# Yoruba World View and the nature of Psychotic Illness

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**Abstract**
**Objective:** The Yoruba are an ethnic group in southern Nigeria. It is said that their world view centers around a continuous battle between forces of good and evil. Adverse events such as illness are due to the malevolence of enemies, using metaphysical means. Remedy often involves corrective metaphysical intervention, either exclusively or in addition to other methods, such as 'western Medicine'. This 'rule' is said to fit mental illness more than any other type of illness, although there is a lack of empirical data on the subject. This study is aimed at identifying elements of a Yoruba world view, and factors relevant to the perception and treatment of psychotic illness. **Method:** 500 Yorubas in Lagos were randomly sampled (with a questionnaire), and 100 'home video' films were analyzed. Data were analyzed for: elements of world view; elements that pertain to illness in general; elements that pertain to psychotic illness; how such illness is to be treated. **Results:** The world view has a significant influence on perception of psychotic illness. **Conclusion:** It is necessary to understand a people's world view in order to understand(and influence) attitudes towards psychotic illness in themselves and other people.

**Key Words:** World view; Psychotic illness; Perception.

**Received:** 04-12-2007
**Accepted:** 26-05-2008

## Introduction

'World view' (Weltanschaung) is a socio-cultural concept that encompasses a people's beliefs about the origins of the universe, and the place of man in it. The world view of a people colours their perception and reaction to every situation. It is especially important when it comes to health and illness. An insight into the person's world view is indispensable, if one is to comprehend meaningfully that person's condition and orientation towards significant issues and problems of existence. The notion that cultural and religious factors affect the manifestation and history of mental disorders has been around for a long time, according to Carothers, and Lambo.[1,2] The possibilities of the traditional Yoruba village as a therapeutic community have been studied by Osborne.[3] Erinosho explored the basis of traditional mental health care.[4] The same author studied the cultural factors in mental illness among the Yoruba, and compared the opinions and knowledge about mental illness in different societies.[5,6] Jegede explored the concept of 'Were' (psychosis) among the Yoruba, and concluded that the people's world view played a major part in defining the concept.[7] The outcomes of these investigations strongly indicate that socio-cultural factors play a significant role in treatment.[8] Elsewhere the conceptualizations of mental illness by South Africans of Indian descent and their mothers were studied by Bhana et al, and the relationship of Caribbean folk beliefs with Western Psychiatry were reported by Schwartz.[9] The belief systems that are widely prevalent in society have also been found to guide the diagnostic nosology of the traditional practitioners.[10] Perhaps the reason why such practitioners are so popular among the people is that they 'speak the same language' in this regard. Lately there is an increasing acceptance within the mainstream of Psychiatry that there is a need to show interest in the 'spiritual' dimension of the patient, principally in order to foster a sense of understanding, improve rapport, and get a complete picture of the patient's situation.[11]

It is a common observation for mental health care workers who have had the experience of working in African communities that many of their patients seek alternative therapies – either of the religious or traditional variety, in place

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of, or in addition to 'Western' psychiatric care. The theoretical perspectives that seek to explain such behaviour suggest a relationship between belief systems, cultural practices, and conceptualization of mental disorder.

The Explanatory Model (EM) that is prevalent in a community about an illness, or a group of illnesses obviously influences health-seeking behaviour. To the extent that traditional healers are known to exist in countries such as Kenya, Botswana and Zimbabwe, who specialize exclusively in the treatment of mental disorders, as distinct from other conditions, it is obvious that African societies recognize some distinction between the mind and the body. Some people have seen in this fact, and the similarities in what is identified as mental illness, a certain resemblance between African cultural perceptions of mental illness and the Euro-American model. However, there are quite clear differences, such as in the concepts held about the mind, its functions, and its localization in bodily structures.

