# Evolution of Modern Psychiatric Care in Nigeria

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The history of modern psychiatric care in Nigeria is rather sketchy for two resasons. First, researchers were, and are still preoccupied with the interplay between emerging western-oriented psychiatric institutions and the traditional healing techniques of the native healers. Two major traditional sources of care for the mentally ill exist in Nigeria. They are : the native healers and the syncretic churches. The native healers have beeen widely reported upon in literature (Leighton et al., 1963 ; Prince, 1960a : 1961). They are assorted because they specialize in the treatment of various ailments. Some native healers handle purely physical illnesses, while others treat psychiatric disorders. The healers who treat psychiatric illness have received harsh and favourable treatment in various studies. They are often criticized for their emphasis on physical restraints through the use of chains or beating ; and for their inability to identify and treat organic cases. The native healers are commended for the use of some pharmacologically active herbs such as rauwolfia, and symbolic rituals in psychotherapy. The latter appears to be most effective for psychoneurotic patients.

The syncretic churches on the other hand emerged as early as 1918 when their healing activities first appeared during the outbreak of influenza (Boroffka, 1970). Innumerable syncretic churches exist in Nigeria today. The syncretic churches are hybrid in the sense that some undertake spiritual healing only. Others however combine traditional healing methods and the spiritual force of the Bible. The churches that rely on the spiritual force of the Bible are skin to Christian Science Movement in the United States. Similar groups in other societies were investigated in the past. For example, Ari Kiev (1964) examined the psychoterapeutic aspects of Pentecostal sects among West Indian immigrants in England.

Second, modern psychiatric care was recently introduced to the country. A considerable part of the present discussion revolves around the history of modern psychiatric care in Nigeria ; the number of psychiatric facilities ; the ideological orientation of the psychiatric

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workers ; past trend in mental health care in Nigeria ; and the future of psychiatric care in the country.

## HISTORY OF PSYCHIATRIC CARE.

Custodial care *per se* for the mentally ill is not the product of British colonial rule. Traditional healers operated a form of custodial care prior to contact with the west. Present day healers in Nigeria still « admit » and treat psychiatric patients for several months in their respective compounds or churches (Prince, 1961 ; Leighton et al., 1963). But the by product of contacts with Europeans are the modern, western-oriented psychiatric facilities. The new mental health delivery — system adopts an orientation and specific treatment modalities which differ markedly from the traditional healing methods. Although the new facilities derived from western-oriented mental health care are still limited in number, yet they are being expanded through large scale government support.

Health care for the mentaly ill Nigerians throughout much of the 20th century did not differ from the way such disabled persons were handled some centuries ago in Euro-American societies (Foucault, 1965). Like in these societies, the mentally ill either drifted into towns as vagrant psychotics or beggars while some received care from assorted native healers (Boroffka, 1970). Others were locked up in prisons having committed criminal offences ; and only a few received care in asylums.

The first asylum in Nigeria opened in 1907 with 48 patients. Asuni (1969 ; 1972) observes that large asylums were in vogue all over the world, hence the establishment of Yaba Asylum. Treatment at Yaba consisted of drug therapy and physical restraints for the aggressive and violent patients. Similarly the services of medical officers of health rather than psychiatrists were relied upon in the asylum.

The determination of the British colonial government to improve mental health care let to the opening of Aro Mental Hospital near Abeokuta in 1954. This hundred-bed facility is modelled along the psychiatric centres which were established long ago in Euro-American societies. Facilities in the hospital typically include wards, occupational therapy centre, an outpatient clinic, a pharmacy, a church, a laboratory, a recreation room, and a treatment unit. The centre also serves as a research and training facility for medical students and nurses.

Modern psychiatric facilities were subsequently established in various parts of the country. The facilities either are government-owned, or affiliated to quasi-government bodies such as university teaching centres. They include psychiatric centre which are affiliated to the universities of Ibadan, Ife, Lagos, Benin and Ahmadou Bello University Zaria. The others are : Uselu Psychiatric Centre, Benin, Lantoro Institution, Abeokuta, Jericho Pchychiatric Unit, and others within general hospitals in part of the country. But Boroffka's (1975)

recent survey of psychiatric centres and asylums in Nigeria reveals that asylums still exist within the various of Prisons.

