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Homicide in Western Nigeria

By T. ASUNI

Homicide is a universal phenomenon which occurs both among developed and developing communities, but to a varying extent. Homicide in this context does not include the lawful killing of criminals convicted of capital offence, or killing in war or in conditions of political strife. Considerable work has been done on various aspects of criminal homicide in many countries—Verkko (1951) in Finland, Jacqueline H. and Murray A. Strauss (1953) in Ceylon, Wolfgang (1958) in the United States. The book *African Homicide and Suicide* edited by Paul Bohanan (1960) contains only a chapter on homicide among the Tivs of Central Nigeria, and this is based on a retrospective study of case files. Lambo (1962) reported twenty-nine cases which he had interviewed for the courts; these came from the whole of Nigeria, and therefore represent different peoples and cultures.

This paper is a report of fifty-three cases of homicide personally interviewed by the author, all from the Western State of Nigeria.

Local attitude to murder

While murder is not acceptable in this society, it is possible that some ritual murder may still occassionally be carried out, even though illegally. When a paramount chief dies, it is traditional that he should not be buried alone, but with some other deceased persons. Immediately after the death of the chief is officially announced, a curfew is imposed. It is suspected that persons who violate the curfew are killed and buried with the chief; it is also suspected that those curfew-breakers are strangers and vagrants in the area, and their disappearance does not attract much notice. It is very difficult to establish the fact of murder in these cases as the whole matter is shrouded in secrecy and mystery. However, this practice appears to be dying out.

It is also said that the most powerful 'juju' often includes parts of the human anatomy, which can be obtained only by murder. This practice is also shrouded in secrecy. The leopard men cult does not exist in this area.

Procedure

The present work was done over a three-and-a-half-year period, June, 1963 to December 1966, in Abeokuta Federal Prison. This prison has the only facility for judicial hanging in the Western State of Nigeria. It is also situated in the same town as the only psychiatric hospital in the State. All cases of homicide sent for psychiatric report, who cannot be accommodated in the closed unit of the psychiatric hospital (Lantoro Institution), are kept in the prison and the author visits and interviews them there.

All persons accused of homicide sent to the hospital and remanded in prison were interviewed, but this report excludes those who were eventually acquitted. Not all the accused had been sent for psychiatric report; a considerable number had already been convicted and were awaiting execution. These are also included in the study.

It was not possible to get transcripts of the court proceedings of all the cases; but the prison records have some useful information, which was supplemented by interview material from the prisoners.

Murderers who were remanded in Ibadan Prison, which was the only local government prison (as distinct from the federal prisons) in the Western State, were sent to Kirikiri Prison in Lagos (outside the State) after they had been condemned to death. These are excluded from this study. On the other hand, those who had been found to be incapable of making a defence by reason of mental illness, and those 'of unsound mind at the time of the

crime and consequently not criminally responsible for the act' were sent to the psychiatric hospital and are included in this study.

The examinations were carried out many months, sometimes over a year, after the offence.

Findings

There were 53 subjects in all, of whom 30 had been sent to Lantoro Institution—a closed unit annexe of Aro Hospital (Asuni, 1967)—either for observation prior to judgement or for indefinite confinement after judgement when they had been found to be 'of unsound mind'.

The remaining 23 were interviewed in prison. These included those who had been condemned to death (Condemned Criminals), those who had had their death sentence commuted to life imprisonment, and those who had been sentenced to life imprisonment directly. A few of those interviewed in prison were later sent to Lantoro Institution.

During the same period of this study nine persons including one woman were sentenced to death at the Ibadan High Court and these were sent for execution to a Lagos prison.