Studies and interactions with traditional practitioners in Senegal, Uganda, Zimbabwe, Botswana, Ethiopia, Ghana, Swaziland, Guinea-Bissau, South Africa and Kenya show that there are great local variations in aetiological models of mental illness, although they have some common strands. Phenomenology is important to classification. Illnesses are divided into 'normal' and 'abnormal' , with the potential implication that the 'normal', or 'natural' ones will utilize either 'Western' medical services or traditional ones, whereas the 'abnormal' would be channeled virtually exclusively to traditional healers.[12]

There is a great deal of interest, but a paucity of empirical data on the whole subject of world view and explanatory models of mental disorder in Africa.

The current study aims to explore empirically, the relationship between the dominant parameters of the Yoruba world view and belief orientations, and their orientation towards illness in general and psychotic conditions in particular.

## Methods

The connection between the world view and perception of Psychotic disorders was explored in this study, using a two-part strategy. The first part involved the administration of a questionnaire designed by the researchers for this purpose. The second part involved the review of a number of films in the Yoruba language. Reviewers met inclusion criteria with respect to the requirements of the study.

The Ikeja area of Lagos metropolis, and rural communities in the Ikotun-Igando areas of Lagos State constituted the settings for the survey. The rationale for this strategy was to give representation to both rural and urban components of the Yoruba population.

500 randomly selected participants belonging to the Yoruba ethnic group domiciled in the catchment areas specified, constituted the sample for the first part of the study. The review of 82 Yoruba language films (from an original collection of 100 films) constituted the second part of the study. They were randomly selected from films produced in the past one year from the popular and very busy local film industry.

Two instruments were specifically designed for this study by the researchers:

*World View and perception of Psychotic illness questionnaire*

This is a 16 item instrument, containing 5 structured questions requiring mutually exclusive 'yes', 'no' or 'cannot say' responses, and 11 open-ended questions. This instrument was designed to explore three core thematic areas:

(a) Cosmological perspective- this involved 5 questions relating to belief systems regarding the origin of the universe, and forces of influence and control affecting human beings and events in the world.
(b) Perspectives on illness in general- the next three questions pertained to the perception of the cause of illnesses in general and the connection between falling ill and identified cosmological forces of influence.
(c) Perspectives on mental illness- the next 7 questions pertained to perception of the nature, causes treatment and forces or influences affecting these aspects of mental illness. The final question pertained to the perception of difference between physical illnesses and mental illness with respect to causation and treatment.

The initial section of the questionnaire captured key socio demographic data pertaining to the participants sans identity to protect confidentiality.

*Development and psychometric properties of the instrument*

Given the nature of the study, which is essentially an exploratory one, three core thematic facets of the main theme of the study were operationalized in a combination of 5 close-ended and 11 open-ended questions. Both English and Yoruba versions of the questionnaire were produced. The English version was constructed first. It was then translated into Yoruba by a collaborator who is fluent in both languages. A pre test of the instrument was carried out by administering 20 English and 20 Yoruba questionnaires to 20 urban and rural subjects respectively by the research team. Feedback from the pretest indicated that the questionnaires were well understood by the pre test sample. The open ended component of question 16 was however found to be confusing. This was deleted from the instrument, while retaining the closed ended component of the question.

This questionnaire has not been standardized, nor are there any reliability indices. The face validity of the instrument was however evaluated by showing the instrument without the caption to 20 medical doctors and 20 nurses from the Lagos State University Teaching Hospital. They were asked independently to state what the questionnaire was evaluating. All subjects stated that the instrument evaluated the belief systems of the respondents and the relationship of the beliefs identified to physical and mental illness. This indicates that the instrument is a valid one, at the face validity level, for the purpose for which it was designed.

*Film Content Analysis Review Questionnaire*

This is essentially a structured instrument with just 1 open-ended question. The instrument consists of 3 sections:

- Section A focuses on the film features and has 4 structured questions requiring direct answers.
- Section B has 1 structured question requiring a yes or no response relating to the existence of a 'psychosis' or madness theme in the film.
- Section C comprises of 4 structured multiple-choice format

check list type questions and 1 open ended question. This section addresses the thematic content of the film being reviewed with respect to the portrayals of the theme of psychosis. Specific areas explored in this section relate to the individuals affected by madness, and the cause, management and outcome of the intervention as portrayed in the film.

