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THE ROLE OF CULTURAL FACTORS IN PARANOID  
PSYCHOSIS AMONG THE YORUBA TRIBE\*

By

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INTRODUCTION

It is certainly noteworthy that, during the last few decades, whatever the contributory forces, more and more emphasis is being placed on the contention that man is a social being and that his individuality as a person is meaningful only in terms of his relations with others. Mead (1947) has shown that man as a social being is subjected "throughout his entire individual existence to systematic cultural pressures" which reinforce or intensify, elaborate or suppress his psycho-biological potentialities in a way which not only refutes the false belief in the uniformity of human behaviour but reveals also its most extreme types.

Recent trends in genetic psychiatry have pointed to the fact that the gene is no longer inviolable and "that man is not committed in detail by his biological constitution to any particular variety of behaviour". It is for this reason that, where the cultural experiences have greatly differed, attempts should be made to discover how closely related are observable personality traits and analysable cultural phenomena.

It is on this great problem of the relationship between mental and cultural processes that the author attempts to shed some light, drawing on the vast clinical and anthropological materials available in Yoruba culture most of which, however, are quite unknown to British psychiatrists.

It is also hoped that this may serve to clear the ground of certain prejudiced observations which have been very detrimental to the problem of the brain-mind relationship and to straight thinking about it; for example, Carothers's (1951) observations on "Frontal lobe function and the African". Carothers argued that "the peculiarities of primitive African mentality might also be seen as a failure of development or lack of function of the cortex *in general*, an approach which would accord with Vint's observation that 'the cortex of the native brain was found to be narrower than that of the European.'"

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The concept of epiphenomenalism, i.e. the correlation between details of brain structure and details of mental processes cannot be carried beyond a very restricted field. It is only by abstraction, permissible (on the premise of biological materialism) but dangerous to scientific thinking, that we allow *caedit questio* purely mechanistic or physical explanation of mental processes in all circumstances. While there is no reason to assume that any real injury is done to the methodological and clinical principles of scientific psychiatry, however, much of Carothers's argument and conclusion, as will be seen later, can be justifiably regarded as a *reductio ad absurdum*.

Cultural anthropologists and those psychiatrists who have been fortunate in working among peoples of different cultural institutions have laid down the hypothesis that cultural factors influence the aetiology and psychopathology of mental disorder.

We may assume that certain types of mental diseases are known in every culture but their incidence has been said to vary from one culture to another—for example, the frequency of melancholia among the Chinese in Java (Van Wulfften-Palthe quoted by Yap, 1951), the rarity of mania among the Eastern Cree (Cooper, 1934), and the relative rarity of classical manic-depressive psychosis, especially depression among some African tribes (Gordon, 1936; Carothers, 1947; Laubscher, 1937).

In still another culture a unique form of clinical picture is found, for example, Wihitiko psychosis of the Cree\* and Ojibway (Cooper, 1933; Hollowell, 1934); the Malayan Amok and Lattah (Ellis, 1897; Van Loon, 1926; Yap, 1952) and the "arctic hysteria" among the Eskimo. The latter is a cultural variation of Lattah but was termed "arctic hysteria" by Kraepelin, who recognized certain common features with the Western form of hysteria. In this connection also can be mentioned the Piblokto of Peary's Eskimos (Brill, A., 1913), Imu—a psychoneurosis occurring among the Ainu, and the work of Geoffrey Tooth (1950) on the West Coast of Africa, who remarked that one is forced to the conclusion that there are real qualitative differences in the psychotic reactions of individuals with different cultural and racial backgrounds, "differences which make it impossible to fit them into the accepted nosological framework . . .".

If such is the case, and there is factual evidence that it is (O'Malley, 1914; Seligman, 1929; Dhunjibhoy, 1930; Sapir, 1932; Lopez, 1932; Faris, 1934; Hollowell, 1934; Shelley and Watson, 1936; Devereux, 1939; Demerath, 1942) the importance of cultural factors can hardly be ignored in any aetiological explanation of their clinical differences.

The hypothesis that cultural variations bear some relation to psychotic behaviour reactions is also supported by the anthropological tenet that from the fact of the close relationship between psychological process and social life the content of the mind in each cultural group is of a specialized kind (Firth, 1952). This fact has, however, been overstressed by many anthropologists, but the students of psychopathology among primitives realize that cultural factors exert their influence in addition to constitutional factors (Morris, 1951).

Paranoid psychosis has been selected for the programme of this research because, according to my clinical experience among the Yoruba tribe, it presents the most florid clinical picture and, particularly it reflects most adequately the psychic stresses which are inherent in the tribal culture.

The conclusions are, therefore, supported by practical experience and by an

\* Cree-speaking people of the Western shore of James Bay, the Southern extension of Hudson Bay.

intimate acquaintance with the subject in its clinical and anthropological aspects. Yoruba was the only language used throughout this study.

It has been said that it is fair to assess the value of any new contribution to scientific theory and practice by the quality and number of problems that have emerged under its impact. Measured by this standard, the value of the theories advanced by Kraepelin, Freud, Jung, Ferenczi, Bleuler, Meyer and their respective collaborators to elucidate the concepts of paranoid psychosis is very high.

Only a few noteworthy attempts (Gordon, 1936; Shelley, 1936; Carothers, 1947; Tooth, 1950; and Yap, 1951), however, have been made to examine these general hypotheses in a large series of paranoid psychoses in other cultural environments. As far back as 1895, the meaning of culture in terms of abnormal human behaviour was emphasized (Maudsley, 1895). In *The Pathology of Mind* Maudsley laid considerable emphasis upon "the importance of a study and analysis of social environment in relation to human thought and conduct in general and the varied types of mental diseases in particular".

It is obvious that the problems which are raised are old enough, but there is no immediate sign of their solution. The concepts of paranoid psychosis in other cultures constitute a major challenge to psychological theory and practice. At the present stage of our knowledge there is no better approach than to study the gradual historical evolution of the psychiatric concepts and to deepen our knowledge of comparative psychopathology by further research.