The sum of 53 in this study, together with the 9 condemned in Ibadan, 62 altogether, is a relatively small number in a region with a population of 10 million. It works out at 1·8 per million per year. Even though statistics in this area should be accepted with some reservation in view of obvious difficulties including the vagaries of legal administration, they still indicate a low rate of murder in this region. Comparison with other countries—a little under 4 per million in England and Wales (Gibson *et al.*, 1961; Morris *et al.*, 1964), a little more than twice as many in Denmark and twelve times as many in the U.S.A.—should also be taken with some reservation for reasons which include administrative and legal differences in the countries.

Sex. There were 47 men and 6 women. All the women came under the psychiatric category, i.e. they were found to be incapable of making their defence or not responsible for their act by reason of psychiatric illness.

Religion. Thirty professed Christianity of various denominations; 17 were Moslems and 6 pagans. Of the six women, 4 were Christians and 2 were Moslems. It should be noted, however, that profession of Christianity or Islam does not exclude animistic practices. In fact a considerable number of Christians and Moslems still believe in animism and practise this secretly, especially when faced with problems.

Civil status. Forty-two were married, eight were single, one woman was widowed, one man was engaged to be married, one man was divorced. All the women except the widow were married, but one of them had left the marital home.

Children. Thirty-two had children of their own, 15 had no children: no information about the remaining six was available. Only one of the women had no issue, and one had lost her two children.

Occupation. The occupations can be classified into two broad groups—traditional and non-traditional. The traditional includes 21 farmers or smallholders, 4 fishermen, 4 labourers, 4 petty traders and 2 traditional healers. The remaining 18 were non-traditional and these include motor drivers, sawyers, corn-mill operators, bricklayers and a domestic steward. The women were traditional workers—three farm workers and three petty traders.

Literacy. Only three men were literate, one in the vernacular and two in English.

The sociological observation that the well-to-do and higher status members of the community do not turn their aggression outwards in homicidal acts, while the lower social classes do, is supported by the findings here. No one of the former group is represented in this sample of murderers (Durkheim).

Domicile. Only seven do not belong to the area where the murder was committed.

Victim. There were six multiple murders, and of these two were by women. Three men were responsible for the murder of a man by drowning. Twenty-eight men and twenty-five women were killed by men, eight children were involved and six of these in three multiple murders. All the women killed men except for two cases of infanticide. Twenty-one victims were related by blood or marriage, of these there were five matricides, two patricides, two fratricides (men), two infanticides and five wives killed by their

husbands; one woman was killed by her lover. Murder is not an overwhelmingly domestic crime in Western Nigeria as reported by Morris *et al.* (1964) in England.

Method. Thirty-six were killed with sharp instruments—sword, knife, but mostly matchets. Six were beaten to death with cudgels or pestles. Four were shot, three drowned and four children were killed by throwing or dropping. The method in the rest of the cases is unknown. Of the six women murderers, three used cudgels, two matchets and one threw a child.

Time of day and place. Nineteen homicides were committed at night, 15 during the day, the others were not known. Twenty-two were committed outdoor, 17 indoor. The others were not known definitely.

Attitude to their offences

The murderers' attitudes differed from those observed by Gillies (1965) in the West of Scotland. Among the psychotics the general attitude, when they were able to express themselves in a rational and relevant manner, was one of amnesia or denial; in the few cases where no claim of amnesia or denial was put forward there was indifference to the consequences of the act. When these few subjects were asked what they would do if they were faced with the same set of circumstances, some of them replied that they would do it again. There was one extreme case in which the murderer took the decapitated head of his victim under his arm to the police station and reported his action with glee. During psychiatric interview he still expressed triumph over his 'enemy', not caring about the consequences.

The non-psychotics either denied the offence —claiming that they were being framed, or that the victim's death was an accident, or tried to justify their offence in terms of self-defence or extreme provocation.

The subjects were usually interviewed in the afternoon after lunch, and they were usually four in a cell lying on the floor (no beds provided) not talking to each other. The quantity and quality of communication that went on between them is not known, but it appeared that they seldom discussed their crime.

