PSYCHIATRY EPIDEMIOLOGY AND COLONIAL HISTORIES

Psychiatric Epidemiology and the "African Mind": Quantifying Madness in Colonial Nigeria

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Abstract

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Keywords*: psychiatry, epidemiology, Nigeria, colonialism, decolonization*

Résumé

L'épidémiologie psychiatrique et l'« esprit africain » : quantifier la folie dans le Nigeria colonial

Matthew M. Heaton est Professeur associé au département d'histoire de Virginia Tech, à Blacksburg, en Virginie (États-Unis). Ses recherches portent sur l'histoire de la santé et de la maladie, les migrations et la mondialisation en Afrique, en particulier sur le Nigeria. Il est l'auteur de *Black Skin, White Coats : Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry* et est le co-auteur de *A History of Nigeria*. Dans cet article, il montre comment les histoires coloniales peuvent influencer notre compréhension de l'évolution chronologique et spatiale de l'épidémiologie psychiatrique, en utilisant le Nigéria comme étude de cas.
Mots-clés : psychiatrie, épidémiologie, Nigeria, colonialisme, décolonisation

The historiography of psychiatry has seen significant expansion in recent decades, with a growing emphasis placed on the development of psychiatric knowledge and practice in non-western settings[1]. In most of these regional histories, processes of European colonialism have been central to examining the structural roots, discursive frameworks, and contemporary legacies of mental health care. Recent works have begun to emphasize the effects of decolonization and the emergence of independent, technocratic states on psychiatric knowledge production and practice in Africa and Asia in the 1950s-60s[2]. Psychiatric epidemiology, however, continues to be neglected within this increasingly globalized field. The histories of psychiatric epidemiology that do exist tend to focus on developments primarily in Europe and North America[3]. Efforts to internationalize the history of psychiatric epidemiology have focused heavily on developments at the World Health Organization and other centralized bodies[4]. There may be reasons for this. While all sites of colonial psychiatry engaged in knowledge production to buttress the logics of everyday practice in one way or another, only a few were invested in scientific acquisition of data about the nature of mental illness in colonial populations, a crucial intention of any work that could reasonably be called epidemiological. In general, it is difficult for historians to tell histories of things that did not happen, or to which they cannot attach great significance.

However, this article aims to demonstrate the ways that colonial histories should impact our understanding of how psychiatric epidemiology has developed chronologically and spatially, using Nigeria as a case study. For most of the colonial history of Nigeria, which lasted from roughly 1900 to 1960, colonial officials were neither qualified nor motivated to assess mental illness amongst colonial subjects. Little knowledge production that could be considered even proto-epidemiological was undertaken. This changed significantly from the 1950s, however, when stronger efforts were made to refine and count patient diagnoses and to assess psychiatric symptoms in general populations. Through this brief overview, I want to suggest that the structures of colonialism and decolonization largely determined when, where, and on what terms psychiatric epidemiological research could happen. As such, the broader contexts of colonialism and decolonization should be considered in

1 Some of the most recent monographs in this field include Leckie J. *Colonizing madness: asylum and community in Fiji.* Honolulu: University of Hawai'i Press, 2019; Kilroy-Marac K. *An impossible inheritance: postcolonial psychiatry and the work of memory in a West African clinic.* Berkeley: University of California Press, 2019; Edington C. *Beyond the asylum: mental illness in French colonial Vietnam.* Ithaca: Cornell University Press, 2019; Meyer M. *Reasoning against madness: psychiatry and the state in Rio de Janeiro, 1830-1944.* Rochester: University of Rochester Press, 2017; el Shakry O. *The Arabic Freud: psychoanalysis and Islam in modern Egypt.* Princeton: Princeton University Press, 2017.

2 Heaton MM. *Black skin, white coats: Nigerian psychiatrists, decolonization, and the globalization of psychiatry.* Athens: Oh: Ohio University Press, 2013.

3 Fuhrer R, Robins L. The epidemiological study of mental disorders since the beginning of the twentieth century. In Holland WW, Olsen J, and du V. Florey C eds. *The development of modern epidemiology: personal reports from those who were there*. Oxford: OUP, 2007; Horwitz AV, Grob G. The checkered history of American psychiatric epidemiology. *The Millbank quarterly,* Dec 2011, 89(4); 628-57; Demazeux S. Psychiatric epidemiology, or the story of a divided discipline. *International journal of epidemiology*, 2014, 43: i53-i66; March D, Oppenheimer GM. Social disorder and diagnostic order: the US mental hygiene movement, the midtown Manhattan study and the development of psychiatric epidemiology in the 20th century. *International journal of epidemiology*, 2014, 43: i29-142.

