Psychiatry in Africa: the myths, the exotic, and the realities

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Abstract
Information regarding the occurrence and nature of mental disorders in Africa is still grossly limited. For many years, anecdotal reports and personal views, many of them based on very limited data, prevailed. Subsequently, many early studies were based on clinical samples and thus limited in generalizability. These factors led to a number of myths about mental disorders among Africans. In this short review, some of these myths are examined in the light of current information. It is observed that sufficient information probably exists to discard some old myths while some other current views, even though suspect in regard to their validity, await further exploration. It is concluded that while some racial differences may have been mistaken, there nevertheless remains the possibility that some unique features of psychiatric and behavioural disorders in Africans offer the prospect of advancing our knowledge in regard to etiology and possible interventions.

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Introduction

Africa's history is inescapably entwined with its history of colonization. Stereotypes were veritable tools in the hands of colonialists who, it would appear, needed to justify their occupation on the ground of having to liberate a backward people with poorly developed mental faculties. Colonial literature, from administrative to scientific, is replete with examples of materials insinuating either clearly or obliquely such belief. Not surprisingly, psychiatric literature, reflecting a science dealing with human behavior and emotion, provides examples of colonial prejudices and stereotypes, albeit couched in technical and scientific jargons.

A good example is provided in the description of the ''the inherent mode of thought'' of the African by Carothers.[1] He suggests that this ''can be explained on the assumption that 'phantastic' (sic) thinking plays a larger part in it than 'directed' thinking. He explains that ''phantastic'' thinking is ''unproductive and uncritical'', is ''characteristic of day-dreams, dreams and myths, is especially marked in children and primitive peoples and and is essentially an immature mode of thought''. Quoting Westermann, Carothers further claims that the thinking is ''…dependent on excitement, on external influences and stimuli, (is) a characteristic sign of primitive mentality….Where the stimulus of emotion is lacking, the (African) shows little spontaneity and is passive…Has few gifts for work which aims at distant goals and requires tenacity, independence, and foresight''.[1]

These claims, some of which border on the exotic, were of course broad generalizations that were made on the basis of rather limited observations and empirical data. Such generalizations often lead to given truths that are rarely challenged but often treated as received wisdom. Such floridly stereotypical claims are much less likely to be made today. However, many present-day workers in the field of mental health still express views that represent no more than ''received wisdoms'' with rather scanty empirical basis.[2]

Myths

''The short but impressive path that psychiatry has traversed in Africa is littered with the splinters of broken myths''.[3] Such myths commonly result from the fact that research activity is still relatively small on the continent and opportunities to examine, accept, or refute research findings on the basis of new data are not many.[4]

Rates of disorders

Myths concerning the occurrence of mental disorders were built on a foundation of limited epidemiological data.[4] Early psychiatrists had no materials on which to base their observations other than the highly selected clinical cases that

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came to their attention in tertiary care settings. The availability of epidemiological data, some of them collected in the context of cross-cultural comparative studies, has provided the information with which to judge those early claims and expose some of them as poorly substantiated myths.[5]

Carothers expressed one early myth when he wrote: '' the incidence of insanity among Africans living in their natural environment is probably very low.[1] And this may be because ''of the absence of problems in the social, sexual and economic spheres'' whereas the frequency of insanity in Europe and America ''is due to the multiplicity of such problems''.[1] Cross-cultural comparative studies that included sites in Africa, Europe and North America have shown that the incidence of psychotic disorders among Africans is indeed not different from that in other cultures (World Health Organization 1973; World Health Organization 1979; Jablensky, Sartorius et al. 1992).[6,7,8]

Carothers also reported a rarity of obsession in the African and ascribed this to ''the African lifestyle being controlled by group obsessional rituals which effectively preclude self-directed ritualistic behavior''.[1] While it is probably true that obsession is rare among Africans, epidemiological studies conducted elsewhere suggest that this rarity may not be unique to Africans. In the absence of comparative studies, it remains a conjecture whether there is any significant difference in rates between Africans and others. Even if this proves to be the case, the explanation proffered by Carothers is unlikely to hold given the variety of cultures and lifestyles in Africa which makes the possibility of one explanatory model for a given behaviour rather tenuous.