Comparison between Condemned Group and Those Committed to Psychiatric Hospital

Number

While the proportion of those convicted who were found to be 'mentally abnormal' in Britain between 1952 and 1960 was 46 per cent to 47 per cent (Gibson *et al.*, 1961), the proportion in this study is 57 per cent, i.e. thirty were 'mentally abnormal', twenty-three 'normal' —none of whom committed suicide. When, however, the number of those who committed suicide in Britain was added to the mentally abnormal, it showed 'very clearly that the majority of murderers are mentally disturbed in some way'.

Age

There is no appreciable difference between the two groups with regard to age.

Sex

As has been stated, the six women in the series were psychiatric cases, i.e. 20 per cent of psychiatric cases are females.

Religion

There does not appear to be much difference in the religious affiliation of the two groups of murderers, except that there are more Christians among the psychiatric cases.

Marital status

There are relatively more married, less single, widowed or divorced among the condemned than among the psychiatric cases.

Victim

The condemned killed as many of their relations as the psychiatric cases.

Some Condemned and Committed Cases

T.O., a 57-year old man, killed his sister and was condemned to death. He had accused his sister of maligning him and made up his mind to kill her, which he did by stabbing.

He had been ill for a number of years prior to this episode. His complaints included insomnia, anorexia, difficulty in seeing well. He had been practically housebound. He was not working. Some traditional healers

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had treated him without success. One even gave evidence in court, but the prosecution argued successfully that the evidence could not be accepted as expert.

The Medical Officer gave the following report: 'I am of the opinion he is mentally normal and quite sane; although he suffers from insomnia and severe loss of appetite, these symptoms being due, I believe, to severe depression, for which he has had to be admitted into hospital [presumably a general hospital], I am of the opinion that he is fit to plead.' He was never sent for psychiatric assessment.

He invited the victim to his house, shut the door and proceeded to stab her. When the police came to the scene, he meekly followed them to the police station and gave a detailed account of his life history and how he came to kill his sister.

He was found guilty, condemned and hanged.

While in prison awaiting execution, for over three years, he refused to take his bath or cut his finger nails. He was indifferent to his situation. He was ambivalent in his statements. Sometimes he denied the offence of murder, at other times he said it was an evil force that pushed him to commit the offence. He was uncommunicative most of the time.

The relationship between the morbid motive of his deed and his depressive illness is not certain. There could have been a paranoid flavour to his illness, and he might have committed this offence under a paranoid delusion.

It is significant that the Medical Officer did not explore his mental state further, and in spite of his awareness he still stated that he was mentally normal and sane. It suggests that even the doctor did not appreciate that depressive illness is a form of psychosis. Consequently the court following the doctor's statement ruled out the possibility of mental illness as a defence.

As already stated, the evidence of traditional healers is not acceptable in court as expert evidence, hence the prosecution successfully asked the court to reject the evidence.

T.L. was 33 years old, married illiterate farmer with three children who had lived at the same address practically all his life. He murdered the 36-year-old widow of his late father. The instrument used was a matchet and the place of the offence was a bush path.

A junior counsel was engaged by the Court to defend him. The defence was insanity, but there was no strong evidence to support this. The Medical Officer first saw him four months after the offence and referred him to a psychiatrist who saw him three weeks later. He reported—'It would appear that he had some visual hallucination and anxiety.

'He attributed this and other unpleasant previous experiences, like falling from a tree, to the evil machinations of his late father's debtors. One would be on surer ground if there was some more information about him to help to confirm or refute his own report. He does not appear psychotic now.'

The court was satisfied that this murder was a climax to a grudge the accused had been nursing against the deceased for some time; in spite of his statement that he mistook the victim for a deer which he had the urge to kill.

He was condemned and executed.

This case illustrates the rather perfunctory manner in which psychiatric opinion is sought without giving the psychiatrist any information regarding the background of the accused and leaving him to rely only on the patient's statement and observation. This is due in part to the lack of an adult probation service.