The history of medicine has shown that:

"Medicine as it is known and taught today is largely concerned with disease in the civilized white man. When the world is considered as a whole the white men are a minority group, and civilized man is a recent phenomenon in history. The study of little-known races living in primitive environments in medically unexplored territory can be expected to reveal manifestations of disease, if not new diseases, which may well prove important in the general advance of medical knowledge . . . It is especially important that such work should be done now, since primitive ways of life and even the people themselves are in danger of dying out."  
—(B.M.J., 1953.)

The study of mental disorders among primitive peoples is a comparatively new field for medical research but it should be realized that so many of the so-called primitive peoples studied today are in varying stages of acculturation. This is especially true of the Yoruba tribe in Nigeria. The literature on the subject is extremely inadequate and in some cases the clinical conclusions were founded on the treacherous sands of unscientific methodology. Paradoxically, others justify their inferences (which often extend beyond the range of observation) by appealing to "our age's gods—science and scientific objectivity".

Objectivity can sometimes become an obstacle in the search for truth. This has happened in varying degrees with some of the accounts given by modern exponents of the subject of "race" and disease. At their worst (e.g. Laubscher, 1937; Schottky, 1937; Carothers, 1951), they have been but glorified pseudo-scientific novels or anecdotes with a subtle racial bias; at their best (e.g. Devereux, 1939; Carothers, 1953), they are abridged encyclopedias of misleading information and ingenious systems of working hypotheses, useful for the guidance of research, but containing so many obvious gaps and inconsistencies, giving rise to so many unanswerable questions, that they can no longer be seriously presented as valid observations of scientific merit.

Our knowledge of primitive cultures which could have thrown considerable light on scientific consideration has been greatly hampered not so much by ignorance of them, but by knowing so much that is not strictly true. This difficulty is even more pronounced in the evaluation of certain psychological

constellations and their relevance to the problems of personality in health and disease in other cultures (Dennett, 1906; Linton, 1936, 1945; Faris, 1937; Landis, 1937; Nadel, 1937a, 1951).

Modern investigators should give consideration not only to variations in personalities, but to the different types of cultural values which personality variations may imply. This study has revealed the fact that where there is a "racial" group so culturally different and historically isolated from Western culture we have the right to expect unfamiliar responses to the problems of social life; and the methods of approach will have to be modified accordingly.

The proper evaluation of abnormal human behaviour outside the framework of socio-cultural pattern is still far in the future. When data are available in comparative psychiatry, the resulting nosological categories or reaction-types will probably be quite unlike the culturally conditioned, highly elaborated psychoses such as those that are described, for instance, under the categories of schizophrenia and manic-depressive psychoses in Western culture (Benedict, R., 1934).

Here, then, on the basis of personal observation and reflection on clinical materials in the light of advances in our knowledge, I have in this work attempted to show the influence of cultural factors insofar as they determine the peculiar *form* and *content* of this mental disorder. These cultural forces, which are also observed to enter into the aetiology and psychopathology of this mental illness as it occurs in the Yoruba tribe of Nigeria, do not give rise to a true occurrence of a "peculiar native psychosis" inexplicable by common psychodynamic formulations (using this latter term in the widest sense possible).

This finding does not support Carothers's (1951) important hypothesis "that African backwardness and the occurrence of 'primitive' psychosis can well be linked with frontal idleness". On the basis of deeper psychological determinants, this investigation has shown that the aphorism, "the nature of men is identical; what divides them is their custom", is a valid statement even at the level of psychotic regression (cf. J. T. MacCurdy, 1946, p. 66).

This work has also provided the opportunity for a critical evaluation of some of the psychiatric concepts and interpretations (within the thesis's terms of reference) advanced to explain psychological manifestations of individuals conditioned to the cultural patterns of Western civilization (Herkovits, 1934).

#### A. THE HISTORY OF THE YORUBA TRIBE AND ITS SOCIAL ANTHROPOLOGICAL BACKGROUND, WITH A SPECIAL NOTE ON THE BEGINNING OF EUROPEAN INFLUENCE

The Yoruba occupy most of the region of South-western Nigeria, extending from the Guinea Coast to the western boundary of the Niger delta and bounded on the west by Dahomey and French Togoland. The territory extends over 200 miles inland to Lokoja, where the rivers Niger and Benue join.

The principal members of the tribal group are the Oyo, Egba, Ife, Ilesha and Ijebu. The most apparent common denominator is the language rather than the culture. However, for practical purposes, the cultural pattern is homogeneous, at least as far as the psychological attitudes to belief in magic, superstitions, rituals, and reactions to cultural conflicts and psychic stresses resulting from supernaturalism are concerned.

Racially, the Yoruba form a greater part of the "True Negroes"—an ethnic group of the African Negroids (Ashley Montague, 1951). The population totals three-and-a-half million people who were until recently mainly agricultural.



Today a large proportion have turned to commerce and trading, but on the whole the Yoruba country still remains a country of peasant farmers.

Culturally, the Yoruba live in a momentous time. They constitute one of the most progressive tribes on the West Coast of Africa, but even so the Yoruba are bewildered at the speed at which they are losing all vestiges of African traditions and their once-cherished age-old cultural heritage. They are faced with the decision of either fighting a rearguard action in order to preserve the most valuable and satisfying elements of their social institutions, or succumbing to the present cultural conflicts. Cattell (1939) has stated that cultural conflicts are creative as well as destructive.

The ancient history of this tribe, as might be expected, is lost in the mists of legend and mythological concepts. Apart from the little accurate historical data that is now available, Yoruba mythology reveals, for the purpose of this work, sufficient empirical evidence to allow certain psychological conclusions to be drawn. Tribal tradition holds that all Yoruba originated from the town of Ife, and claim the Oni of Ife as their ritual leader.

Yoruba mythology is, as a rule, tribal history handed down from generation to generation by word of mouth. It represents the experiences of the whole tribal group; the mythological world of their ancestors is a reality of immense importance. The mythological approach enables us to view traditional, primitive religious concepts in an evolutionary perspective. It also reveals the building up of a traditional system of ideas, that is, how the tribes have learnt to appease the angry gods and even win their kindly support and approval by the institution of sacrifices. Thus the unsophisticated and undifferentiated mind began to react to the intricacies of his social environment and evolved some traditional ceremonies for manipulating the powers of the unknown world. The psychological implications of the religious sacrifices as powerful cultural forces in this tribe are of considerable interest.