4 Lovell AM. The World Health Organization and the contested beginnings of psychiatric epidemiology as an international discipline: one rope, many strands. *International journal of epidemiology*, 2014, 43: i6-18; HY W. World citizenship and the emergence of the social psychiatry project of the World Health Organization, 1948-c.1965. *History of Psychiatry,* 2015, 26, 2: 166-81.

histories of psychiatric epidemiology alongside scientific developments and programs initiated in Europe and North America if we are to understand the genealogies of the field and its contemporary contours.

No Knowledge is Power in Colonial Nigeria

Early colonial governments in Nigeria established two lunatic asylums in the south, one at Yaba outside Lagos in 1906 and one in Calabar shortly after. A number of smaller asylums run by Native Administrations existed in the various provinces of Nigeria. However, nothing resembling psychiatric medicine or science existed alongside those asylums. They were primarily places where excessively violent, aggressive, or otherwise dangerous "lunatics" were sequestered from society in the interests of preserving social order. No psychiatrist was even posted in Nigeria prior to the 1950s, with the exception of a brief period in the late 1920s and again in the late 1940s[5].

As a result, the only meaningful categorization of "madness" for colonial authorities was as a broad category of easily identifiable and unacceptable behavior. Capacity for differential diagnosis was extremely limited, and the value of such distinctions was immaterial in a situation in which treatment for specific illnesses was not a serious consideration anyway. People went into the asylum only when their "madness" was too conspicuous to ignore and were frequently discharged upon prompting from family if dangerous behaviors had subsided in the interim. Over half of all committed "lunatics" found their way into one of the asylums as a result of having committed a violent crime[6]. The act itself was often the best evidence of insanity.

Take as an example, the case of O.O., "a woman of between 25 and 30 years" who, shortly after the birth of her fifth child in 1937, murdered her husband's uncle in cold blood. The judge in the case described the murder thusly:

> The facts of the murder were that while J.N. [the victim] was sitting chatting with his sister the accused walked slowly into the room where they were, with her hands behind her back. When she got up to J.N. without saying a word, she produced a matchet from behind her back and taking it in both hands she hit J. with such force on the top of his head that his skull was split and his brains protruded. As a result of this wound J.N. died in hospital. After hitting J.N. with the matchet the accused sat down quietly[7].

The judge ultimately found the accused guilty by reason of insanity on the grounds that:

> at the same time the murder was committed the accused was suckling an infant of a few months and according to the doctor who gave evidence in the case, the facts of the case as I have narrated them suggested to his mind that the accused must have had an attack of acute violent madness which sometimes comes to a woman just before or just after child birth or while she is suckling a child.

Such a diagnosis was not uncommon. Historians writing from a variety of colonial context have noted the high rates of gendered psychosis attributed to female reproduction, menstruation, and lactation[8].

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5 Sadowsky J. *Imperial Bedlam: institutions of madness in colonial southwest Nigeria.* Berkeley. University of California Press, 1999.

6 *Ibid*.

7 Nigerian National Archives, Ibadan (NNAI), MH 624/21, G. Graham Paul, Puisne Judge, Acting High Court Just, Ibadan Division to the Governor of Nigeria, Lagos, 6 December 1937.

8 Leckie J. Unsettled minds: gender and settling madness in Fiji. In Mahone S and Vaughan M eds. *Psychiatry and empire.* New York: Palgrave, 2007: 99-123; Jackson L. *Surfacing Up: psychiatry and social order in colonial Zimbabwe, 1908-1968.* Ithaca: Cornell University Press, 2005, ch.4; Edington, *Beyond the asylum…, op. cit.*: 70-2.

O.O.'s puerperal psychosis, however, was not diagnosed on the basis of medical examination per se, but on the judge's inability to determine a rational motive for her violent outburst. As he noted, "There seemed to me to be no other possible explanation on the evidence before me and I therefore on 1st December, 1937, found the accused guilty of murder but insane at the time when she committed the murder[9]" O.O. was transferred to Yaba Lunatic Asylum where she spent the next year before being declared of "sound mind" in December, 1938.