I.A. killed a woman, his previous lover, another person's wife, because she caused him to be impotent. According to his statement in court. 'I had sexual intercourse with her and after that I started to feel uneasy with my penis, and not long after I started to excrete my semen. I told the deceased the nature of my ailment after I had had sexual intercourse with her. After that I became impotent and I could not have sexual intercourse with any female again.'

He had accused his ex-business partner of threatening him with some everlasting scourge some time prior to this, and he believed that this impotence was the threatened scourge. He had also threatened this ex-partner with some physical violence (death) and the latter had reported this to the police, who advised him to go and settle their problem in their village. Two conciliatory meetings were held in the village.

The accused went from his village to report the murder himself. Besides several matchet wounds, he completely decapitated the victim. He expressed the wish to kill his ex-partner and had planned to commit suicide by drinking some insecticide.

In this case, no medical nor psychiatric evidence was called. The defence counsel appointed by the court did not even address the court, leaving the court to sort out the facts.

The accused was condemned and hanged. When interviewed in the condemned cell, he was withdrawn and negativistic. He refused to give any information. All he said was that he had accepted the court's verdict.

Psychiatric impression of this case is that the accused suffered from anxiety state consequent on his illicit sexual intercourse with a married woman. This anxiety state resulted in his impotence. His statement that he excreted his semen could mean that he contracted some venereal disease which might have increased his anxiety.

He then projected his problems on his ex-business partner who might have threatened him with some misfortune, or not. In this culture, projection leading to paranoid ideas is a very common occurrence.

What also aggravated the accused's condition was that the last of his three children, by his wife who left him because of his impotence about a year before the murder, died.

Another noteworthy observation is that the police to whom the partner reported the homicidal threat of the murderer were not aware of the seriousness of the situation. It has been known for a paranoid schizophrenic to report his case to the police and on getting no satisfactory solution,

not even the suggestion of psychiatric treatment, to take the law into his own hands and murder his imagined assailant or antagonist.

It is also worthy of note that impotence, a significant psychiatric symptom, is not regarded as such by most people in this community including members of the judiciary and bar, and this symptom has been the immediate cause of homicide and suicide (Asuni, 1962) in a number of cases.

J.O., aged 34, a farmer, was charged with the murder of his wife, and the trial judge on the evidence of a psychiatrist found that at the time of the offence he was by reason of his unsoundness of mind incapable of knowing the nature of the act he committed or that it was wrong or contrary to law. He was sent to the psychiatric institution by the order of the Governor until further directions.

The circumstances of the offence were that he butchered his second wife with whom he had had no quarrel. He reported what he had done to the police himself. In his defence it was alleged that he had episodes of anxiety for which he had received treatment from traditional healers. This anxiety was related to the fact that he had seduced this second wife from another man, but he paid back the dowry.

The traditional healers who had treated him for anxiety were not called by the defence.

When he was inteviewed by the psychiatrist of the mental hospital to which he was committed, the latter was of the opinion that his episodic psychosis could be epileptic, but there was no facility for investigating this further.

G.K., a 30-year-old man, was found guilty but insane and was committed to the psychiatric institution on the Governor's order.

On admission to the institution, he gave a lurid account of how he decapitated a man, a distant relative, whom he believed to have been the cause of his three wives deserting him and the cause of his mental illness for which he had been treated on three occasions by traditional healers. He decided to kill him to put an end to his troubles. He took the disembodied head to the police station as evidence of his story.

The victim was apparently reputed to be versed in the art of black magic—how to kill an enemy or make him crazy. This was the view held not only by the convict but also by members of his family.

The gruesome circumstances of the offence and his obvious psychotic state led to the decision of the court. No psychiatric evidence was called.

T.O., a woman of about 28 years, the second of three wives, was charged with the murder of a child of the third wife. She had also killed the husband and one other child of the third wife. She had done the killing with a matchet. She had attempted killing the third wife. Both the husband and the third wife were native healers and the husband was also a soothsayer. She voluntarily surrendered herself to the police after the offence.