The claim that depression was rare in the African was also based on observations made in tertiary standalone psychiatric hospitals where the most disabled, commonly with severe psychotic disorders, presented.[9] Majordina and Attayah Johnson, using the World Health Organization's Standardized Assessment of Depressive Disorders (SADD) in Ghana, not only showed that depression was common but that the claim that the experience of guilt among Africans persons with depression was rare, a rarity that had been ascribed to ''a lack of responsibility'', was equally a myth.[10]

Somatization

One common myth that has persisted despite empirical evidence to the contrary is that Africans are more likely than Caucasians to somatize.[11] The expression of psychological distress in the idiom of bodily language, which is presumed to underpin the concept of somatization or medically unexplained symptoms, is often suggested to be associated with less psychological sophistication or a lack of adequate psychological language to describe emotional distress on the part of its sufferers. There has however been no convincing demonstration of ''lack of psychological sophistication'' among somatizers. Studies in many parts of the world show that somatization, irrespective of the way it is defined, is common in every culture.[11] Nevertheless, the myth about higher rates of somatization by Africans, or in some instances ''patients from developing countries'' persists. Even though several studies have shown that patients with psychological illness in general, and those with depression in particular, often present with multiple bodily symptoms everywhere, the question about whether Africans do so more than other racial groups can only be addressed in a cross-cultural comparative study. Such study will have to be conduced in similar settings, use identical ascertainment procedures, and elicit a broad array of symptoms that is likely to include those that are peculiar to the participating cultures.

The research project Psychological Problems in General Health Care (PPGHC), a WHO collaborative study conducted in general health care settings in 14 countries provides a good basis for examining the claim about the differential occurrence of somatization (Ustun and Sartorius 1995).[12] Conducted in Ankara, Turkey; Athens, Greece; Bangalore, India; Berlin and Mainz, Germany; Groningen, the Netherlands; Ibadan, Nigeria; Manchester, UK; Nagasaki, Japan; Paris, France; Rio de Janeiro, Brazil; Santiago, Chile; Seattle, USA; Shanghai, China; and Verona, Italy, it provides an opportunity for examining cross-cultural variations in the rates of several possible definitions of somatization. Thus, the DSM-IV definitions of somatization and hypochondriasis as well as sub-syndromal definitions of the same disorders were examined along with persistent pain disorder and the presentation of physical complaints by patients with major depression.[13,14,15,16]

Cumulatively, the results for the studies show that, irrespective of the definitions used, there was evidence to show that somatization was common across diverse cultural settings and that, even though variations in rates were evident, there was no empirical basis to regard Africans as being more (or indeed, less) likely to somatize than other racial groups. On the other hand, there was evidence suggesting that the profile of the clinics where patients obtained service might, at least in part, explain their propensity or likelihood to somatize.[16,17] Many clinics in sites from developing countries had features that seemed to influence the tendency of their patients to somatize, but those features were not exclusive to clinics in such countries.

These findings, based on the largest cross-cultural study in primary care settings, provide compelling evidence that the claim that Africans somatize more than other races is not supported by empirical evidence. It also throws light on what may be responsible for claim: a confounding factor of care delivery characteristic. Clearly, the evidence is that somatization is common everywhere and may be a product of how the doctor-patient interaction is negotiated and conducted.

Stigma is uncommon

How true are the notions that ''Every individual in an African community …is regarded as a valuable asset by his clan …(and) unlike in civilized communities, the unwanted individual hardly occurs'' and that stigmatization of the mentally ill is rare.[1,18]

As a clinician working in Africa, my view is that these notions are a myth and probably reflect a tendency to present Africa as some sort of exotic El dorado where, unlike in ''civilized communities'', no distinction is made between the sane and the insane, with everybody living together in blissful happiness! Mental health workers are aware that mentally ill patients are commonly socially alienated (often along with their families) and often abused as a result of their illness. Clinicians know that disaffiliated families often abandon and disown their sick members because of societal stigma and

shame. However, now there is indeed empirical evidence showing that not only is the stigmatization of the mentally ill present, it is often very rife and deep-seated.[19,20,21] Not surprisingly, beliefs in the supernatural causation of mental illness and that sufferers are in some way deserving of their lot often lie at the root of the negative attitude to the mentally ill.[22]

Outcome of Schizophrenia

The claim of a better outcome of schizophrenia in developing countries is one of the Holy Grails of psychiatry.[23] The initial impression of a better outcome was obtained from the analysis of the 2-year follow-up assessment of patients in the International Pilot Study of Schizophrenia. Compared to patients from developed countries, those from Nigeria, India, and Colombia had a better symptomatic and functional outcome at two years.[6,7] However, the patients had been recruited from hospitals thus raising the possibility that selection bias might be responsible. A subsequent study sought to avoid such bias. The WHO 10-country study recruited patients from community treatment settings and found broadly similar results.[8] Again, patients from Nigeria, India, and Colombia showed better outcome profile at the two-year follow-up They were, for example, less likely to have a continuous episode or to have been hospitalized and more likely to have complete symptomatic remission.

