Cultural Psychiatry in the Era of Colonization and Decolonization: Nigeria

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Overview

- **Brief History**
  - Governance
  - Dominant ethnic groups
  - Dominant Religion and traditional beliefs (Yoruba)

- Cultural psychiatry during colonization
- Cultural psychiatry during decolonization/post-independence
- Nigerian Economy/current mental health facts
Nigeria

- 140 million people, roughly 130 psychiatrist
Government/Politics

• 1960: Independent from Britain
  – Hausa, Yoruba, Igbo dominate politics
  – Goodluck Johnathan, President since 2010
  – Legislative/Judicial system - Similar to UK.
Nigeria
Hausa/Fulani
Nigeria

Igbo
Nigeria
Yoruba
Religion

Islam
• North
• 48.8%, (Majority Sunni)

Christianity
• South
• 49% (Majority Protestant)
Traditional Religions
Traditional Yoruba Religion

Ifa divination oral tradition

Concept of Destiny - explanatory models for mental illness

- Ayanmo narratives ("That which has been selected as part of oneself")

- Choosing ones ori (or head) before birth (qualities like aptitude, personality, life outcomes, possibility of madness)

- Either with Assistance by Ajala (God’s helper) or “going at it alone”

Traditional Yoruba Medicine

- Babalowos – practitioners, healers
  - Organized within professionalized societies
  - Specialized in certain areas – psychosis
    - Rauwolfia (Row-wool-fia) plant – antipsychotic properties
- Comprehensive therapies for illness – ritual, consultation, herbal methods

Abimbola, “Exposition of Ifa” (1976)
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• **Cultural psychiatry during colonization**

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British rule: Late-19th century

- Anti-slavery era
  - Protection/Development

- Berlin Conference
  - European powers
  - Partitioned into 41 colonial states
    - 2,000 ethnic groups
1885: Colonial Era

• Initially owned and run under management of private companies

• 1901: Bought from Royal Niger Company
  – 800,000 pounds
  – Official British Protectorate
1900: British Colonial Era

- Divided administratively into North and South until 1914
  - South: Diverse, Heavy Christian missionary influence. more developed, education
    - Imported western education, healthcare, social services
  - North: Homogenous, Preserved Tradition, Islamic institutions
Indirect Rule

- Northern (rulers/emirs) continued to rule
- Indirect Rule: Day-to-day governance in hands of traditional rulers, but at the cost of taxation, military services in hands of the British
- Throughout colonial Africa and Asia

Frederick John Deastry Lugard (standing center), the British colonial administrator of Africa, accompanies a delegation of West African kings on a visit to the London Zoo in 1934
Indirect Rule and Asylums

• Why relevant?
• Maximize profits
• Limited public service expenditure
  – Impact on psychiatric institutions
    • Also justified by “Detribalization”
• Asylums – For public safety
  – mainly custodial in nature
    • Minimal therapeutic services

Sadowsky, Imperial Bedlam (1999)
“Detribalization”

• A staple term within colonial psychiatry
• Psychopathology secondary to becoming “modernized”
• Views from Asylums/Prisons – very narrow, extreme ends
  – Generalized to all exotic/non-westerners

Heaton, “Black Skin, White Coats” (2013)
Colonial Asylums

- Yaba Asylum – in Lagos, Nigeria
- Calabar Asylum, SE Nigeria
- Lunacy Ordinance Act of 1906
  - Empowering regional governors to build asylums
  - Emergency detainment
- Indirect Rule/Detribalization influence
  - Undervalued, overcrowded
  - Makeshift prison extensions
- Understaffed
  - But three British Aliens(ist) did visit: Bruce Home (1928), Cunyngham Brown (1938), J.C Carothers (1955)

Sadowsky, Imperial Bedlam (1999)
Minimalism and Ethnopsychiatry

• Influence on Colonial gov’t officials
  – Minimalist development approach
  – Ethnopsychiatry – comparing non-Western psychology to European standards

• Natural hierarchy of human psychological
  – Express psychological symptoms – mature/sophisticated
  – Somatic symptoms – immature/primitive

Heaton, “Black Skin, White Coats” (2013)
First two Independent Observers:
Bruce Home (1928), Cunyngham Brown (1938)

  - “Rapid modernization” related to mental illness (South > North)
- Brown, 1938: Repudiated “Detribalization”
  - True prevalence of mental illness hidden
  - Stressed diversity within Nigeria
    - Weak comparison to Europeans
- Recommendations: Increased beds, curative and rehabilitation services
  - In the end, inertia and indirect rule carried the day

Sadowsky, Imperial Bedlam (1999)
J.C Carothers

- 1950s: Conditions similar to predecessors
- First colonial ethnopsychiatrist with previous African experience
- Spent multiple years as medical officer in Kenya, consultant for E. African Command in WWII

Heaton, “Black Skin, White Coats” (2013)
J.C Carothers (1955)