Her story was a long one, the salient facts in which are:

(*a*) Two of her children died within five months of each other.
(*b*) The husband, who was a healer, did nothing to treat them.
(*c*) He did not even give her money to take a third one who was sick to hospital; rather he asked her to take the sick child to her mother so as not to mar his reputation as a healer.
(*d*) She was accused of bringing ill luck on herself.
(*e*) The husband refused to pay even part of the money she had lent him to marry the third wife. She wanted the money to pay for the treatment of her child.
(*f*) The third wife was believed to be actively in league with the husband in his callous treatment of her.
(*g*) The husband was said to have put a curse on her.

All this culminated in her near-homicidal fight with the third wife, and her subsequent homicidal attack on her husband and the two children.

The first psychiatrist to whom she was referred found nothing abnormal in her behaviour and concluded, in view of the circumstances, that she committed the offence under acute stress and depression. A second psychiatrist examined her later, independently of the first, and reported: 'I thought extreme suggestibility was provoked by the curse of the husband, sustained by repeated curses and then reinforced by the divination of a native healer . . . bringing about transient or sustained delusions of persecution giving rise to abnormal behaviour.'

The judge concluded that, on the report of the psychiatrists, and in view of the maniacal manner in which the offence was committed, the accused, by reason of unsoundness of mind was at the time she committed the act incapable of knowing the nature of the act and incapable of controlling her actions. She was committed to a psychiatric institution.

Diagnostic Categories

Psychotics

Of the 30 cases sent to the psychiatric hospital, 21 had schizophrenia, the paranoid type being the most predominant. One patient had a schizoaffective disorder, and another one (a female) committed her offence when she was in a state of acute distress and depression. Three patients presented histories suggestive of psychomotor epilepsy. It was not possible to do an EEG on them. In three cases no evidence of psychosis was observed.

One patient attempted suicide after the offence, by hanging. The paranoid patients explained their killing in terms of their delusions. The catatonic schizophrenic and epileptic claimed amnesia for the offence; most of the others simply denied the offence.

Of those who were condemned or had their

sentence commuted to life imprisonment, several showed evidence of psychiatric disorder —mainly paranoid, at the time of examination; for instance: accused wife of adultery, accused victim of driving his wife away, accused of incest, victim was sent to test his impotence which had been inflicted on him. One explained that his thought became audible and he had auditory hallucinations.

Three had attempted suicide—two immediately after the offence by cut throat and abdomen. The third attempted suicide while in prison.

In these cases it is not possible, in the absence of detailed information about their previous personality, to determine whether their mental state at the time of interview was a stage in a psychotic process which included their offence or whether it was a condition which arose while in prison in the face of the legal consequences of their offence. However, there is sufficient evidence in some cases to suggest that the condemned accused had had definite psychiatric problems prior to the offence, and these problems were related to the offence in terms of psychopathological motivation. (See Case Note Summaries.)

It becomes obvious that the system is defective in distinguishing between those with psychiatric disorder associated with their offence and those without. This defect may be explained in terms of (a) extreme shortage of doctors, especially psychiatrists; (b) the lack of appreciation of significant psychiatric symptoms by the community—including the judiciary and doctors; (c) the general tendency towards acceptance of the offender's own paranoid interpretation of his symptoms. This raises the question of the validity of capital punishment in such a situation where the distinction between the mentally ill and sane in relation to homicide is blurred.

There was only one case in which a depressive illness was presumed. This man killed his mother without any apparent reason, and then slashed his own throat. He was not seen by me until after hospitalization. He claimed amnesia for his offence. It was reported by his relatives that he was the one who loved his mother most of all her children, and his general disposition was described as being quiet, withdrawn and peaceful.