The relevance of Yoruba mythology to the present study can fully be appreciated in Reik's (1931) description of myth as older than religion and as one of the oldest wish-compensations of mankind in its eternal struggle with external and internal forces. According to his view, its origin can perhaps be traced back to the time when all aspects of human life were still pervaded by animism and its usefulness is best illustrated in its importance for our understanding of the first psychological conflicts of primitive people.

The outstanding works of Freud, Jung, and Roheim are especially relevant here. In order to appreciate the significance of or to interpret specialized thought-content, it is essential to know through what myths, what legends, what succession of traditional customs it has come to its place within the particular cultural group which is attracting our attention. This procedure would only be unnecessary if they were, in fact, certain original and perfectly universal thought-contents demonstrable in all cultures.

European contact with West Africa started from the 15th century; it has been reported that the Portuguese had been in touch with the kingdom of Benin as early as 1472, dealing in ivory and slaves. Western impact did not begin to be felt in Yorubaland until the advent of missionary work of both the Church Missionary and the Methodist Missionary Societies about 1842. The discovery of America and the colonization of the West Indies by Spain led to the tragedies of slavery in the vast country of Yorubaland.

Long before this it was the great Mohammedan Emirs of the North, with the help of the "Arab" traders, who raided the pagan tribes scattered in the forests. The powerful Nupe and Yoruba chiefs took this opportunity to enrich

themselves and, consequently, strifes and inter-tribal disorder took a grip on the country. Gradually Lagos became an important factor in the contact with the British. It was conquered in 1851 and became an important centre of commerce after the bridgeheads established by the slavers had been wiped out. Penetration into the interior of Nigeria was first confined to the route of the great river Niger "which for so many centuries was known only by tradition and romance".

By 1900 the British Protectorate was well established over the whole of the country. The conspicuous but unfortunate role the continent of Africa had played in the history of the Western world as the "cultural melting pot of the Old World—the place where countless influences came together and mingled to branch anew or lie dormant but, in every case, taking a new turn"—can now be appreciated fully by the student of history, especially by those who regard the historical approach as essential for the study and analysis of contact situation and behavioural manifestations.

Acculturation processes have affected the tribal communities to a varying degree but many aspects of aboriginal life are still flourishing in considerable strength. In the attempt to study the psychological realities of today which either result from, or are connected with, the European influence within our term of reference, the field of psychopathology offers a new approach.

#### B. CULTURAL FACTORS AND "AFRICAN MENTALITY"

Yoruba culture, from which have evolved certain mode of thinking, art of living and basic attitudes, does not differ materially from most primitive cultures. From the preceding account of Yoruba mythology we see the gradual evolution of primitive thinking. The basis of mythical, and therefore primitive, thinking are not logically formulated ideas but emotions which also accompany and colour ideas. In accordance with tribal custom, social authority is the source of reality and truth.

Nothing is more paradoxical than the immense interest in, and the immense ignorance of, primitive cultural institutions and their psychological implications, which so surprisingly co-exist in our mind today. Throughout the primitive world the most cherished traditional beliefs are being scrutinized, while no institution, however benign, escapes the fire of criticism. Many authors (for example, Westermann, 1939; Ritchie, 1943; Silberman, 1951; Carothers, 1947, 1951, 1953) have described African culture and, therefore, personality formation in various ways and from different angles, expressing opinions and expounding theories under the jargon of technical scholarship and effectively insulated from scientific criticism. Carothers's (1951) picture of the African personality is one of an illogical blend of low intellect and immoral qualities, tainted with primitive passions and perversities.

Carothers (1951) argued that "normal African mentality closely resembles the mentality of a section of the European population which is commonly entitled psychopathic or sociopathic". He continued, "Except insofar as the African's ritual training mitigates some of the more socially flagrant symptoms (e.g. rudeness and tactlessness), and except that the African shows no lack of verbal ability or of phantasy, the resemblance of the leucotomized European patient to the primitive African is, in many cases, *complete*" (author's italics). He also stated that "for the most part Bantu Africans are very happy-go-lucky and inaggressive and would fall into the class of psychopaths called, 'Inadequate.'"

In spite of isolating these phrases from their normal contexts, they serve

as a good example of one of those attempts by some authors who, confronted with the baffling problems of the incomprehensible, adopt the popular procedure of making sweeping generalizations behind a veritable smokescreen of technical terms, involved abstractions and semantic confusion.

After "a study of African reliability", Carothers (1951) drew up a list of African character traits and concluded, "The striking thing, however, is that they would only occur frequently in Western European civilization in persons who would be considered thoroughly irresponsible, whereas Africans who do not frequently default in ways like these are rather exceptional people." We may agree about the value of this feature of Carothers's work without accepting his sharp distinction between Africans and civilized men. His evidence is incomplete and anecdotal. Often the fanatical racists forget the fact that civilized man, in spite of his more recently evolved mental and moral qualities, has failed to prove yet that he can remain "permanently" civilized.

Others have depicted the African as an irrational, passionate, restless creature, who naturally loves to hunt, wander, brawl, play, dance and sing, take risks and above all has weakly developed ego-consciousness. Ritchie (1943) has stated that

"because of the long period of unbroken indulgence as a nursling, ended by an unbearably sudden and severe weaning, the African has two diametrically opposite convictions about himself, reflected in an equivalent unbalanced attitude to the world. At one level of his mind he is omnipotent, at another he feels absolutely impotent, while the world is divided into two forces—a benevolent power which would give him everything for nothing, and a malevolent which would deprive him of even life itself. As the world of reality denies his omnipotence, he is thrown back on the opposite conviction and remains helpless and psychically dependent on parents or parent surrogates all his days. His own individual personality, with all its latent powers, is never liberated and brought under conscious rational control, and self-realization is thus unknown to him."

It is thus obvious that the modern observers, limited to meagre stocks of fact-data, usually mix their scientific observations with philosophical, psychological or anatomical speculations which tend to vitiate their conclusions.

There is no such thing as "African culture" and therefore "African mentality". Even if we admit that "human societies are never alone", diversity of human cultures in Africa has been emphasized by many competent anthropologists. This diversity is brought about much more by the relations between the various groups and, to a less extent, by the isolation between the groups.

