical treatments, etc. *High income families* were categorized as those who lived in a relative abundance of resources, with no realistic fear of a forth-coming financial constraint.

Albeit crude and arbitrary, this operational categorization was found, under the circumstances, both appropriate and feasible.

Diagnostic Groupings

Psychiatric diagnoses were initially made according to ICD-9. This resulted in a thin distribution of cases over the whole spectrum of individual diagnostic entities. Meaningful statistical computations demanded the regrouping of disorders into a few major diagnostic sections, namely: Anxiety Disorders, Mood Disorders, Conversion/Dissociative Disorders, Adjustment Disorders, Schizophrenia, Organic Mental Disorders, and a residual category of Miscellaneous Disorders (American Psychiatric Association, 1977).

Sample Size:

In all, there were 987 female patients in the age range 40 - 54 years. Of these, 148 cases could not be assigned to either Zar or control group because of incomplete information. Obviously, these cases had to be excluded from the comparative study. Scrutinizing the relevant available data about these cases, they were judged to be of a random distribution that could not have significantly depreciated the representative nature of the remaining sample. Out of the valid 819 cases, 287 (35%) satisfied the criteria for inclusion in the Zar Group. The remaining 532 cases were assigned to the Control Group.

Data Analysis:

Data entry and analysis were performed by SPSS/PC+ (version 4) statistical package, including Student's t-Test and F value for comparing means and regressions of continuous variables, chi-Square for contingency tables of cross-tabulated nominal and ordinal variables, logistic regression for multi-variable analysis of variables contributing to the prediction of Zar attendance, and multiple regression to determine the individual contribution of independent variables to the explanation of the variance in the frequency of Zar Visits. Only data that reached statistical significance at the level of $p < 0.05$ are reported.

Results

Comparison of Groups: As the age range of 40 to 54 years was a criterion of inclusion in this study, there was no statistically significant difference in mean age between the Zar and Control Groups (47.02 and 46.73 years respectively).

For brevity the main findings are provided here in tabular form. As seen in Table (1), a significantly greater proportion of patients in the Zar Group was found to be of rural origin than were those of the Control Group.

Regarding education, patients in the Zar Group were significantly lower in educational level than their controls. They had higher rate of absolute illiteracy, and lesser number of completed grades. None of the 8 university graduates fell in the Zar Group. Most of the patients in both groups reported no outdoor economic activity. This unemployment was significantly more characteristic of the Zar Group.

Among those who were enrolled in gainful occupations Zar patients were more frequently of lower job status. The marital status of patients in the Zar Group was characterized by a higher frequency of being single, separated or divorced. Those of them, who were married, had less educated husbands.

The economic standard of the families of Zar patients was most frequently middle one. They were significantly under-represented in both the higher and lower economic levels.

Clinical characteristics: The distribution of cases according to psychiatric diagnoses is provided in Table (2).

In comparison with the Control Group, Zar patients had significantly higher frequencies of conversion disorders, anxiety disorders and mood disorders with correspondingly lower frequencies of adjustment disorders, schizophrenia and organic mental disorders.

A wide variety of stressful personal and inter-personal problems were reported by patients in both the Zar and control groups, each patient expressing her difficulties in her own words. As shown in Table (3), Zar patients had higher frequencies of various long-term psycho-social stressors (somatic illness, remaining single beyond conventional age of marriage, divorce without remarriage, being childless due to infertility or child loss, marital difficulties or other inter-personal conflicts).

Logistic Regression:

Zar Attendance as a dichotomous dependent variable was entered in a logistic regression equation with the independent variables, which in bivariate analyses had shown significant difference between Zar and control groups.

Table (4) summarizes the results of the Logistic Regression (forward stepwise Wald method). Some independent variables (patient's occupation, husband's education, and economic standard) did not contribute significantly to the prediction of Zar attendance and were rejected by the regression equation.

The remaining variables which showed significant predictive contribution were enduring psycho-social stressors (11 times more likely to fall in the Zar Group than otherwise), rural residence (more than twice), low educational level (about twice), being divorced or separated (about twice), and having family history of Zar (about twice). Regarding diagnosis, patients who had conversion/dissociative disorders were 4 times more likely to belong to the Zar Group, and, on the contrary, Schizophrenia was only about half as likely.