The inter-reviewer agreement of the instrument was assessed by two of the reviewers viewing the same five films. It was found that there was complete agreement on the answers to the questions except for the open ended question where there were some variations in the reviews. In general the instrument was deemed to possess adequate inter rater agreement level.

*Procedure*

The first part of the study involved the administration of the 'World View and perception of psychosis' questionnaire to the study sample. 250 English and 250 Yoruba questionnaires were administered to urban and rural Yoruba participants randomly selected respectively from the catchments areas identified. The administration was carried out by 2 collaborators from the social work and nursing departments of the Lagos State University Teaching hospital. In the few instances where participants were unable to read the questionnaires, the collaborators administered the questionnaires themselves, verbally eliciting then responses, and noting them down.

In the second part of the study, 100 Yoruba language films were distributed to reviewers who were selected on the basis of their knowledge in psychiatry and psychopathology. Medical students of the Lagos State University College of Medicine who had completed their one month clinical posting in Psychiatry formed the bulk of the reviewers. Staff members from the psychiatry department including psychiatrists, and psychiatric nurses also participated in the review process. All reviewers belonged to the Yoruba ethnic group and were fluent in the language.18 of the films were found to be defective. Thus 82 films were properly reviewed and constituted the effective sample for analysis.

*Data Analysis*

Data was computer analyzed using the SPSS package version.

*World view and psychotic illness*

A total of 440 properly answered questionnaires were returned and constituted the effective sample for analysis. The responses elicited were content analyzed in two stages.

The first stage involved the location of each response to one thematic content area within one of the following 7 emergent factors.

1. The metaphysical supernatural domain.
2. Natural, physical or organic domain.
3. Psychological, intra-psychic or behavioral domain.
4. Social, interpersonal domain.
5. Stress factor.
6. Yoruba traditional domain (only where specified)
7. Combinations of the above.

The second stage involved frequency analysis of the response factors for each thematic content to determine the thematic profile.

*Film Content analysis*

Frequency analysis of each of the responses to each question was carried out to generate the thematic content profile of the films reviewed. The content areas analyzed were as follows:

1. Category of persons affected by psychosis or madness in the film.
2. The cause of the ailment as portrayed by the film.
3. The management or treatment of the psychosis in the film.
4. The outcome or resolution of the psychosis or madness.
5. In addition, there was an open ended question exploring the reason for the outcome.

Frequency analysis of the emergent categories was undertaken.

**Results**

*Socio-Demographic Profile*

*Gender distribution:* Males constituted 44.3% and Females were 29.1%. 26.6% of the participants did not indicate their gender.

*Educational profile:* Graduates (40.9%), Post graduates (6.3%) and School certificate holders (18.3%) constituted the bulk of the participants. This indicates a reasonably high level of literacy in the sample.

*Occupational Profile:* 27 occupational categories were reported. Civil servants (19.6% ), business persons (15.7%), Teachers (9.1% ) and Students (12% ) were the largest groups. Participants thus represented a wide variety of occupations.

*Age:* The mean age was 35.14 (sd=9.72) with a range of 17 to 76.

*Location:* 45.5% were from rural areas while 51.6% were from urban areas. 3% did not indicate. This shows a fairly even rural – urban distribution of participants.

*State of Origin:* 50.3% of the participants were from Lagos State. The rest of the participants were spread across 6 other states representing all the predominantly Yoruba speaking areas in Nigeria.

The socio-demographic parameters indicate a wide distribution indicative of a broad representation of the Yoruba population in Lagos.