There is no evidence, however, to support the view that Yoruba cultural institutions are significantly different from those of the other African tribes. A review of the literature on this subject reveals the fact that there are important points of similarity. Insofar as his personality structure is influenced by the cultural pattern, a rural (non-literate) Yoruba, for practical purposes, is a fair representative of the primitive African.

African cultural institutions may be different in certain respects. In one respect, they may lack the beauty of the Greek, the durability of the Chinese, the profound mysticism of the Hindu, and the effective knowledge of scientific facts and control over natural forces acquired by the West; in another, the functional and psychological significance of cultural factors may show considerable variation, but these cultural differences neither take origin from, nor have any correlation with, the biological differences between races.

It has been shown by many anthropologists that the naïve mind of the primitive man is not capable of thinking consistently and particularly not capable of comprehending the concept of a general law or of inevitable causality and necessity.

Primitive people are often accused of logical fallacy—so-called “pre-logical” type of primitive mentality (Lévy-Bruhl, 1926). In Yoruba culture, for example, if a man finds the hair or a nail belonging to, or even a piece of material which has been worn by, an enemy, he believes he has only to “use” them in order to bring about his enemy’s death or to injure him. In this mode of thinking, there may be said to be a magical or mystical denial of the concept of causality and of the reality of their spatial and temporal relations. Lévy-Bruhl, however, omits the fact that “pre-logical” mentality occurs in both civilized and primitives, though to the civilized it is, of course, much more in evidence in primitives.

If it is right to believe that the magical period in the history of mankind was the “pre-causal” one, then primitive man’s magic is no sign of a “pre-logical” mentality, as Lévy-Bruhl believes, but of a “pre-causal” (that is, pre-scientific) thinking. Strauss (1953) in *Reason and Unreason in Psychological Medicine* has stated that

“Even primitive magic relies on the necessity of establishing a causal sequence, especially if anything has to be *done* (author’s italics), seeing that man is a rational animal. For example, a tribal rainmaker must have the inner conviction that, when he pours a bowl of water on the ground with the appropriate incantation, the next rainfall has a direct causal relationship with his magical ceremony. A rainmaker who is not so convinced is a bad rainmaker. We shall see later that a psychotherapist—of any complexion—who doubts the validity of his own particular system is a bad psychotherapist. Magic develops into science when it can be shown that the chain of cause and effect is false; and this occurs more often as the result of trial and error (the experimental method) than through pure ratiocination. In this way alchemy, which according to Jung, started as a symbolic substitute-religious discipline, developed inevitably into chemistry.”

Alfred Storch (1924), Schmideberg (1930) and Burstin (1935) have shown that the mystical thinking of primitive man (as exemplified in this culture) is analogous to that of the schizophrenic. This is exemplified in his lack of causal thinking, “especially in his magical taboos, his unshakeable belief in the omnipotence of thought and in the supernatural efficacy of physical phenomenon and further, in his lack of any sharply delimited ego-feeling”. With regard to these analogies, the psychoanalytical school asserts so much and so positively, but it would be a dangerous suggestion for scientific orientation to think that being different is being pathological. In addition, to this apparent and superficial analogies are often drawn whereas the underlying differences in their genesis are often ignored.

The Yoruba, in common with most primitive peoples, regard nature as an important part of the society. This implies a social and not a mystical association. “Reality in the Western world,” according to Brelsford (1935), “has gone the way of attempting to master things; reality for the African is found in the region of the soul—not in the mastery of self or outer things, but in the acceptance of a life of acquiescence with beings and essences on a spiritual scale. In this fashion only is the native mystic. Not because of any pre-logical function of mind but merely because he is the possessor of a type of knowledge that teaches that reality consists in the relation not of men with things, *but of men with other men, and of all men with spirits*” (my own italics). The cultural machinery, which lays great emphasis on the perceptual world of the individual in this culture, conditions the tribesman to a psychological attitude with which he refers the sensations, pleasures, pains he experiences to something outside himself.

Thus he formulates a naïve psychological and epistemological attitude—a way of comprehending his social environment by identifying himself with his life soul (the “*élan vital*” of Bergson) even to a point of confusing its spatial



relationship by regarding it as an external force. This conception of the world is pre-determined by a confused distinction between the ego and the non-ego (the external world), between the subject and the object of cognition. The soul, according to native concept, has a quality which is not only phenomenological but largely existential.

A consideration of the predominance of emotional component, with its function, in primitive culture is extremely important for an understanding of primitive modes of thinking and therefore of the peculiarity of resulting psychological manifestations.

This work among the Yoruba tribe of Nigeria has shown that in practice it is not always possible to delineate confidently where normal primitive beliefs cease and paranoid psychosis begins. The differentiation is only possible after a thorough assessment of the clinical picture, social setting, and exhaustive investigation of the complex-determined factors in the history of individual cases.

The importance of this cannot be over-emphasized, especially in a culture where foreign observers may rashly postulate that which is assumed to be self-evident, but which in reality is a product of confused thinking. Thus Laubscher (1937), who conducted a clinical study of mental diseases occurring among the South African Pagan Natives (Tembu tribe), regarded witchcraft as a phase of schizophrenia and concluded that "a study of the histories of a few witches bore ample evidence that they were psychotic persons suffering from schizophrenia".

In Yoruba cultural environment the general disease concept embraces both mental and physical diseases. This clinical enquiry shows that, as a result of the lack of awareness of causal relations, especially with regard to soma and psyche and complicated by the conception of soul, 95 per cent. of the psychiatric cases studied (both in England and in Nigeria) in this work put considerable emphasis upon bodily complaints, especially in the early phase of the illness.

Psychotic patients in other cultural settings, for example, the West, may manifest the same degree of unusual pre-occupation with somatic complaints at the outset or during the course of their illness. In the Yoruba patients studied, these symptoms, however, occurred with such frequency in individual cases that they significantly contributed to the clinical picture.