Table (1) Demographic characteristics of Zar and Control groups: N(%)

Total	Zar Group (819)	Control Group (n=287)	(n=532)
Residence *			
Rural	499 (60.9)	221 (77.0)	278 (52.3)
Urban	320 (39.1)	66 (23.0)	254 (47.7)
*Education***			
Illiterate	442 (54.0)	173 (60.3)	269 (50.6)
Elementary	197 (24.1)	75 (26.1)	122 (22.9)
Intermediate	106 (12.9)	28 (9.8)	78 (14.7)
Secondary	66 (8.1)	11 (3.8)	55 (10.3)
University	8 (1.0)		8 (1.5)
*Occupation****			
Nil	479 (58.5)	186 (64.8)	293 (55.1)
Unskilled	67 (20.4)	61 (21.2)	106 (19.9)
White Collar	135 (16.5)	28 (9.8)	107 (20.1)
Other	38 (4.6)	12 (4.2)	26 (4.9)
Social Status**			
Single	66 (8.1)	31 (10.8)	35 (6.6)
Married	559 (68.3)	163 (56.8)	
Separated	137 (16.7)	63 (22.0)	74 (13.9)
Divorced	41 (5.0)	23 (8.0)	18 (3.4)
Widow	16 (2.0)	7 (2.4)	9 (1.7)
Husband's education***			
Illiterate	90 (11.0)	41 (14.3)	49 (9.2)
Elementary	339 (41.4)	135 (47.0)	204 (38.3)
Intermediate	210 (25.6)	61 (21.3)	149 (28.0)
Secondary	156 (19.0)	44 (15.3)	112 (21.1)
University	24 (2.9)	6 (2.1)	18 (3.4)
Economic Status			
High	92 (11.2)	27 (9.4)	65 (12.2)
Middle	324 (39.6)	148 (51.6)	176 (33.1)
Low	403 (49.2)	112 (39.0)	291 (54.7)

*Chi-sq.=47.96;df=1;p< .00001, *1Chi-Sq.=21.63; df=4; p}.001, *2 Chi-Sq.=15.51; df=3; p}.01, *3 Chi-Sq.=28.35; df=4; p<.0001, *4 Chi-Sq.=15.36; df=4; p<.01, *5 Chi-Sq.=26.72; df=2; p<.00001

Table2: Psychiatric Disorders in Zar and Control Groups : N (%)

Disorder	Total N=819	Zar Group N=287	Control Group N=532
Conversion/Dissociative	90 (11.0)	66 (23.0)	24 (4.5)
Anxiety Disorders	164 (20.0)	73 (25.4)	91 (17.1)
Mood Disorders	122 (14.9)	52 (18.1)	70 (13.2)
Schizophrenia	90 (11.0)	25 (8.7)	65 (12.2)
Organic M. Disorders	99 (12.1)	17 (5.9)	82 (15.4)
Adjustment Disorders	79 (9.6)	13 (4.5)	66 (12.4)
Miscellaneous disorders	175 (21.4)	41 (14.3)	134 (24.6)

Chi-Sq.=105.85; df=6; p<.00001

Table 3: Psycho Social Stress Among Zar

	Total	Zar	Control	Sig.
Somatic Ill-health	146 (17.8)	87 (30.3)	59 (11.1)	p<.001
Harsh/insensitive husband	150 (18.3)	83 (28.9)	7 (12.6)	p<.001
Polygamy	111 (13.6)	59 (20.6)	52 (9.8)	p<.01
Unwanted marriage	112 (13.7)	50 (17.4)	62 (11.7)	p<.05
Disabled husband	82 (10.0)	46 (16.0)	36 (6.8)	p<.05
Infertility	63 (7.7)	35 (12.2)	28 (5.3)	p.<01
Never married	66 (8.1)	31 (10.8)	35 (6.6)	p<.05
Divorced	41 (5.0)	23 (8.0)	18 (3.4)	p<.05
Conflicts with relatives	54 (6.6)	23 (8.0)	31 (5.8)	p<.05
Mean No. of stressors	0.97	1.52	0.67	p<.01

Table 4: Logistic Regression of Zar Attendance* on independent variables.

Variable	B	S.E.	Wald	Sig	R	Exp (B)
Enduring Stressors	2.4108	8452	8.1352	0043	0810	11.1432
Conversion/Dissoc.	1.4704	1816	65.5661	0000	2607	4.3509
Schizophrenia	7935	1837	18.6532	.0000	1334	.4523
Family History	.6040	1891	10.1999	0014	0936	5466
Rural Residence	0.7846	1829	18.4028	0000	.1324	2.1916
Patient Education	0.6590	1789	13.6765	0002	1117	1.9328
Separated/Divorced	0.6749	1908	12.5088	0004	1060	1.9639
Constant	1.3809	1931	51.1174	0000		

* Zar Group=1, Control Group=0.
-2 Log Likelihood Chi-Sq. =762.518; df=713; p=.0269
Model Chi-Sq =172.766; df=7, p=.0000Goodness of Fit =719.844; df=713; p=.4218