*World View Analysis*

Table I shows the analysis of the world view of the Yoruba based on the responses of the 440 participants surveyed. Origin of the cosmos was attributed overwhelmingly to metaphysical forces. There was substantial level of belief in controlling forces, which were also considered predominantly as emanating from the metaphysical realm. There was no clear consensus on the impact of these forces on humans. While the impact of these forces were considered to be more negative than positive, most of the participants were of the view that the impact was a combination of positive and negative influences or were unsure. The majority of the participants indicated that forces impacted humans mainly through metaphysical means.

**Table I: World View Analysis**

| | *Variable* | *Response categories (N & %)* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| No | | Meta-physical 9A) | Natural / Physical (B) | Psychological/ Intrapsychic (C) | Inter personal/ social (D) | Stress related (E) | Combinations | No response | Total |
| 1 | Origin of Cosmos | 398 (90.5%) | 15 (3.4%) | - | - | - | 16 (3.6%) (A&B) | 11 (2.5%) | 440 (100%) |
| 2 | Existence of controlling forces | Yes 380 (86.4%)<br>No 22(5%)<br>Cannot say 38(8.6%) | | | | | | | 440 (100%) |
| 3 | Identity of controlling forces | 349 (79.3%) | 16 (3.6%) | 5 (1.1%) | 3 (0.7%) | | 5 (1.1%) | 62 (14.1%) | 440 (100%) |
| 4 | Nature of impact of forces | Positive – 66 (15%)<br>Negative – 95 (21.6%)<br>Positive & negative – 108 (24.5%)<br>Not sure 171 (28.9%) | | | | | | | 440 (100%) |
| 5 | How forces affect humans | 291 (66.1%) | 25 (5.7%) | 13 (3%) | 1 (0.2%) | 2 (0.5%) | 12 (2.7%) | 96 (21.8%) | 440 (100%) |

***Perspectives on physical illness***

Table II shows the perspectives of the participants on physical illnesses in general with respect to their etiology, and the relationship between forces of influence and physical illnesses.

More than one third of the participants cited organic physical factors as being responsible for falling physically sick. Substantial numbers cited combination of factors. Among the possible combinations identified, the most prevalent pattern involved metaphysical and physical factors. Other notable combinations include organic factors and stress, as well as the combination of psychological and physical factors. With respect to impact of forces of influence, a substantial majority of participants felt that there is a connection between forces identified and physical illness. These forces were also predominantly metaphysical in nature. A substantial number of participants were also not sure of the nature of influence. In general, analysis of the pattern indicates that factors that affect one's physical health are predominantly supernatural and metaphysical. However the actual causation of illnesses can be substantially explained in terms of physical, natural and scientific perspectives.

***Perspectives on mental illness***

Tables III and IV show the perspectives of the participants on mental illness (Psychosis or ''Insanity'' in particular) with respect to the beliefs and ideas regarding the nature, causation and treatment, as well as forces or factors that influence these aspects.

Psychotic conditions are predominantly viewed as manifestation of abnormal or dysfunctional thinking and behaviour. However, a substantial number of participants considered it as an organic and physical ailment. Only a few considered it as a supernatural phenomenon. Whilst mental illness appears to be perceived as being mainly caused by

**Table II: Perspectives on Physical Illness**

| | *Variable* | *Response categories (N & %)* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| No | | Meta-physical (A) | Natural /Physical (B) | Psychological/ Intra psychic (C) | Interpersonal/ social (D) | Stress related (E) | Combinations | No response | Total |
| 1 | Causes of illness | 51 (11.6%) | 163 (37%) | 26 (5.9%) | 0 (0%) | 55 (12.5%) | 127 (28.9%) | 18 (4.1%) | 440 (100%) |
| 2 | Combination analysis (3 most prevalent | Metaphysical & Physical – 56 (12.7%)<br>Physical, Organic & Stress – 15 (3.4%)<br>Psychological & Physical – 14 (3.2%)<br>Others – 42 (9.6%) | | | | | | | 127 (28.9%) |
| 3 | Connection between identified forces and falling sick | Yes. Connection Exists – 287 (65.2%)<br>No. There is no connection – 75 (17%)<br>Not sure – 78 (17.8%) | | | | | | | 440 (100%) |
| 4 | Nature of influence of forces on course of illness | 192 (43.2%) | 32 (3%) | 15 (3.4%) | 7 (1.6%) | 4 (0.9%) | 40 (9.1%) | 150 34.1%) | 440 (100%) |