The same degree of somatic complaints in connection with mental illness among the Tembu has been observed by Laubscher (1937). He writes, "Hypochondriacal narcissistic states are quite common, all disturbances in the psychomotor sphere are attributed to stomach-ache, headache and bodily pains . . . It has almost become a conditioned pattern of formulating all symptoms . . ." In contrast to this finding is Tooth's (1950) observation in the Gold Coast: "The rarity of hypochondriacal delusions in all forms of psychosis was noteworthy." This observation may be due to the fact recorded by Tooth that "most of those seen were in a subacute or chronic state and the form of the psychosis was masked by the degree of social adjustment the individual had achieved. In over two-thirds, a stormy onset had been followed by a simple regression to a more childish pattern of living."

The complex mental structure of the Yoruba in relation to their culture has been the main theme of this section. The limitations of this correlation between details of cultural forces and those of mental processes are obvious; Sapir (1932) has warned us that culture varies infinitely. "No doubt there are cultural patterns which tend to be universal," he explained, "not only in form but in psychological significance, but it is very easy to be mistaken in these matters and to impute equivalences of meaning which do not truly exist."



With this reservation in mind, this work has established a firm relationship between the elements of cultural forces and those of mental processes by demonstrating that among the non-literate ("bush") Yoruba tribe the *form* and *content* of paranoid schizophrenia is culturally determined; while the picture of the paranoid schizophrenia occurring in the literate (Westernized) section of the tribe is, in large measure, identical with that found in Europeans.

#### INTRODUCTION TO FIELD OF INVESTIGATION

The main purpose of this work, therefore, was to determine the role of cultural factors in the aetiology and psychopathology and clinical manifestation of paranoid psychosis as it occurs in the Yoruba-tribe of Nigeria. To this end, a considerable length of time was devoted to a thorough study of the most relevant Yoruba cultural institutions in a restricted area where the author had spent most part of his youth and has had intimate contact with the people.

Clinical observations were based entirely on the manifestations of paranoid psychosis in twenty Yoruba patients selected for detailed study in Nigeria (1950–51), none of whom was above the age of 36 years. Ten of these were from entirely rural areas and had had very little prolonged contact with the Europeans or Westernized Africans. These comprised the non-literate (rural) group, two of whom were criminal paranoid psychotics admitted to the hospital from their villages, and two who were sent in because they became a nuisance. All four were of recent duration. The remaining six were observed in their homes in Abeokuta Province—the subtribal group to which the observer belongs. Three had participated fully in several native religious cults, rites and ceremonies.

The remaining ten patients were urbanized and Westernized to a considerable degree. Five of these were observed in their homes, while the remaining five were hospitalized.

Similarly ten students were selected and studied in England (mostly in the London area) between June, 1952, and December, 1953. Most of these were private students involved in fairly long courses ranging from nursing to medicine. Their ages were between 22 and 36 years. The clinical research was carried out with the close collaboration of the Liaison Officers (for the Nigerian Students in England) at the Colonial Office, London, where all private files dealing with individual students—family background, tribe, finances, social life and other relevant matters—were made available for thorough scrutiny in conjunction with the clinical picture.

The background of the students exhibited important variations, but marked similarities existed.

A brief sociological study was made of the colonial students' life in London, with emphasis on the change from accustomed mores, the new competition and complexity of city life in London, and the humiliation of racial prejudice and colour discriminations. Several interviews took place between the author and a number of Yoruba students who had some difficulty in adjusting themselves and particular attention was paid to students whose life in England necessitated a greater degree of interpersonal relations, for example, nurses, teachers, and medical students.

The most important single factor revealed here was the high correlation between previous maladjustment due to various environmental stresses and the subsequent development of paranoid psychosis. Some of those who showed minor degrees of maladjustment only manifested, at some period, transient paranoid ideas of sufficient intensity to be described as follows:

"Was never admitted to a mental hospital but was labouring under delusions and convinced that Mr. J. and myself had concocted a plot to murder him. He still writes violent letters from Nigeria."

"Was never admitted but very strange and sometimes violent. Has ideas that he was being persecuted. Now working satisfactorily in Nigeria."

Eight members of this group (who had already been repatriated to Nigeria) were followed up by letters to their families. Two made a fairly good social recovery and the remaining six finally broke down after a varying period of two to six months on returning to Nigeria. Similarly, clinical records of six Yoruba paranoid schizophrenics were requested from a number of mental hospitals in England and examined. These patients were never seen by the author, but had been admitted to various mental hospitals in the south of England within the last six years and had been diagnosed by British psychiatrists. The selection of the records was made from the clinical reports sent to the Colonial Office. The average age of this group was 30.

The selection of cases of paranoid psychosis was made purely on an empirical basis and, within the terms of reference of this work, embraced a fairly wide group of clinical entities, such as paranoid schizophrenia and certain ill-defined clinical states. In this latter group, personality deterioration was less pronounced than in the paranoid schizophrenic group, and it is also characterized by the development of more highly elaborated hallucinatory features, usually but not exclusively auditory. In certain respects, there were similarities between this group and Kraepelin's paraphrenia.

Organic paranoid psychoses, for example, trypanosomiasis, cerebral malaria, and other toxic-infective conditions, cerebral lues, cerebral cysticercosis, etc., were excluded from the body of the clinical enquiry but were considered together in the differential diagnosis.\*

On the basis of the above criteria, the group with paraphrenic features lies at one end of the scale of a psychopathological continuum and paranoid schizophrenia at the other. It was, however, discovered in personal practice that among the Yoruba tribe the two clinical groups approximate so closely and tend to merge into each other that at times differentiation is almost impossible. This clinical formulation agrees with Noyes's (1953) experience in that paranoid psychoses, when broadly considered, can be regarded as constituting a continuous transition with almost imperceptible gradations.

#### NOTES ON CLINICAL MANIFESTATIONS OF PARANOID PSYCHOSIS IN LITERATE (WESTERNIZED) AND NON-LITERATE (PRIMITIVE) YORUBAS

It should be re-emphasized that "culture" and not "race" is the dominant theme in this work. While the concept of race is a biological one, culture, strictly speaking, implies environment but in its totality. The racial concept is based on the assumption that genetically determined mental differences do exist between different races but the fact should be stressed that, in the light of our present knowledge, while the range and levels of innate mental capacities between races have not been proved to exceed those that are usually encountered in individuals of the same race, there is no evidence to support the view that psychological differences between groups are racially determined.