Table 5: Response to Zar Treatment According to Diagnosis

Diagnosis N=78	Good N=59	Moderate N=32	Doubtful N=118	Absent
Conversion/Dissociative	72.7	22.7	3.0	1.5
Anxiety Disorders	30.2	35.6	16.4	17.8
Mood Disorders	0.0	7.7	7.7	84.6
Schizophrenia	0.0	0.0	8.0	92.0
Organic M. Disorders	5.9	5.9	5.9	82.3
Adjustment Disorders	15.4	53.8	15.4	15.4
Miscellaneous disorders	12.2	2.05	1.2	

Chi-Sq.=201.53; df=18; p<.00001

Table 6.Multiple Regression of Response to Zar

Variable	B	S.E	Beta	T	Sig. T
Conversion/Dissoc	**223090**	**032060**	**279589**	**6.958**	**0000**
Divorced/Separated	**090761**	**016241**	**233869**	**5.588**	**0000**
Enduring Stressors	**306114**	**061280**	**198122**	**4.995**	**0000**
Age of Onset of Zar	**097607**	**023059**	**173766**	**4.233**	**0000**
Family History	**127747**	**037684**	**148442**	**3.390**	**0008**
Grades of Education	**039076**	**013850**	**125034**	**2.821**	**0050**
Constant	**380680**	**285858**	**1.332**	**1836**	

Multiple R = .58986, R Square = .34794, Adjusted R Square = .33413, Standard Error = .61975
F = 25.18599 , Sig. F= .0000

Zar Visits

In the Zar Group 93 out of 287 (32.4%) of patients attended Zar only once, while 133 (46.3%) did so 2-5 times and 61 (21.3%) more than 5 times. The mean patient's age at the time of first Zar attendance was 31.59 years, with most patients (62.1%) between 26 and 35 years and only very few patients (4.2%) below 20 or above 40 (8.0%).

The mean duration of time elapsing since the patient's first Zar attendance till the time of the investigation was 15.43 years. Zar was rarely (1.3%) the patient's first attempt to get some help from her illness. Most of these patients (71.8%) reported having been to several physicians and received some medications for what had been variably diagnosed as anemia, nervous exhaustion, malaria, migraine, gastritis, irritable bowel, rheumatism, etc. On the other hand, three quarters of patients (75.8%) had been to religious, faith healers, who usually treat patients with verses from the Holy Quran.

One third of the patients (33.8%) had consulted other traditional healers, like herbalists, bonesetters, native physiotherapists, soothsayers, exorcists. By

the time of embarking on Zar therapy 71.2% of patients had lost confidence in all other treatment modalities.

Response to Zar

The outcome of Zar therapy was extremely variable (Table 5). Only one quarter of patients reported good response, a fifth reported a moderate one, about a tenth were doubtful, and the remainder 43.9% showed no response to Zar.

This variance in response to Zar proved to be most closely related to the nature of the psychiatric disorder. Patients with conversion/dissociative disorders were the best respondents, followed by patients with anxiety and adjustment disorders.

On the other hand, the bulk of patients with schizophrenia, affective disorders and organic mental disorders did not exhibit a worthwhile response to Zar.

Multiple Regression:

Response to Zar, as a continuous dependent variable (scored 0-3), was entered in a multiple regression equation against a collection of all the independent variables, which had been significantly associated with it at the level of bi-variate analysis.

As seen in Table (6) the factors which made statistically significant contributions to the explanation of the variance in response to Zar were (a) having conversion/dissociative disorders (b) having severe psycho-social stressors (c) being divorced or separated (d) early age of onset of resorting to Zar (e) family history of resorting to Zar (f) low level of education.

These factors collectively explained one third of the total variance in the Response to Zar (R square= 0.34794).

Discussion

Limitations of the Study: The study was limited to female patients of a specific age range, attending a psychiatric clinic for what had been taken to be mental disorders. This contingent does not include those Zar attendants in the community who either did not have mental disorders, or had them but did not seek treatment for them at our psychiatric facilities.

Thus, our sample does not represent the total population of Zar attendants in the community. Data drawn from this sample can neither estimate the over-all prevalence of Zar in the community, nor reflect the full spectrum of psychological and social phenomena, which may be associated with Zar. Our data miss the Hidden Psychiatric Morbidity" and under-represent the "Minor Psychiatric Morbidity" (Goldberg and Huxley, 1980). Yet, choosing middle-age women enabled us to reach a substantial proportion of Zar attendants; and carrying out the study in a medical setting provided an opportunity to interview, examine, investigate, diagnose, treat, as well as follow-up the subjects. This would not have been achieved through field- work. The two groups, matched for sex and age, were drawn consecutively from the same pool of patients reporting for treatment in the same facility at the same time. As they were dichotomized according to a singular criterion of Zar attendance, any significant differences between them are likely to be of some relation to Zar.