This example demonstrates several characteristics of the process of diagnosing "madness" in colonial Nigeria. First of all, the primary evidence of psychiatric disorder comes not from a case history or interview, but from a single inexplicable and, in this case, criminal act. There is no detailed diagnosis offered, and the judge's conclusion of "insanity" is by his own account based on a flimsy postulation about post-partum psychosis arrived at mainly as a result of finding "no other possible explanation." It is worth pointing out that no one involved in O.O.'s case was a trained psychiatrist, there being none in Nigeria at the time. As a result, O.O. was declared insane, incarcerated for a year for a crime she clearly committed, and a year later declared of "sound mind" and released, all without the intervention of anyone with specialized knowledge of mental illness. A system that operated on these terms placed little value on quantifying or assessing mental illness, and made no particular effort to do so. And given the process by which individuals found their way to asylums, any data produced about the form, content, or prevalence of psychiatric disorder was highly questionable, and was recognized as such at the time[10].

Such was the conclusion of Dr. R. Cunyngham Brown, a one-time Deputy Commissioner of Lunacy for Scotland, to conduct an independent study of mental health policy in Nigeria in 1936[11]. Brown canvassed Nigeria from June to September 1936, visiting the two colonial mental asylums in Yaba and Calabar, as well as dozens of native administration asylums, prison asylums, and even some indigenous medical practitioners, who it was well recognized treated the vast majority of the cases of psychiatric disorder in Nigeria. In his report, Brown attempted to quantify the overall incarceration rate and to distinguish discreet diagnoses within the larger asylums. He found that in the twelve months ending March 31, 1936, 290 persons (247 male, 43 female) had come to the attention of colonial authorities as potential lunatics. Of these, 169 (58%) were ultimately certified insane and placed in asylum. Using contemporary estimates for the population of Nigeria, the admission rate in Nigeria was thus approximately 8 per 1,000,000, compared to a rate of 8.8 per 10,000 in England and Wales. Nigeria was identifying 100 times fewer lunatics proportionately than the imperial metropole. While Brown gave lip service to the prevailing notion that Africans suffered less mental illness than "more civilized" Europeans, he nevertheless concluded that the vastness of the discrepancy "strongly suggest[s] that the numbers of lunatics discovered to official bodies have little relation to the true annual rate of lunacy in these provinces[12]."

Brown also attempted differential diagnoses both of patients in a handful of native administration asylums and home care patients outside of asylums. He appears to have made these diagnoses based on his own notes from interactions with the patients. Brown found dementia praecox to be the most common disorder among home care patients at 18 percent, with a variety of more general diagnoses following behind: "imbecility" at 15.5, secondary dementia (12), confusional insanity (11.2) and delusional insanity (10.6) rounding out the top five. Following conventional wisdom, he found

9 NNAI, MH 624/21, G. Graham Paul, Puisne Judge, Acting High Court Just, Ibadan Division to the Governor of Nigiera, Lagos, 6 December 1937.

10 Shelley H and Watson W. An investigation concerning mental disorder in the Nyasaland natives. *Journal of mental sciences,* 1936, 82: 703.

11 Sadowsky J. *Imperial Bedlam…, op. cit.*: 102.

12 Cunyngham Brown R. *Report III on the care and treatment of the mentally ill in British West African colonies.* London. Garden City Press, 1938: 19.

depressive disorders to be quite rare, accounting for only 2.5 percent, with manic-depression another 7 percent[13]. Findings for institutionalized lunatics mirrored home care patients with dementia praecox and secondary dementia the most common. Differences with home care patients were found in lower rates of "imbecility" in asylum populations, and higher rates of chronic mania in asylums, in keeping with asylums' tendency to house more agitated, uncontrollable individuals.

Brown's methodology is unclear from the report, and his diagnostics were less important to colonial officials than his general conclusions that conditions in asylums were abysmal and that home care offered a more humane, and cheaper, method of treating most psychologically disturbed subjects. Partly as a result of Brown's report, little was done to improve the mental health infrastructure of Nigeria until after the Second World War.