The paradoxical observation of a better outcome in settings with suboptimal medical care has been a subject of debate as to what might be responsible. Not surprisingly, one of the more widely held view is that the living environment of third world countries is less stressful and more socially supportive. Indeed, the claim about less stigmatizing attitude to the mentally ill has also come in handy in explaining the finding.[24]

Do the findings of these studies, conducted in broadly similar fashion, represent another myth? The 10-country study was not free from selection bias. Recruiting patients from community treatment facilities, rather than hospital settings, presumes that a representative sample would accrue. However, such might not necessarily have been the case. Patients with insidious onset of illness, those with predominantly negative symptoms, and hence those more likely to have a poorer outcome might have been less likely to enter the study. In a setting as Nigeria, such patients would be perceived as having an incurable illness, and to the extent that they do not pose any immediate danger to others, may not be taken to any treatment setting, including those of traditional healers. Also, the assessment of outcome in the studies may have been rather narrow, not capturing the range of disabilities that patients in non-Western settings might have experienced. An indication that this might have been the case was the observation that in IPSS, the percentages of patients in Agra and Ibadan who died during the 5-year follow-up were 9.0 and 7.1 respectively, compared with 4.9% for the entire study cohort.[25] A 20-year follow-up study of the Indian cohort in the 10-nation study also showed very high level of mortality.[26] The question as to how a better symptomatic outcome at 2-year follow-ups translated to poor mortality outcomes at 5 and 20 years is an open one.

The presumed better outcome of schizophrenia in developing countries, including those in Africa, is based on the cited cross-national studies that have examined the issue. The studies are the only ones we have, despite their flaws. The findings are empirically-based, even though they run counter to common clinical observations on the ground. However, the possibility that this is another myth especially in regard to psychiatry in Africa is one that awaits refutation by future studies. As stated by Patel et al., factors such as widespread stigma, lack of treatment, and human rights abuses against persons with mental disorders invite us to interpret the claim about better outcome of schizophrenia in developing countries with caution.[23]

Realities

Are we to suppose from the foregoing that Africa, or Africans, have no peculiarities that might make their mental health status different in some ways from other races or cultural groups? Is it being suggested that we are all the same under the skin?

Of course, this is not the case.[11] Indeed, not only are differences in the occurrence of some mental and neurological disorders probable, such differences, whenever demonstrated, can serve to throw light on indicative etiological features which may in turn provide leads for possible prevention or intervention. The realities of psychiatry in Africa may be that some important differences do in fact exist between Africans and other racial groups in the world and that such differences offer potential opportunities for a better understanding of mental disorders and how to treat them. The on-going Ibadan-Indianapolis Dementia Project (IIDP), a comparative community-based study of dementias in Yoruba, in Nigeria,and African-Americans, provides an example of such possibility. Using identical case-ascertainment procedures in a longitudinal two-stage survey of persons aged 65 years and over, the study has demonstrated significantly different rates of dementia and Alzheimer's disease (AD) in the two populations.[27,28]

The observation that the Yoruba, as Africans, and African Americans, with their shared, but not necessarily identical, genetic pool, have significant differences in the occurrence of AD, is interesting. It opens the possibility that cultural and environmental factors, including those relating to lifestyles, may be responsible for the differences in rates. It thus provides an opportunity for examining putative risk factors in the two communities. Initial efforts to explore such possibilities have yielded one surprise. The _4 allele of apolipoprotein E gene (APOE) constitutes a major susceptibility factor for the development of AD in most racial groups, including in African Americans.[29,30] However, such a relationship has not been found in Nigerians.[31,32] The lack of association of Apo _4 with AD in the Yoruba in the context of the low incidence rate of AD provides an interesting prospect for examining genetic and environmental factors further in this collaborative study.

Conclusion

Community-based epidemiological studies and carefully conducted clinical studies are likely to throw more light on the African continent about which many things remain unknown in regard to the mental and behavioral profiles of its peoples. Only with sufficient light from empirical studies can we expect that previous research findings or anecdotal observations may be confirmed or refuted and that myths may be differentiated from realities.

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