- Nigerian report written in 1955
- Surveyed in context of the decolonization of Nigeria
  - Preparation for an independent state
- Emphasized “Degrees of detribalization”. East > West
- Stressed diversity of Nigerian culture
  - Differences in psychological make-up

- All three observers reinforced indirect rule/Detribalization
  - Suggestive reforms: seen as counterproductive, waste

 Hearing, “Black Skin, White Coats” (2013)
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1940-59: Decolonization

- Increased development planning
  - Increase in infrastructure:
    - Education - 1948 – University College, Ibadan
    - Healthcare, Social Services
- Transformation of cultural psychiatry: search for “universals” in psychology
  - Mental health infrastructure atrocious with noticeable criticism (politicians, media)
Oct 1\textsuperscript{st} 1960: Independence
1950-60s: Around the World
Dr. Thomas A. Lambo

• Yoruba Nigerian, First African psychiatrist
• Trained in the UK for medical school
• Influences:
  – Maudsley psychiatric institution in London
  – cultural anthropology (i.e Dr. Margaret Mead)
• 1954: Medical director of Aro Mental Hospital
  – Strong relationships with hometown community formed
• Established the Aro Village system (1954)

Heaton, “Black Skin, White Coats” (2013)
The Aro Village system (1954)

- Holistic community based therapeutic approach
  - Emphasizing outpatient/village therapy
  - Integrated “modern” psychiatry with local cultural modalities
    - Arrangements made with local chiefs and elders
    - 24hour nursing care within the village
    - ECT, Insulin coma therapy, psychopharm available
    - Community projects and activities throughout
- Collaboration with traditional healers
  - Firmly embedded within the culture

Asuni, African J. Psychiatry (1979)
Dr. Raymond Prince

- Canadian born, trained psychiatrist
  - Professor, McGill University
  - Arrived at Aro Hospital in 1957
Traditional Healers and Psychotherapy

– Finding allies in Traditional Healers
  • “Western psychiatric techniques are not in my opinion demonstrably superior to many indigenous Yoruba practices”

– Dr. Prince: Why so effective?

Heaton, “Black Skin, White Coats” (2013)
Traditional Healers and Psychotherapy

- **Four Factors** in Healer-Patient relationship to promote treatment efficacy:
  - Each enhanced their revered position in Yoruba culture.
  - 1.) Patient’s belief in the unlimited power of the healer
  - 2.) The Healers impressive performance. His Intuition. Making “blind” diagnoses
  - 3.) Use of sacred, gestures, magical modalities, paraphernalia
  - 4.) Patient’s anxiety contrasted by the Healers confidence

  – Patients improved because they believed

*Heaton, “Black Skin, White Coats” (2013)*
1950-60’s: Transcultural Psychiatry

- Searched for “Universals” amongst cultures worldwide
  - Effects of culture on mental illness
- Regardless of race, ethnicity, culture
  - High levels of stress will produce similar psychological disruptions.

Heaton, “Black Skin, White Coats” (2013)
1967-1970

- Increased criticism of “Universalism”
- Coinciding with Nigerian Civil (Biafran) War (1967)
  - Forced unification of a ethnicities inevitably erupts
1970-90s: Cross Cultural (comparative) Psychiatry

- Emphasizing cultural variations of mental health
  - Increased Utility of medical anthropology
  - Arthur Kleinman and Comparative psychiatry: embraced “the ways culture influenced the perception, classification, process of labeling, explanation, experience of symptoms, course, decisions regarding, and treatment of sickness”.

- Western-disease models were culturally bound

*Kleinman, Social Science and Medicine (1977)*
Culture-Bound Syndromes: Ode Ori

- Yoruba-bound disease
- Ode Ori ("hunter of the head")
  - Dx by Traditional healer
  - Organism placed by supernatural powers. Able to migrate
- 1970-80’s: Increased presentation by Nigerian physicians (Euro-trained)
  - Unique somatic and psychological

Table 1
Frequency of various somatic complaints in the 30 patients

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawling sensation</td>
<td>25</td>
</tr>
<tr>
<td>Noises in ears</td>
<td>22</td>
</tr>
<tr>
<td>Palpitations</td>
<td>19</td>
</tr>
<tr>
<td>Peppery sensations</td>
<td>10</td>
</tr>
<tr>
<td>Darkened vision (&quot;oju ışıu&quot;)</td>
<td>10</td>
</tr>
<tr>
<td>“Dizziness” (&quot;oyi&quot;)</td>
<td>9</td>
</tr>
<tr>
<td>Headaches</td>
<td>7</td>
</tr>
<tr>
<td>Other pains (apart from headache)</td>
<td>5</td>
</tr>
<tr>
<td>Itching or tickling sensation</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 2
Frequency of the more common present state examination (PSE) symptoms and signs in the 30 patients