Therefore, this enquiry is based on the hypothesis that mental traits (actual and potential) might be conceived as cultural emergents and thus become objects of scientific study and comparison.

This work has revealed that there are important qualitative differences in

\* Paranoid illnesses appearing as part of other psychoses were also excluded from this study.

the psychotic reactions of these two sub-cultural groups. The clinical differences elicited are highly significant inasmuch as they influence the diagnosis, severity of clinical manifestation, and prognosis of the mental disorder under consideration, and there seems no reason to doubt that the observed differences have their origin in the prevailing superstitions, customs, and mythological concepts (that is, they are culturally predetermined).

Paranoid psychosis in the non-literate (rural) tribal group manifests some features which are apt to be indefinite, transitory and multiphasic. In some of these patients, this mental disorder genetically resembles a hypothetical mental disease lying midway between psychotic and psychoneurotic illnesses in Euro-American cultures.

Clinically, it is essentially atypical in its form, when compared with that of the literate tribal group, and, in the majority of cases, it closely simulates the picture of organic confusional psychosis that is usually found in Europeans and Westernized Africans. In most cases, a peculiar complex of symptoms (anxiety, repeated confusional attacks, absences, automatisms) may be prominent, though transitory. The significance of this symptom-complex will be discussed later.

The cultural pattern to which the primitive Yoruba belongs, determines not only the nature of his psychic content, as manifested by the forms in which his delusions are cast, but also affects the particular *form* of that mental disorder insofar as its structure is involved. Whether this change in the structure is reversible or irreversible is important since an irreversible structural change may imply a unique form of disorder peculiar to this culture. The present observation suggests that the change in the structure of the psychosis is a reversible one. Paranoid psychosis in the Westernized (literate) group of the tribe, on the other hand, does not differ qualitatively from that which is seen in European culture.

The differences in the patterns of clinical response (with both quality and quantity of the symptom-complex as determining factors) between the two sub-cultural groups of this tribe are due to certain features of the psychosis. In order to group together these characteristics for descriptive purposes, I propose to adopt Birnbaum's terminology. Karl Birnbaum in his *Strukturanalyse* coined the word "pathoplastic" for those factors which contribute to the clinical picture in individual cases or groups of cases and which are attributable to cultural and other influences tending to modify the basic manifestations of mental disorders (i.e. these pathoplastic factors are shaping factors).

The responses or activities which come into play are extraordinarily complex and their interrelations are manifold, but they are produced or ruled, in a way which defies any attempt at interpretation. This symptom-complex which, in the primitive group, is superimposed upon the fundamental features of paranoid psychosis and alters its structure, may well be due to the simplicity and naïveté of the psychic apparatus of the rural tribe. This implies a fairly uniform "collective unconscious" (Jung, 1917), with its undifferentiated archetypated contents. It is these primordial forms of thought and feeling of the unsophisticated tribe which determine the baffling uniformity and strangeness of their psychological manifestations.

This is not surprising. It has been shown that ancient civilization constructed innumerable gods as projections of the wish, and in the swing between the illusions and delusions of phantasy to the efforts at controlling reality of natural forces, the wide history of mankind's behaviour records countless steps between the extreme conceptions.

This symptom-complex consists of anxiety state (pseudo-running amok), neurotic depression, vague hypochondriacal symptoms, magico-mystical (bizarre) projection symptoms, episodic twilight or confusional states, atypical depersonalization phenomenon, emotional lability and retrospective falsification of hallucinatory experiences. These are usually present in varying degrees and in various combinations in individual cases.

In the active stage of the illness these pathoplastic factors, which are cultural precipitates, tend to be multiple, but as the case progresses the quantity is reduced. Some of these are apt to be paroxysmal in the acute stage, only to assume an episodic nature as the case graduates towards chronicity or as soon as the acute stage is passed. It is possible that this fact is responsible for the multiplicity of its phases. On the basis of these qualities it is possible to differentiate sharply between the two groups of psychotic patterns of reaction.

These culturally-conditioned contributory factors are found to be much greater in quality and quantity in the cases that were under hospital care than in those observed in the rural area. The cases under home care, however, deteriorated much more readily than those that were hospitalized. If this observation can be countenanced at all, one may therefore assume that the presence of some pathoplastic traits is a pathological attempt at restitution, that is, essentially reparative in nature. While this assumption may be true to a certain extent, the pronounced degree of personality disintegration in the rural group might partly be due to other factors (for example, lack of general medical attention and of institutional life).

An account will now be given below of individual symptoms from each of the groups, with a note on possible pathogenic and pathoplastic factors. One or two cases will be referred to in respect of each form of manifestation.

#### (a) *Delusions*

Delusions of persecution figure prominently in both groups. Delusions of grandeur are rare in the non-literate group in contrast to the expansive ideas of noble birth with continual self overvaluation, and extravagant themes which one frequently encounters in the urban or literate group.

In the rural non-literate Africans in this tribe, the delusional contents are often centred around the concepts of supernaturalism and ancestral cults, while in the literate African, hypochondriacal delusions, especially in the early stages, seem to dominate the picture. On the whole, in both groups, the ways the delusions are cast throw some light on the tribal interpretation of nature in the environment. The most important finding here is the readiness with which most of the members of the literate group, even the most fervent Christians, regress in their delusions to super-naturalism or magico-mystical influences. This regression is usually transient and often these delusions in the primitive group, based on the concept of supernaturalism, lack the tenacity and conviction that are often encountered in similar delusions of the primitive group. The same observation has been made among the American Negroes (Acherman, 1938).

The rarity of delusions of grandeur is characteristic and this is of cultural origin. Bleuler (1924) has observed that "certain ideas of persecution and grandeur are only possible in definite strivings and in definite characterological relations to the environment . . .". Yoruba culture demands total allegiance to ancestral cults and nether world gods, and it is this submissive attitude which seems to influence their choice of delusion.

Due to the influence of pathoplastic factors, especially episodic confusional

states and excitement, systematization is usually vague in most of the non-literate (rural) cases.

(b) *Hallucinations*

The observations are equally true of hallucinations in the non-literate group. There are, however, one or two features which are of importance clinically: hallucinations tend to be transitory, predominantly auditory and ill-defined.