A substantial number of the mentally ill still seek primary help from assorted native healers despite the opening of modern psychiatric facilities (Lambo, 1964 ; 1968 : Asuni, 1967). Available evidence suggest that care is voluntarily sought from traditional healers partly because of the inaccessibility of western-oriented psychiatrists and mental health institutions, and largely because of patient's greater confidence in the healers than in the therapeutic skills offered in modern psychiatric centres. Because many psychiatric patients were strongly disposed to traditional healing methods, and due to the limited resources available to develop comprehensive psychiatric facilities, a community-oriented program was establised around Aro Mental Hospital many years ago (Lambo, 1968). The rationale for the program was governed by the desire to establish a beneficial and appropriate environment in which African patients could be treated. The community village programm was introduced as a therapeutic alternative to western-oriented, custodial care system. Attempt was made to integrate traditional healing methods (viz., through the participation of native healers in psychotherapy) and western-oriented treatment modalities into the community village programm experiment. The community program which involved some villages within a short distance from Aro Mental Hospital, has now expanded into other communities. Community-oriented programs were later introduced to parts of Nigeria and East Africa. Dr. Asuni (the successor to Dr. Lambo at Aro) is presently initiating a slightly dissimilar village program.

The treatment centre in the community village program is equipped with facilities such as electroshock therapy, drug therapy, modified form of insulin. At the time of this study, only twenty-five to thirty patients were receiving care in the main village of the program. It appears that lack of facilities, manpower, and funds constrained the scope of the program.

Intensice care in the community program entials the active participation of kin and significant others. Limited supervision is undertaken by the staff members. Hospital administrators sought and obtained the co-operation of chiefs, elders, and villagers at the inception of the program. Co-operation was facilited because Aro villagers continue to derive some money from patients, monthly rent, as well as through the provision of health and other facilities which Aro village proviously lacked. A subsequent research which was undertaken to assess the impact of the community program upon the villagers revealed that the latter (i.e., the villagers) continue to give maximum co-operation and support to the program (Osborne, 1969).

However, public attitudes towards the mentally ill may be changing if we are to judge by a recent survey. Whilst Boroffka (1970) observes that symptoms reported by patients might vary with socio-

economic status, background or exposure to modernizing influences, Asuni (1968) points out that non-literate Nigerians tend to accomodate vagrant psychotics much more readily than these highly « modern » and literate.

So far, there is no national case register for the mentally ill in the country. Except for Aro Psychiatric centres where crude figures and data for the treated patients are readily available, many of the psychiatric units have not developed a comprehensive record-keeping system. The availability of such records might have facilitated an instant review of incidence and prevalence data on mentally ill in Nigeria. Nevertheless, if we are to judge by evidence from Aro Mental Hospital (the largest and perhaps most modern custodial centre), it seems many cases are treated annually. For instance (Table 1) shows that between January 1967 and December 1971, 4, 235 impatient and 11,886 cases were seen and treated in the centre.

Table 1 : *Cases (a) Admitted or seen In The Outpatient Clinic of Aro Mental Hospital From January* 1967 *to December,* 1971

| Year | Inpatient | Outpatient |
|---|---|---|
| 1967 | 784 | 1,130 |
| 1968 | 810 | 1,797 |
| 1969 | 896 | 2,255 |
| 1970 | 906 | 2,975 |
| 1971 | 839 | 3,754 |
| N | 4,235 | 11,886 |

(*a.*) The above figures should be read as cases not persons. Hence each patient must have reported at Aro Mental Hospital for car more than once.

In general, schizophrenia is the most frequently diagnozed illness in various psychiatric centres ; While more male than female patients are treated.

## PSYCHIATRIC MANPOWER

There are between 30 and 35 formally trained psychiatrists and perhaps close to 400 registered psychiatric nurses in Nigeria. On the other hand, Ademuwagun (1969) estimates that 4 percent of the adult

population in urban areas are medicine men. Many of such medicine men probably treat psychiatric related problems.

Most psychiatrists and nurses received their training in England. (Asuni, 1972). The government of Nigeria anticipates that there will be two psychiatrists per a million people by 1985 (Akinkugbe et al., 1974). The projection clearly indicates that formally trained psychiatrists will be in short supply to the population for many years.