Decolonization and Cross-Cultural Psychiatric Epidemiology

Concerted efforts to develop epidemiological approaches to the understanding of mental illness prevalence in Nigeria began in the mid-1950s. Key to this development was the founding of Aro Mental Hospital in Abeokuta in 1954 as Nigeria's first treatment-oriented psychiatric facility, and the hiring of Thomas Adeoye Lambo, Nigeria's first European-trained psychiatrist of indigenous background, as its first superintendent in 1957. The timing of these developments is not a coincidence. Both can be linked directly to the political and social transformations of decolonization, as Nigeria made graduated steps toward independence. In this late colonial context, Lambo made a number of important contributions to the development of psychiatric knowledge and practice, both in Nigeria and internationally, including his famous Village Scheme experiment. His novel approaches to diagnosis and the epidemiological implications within them were among the most significant[14].

Two quick examples of Lambo's diagnostic interventions should suffice. First, whereas earlier colonial psychiatric orthodoxy (to the extent there was such a thing) found schizophrenia to be a higher risk for literate, urban, "detribalized" Africans, Lambo argued that schizophrenia was actually much more common amongst, rural, illiterate, "tribal" populations than assumed. He argued that Europeans simply could not identify the symptoms effectively because they were not attuned to indigenous cultures[15]. Second, Lambo also contested the notion that Africans rarely experienced depression, again arguing that Europeans simply could not identify the symptoms of depressions amongst populations that frequently did not have cognate words in indigenous languages for "depression." Rather, Yoruba patients suffering from depression tended to present with somatic complaints and rarely discussed mood disturbance as problematic[16].

Lambo's innovations at Aro Hospital quickly established southwestern Nigeria as a place where meaningful cross-cultural psychiatric research and practice might be undertaken. In 1959, the Canadian psychiatrist Raymond Prince took up a position at Aro to undertake just such work. Prince is probably most famous for the work he did in southern Nigeria defining 'brain fag syndrome', a term he coined for a supposedly culture-bound syndrome characterized by burning and crawling sensations

13 *Ibid* :38.

14 Heaton MM. *Black skin, white coats…, op. cit.*: ch.2-4.

15 Lambo TA. The role of cultural factors in paranoid psychosis among the Yoruba tribe. *Journal of mental science*, 1955, 101: 239-66; Lambo TA. Some unusual features of schizophrenia among primitive peoples. *West African medical journal* 1957, 6: 147-52.

16 Lambo TA. Further neuropsychiatric observations in Nigeria with comments on the need for epidemiological study in Africa. *British medical journal* 1960, 2: 1696-1704.

in the head and body, poor vision, and inability to read and comprehend found in students and other 'brain workers'[17].

Incidentally, Prince's studies of brain fag produced perhaps the first attempt at a cross-cultural epidemiological survey in Nigeria. In 1960, just months before Nigerian independence, Prince sent a hand-crafted questionnaire to five secondary schools, asking about symptoms they might have that they associated with their studies. He received 844 responses that showed a wide range of symptoms. Prince tallied the symptoms and reached the conclusion that 54% of Nigerian secondary students experienced "symptoms associated with study", seemingly confirming a cultural basis for the BFS diagnosis through a quantitative analysis of the responses[18]. The questionnaire was poorly constructed and generated criticism even at the time he conducted the study: nevertheless it represented possibilities for population-based research on psychiatric symptoms[19].

In 1961, both Lambo and Prince collaborated with Alexander Leighton and his team conduct the first truly cross-cultural psychiatric epidemiological project in Africa. Dubbed the Cornell-Aro project, and published as *Psychiatric Disorder among the Yoruba*, the project had two main goals: 1) attempt to assess the prevalence of psychiatric symptoms – but not diagnoses – in Yoruba communities; and 2) compare results in Yorubaland to those produced by Leighton's Stirling County study in Canada from over a decade earlier. The research team employed several methods to gather information about potential psychiatric disorder, including third party reports from local authorities about individuals, collecting blood samples, and conducting full medical exams in some cases. However, the primary assessment tool was a 66-question survey administered in person. Some questions solicited information about the respondent's personal history, but roughly two thirds of the questions asked about specific psychiatric symptoms. The answers were recorded, as were any relevant observations made by the research team member administering the survey[20].

There was no particular standardization of the administration of the survey. Some respondents were given the survey in hospital, others in their villages. While the Yoruba survey conformed broadly to the Stirling County survey, a number of questions were added to the Yoruba questionnaire to attempt to calibrate for cultural differences. Ultimately, the Cornell-Aro project drew rather limited conclusions, finding broad similarities in symptom makeup between the two communities but refusing to make generalizations about relative rates of psychiatric cases or even the likelihood that the results might apply to other cross-cultural comparisons. Its strongest conclusion was simply that the project had proven that cross-cultural psychiatric epidemiological tools could be effectively created and implemented.