Temporal, spatial and causal relations are meanings we read into sense-impressions we receive. There are, however, many other forms of meaning (meanings which are culturally determined) which, in similar fashion, we read into or add to different perceptions. In Yoruba culture one is never struck by the conventional meaning of a word, but rather great emphasis is laid on the whole complex meaning of the situation, the complex of emotional relations between man and man. Verbalization is the most predominant form of communication of primitive African, hence the cultural emphasis on auditory sense-impressions and their symbolization.

The other important observation is the ability for retrospective falsification of hallucinatory experiences. This observation was present in about 40 per cent. of the rural cases and in about 10 per cent. of the cases it was associated with confusional states.

(c) *Episodic Confusional States, Incoherence, and Emotional Lability*

One or more of these symptoms is invariably present and it is this constant feature of the clinical picture of paranoid psychosis in the non-literate Yoruba tribe which distinguishes it from that which occurs in the literate tribesman.

It is not uncommon for marked emotional fluctuations in normal and diseased persons in any culture to lead to affective confusion at some time or other. This, however, does not usually assume a definite pattern. During the twilight state which accompanies this psychosis in the non-literate Yoruba, there is much more profound confusion of thought process, disturbance of association, falsification of the situation by illusions, hallucinations, and depersonalization phenomena. The most constant content of this state is that of (paranoid) anxiety. During one of these confusional outbursts, one of the cases observed had anxious and hostile illusions which provoked him to kill his mother-in-law.

This clinical feature has also been noticed by Shelley and Watson (1936) and Carothers (1947), in different parts of Africa which have similar cultures.

*Because of the African's (Yoruba's) cultural environment, intellectual and affective factors are closely interwoven (that is, a form of autoplasmic adaptation), but the affective sector predominates and it dominates his life: his interpretation of reality is not in relation to its temporal environment but of men with other men, and of all men with the supernatural.* This is the most important single cultural factor which conditions the evolution of paranoid psychosis and its reaction types between the two groups.

If one attempts to relate this syndrome, consisting of extreme affective disinhibition associated with cloudiness of consciousness and incoherence of thinking, to the syndrome known in clinical psychiatry, one will have to think of hysterical and epileptic manifestations, but in none of the cases observed had there been any state of epilepsy.

Bleuler was one of the earliest authors to notice the clinical significance of "psychically determined excitements, or twilight states" in schizophrenia.



He further observed that they may not be "directly connected with the process of the disease, but are only transient reactions of the diseased psyche to certain stimuli".

(d) *Anxiety State*

This condition may be an important component of, or an underlying factor in, the confusional or twilight state described above, or may exist alone when it is usually seen as a precursor of the psychosis. Anxiety state as a concomitant of some other psychiatric conditions may occur in any culture, but the forms it takes, as already pointed out under (c), is culturally determined.

Anxiety is almost invariably interpreted as the result of a bewitchment which constitutes a threat to life. Thus psychogenic foci often excite activity of a kind (as pointed out above). In a small proportion of cases, this anxiety state has only a taint of hypochondriacal features. In the literate group, on the contrary, the anxiety state (which usually precedes the psychosis) shows very marked hypochondriacal features, while the "action" component (that is, frenzied fury and homicidal tendencies) is conspicuously absent.

In both groups the anxiety may persist in the acute stage, but is usually absent when the mental illness becomes well-established in the non-literate group, with the exception of when it is present as a component part of twilight state. In the episodic twilight state or recurrent confusional state that dominates the clinical picture of the psychosis in the rural tribesman, anxiety is likewise recurrent or episodic.

(e) *Hysterical Conversion Symptoms*

One patient (among the rural, non-literate group), after a month in hospital, developed hysterical aphonia (long after appearing in Court). A few days previously he had been preoccupied with answering the ever-present persecutory voices. Another patient, who at one time put cotton wool in his ears, finally developed hysterical deafness; while hysterical conversion symptoms developed, with subsequent partial recovery, in one other patient. These were the only three cases in whom the hysterical nature of the affection could be adequately appraised. In the literate group, as a whole, no hysterical symptoms were elicited.

Thus the clinical manifestations of paranoid psychosis in the non-literate Yoruba are ill-defined, punctuated with multiple pathoplastic features and, on the whole, the picture of mental confusion being the most prominent trait. Hence its form is essentially amorphous.

It should be stressed that these pathoplastic factors exist only in addition to thought disorder, passivity feelings, affective disturbances, disturbed association of ideas and other symptoms which are varying aspects of the fundamental schizophrenic disorder, common to both groups. In the early stages of psychotic process in the non-literate (rural) group psychoneurotic-like symptoms of an ill-assorted nature are going on at the same time.

The following four cases selected from the primitive group will be dealt with in detail to illustrate some of the atypical features mentioned above.

CASE 1

*Summary.* Paranoid psychosis of insidious onset. Longstanding self-reference tendencies and vague depersonalization symptom, consequent upon an incident with a very strong affective value.

Pre-psychotic personality was mixed with comparatively schizoid traits. Mixed constitutional make-up with asthenic features. Family history was clear of mental disease.

Initial stage of excitement, confusion and auditory hallucinations. Few pathoplastic traits

and multiphasic changes. Examination under anaesthetics seemed to have uncovered the schizophrenic layer, which was revealed for a comparatively short time before being screened once more by recurrent confusional attacks.

The most significant and relevant physical finding was a uterine fibroid which reinforced her wish-fulfilling delusions (that she was pregnant, etc.). Rapid deterioration.

J.D., a Yoruba-woman aged 35, married with no children, was seen at Owode, near Abeokuta, in 1951. She was the first wife (with two co-wives) of a prosperous local farmer who dealt in kola nuts.

She was quite well until the end of November, 1951, when she suddenly started to show restlessness and excitement and began to laugh a great deal. The husband sent for her relatives, who diagnosed a "brainstorm" due to the "evil work of one of the co-wives". She was removed to one of the huts where she was seen by a native medicine man who, after a long ritual, diagnosed the patient to be the "offender", that is, that the patient had previously used a powerful magic against somebody whose defences were strong and the effect of the rebound was supposed to be the cause of her illness. The native medicine man left after a week of treatment. (It is not unusual for the native medicine men to tactfully manoeuvre themselves out of the picture in cases where the acute symptomatology is overwhelming and accessibility is difficult.)