Asuni's (1972) assertion that no definite school of psychiatry has emerged in Nigeria may be partly valid if the present trend in the country's mental health care is seen strictly within the context of western conception of therapeutic schools. While the assertion may be true in the past, it would seem that at least two major conceptual orientations are being crystallized among Nigerian psychiatrists. The orientations stress : (i) « nonculture bound » treatment, and (ii) a « culture-bound » orientation. The former approach clearly recognizes, but does not accept *in toto,* the overall importance of traditional healing methods and the role of native healers. The second orientation emphasizes a convergence of healing methods trough the joint role of native healers and western–oriented psychiatrists or their treatment techniques in the therapeutic process. Both Drs. Lambo and Asuni are the leading psychiatrists and theorists in this respect. Lambo has always stressed the vital role of native healers and their healing methods. This orientations has following not only in Nigeria, but in several non-literate developing societies. Asuni, on the other hand recognizes the fact that traditional healers have potent herbs and psychotherapeutic techniques which they can contribute to psychiatry. For him however, their role will diminish when more and more people become educated. In a sense, Asuni (1974) is more optimistic about the breakdown of belief-system through western education and consequently the place of western-oriented psychiatric facilities in Nigeria. This position is not strictly « anticulture » but « non-culture-bound » and opposed to Lambo which is definitely anchored in the need to take into account the role of individual healers.

The two orientations are partially valid, Lambo is concerned with the relevance of normative systems and symbolic rituals to psychotherapy and consequently rehabilitation, whereas Asuni is concerned with the problems of integrating « non-scientific » healing methods into psychiatry.

The orientations have implications for the psychiatrists handling of patients and in the management of next of kin. Take the Yoruba ethnic group of Nigeria for instance in this context. Yoruba people in general recognize, and are familiar with the native healers procedure in reaching a social diagnosis of mental illness, and with the use of herbs or symbolic rituals in therapy. For most patients and non-patients, such treatment is seen to entail accepted rituals which are meant to placate, or destroy diabolical spiritual forces. Group psychotherapy

sessions for Yoruba patients are dominated by patients' verbalization of the evil forces which lie behind their illness (Erinosho, 1975).

Physicians who share the « non-culture-bound » orientation tacitly recognize the importance of these rituals in individual psychotherapy, but stop short of encouraging their patients to undertake such rituals. In contrast, the « culture-bound » therapists not only acknowledge the role of the rituals and native healers, but affect their integration into the normal therapeutic process.

## DISCUSSION

The future of modern psychiatric care in Nigeria inevitably presupposes a cursory look into the past and the present trends in the country's mental health program. First, psychiatric patients tend to seek care from assorted traditional healers prior to their admission to modern psychiatric facilities. This is not necessarily indicative of the unavailability of general practitioners (which is in fact the case with Nigeria), but due to the world-view of the patients and significant others. The etiology of mental illness is rooted in evil machination of the enemy, cosmic forces, or excessive strain in interpersonal relations (Leighton et al., 1963 ; Lambo, 1960). It may be premature to suggest that with increasing awareness of western-oriented delivery-systems, many more psychiatric patients would seek immediate care either from general practitioners, or the psychiatric outpatient clinics. In fact, the present trend indicates that literate as well as non-literate (if literacy is an index of modernization) seek help from traditional healers prior to their admission into modern health or psychiatric facilities (Lambo, 1968 ; Erinosho, 1975). One could suggest that modern mental health care ought to be juxtaposed into the world-view (vice versa) of the people in this society largely because of patients' confidence in, and reliance on assorted healers during mental ill-health.

It seems that a range of mental health delivery-systems are available in Nigeria. On the one hand are the traditional healers (viz., the native healers or syncretic churches), and on the other are the western-oriented delivery-systems (viz, custodial and community-oriented). The two broad systems of mental health care appear to compete and overlap. Because of this trend, substantive areas in policy-making may be explored. First, either traditional healers are completely ignored as a matter of policy, or integrated into the therapeutic process in modern psychiatric centres. While total integration of the healers into modern therapeutic facilities may pose several problems, their peripheral participation in group or individual psychotherapy through the use of symbolic rituals, or the training of a selected group of competent native healers may require careful consideration and certainly experimentation.

A brief comment on the training of mental health personnel is essential at this point. It may be futile for professional personnel in Nigeria to adopt a soley wester-oriented approach to mental health

care when the ideas of the patients whom they treat are deeply rooted in magico-religious belief-system, and in the utilization of traditional healers. Neither would patients derive maximum treatment benefits if their ideas of concerns about mental illness are merely dismissed by western-oriented professionals on the ground that such notion of illness have no foundation in « scientific psychiatry ». In short, an accepted ideological orientation of staff members, acquired through training must be relevant to the socio-cultural context of treated patients before rehabilitation can be effectively pursued.

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