**Table III: Perspectives on Mental Illness: General concepts & Etiology**

| | *Variable* | *Response categories (N & %)* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| No | | Meta-physical (A) | Natural /Physical (B) | Psychological/ Behavioiural (C) | Interpersonal/ social (D) | Stress related (E) | Combinations | No response | Total |
| | Nature of Mental Illness | 12 (2.7%) | 126 (28.6%) | 257 (58.4%) | 2 (0.5%) | 7 (1.6%) | 27 (6.1%) | 9 (2.1%) | 440 (100%) |
| 1 | Causes | 29 ((6.6%) | 96 (21.8%) | 48 (10.9%) | 7 (1.6%) | 10 (23%) | 228 (51.8%) | 22 (5%) | 440 (100%) |
| 5 | Combinations (Causes) | Metaphysical & Organic – 90 (205%)<br>Physical & Psychological – 27 (6.1%)<br>Metaphysical & Psychological – 22 (5%)<br>Other Combinations – 89 (20.2%) | | | | | | | 228 (51.%) |
| | Connection with forces of influence | Connection exists – 300 (68.2%)<br>Not connected 59 (13.4%)<br>Nom sure – 81 (18.4%) | | | | | | | 440 (100%) |
| | Curability | Is Curable – 373 (848%)<br>Not curable 7 (6.1%)<br>Cannot say 39 (9.1%) | | | | | | | 440 (100%) |

natural, organic factors these factors are also seen to be combined to a considerable extent with metaphysical or supernatural forces on the one hand, and psychological factors on the other to cause mental illness.

The general emerging perspective when the total pattern is examined appears to be a multi-factorial view of the etiology of psychotic conditions, with the strongest component being organic factors

Mental illness appears to be considered as being closely connected to forces which are mainly of spiritual, supernatural or metaphysical. With respect to the curability of mental illness, an extremely optimistic orientation emerged, with more than four fifths of the participants stating that it is curable.

The preferred treatment strategy emerges as 'Western' psychiatric care by itself, or in combination with metaphysical approaches. Psychiatrists also emerged as the major group who are considered as being able to treat mental illnesses. A notable feature that emerged is the propensity for multiple

**Table IV: Perspectives on Mental illness: Treatment approaches**

| | *Variable* | *Response categories (N & %)* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| No | | Meta-Physical (Spiritual) (A) | Psychiatric (B) | Psychological/ Behavioural (C) | Interpersonal/ Social/Community based (D) | Traditional (E) | Combinations | No response | Total |
| | Treatment Strategies | 68 (15.5%) (includes traditional therapies) | 192 (43.6%) | 13 (3%) | 4 (0.9%) | | 135 (30.7%) | 26 (6%) | 440 (100%) |
| | Treatment strategy combinations | Metaphysical & Psychiatric – 106 (24.1%)<br>Medical (Psychiatric) and Psychological – 11 (2.5%)<br>Spiritual and Psychological -5 (1.1%)<br>Other combinations 13 (3%) | | | | | | | 135 (30.7%) |
| 5 | Treating Person | 65 (14.8%) Religiously oriented spiritualists | 178 (40.7%) Psychiatrist | 7 (1.6%) Psychologist & counsellors | 3 (0.7%) Social workers / community therapists | 11 (2.5%) Traditional therapists | 162 (36.8%) | 11 (2.5%) | 440 (100%) |
| | Combinations (Treating person) | Religiously oriented spiritualist & Psychiatrist – 71 (16.1%)<br>Psychiatrist & Traditional therapist – 35 (8%)<br>Pastor, Psychiatrists & Traditional therapist – 27 (6.1%)<br>Other combinations – 9 (6.6%) | | | | | | | 162 (36.8%) |

consultations, particularly involving the psychiatrists and spiritualists or pastors on the one hand, and psychiatrists and traditional therapists on the other. There were also a considerable number of participants who would consult the psychiatrist, the pastor or spiritualist, as well as the traditional therapist.