<table>
<thead>
<tr>
<th>PSE Item No.</th>
<th>Symptom/sign</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Depressed mood*</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>Tension pains</td>
<td>21</td>
</tr>
<tr>
<td>1</td>
<td>Adverse evaluation of physical health**</td>
<td>20</td>
</tr>
<tr>
<td>35</td>
<td>Delayed sleep</td>
<td>20</td>
</tr>
<tr>
<td>11</td>
<td>Free-floating autonomic anxiety</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>Tiredness or exhaustion</td>
<td>16</td>
</tr>
<tr>
<td>34</td>
<td>Loss of weight due to poor appetite</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>Worrying</td>
<td>12</td>
</tr>
<tr>
<td>10a</td>
<td>Hypersensitivity to noise</td>
<td>12</td>
</tr>
<tr>
<td>37</td>
<td>Early waking</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>Subjective feeling of nervous tension</td>
<td>11</td>
</tr>
<tr>
<td>22</td>
<td>Loss of interest</td>
<td>11</td>
</tr>
<tr>
<td>121</td>
<td>Observed depression</td>
<td>11</td>
</tr>
<tr>
<td>8</td>
<td>Restlessness</td>
<td>10</td>
</tr>
<tr>
<td>13</td>
<td>Autonomic anxiety due to delusions, etc</td>
<td>10</td>
</tr>
<tr>
<td>28</td>
<td>Social withdrawal</td>
<td>10</td>
</tr>
<tr>
<td>40</td>
<td>Irritability</td>
<td>10</td>
</tr>
<tr>
<td>74</td>
<td>Delusions of persecution***</td>
<td>9 (8)</td>
</tr>
<tr>
<td>24</td>
<td>Hopelessness</td>
<td>8</td>
</tr>
</tbody>
</table>
Ode Ori

- 1987 – Dr. Roger Makanjuola
- Retrospective study (1982-1985)
- 30 Yoruba patients, 5 M, 25 F, 16-80 years, various socio-economic backgrounds
  - Initially seen by traditional healer -> Ode ori
  - Seen by PCP/Psychiatrist – Diverse range of dx
  - Affective/anxious symptoms tx, but somatic remained

What could these Somatic symptoms represent?

- Residual Affective/anxiety symptoms from Affective spectrum
- Single underlying disorder itself....Ode Ori?

..or.............
......Neglected Tropical Diseases

- Roundworm (*Ascaris Lumbricoides*)
- Hookworm (*Necator Americanus*)
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• **Nigerian Economy/current mental health facts**
Economy

- Ranks 30\textsuperscript{th} in world in GDP (2012)
- Vast Natural/mineral resources:
  - Underutilized
  - Poor mining industry, thus......

Economy: Oil

- Money maker
- World rank: 12th producers, 10th reserves, 8th exporter
- 40% of GDP, 80% of government earnings

U.S. EIA, Nigeria Analysis 2013
Economy

7%/year economic growth rate since 2000

Economy

• Wide income inequality gap
• Over 50% live in poverty

Economy and Mental Health Services

- Health Budget is 4.6% of GDP
  - About 3.3% towards mental health
- 91% for gov’t run mental hospitals

WHO-AIMS Report, Nigeria 2006
Mental Health in Modern Nigeria (statistics)

- Majority of beds are provided by mental (State-run) Hospitals

**Graph 2.1 - Beds in Mental Health Facilities and Other Residential Facilities**

- Mental Hospitals: 82%
- Inpatient Units: 9%
- Residential Fac.: 1%
- Forensic Units: 2%
- Other Res Fac.: 6%
Mental Health Education

• Within medical schools
  – 3% of training hours towards mental health education

• Graduate medical training
  – 8 (0.03/100,000) out of 3,200 graduated as psychiatrist
  – Brain drain: 25% migrate within 5 years of training completion

WHO-AIMS Report, Nigeria 2006
Mental Health Education/Stigma

The State of Readiness of Lagos State Primary Health Care Physicians to Embrace the Care of Depression in Nigeria

- 41 PCPs in 2 day workshop on Tx and Recognition of common mental disorders
  - 83%: Depression, a way people with poor stamina deal with life difficulties
  - 80%: Difficult differentiating unhappiness vs. clinical depressive disorders
  - 51: Biological abnormalities are not the basis of severe depression
  - 61%: PCPs are not useful to support depressed patients
  - 85%: Patient do not need to see a psychiatrist if antidepressants not needed

“It is easier to see new buildings and new roads as evidence of progress,...but unfortunately delinquency, prostitution, drug addiction and other social disasters accompanying ‘progress’ are often tucked away from full view” – T.A. Lambo
Thank you
References

• Wande Abimbola, Ifa: An Exposition of Ifa Literary Corpus (Ibadan: Caxton, 1976)
• Tolani Asuni, “Therapeutic Communities of the Hospital and Villages in Aro Hospital Complex in Nigeria,” African Journal of Psychiatry 1(1979): 41