An initial finding was that, one out of every three middle-aged female psychiatric patients had resorted to Zar with therapeutic intentions. This seemingly high rate of Zar was not unexpected. Boddy (1989) has carried out extensive epidemiological field-

work on Zar in a rural Sudanese community, and reported a prevalence rate of Zar in the range of 42 - 47 % of all women in the village who were ever married. In our study, we found higher frequencies of Zar associated with rural residence and low level of education. This finding supports earlier reports (Lewis, 1986; Boddy, 1989; Baasher, 1961; Barcley, 1964 and others). The preponderance of Zar among the less educated may be related to their stronger adherence to mystic heritage. The Western-trained intellectuals ridicule Zar as a superstition, incompatible with scientific reasoning; and religious scholars denounce Zar as a heretical "innovation", inconsistent with fundamental Islamic teachings (Lewis, 1986; Boddy, 1989). In bi-variate analysis Zar was found more frequent among patients from middle rather than high or low family standard. Perhaps, women from rich families have other channels of airing their grievances and of obtaining some satisfaction (Lewis, 1986); the poor can not afford the heavy expenses of Zar ceremonies (Boddy, 1989). The latter estimated the expenses of Zar in Sudan to be in the range of 50 -100 USD in rural areas and more than 500 USD in the city, representing three to five times the monthly income of an average town dweller, and about one third to one half of the expense of a wedding. Family history of Zar contributed significantly to the explanation of the variance between patients in the Zar and control groups. Relatives of Zar patients are more likely to be exposed to the concepts, lexicon and rituals of Zar. Suggestion plays a role; older patients act as prototypes. Many patients related their first Zar trance to their watching a Zar performance for a relative at home. Another set of factors determining Zar Attendance concerns the nature of psychosocial problems in the life of patients. The chronic type of upsetting situations was found to be significantly more frequently associated with Zar attendance than acute life events. These findings support most previous reports. Constantinides (1985) interviewed sixty Zar clients to find that thirty-one of them linked the onset of Zar to an antecedent social crisis, mostly falling in clusters related to marriage, fertility, childbirth, or death of kin. Boddy (1989) found in Zar clients significantly higher frequencies of divorce, multiple marriages, co-wifery, infertility and childlessness through loss. Lewis (1986) testified that in every example known to him there was some grudge against the spouse. According to him, the typical Zar client is a hard-pressed woman struggling to survive in a harsh environment, liable to neglect from the husband, or subject to jealousies and tensions of polygamy and divorce.

A third determinant of resort to Zar in our study was the nature of the mental disorder. In this respect, our findings go in line with previous reports that conversion and dissociative disorders are the most common among Zar attendants, followed by anxiety and adjustment disorders. Okasha (1966) studied 100 women attending Zar and diagnosed 40% of them as hysteria, 16% "organ neurosis", 8% anxiety states and 4% obsessive-compulsive disorder. According to Kennedy (1967) "hysterical and hysteriform ailments" are closely associated with Zar, and the problems most effectively treated by Zar are those of hysteria. Most researchers considered the states of possession and trance that occur during Zar as hysterical reactions (Lewis, 1986; Al-Masri, 1975; Giel et al, 1968). Boddy