Aggressive psychopaths

No case in this series can be convincingly described as an aggressive psychopath. It was not possible to get a reliable anamnesis from those murderers, and it is in only very few cases that relatives have shown any interest in them after their arrest. This apparent rejection may partly be due to the distance of their homes from the prison, and partly to the ignorance of relatives about the processes of law and the legal rights of the individual. Relatives who responded to our letters of inquiry regularly informed us that they had not been aware of the whereabouts of the murderer since his arrest. There may also be definite rejection of a family member who has committed such a grave offence.

In spite of the lack of adequate information, it is difficult to imagine that any child in this community can be exposed to such aggressive, cruel and callous upbringing as is often described in the case of murderers in Europe and North America. The extended family constellation protects children from such cruelty, and neighbours can hardly be kept from interfering with their commiserating response to a suffering child, whose cries can be heard very easily in a tropical country where doors and windows are kept open and if shut are not sound-proof.

Malignant anxiety (Lambo 1962); Frenzied anxiety (Carothers 1948)

The absence of any case in this series answering to the description of malignant anxiety or frenzied anxiety is very striking. Malignant or frenzied anxiety may be prodromal signs of schizophrenia, which had become more manifest by the time the accused persons were examined.

The only case which might have answered to the description was not included in this series, as he had been sent to the psychiatric institution before the period of this study, but an X-ray of his skull suggested that he had a meningioma. The lack of electroencephalographic and other investigation facilities makes such conditions difficult to diagnose with certainty.

Epilepsy

There were three cases in which psychomotor epilepsy was suspected purely on the scanty history available. It was not possible to confirm this suspicion because of lack of facilities for investigation. The murders were so sudden and purposeless that it was possible to convince the court that the mental state of the accused was disturbed at the time of the offence.

Previous psychiatric illness and treatment

A number of these cases consulted traditional healers prior to their offence, but they did not associate their complaints at that time with their present illness. In fact one man killed his traditional healer. One man had been treated in a mental hospital prior to his offence, and it was possible in this case to write to the hospital for clinical information.

With the scarce and rather localized psychiatric facilities in the country, most pre-psychotic and psychotic patients are first taken to traditional healers whose evidence is not admissible in court especially about the technical nature of the illness they are treating. While it is conceivable that they may be invited to court to state whether or not they have at any time treated an accused person, their statement can hardly be relied upon, since they do not keep any written record of their cases and have to rely on their memory. This situation calls for the expansion of modern psychiatric services if adequate justice is to be done.

Fortunately, however, the judiciary takes cognizance of the information that an accused has been treated by a traditional healer prior to his offence. The difficulty is to decide whether the ailment for which he has been so treated is physical or psychiatric. In some cases there is sufficient information to suggest that his earlier problem was psychiatric. On the other hand, when his main complaint in the past has been impotence or bad dreams—which are usually early symptoms of psychosis—the now psychotic accused who had consulted a traditional healer on his own is not in a mental state to give this information; and even if he is, he may not consider it to be relevant to his present situation.

A recent case not included in this series is a man who had received treatment in this hospital, and should have continued as an out-patient, but ceased to attend, and some months later killed two people.

Such cases of murder could be prevented if adequate psychiatric facilities, including community mental health services, were freely available.

Alcohol and murder

It is significant that neither alcohol nor abuse of drugs featured in any of these cases. The police did not record any case of drunkenness associated with the offence, neither did any of the prisoners during interview suggest that the offence had been committed under the influence of alcohol or drugs.

Alcoholism is not yet an overt problem in this State. The local alcoholic beverage is palm wine, which is a juice tapped from a species of the palm tree. Its alcoholic content is low, but increases with fermentation. It is also distilled illegally, especially along the coastal areas, and the distillate is very potent indeed.

Beer, which is now brewed in Nigeria, is more expensive, and its use is limited to the more affluent section of society. Spirits are used sparingly. Week-end drinking orgies are limited to the wage earners in the big towns. Even then the usual week-end drunkenness one sees in western countries is not usual in this community.