Shortly after the Cornell-Aro project concluded, Lambo joined another large cross-cultural psychiatric epidemiological study, signing on the University of Ibadan, where he was now the first head of the Department of Psychiatry, as one of the nine catchment areas for the WHO's International Pilot Study of Schizophrenia[21]. The main goal of the IPSS was to attempt to establish a universal methodology for the cross-cultural identification of schizophrenia. Each center screened for inclusion in the study all patients presenting at the psychiatric hospital in their region during the reporting period 1 April 1968 to 1 April 1969 who had slept in the catchment area for the previous six months and were between the ages of 15 and 44. The report concluded based on examination of over 1200 admitted

17 Prince R. The "brain fag" syndrome in Nigerian students. *Journal of mental science*, 1960, 106: 559-70.

18 Prince R. Functional symptoms associated with study in Nigerian students. *West African medical journal,* 1962, 11: 198-206.

19 Prince R. *Why this ecstasy?: reflections on my life with madmen.* Montreal: Amvor Art and Cultural Foundation, 2010: 249.

20 Leighton AH *et al. Psychiatric disorder among the Yoruba: a report from the Cornell-Aro mental health research project in the Western Region, Nigeria.* Ithaca: Cornell University Press, 1963.

21 World Health Organization. *International pilot study on schizophrenia.* Geneva: WHO, 1973.

patients across field research centers that all nine catchment areas were able to consistently differentiate schizophrenia from major affective disorders and that a "concordant group" of schizophrenic patients representing a somewhat normative pattern of presentation existed in all nine catchment areas, although there were some anomalies[22]. Some cross-cultural psychiatrists criticized the process of the IPSS on the grounds that it paid far more attention to social indicators (eg. marital status, education level, wealth, etc.) than to explicitly cultural factors in its analysis[23]. Nevertheless, the IPSS has become a touchstone study in the global history of psychiatric epidemiology for its ability to build broad professional consensus around the process of diagnosing schizophrenia. Even critics of the study have noted that "the World Health Organization procedures used in the IPSS are presented regularly as a model for successful cross-cultural, international scientific collaboration"[24]. Nigerian data played an important role in the qualified success of the *IPSS*, an outcome that simply could not have been produced even twenty years earlier.

Conclusion

By the late 1960s, Nigeria had become an important node in international research networks of psychiatric epidemiology. The quality and meaning of all of these studies has been and continues to be debated. However, for those of us interested in understanding its history, I hope that this focus on the trajectory of Nigeria's involvement in the discipline provokes two considerations. First, the historiography of psychiatric epidemiology, nascent as it is, continues to be largely Eurocentric in orientation. I can't even suggest that it shouldn't be: its origins are conspicuously in the North Atlantic. However, I think it is important to note that part of the reason for that lies very much in the processes of European colonialism that incorporated, but systematically underdeveloped, research capacities in most of its territories. Nigeria is not a quintessential exemplar – there were colonies where psychiatric research took place[25] – but it is in many ways a representative example, I think. Secondly, the incorporation of Nigeria into networks of international psychiatric research was much more a story of *decolonization* than one of colonial legacy. Processes and structures of colonialism and decolonization thus fundamentally shaped when, where, and on what terms psychiatric epidemiological research could be undertaken on a global scale. Our understanding of the history of the field should be more cognizant of the colonial roots of the discipline in many parts of the world, and the ways that political and cultural processes of European empires shaped the development of psychiatric epidemiology even in Europe and North America by curtailing the possibilities for the discipline to develop more equitably. Such a recognition adds necessary context to assessing how the results of psychiatric epidemiological surveys have shaped understandings of the psychiatric needs of human civilization over time.

22 *Ibid*.:168-75.

23 See, for example, Murphy HBM. Historical development of transcultural psychiatry. In Cox JL ed. *Transcultural psychiatry*. London: Croom Helm, 1986: 7-22; Edgerton RB. Traditional treatment for mental illness in Africa: a review. *Culture, medicine and psychiatry,* 1980, 4: 167-89.

24 Williams CC. Re-reading the IPSS research record. *Social science & medicine,* 2003, 56: 501-15.

25 Keller RC. *Colonial madness: psychiatry in French North Africa.* Chicago: University of Chicago Press, 2007.