(1989) argues that while parallels can be drawn between hysterical neurosis and Zar possession, in that both conditions involve some dissociation and somatization, the two phenomena are grounded in disparate cultural contexts. For, despite the thorough dissociation of the untoward event from the possessed woman's self, she does not, like the text-book hysteric, unconsciously deny her experiences of others so much as embrace them, while consciously recognizing them as aspects of her being over, which she has limited, if potentially increasing, control. Response to Zar was best-reported in-patients with conversion and dissociative disorders followed by anxiety disorders. This finding confirms many earlier reports. Baasher (1975) argues that the therapeutically beneficial response to Zar can be attributed to its being a form of group therapy and psychodrama. Kennedy (1967) emphasizes the role of such factors as faith, suggestion, catharsis and group support together with dramatization and symbolism. Okasha (1966) considered Zar ceremonies an opportunity for women to abreast their frustrated desires. Opler (1959) referred to the beneficial effect of the indigenous therapeutic milieu that is developed during Zar ceremonies. Leff (1988) drew attention to the transparent wish-fulfillment aspect in the behavior of clients in the course of the Zar ceremony and its rituals. Three quarters of Zar patients resorted to it after making some therapeutic trials with medical doctors and/or traditional healers. The relative popularity of Zar in rural areas, which has been in part attributed to the relative harshness of village life (Lewis, 1986; Boddy, 1989; Baasher, 1962) may be influenced by such factors as lack of health awareness, inaccessibility of medical services, prevalence of endemic tropical diseases, as well as the socio-culturally inherited confidence in, and reliance on, time-honored indigenous healing practices. When an ailment is of a recognized causation, short duration, or known treatment, people are unlikely to suggest a protracted and expensive therapy, like Zar. But, for those who are emotionally disturbed, the stigma of mental disease may be perceived as so damaging to the personal and family reputation, that identification with the socially sanctioned and popularly proclaimed Zar membership may become face-saving, particularly when the nature of the disorder is not self-evident, being disguised by common somatic complaints. Many Zar healers, whom we had occasions to interview, frankly admitted earlier emotional problems from which Zar used to help them for a considerable time prior to becoming Zar healers. Their subsequent career as Zar healers might be satisfying a personal need for regular involvement in Zar ceremonies and rituals.

What is it that makes Zar so helpful to so many people? Attempts to answer this question have, hitherto, been rather speculative, oblique or superficial. Well designed, wide-scale multi-disciplinary team investigations, which incorporate inputs from anthropologists, sociologists as well as mental health professionals and others may help putting this form of cultural therapy in its proper context, and drawing from it lessons that enrich the theory and practice of modern psychotherapy.

Another line of research concerns the phenomenology of the Zar trance, in which the client loses awareness and control of her body and behavior, becoming possessed by one Zar spirit after another. What

objectively observable changes can be noted in the client's mental functioning during such possession trance? And, what are the parallels that can be drawn between the socio-culturally mediated state of "otherness" (Boddy 1989) occurring during a possession trance on the one hand, and the clinically classified (American Psychiatric Association, 1994), if etiologically contestable (Mersky, 1992), multiple personality disorder on the other?

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ثقافة الزار والمرضية النفسية

الزار هو طقس ثقافي مرتبط بالتلبس كما انه لا زال أحد أساليب العلاج الشعبي المنتشرة بين النساء في السودان. تهدف هذه الدراسة إلي التعرف على السمات الاجتماعية والديمغرافية والإكلينيكية الأساسية التي تميز المرضى النفسيين من النساء اللاتي تمارسن طقس الزار. وقد تم عمل الدراسة استنادا إلى المقارنة بمجموعة ضابطة. تضمنت الدراسة ٨١٩ امرأة تتراوح أعمارهن ما بين ٤٠ و ٥٤ سنة توافدوا للعلاج على عيادة الأمراض العصبية في الخرطوم بشمال السودان وذلك في الفترة ما بين ١٩٧٣ و ١٩٨٣. النساء اللاتي ترددن على جلسات الزار عرفن بـ "مجموعة الزار" والأخريات عرفن بالمجموعة الضابطة. وقد تضمنت المقارنة بين المجموعتين

عددا من المتغيرات الديمغرافية والإكلينيكية وذلك باستخدام المعدلات الإحصائية المناسبة. كما تمت دراسة مدى تأثير الزار في علاقته بالتشخيص الإكلينيكي للمرأة. أظهرت النتائج ان المترددين على الزار كانوا ٢٨٧ من المرضى بنسبة ٣٥٪، وقد كان التردد على الزار أكثر شيوعا بين المرضى من الريف وذوي المستويات التعليمية والوظيفية المنخفضة ، كما ارتبط بحالات الطلاق أو الحياة العزباء ووجود تاريخ عائلي من التردد على الزار والتعايش مع أحداث حياتية صعبة (مثل عدم الانسجام في الزواج وعدم القدرة على الإنجاب وفقدان طفل والصراعات الشخصية) والاضطرابات الجسدية المزمنة. وقد كان للزار أفضل تأثير في حالات الاضطرابات التحولية والانشقاقية وبدرجة أقل اضطرابات القلق. وقد خلصت الدراسة إلى أن الزار عادة ما يلجأ إليه في السودان في حالات الاستجابات النفسية والعصابية لضغوط الحياة النفسية المزمنة خاصة بين الأفراد الأكثر عرضه للإصابة بالاضطرابات التحولية والانشقاقية. كما أوصت الدراسة بالحاجة إلى مزيد من الدراسة للأعراض الموازية بين تغيرات الشخصية أثناء غفوة الزار وبين اضطراب الهوية الانشقاقي.