*Film content analysis*

Table V shows the results of the content analysis of 82 Yoruba films with respect to the incidence and treatment of the theme of mental illness in the films, with specific reference to issues of causation, treatment and outcome.

More than one third of the films were found to have mental illness, specifically psychosis as a theme as part of the story. This suggests that there is a substantial level of interest in mental illness as a theme in the environment. With respect to who was afflicted with mental illness, the bulk of the films portrayed adults as being afflicted with psychosis, males being almost twice as many as the females. In other age categories, a few films depicted elderly people and female children as well. Causation of mental illness comes across as being multi-factorial in the films. The viewpoint that supernatural forces cause mental illness is the most widely prevalent. However, the combination of social and family issues and interpersonal relationship issues is the most prevalent causative factor portrayed.

Spiritual approaches to the treatment of mental illness was the most prevalent management scenario. In combination with Traditional therapy, alternative metaphysical approaches appear to be the most dominant therapeutic pathway as portrayed in the films. More than half the films portrayed the outcome of the mental illness as being unresolved. Nevertheless, a quarter of the films showed complete cure. Almost half the films did not identify any reason for the outcome. A variety of factors however emerged as being responsible for the outcome, for the remaining films, with negative emotions and personality characteristics being more prevalent than the others.

**Table V: Film Content Analysis**

| *No* | *Variable & Response Category* | *N* | *%* |
|---|---|---|---|
| | *Presence of Psychosis* | | |
| 1 | Yes. Psychosis is present | 32 | 39 |
| 2 | No. Psychosis is not present | 50 | 61 |
| | Total | 82 | 100 |
| | *Characters affected by psychosis in film* | | |
| 1 | Adult Males | 23 | 72 |
| 2 | Adult Females | 13 | 41 |
| 3 | Elderly Males | 5 | 16 |
| 4 | Elderly Females | 3 | 9 |
| 5 | Adolescent Males | 1 | 3 |
| 6 | Female Teenagers | 1 | 3 |
| 7 | Male Children | 0 | 0 |
| 8 | Female Children | 3 | 9 |
| 9 | Infant Males | 0 | 0 |
| 10 | Infant Females | 0 | 0 |
| | *Causes of Psychotic illness as portrayed in the films* | | |
| 1 | Physical / Biological factors | 3 | 9 |
| 2 | Social / Family conflicts | 10 | 31 |
| 3 | Interpersonal / Relationship issues | 9 | 28 |
| 4 | Stress (physical/psychosocial/Lifestyle) | 6 | 19 |
| 5 | Supernatural Forces | 13 | 41 |
| 6 | Promiscuity | 1 | 3 |
| | Not clear | 2 | 6 |
| | *Treatment of Mental Illness* | | |
| 1 | Medical / Psychiatric treatment | 5 | 16 |
| 2 | Spiritual approaches / Prayers | 11 | 34 |
| 3 | Traditional (Culture based approach) | 8 | 25 |
| 5 | No treatment | 8 | 25 |
| | Total | 32 | 100 |
| | *Resolution / Outcome* | | |
| 1 | Complete cure | 8 | 25 |
| 2 | Partial cure | 1 | 3 |
| 3 | No cure or left unresolved | 18 | 56 |
| 4 | Death | 5 | 16 |
| | Total | 32 | 100 |
| | *Factors responsible for outcome* | | |
| 1 | No factor identified | 15 | 47 |
| 2 | No cure attempted | 1 | 3 |
| 3 | Accidental occurrence | 1 | 3 |
| 4 | Negative emotional states | 6 | 19 |
| 5 | Dysfunctional Personality characteristics | 5 | 16 |
| 6 | Appropriate Medical intervention | 2 | 6 |
| 7 | Positive spiritual approaches | 2 | 6 |
| | Total | 32 | 100 |

## Discussion

It is apparent that the majority of the participants believed that metaphysical or supernatural forces are primarily responsible for the origin of the universe. These forces also control human beings and what happens in the world. The nature of the impact can be positive, negative or a combination of both, and they exert their influence mostly through metaphysical means.

