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A Case of Brain Fag in East Africa

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Opportunities exist for psychiatrists to spend a short term, from two weeks to four months, in underdeveloped countries under the auspices of the Inter University Council, (IUC, 1978). This is accepted as a desirable part of training and experience, as outlined in the Royal College of Psychiatrists *Handbook for Inceptors and Trainees in Psychiatry* (1980), and allows first-hand experience of symptom patterns and features peculiar to another culture. The present case showed a number of features characteristic of African psychiatry, including 'brain fag' syndrome (the syndrome which owes its name to the patient's explanation of his illness as being due to tiredness of the brain), a bizarre colourful presentation of the condition at the onset, and at one point a concern with witchcraft. Behind the illness lay family problems and significant life events which could be grasped by the outsider.

The Case

The patient was a 22-year-old single African male who because of mental symptoms over the previous six months had to refrain from studying for the equivalent of British 'A' level examinations in biology, chemistry and physics. His presenting complaint was that he was unable to study because of the feeling of pressure around his head. He was convinced that the effect of print was to constrict his pupils and this made him experience a feeling of tiredness in his brain, somehow related to the amount of light getting into his eyes. In addition he was unable to understand or remember what he had read.

The family of the patient was bi-lingual (Swahili/English), his father being a Lutheran pastor. He described his father as being a strict disciplinarian to whom he related very poorly in his childhood years. Great emphasis had been laid on studying, and he saw his father in terms of a tyrant who beat him mercilessly in order to make him study.

The patient was the oldest of eight siblings, the whole family having lived in Dar Es Salaam, with living standards which were rather better than those of most Tanzanians. He had attended local day schools and had done reasonably well, having obtained the equivalent of eight 'O' levels by the age of 19. He had always been a shy, reserved person who experienced great difficulty in making friends. For example, he had never had a girlfriend, although he was attracted to the opposite sex. Also he had never masturbated because of his religious beliefs.

The onset of his illness had been acute: he presented beating his chest with his fists, not being able to keep still and jumping and singing. The songs expressed his troubles to the world and he sang his own words over and over to hymn tunes. In his agitated state he complained that all objects around him were brightly coloured and that from time to time they changed colour from yellow to black and white.

Because of his illness he had made a disturbance in the street, and in usual Tanzanian fashion he had been arrested, handcuffed and brought to the hospital. His school friends gave information that he had been experiencing severe difficulty in getting off to sleep. He had also been having nightmares. He had been unable to concentrate on his studies and had showed marked loss of appetite. It was not possible to take a thorough history at the time of admission and he was left in the locked ward to settle, with diazepam 2 mgms t.d.s. for his symptoms of anxiety.

During his week in hospital he was visited by some of his school fellows who attempted to calm him. He became convinced that they had cast an evil spell on him and that this was the explanation of his illness. He had realized this several days after admission when one of the student visitors had suggested that possibly a relative had cast a spell on him. The suggestion had made the patient realize that it was the student himself who had gone to a witch doctor and produced the spell. This fitted in with the fact that at school he had many enemies who did not want him to succeed with his studies.

The only way to overcome this was by resorting to a traditional healer or witch doctor, who visited the patient. The witch doctor (a title used by the patient) sat and listened to the patient's story in song, agreed with the diagnosis and prescribed traditional medicine. The acute florid features soon disappeared and the patient was discharged home and attended as an outpatient since, with residual symptoms of a 'brain fag' syndrome.

During the course of my psychotherapy a number of significant life events came to light. Approximately a

year earlier the whole family had moved to another town in Tanzania, 300 miles away, where they found themselves to be very unhappy and isolated. Four months prior to the onset of illness the patient's father had become physically ill and the family then returned to Dar Es Salaam. Two months after this the patient had failed all his mock 'A' levels and had obviously been experiencing difficulties with his educational course despite intensive study at a boarding school. Several days before admission the patient's family had received bills which they were unable to pay. It would seem that the threat of his father's death, educational failure, the family move and finally financial difficulties, were enough to precipitate a reactive illness with well-marked features of anxiety.

Psychotherapy was mainly supportive and the patient was encouraged to come to terms with his academic abilities. He became less ambitious and instead of aiming at medicine he took a clerical job in the University. His financial situation improved and pressures on his family diminished. The residual features of brain fatigue syndrome remained and were the basis of a letter to the government authorities requesting that the patient's studies be postponed. This appeared to satisfy him and psychotherapy was terminated.

Comment

The case illustrates a number of features characteristic of African psychiatry. First, the manner of presentation, with colourful symptomatology and acutely disturbed behaviour, is a feature of most hospital admissions in various African cultures, and German (1972) points out that acute transient psychoses characterized by gross disruption of mental function and an excellent prognosis are the most common types of psychotic state seen in African hospital practice. He suggests that such acute psychotic episodes are preconditioned in part by cultural patterns. Others have suggested that there is a tendency for such societies to respond sympathetically to acute emergency reactions, while similar psychotic behaviours in Western societies cause social rejection and hence are discouraged (Jilek and Jilek-Aall, 1970).

Second, resorting to witch-doctors or traditional healers is extremely common; in Dar Es Salaam there may be as many as 1 per 1,000 of the general population (Holmes and Speight, 1975). In my patient the dramatic response to the witch doctor supports the view that the psychosis was psychogenic. The patient was not deluded, his beliefs were in keeping with his culture.

Third, the patient illustrates a number of points about 'brain fag' which have been well documented by various workers. In keeping with the observations of Morakinyo (1980) he was obviously of high intelligence with strong motivation to achieve. In his particular culture education is seen as a key to success, perhaps even more so than in Western culture. His mental breakdown and onset of symptoms were related to the intense mental activity of preparing for mock 'A' levels together with examination failure (Prince, 1960). He had been studying into the early hours of the morning, but there had been no abuse with amphetamines, a feature described by Morakinyo (1980). It is likely however that he had experienced some sleep deprivation.

Finally, although the features outlined are typical of African psychiatry, the illness involved significant life events which could be easily grasped and understood by the outsider. The father's illness was of particular significance in that in Tanzanian society the patient as the oldest of eight siblings would have been responsible for the support of the family in the event of his father's death.

References

GERMAN, G. A. (1972) Aspects of clinical psychiatry in Sub-Saharan Africa. *British Journal of Psychiatry*, **121**, 461–79.

HOLMES, J. A. & SPEIGHT, A. N. P. (1975) The problem of non-organic illness in Tanzanian urban medical practice. *East African Medical Journal*, **52**, 225–36.

INTER UNIVERSITY COUNCIL (1978) *IUC and Related Services, A Guide*, Second Ed., Chapter III, p. 9. London: IUC.

JILEK, W. G. & JILEK-AALL, L. (1970) Transient psychoses in Africans. *Psychiatria Clinica*, **3**, 337–64.

MORAKINYO, I. (1980) A psychophysiological theory of a psychiatric illness (the brain fag syndrome) associated with study among Africans. *Journal of Nervous and Mental Disease*, **168**, 84–9.

PRINCE, R. (1960) The 'brain fag' syndrome in Nigerian students. *Journal of Mental Science*, **106**, 559–70.

ROYAL COLLEGE OF PSYCHIATRISTS (1980) *Handbook for Inceptors and Trainees in Psychiatry* (eds. T. Bewley and S. Mahapatra), p. 3. Ashford, Kent: Headley Brothers.

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