Murder associated with other crimes

It was possible to establish the association of murder with robbery in only one case. This involved three men who attempted to rob a man of his possessions in a canoe. In the process of robbing him the man was drowned. These men all denied the offence, even the offence of robbery. They were executed.

Suicide and homicide

The suicide rate in Western Nigeria is extremely low (Asuni 1962). This study indicates that the homicide rate is also very low. These findings do not support the negative correlation theory of suicide and homicide.

If we look at the provincial frequency of both suicide and homicide we find that in decreasing order of frequency the following emerge:

Suicide. Abeokuta, Akure, Ibadan, Ikeja (Asuni, 1962).

Homicide. Abeokuta, Ijebu, Akure, Ibadan, Ikeja.

The trend is towards a positive correlation between suicide and homicide at the provincial level.

It is observed that not one case charged in court of murder and remanded to prison or psychiatric hospital committed suicide. In fact hardly any murder was followed by the suicide of the murderer (Asuni, 1962). This may be compared with the observation in Britain that one-third of all suspects in cases finally recorded as murder committed suicide (Gibson *et al.*, 1961).

There were, however, four cases of attempted suicide in this series, one among the psychotics who tried but failed to hang himself. The three who were condemned or had their sentence commuted attempted suicide by cutting their throats or slashing their abdomen, before judgement was pronounced.

General Observation

Most cases of murder do not have defence lawyers paid by themselves or their relatives. It is the State which nominates defence counsel on a small fee. Most of those so nominated are relatively junior at the bar, and performances vary in quality.

In most cases it is the defence counsel who raises the question of the mental state of the accused. In Nigeria, possibly because of the shortage of trained psychiatrists, it is not the practice for both prosecution and defence to call different psychiatric experts. In any case all the psychiatrists, nine in the country, except one who is exclusively in the academic field, are employed by the government to work primarily in mental hospitals. The Western State has four psychiatrists, including the academic one.

All the cases sent for psychiatric opinion are seen by the psychiatrists many months, sometimes a year or two after the offence has been committed. In most cases no information is given to the psychiatrist to guide him in his observation and examination of the accused. Even when information is requested by the psychiatrists it takes months for this to be supplied. This adds more time to the interval between the offence and effective psychiatric examination.

It is therefore difficult for the psychiatrist to pronounce with much confidence on the mental state of the accused at the time of the offence. If he is psychotic at the time of the examination, the problem often arises whether he was psychotic or pre-psychotic at the time of the offence or whether the psychosis developed *de novo* as a reaction to the offence and the incarceration and the possible fearful anticipation of hanging.

The general rule is that if there is any doubt about the sanity of a person awaiting execution he should be examined and not executed unless certified sane. This is hardly done in this country, because of the dire shortage of psychiatrists, and also because the less flamboyant symptoms of psychotic disorder are not recognized as such by the prison warders who are expected to report such cases to the authority.

Summary

A study of homicide in Western Nigeria between 1963 and 1966 involved 53 cases personally interviewed by the author. Thirty, or 57 per cent, were found by the court to be mentally ill. The diagnostic categories are schizophrenia (21) with the paranoid type predominating, schizo-affective (1), depression (1), acute distress and depression (1), psychomotor epilepsy (3), and three of undetermined diagnosis. There was no appreciable difference found between the psychiatric cases and the others in their circumstances and in the execution of their crime.

There is a strong indication that many of those condemned and executed committed the offence when their mental state was disturbed; this means that the machinery for distinguishing the category of the sane and the mentally ill in relation to homicide is very faulty.

Alcohol was not recorded to be associated with any of the cases, and only one case, involving three murderers, was associated with other crimes.

There appears to be a positive correlation between homicide and suicide geographically.

The study substantiates the finding that

murder tends to be committed by members of the lower classes rather than by those of higher status.

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