The causes of illness are considered to be mostly organic or physical in origin, while in many instances spiritual forces combine with the physical processes to produce illness. Supernatural or spiritual forces are also perceived to play a dominant role in influencing the course of illness.

Mental illness is predominantly considered as psychological and behavioral, or an organic phenomenon (brain disorder or drug addiction). The cause of mental illness is considered to be primarily organic, in combination with metaphysical factors. As in the case of other illnesses in general, mental illness is also considered to be influenced by metaphysical or supernatural forces.

The prognosis for mental illness is generally optimistic, with substantial numbers of participants stating that the

condition is curable. Medical and psychiatric intervention emerged as the preferred treatment mode. However, there was substantial preference for combining medical treatment with spiritual approaches - the religiously based as well as traditionally based.

The popularity of local home video films, which leads to the production and release of thousands of films every year (most of which are for the domestic market) is an indication that they deal with content which resonate with the thinking and belief systems of the population. There is a preoccupation with the theme of madness which seems greater (at 39%) than what one sees with Hollywood films. Most of the patients in the films are male adults. The causation of the condition is 'supernatural' or due to stress or relationship difficulties. Treatment is usually by spiritual or traditional intervention. Outcome may be complete cure, no cure, or even death. There is no clear statement about what has brought about such an outcome in each case.

One factor that clearly emerges is that there is a strong current of positive orientation towards psychiatric intervention for mental illnesses, particularly psychosis. However, the intensity of the metaphysical or spiritual orientation towards most phenomena also affects the Yoruba approach to mental illness. This might be the underlying rationale for substantial number of participants indicating a combination of spiritual or traditional and medical treatments for psychosis.

A notable difference in the findings of the two components of the study pertains to treatment strategies for psychotic conditions. While the questionnaire survey strongly indicates support for hospital-based psychiatric treatment, the films depict preference for alternative therapies. Films are artistic expressions that often mirror endemic belief systems, but they are also prone to some degree of dramatization and exaggeration. Taken together however, the findings may reflect a certain ambivalence in the minds of the Yoruba regarding the most effective therapeutic approach for psychotic conditions.

When practising in the Yoruba environment, it is important to understand the mind-set of the patient and their relations in order to have a meaningful therapeutic relationship. Such findings as these would explain for instance, why the relatives of the patient on admission would insist on bringing someone to 'pray' for him while he is receiving treatment on the ward. They would do other things, such as smuggling in other medicines to be used on the wards, or requesting to take the patient away for brief spells for other interventions. An early and open discussion on the patient's world view would eliminate the need for subterfuge and generally create a healthy communication.

Many factors influence the outcome of treatment, including the family milieu of the patient, according to Erinosho.[13] The family milieu may itself be influenced for good or ill by the prevalent world view – for instance where it creates a judgmental or blame-setting attitude that implies the patient is somehow responsible for his condition.

The implications of the findings from this research in the Nigerian environment are multifarious, despite the fact that its coverage has been deliberately restricted to psychotic illness. They range from those for the patient himself, to the family, and the society at large.

With regards to the patient, there is at least a certain amount of ambivalence about whether their issues can be fully addressed through biomedical intervention. They may have tried to get help from traditional and/or spiritual sources before presenting in hospital. They may show a readiness to try these alternatives even while undergoing conventional treatment. Treatment compliance in the short or long term may be adversely affected, with the patient losing patience with the requirement for long-term care, which may be held as evidence that biomedical intervention was not appropriate in the first place, and other alternatives should be sought. The cost factor is also significant, as the other forms of intervention are generally cheaper than the conventional, especially where treatment has to be taken over a long time, and newer drugs such as atypical anti-psychotics are employed. All of these are common observations in the clinical practice environment in Lagos, and elsewhere in Nigeria.

Similar considerations influence the judgment and behaviour of family members, who are often the ones charged with making decisions about what service to use and what expectations are logical from the treatment process. Any apparent delay in achieving full recovery with the use of biomedical interventions immediately plays into the existing doubts about appropriateness and efficacy of the whole process. Often the decision is to 'play safe' by combining alternatives. Such common observations become understandable in the light of the findings.

The findings also reveal a clear line of discontinuity between 'normal' persons and the 'mentally ill'. Despite some expression of optimism about outcome of treated illness, the 'well' person does not see themself in the situation of the 'ill' person. It is fertile ground for stigma. It is a common observation that there is significant social distance even within the healthcare community in Lagos, and in other parts of Nigeria. There is widespread stigma in the larger community, and these have not been affected to a remarkable extent by the anti-stigma initiatives that have been undertaken so far.

The 'points of attack' for the design of future interventions to influence help-seeking behaviour and to influence attitudes to mental illness are identifiable from the results presented. Anti-stigma campaigns would need to be tailored to fit the different strands of the world view and culturally prevalent explanatory models.

## Conclusion

It is important for everyone practising in an African community to make efforts to be aware of the socio-cultural environment and the world view that is prevalent in it. It is not required that such beliefs are accepted uncritically. What is required is that beliefs, and the people's rights to hold them, are acknowledged. By such practice, the humanity and integrity of the individual are affirmed, and communication, treatment, and rehabilitation are facilitated. Open acknowledgement would also open up discussion channels with traditional practitioners and other forms of alternative practices, and facilitate the eventual attrition of dangerous practices based on inaccurate assumptions.

It would be useful to employ the same instruments to survey different populations within Africa to get an insight into their world views and the explanatory models they have developed on the subject of mental illness.

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## ANNOUNCEMENT

# The Association for the Improvement of Mental Health Programmes (AIMHP) Small Grants Programme

Problems of breaking through the bureaucracy of low income countries with any projects - even the most ingenious ones - are severe. The delays and official chicanery discourage even the most motivated people who, after a while, give up trying.

To support community initiatives aiming to help people with mental illness and their families, the AIMHP is announcing a new programme aiming to provide help to the establishment and functioning of community projects developed to support people with mental illness and their families – such as the creation or strengthening of patient or family self-help and mutual help groups - as well as other initiatives sharing the same goal, particularly in the least developed countries (LDCs). The AIMHP launched this programme in 2006 with the support of an unrestricted grant by the Eli Lilly Company.

Applications should be in English, presented in typed-written form and be no longer than two pages. Applications should describe what has been done already, and for what specific purpose the support is requested. They should also include a list of individuals involved in the development of the project as well as the address of the person with whom the AIMHP should correspond, and a budget expressed in USD or Euros. Additional material can be provided in annexes. Proposals from developing countries and in particular from the least developed countries will be given priority consideration.

Successful candidates will receive a grant that has to be used for the project submitted to the AIMHP and found worthwhile by an international committee composed of experts in the relevant fields who, in addition to their expertise, have a good knowledge of the situation in the LDCs, and of representatives of patient and family organizations. The grants are limited to a maximum of USD 5'000. The support is intended as a one-time-only grant and will not be repeated. The grants provided are not meant to cover or contribute to the normal functioning of an institution or project, i.e., costs of personnel, hiring of buildings and other recurrent expenses. A report of what has been achieved will be requested and will be published in an appropriate manner.

**Applications should be sent by email, fax or in hard copy to the following address:**
Action for Mental Health
Association for the Improvement of Mental Health Programmes
c/o Professor Norman Sartorius, President
14, chemin Colladon
1209 Geneva, Switzerland
E-mail: sartorius@normansartorius.com