The patient was seen by me three weeks after the onset of her illness. She was still confused, excited and grossly aurally hallucinated. She was hearing the crying of many children. She was naked and was walking about the room in a very anxious, apprehensive manner, but without any co-ordination of purpose or movements. The phase of the illness was one of mental confusion during which she was incoherent in her speech, excited and acutely hallucinated. After her relatives refused to have her admitted into the Asylum at Abeokuta, she was sedated.

After the initial state of excitement and confusion she was still manifesting symptoms of the acute stage but it was obvious that the illness had entered a new phase. When she was seen on the sixth day her confusion had abated considerably but she was anxious and her emotion was one of lability. She was incapable of giving a good account of herself, except for her complaints of her womb—"my children are in there". Her behaviour at some periods could be said to have been based on the fundamental pattern of hysteria. She was convinced that some people were persecuting her and conspiring to "drain her womb" of its contents. She could feel movements in her womb and her illness, according to her, was due to the fact that the vaginal passage was blocked by the effect of native medicine. After a week she still remained in this state of mixed psychoneurotic-psychotic state, with no other evidence of the basic features of any known psychosis.

Her relatives were co-operative and gave the history of the patient. The family history was clear of mental and nervous disease. Her mother had had seven children, five of whom were alive—three women and two men, married with children. The patient's pre-psychotic personality was good—a quiet, but sociable, person. She was of a mixed body build.

Her husband said that the patient had been worried for a very long time over her inability to have children. They had done everything possible but no pregnancy seemed to be forthcoming. They had paid a lot of money to the native medicine men of various cults and they had themselves made several sacrifices to the gods and ancestors. When her husband became apprehensive, though sympathetic, he "married" another wife who later had children by him. The third wife came in 1948 and had already had one child. Although the first wife (the patient) still kept her place and played the role of the first wife, she nevertheless became jealous of the procreative ability of the co-wives.

In October, 1950 she started to report the movements of the co-wives to their husband. She complained that one of the co-wives was using native medicine against her because she was having bad dreams about her. The husband investigated this allegation but found it groundless. By December, 1950, she incorporated her husband into her delusional system and later was able to persuade her own relations to believe her ideas of influence and persecution. She thought her husband was planning to get rid of her because of her inability to have children.

The husband further elaborated on the central core of the psychogenesis of this illness by revealing that as far back as 1944 he could remember her getting restless and worried over an incident. It was revealed that the patient lost her "aso Osu"\* after putting it outside to dry in the sun. Her suspicion that somebody might have taken it for magical purposes was confirmed when after many years she found that she had failed to have children. The second wife, who had two children for their husband, was a local girl, and after she came the patient thought that the co-wife's parents must have been responsible for taking her "piece of menstrual cloth", so that when she had failed to procreate, their daughter could usurp her position. Thus the patient built up a plausible system of ideas. The patient later confirmed what her husband said about her illness but entreated me to "open" her womb and to release her children.

On further enquiry it was found that she had missed her menstrual periods for over a year but "her pregnancy was suppressed" by some magico-mystical power of the "evil doer".

\* This is the term used for the piece of cloth that native women use for their monthly periods. These pieces of cloth are usually washed and kept from month to month and guarded very closely for fear of being taken by an enemy who might then prevent them from having children or even kill them.

Physical examination was negative. The abdominal examination was quite unsatisfactory. The patient did not allow palpation and every effort to conduct any pelvic examination (per vaginal route) was met with hysterical outbursts because of suspicion. On my advice she was removed to Abeokuta General Hospital, where she was examined under anaesthetics and fibroid was tentatively diagnosed.

Two days after the examination, the patient manifested a florid picture of paranoid schizophrenia. Her prior vague symptom depersonalization (she thought she had changed and become "inexistent" since her "menstrual cloth" was lost), ideas of persecution (of psychogenic origin), and auditory hallucinations (voices of other women saying that she would not live to bear the children in her womb) became well-established.

It has been revealed here that prior to the development of her illness there had been self-reference tendencies of a mild nature. These self-reference tendencies became intense in the acute stage of the disease when only a few pathoplastic features were apparent.

By the middle of February, 1952, pathoplastic features became more pronounced and could easily be studied. Recurrent confusional states (her abdominal "movements" acted as a trigger point) characterized by perplexity, hallucinations of magico-mystical nature, and hysterical hypomanic behaviour completely dominated the clinical picture, while the basic schizophrenic features seemed once more to be clinically quiescent or screened. Not only did the pathoplastic features nullify the intensity of the basic schizophrenic features but the entire symptomatology became less intense and much more vague.

A study of the symptomatology of all the phases of the psychosis revealed a number of the central aspects of her emotional life, within the tribal social expectation. Due to the existence of a primary anxiety the content of her delusion was coloured in this sense. The pathoplastic features seemed to be a purely functional attempt to keep certain affective occurrences out of consciousness.

It should be added here that fibroids (though relatively rare) are a well known cause of psychiatric disturbances in the native women. This patient was later removed to another village to see a medicine man and the writer was never allowed to follow her up. All attempts at hospitalization were unsuccessful.

This patient, after three years in the village, is now reported to have been admitted to Yaba Mental Hospital, Lagos, and the clinical picture is one of clear-cut chronic paranoid schizophrenia.

#### CASE 2

*Summary.* This patient was originally diagnosed as paranoid schizophrenia but since she is still well-preserved she is now considered to be among the paraphrenics.

The apparent lack of psychogenic factors is the main feature, but, on the analysis of the cultural factors, a mass of relevant facts had been found symbolized. Her paranoid trends were comparatively localized.

The insidious onset with massive symptomatology, the history of hereditary factor, the psychopathology in relation to the kinship cultural traits, are noteworthy.

The actual precipitant is interesting. Her faith in another religion was betrayed by the return of an exiled chief. She was still able to cope with her mental disturbance until she was abreacted by the violent religious conversion.

The clinical picture was a mass of pathoplastic factors which altered the form of the psychosis.

A.A., a Yoruba-woman aged 36, married, was admitted to Yaba Mental Hospital in 1951. She was brought in by the police because of her confused state and efforts to drown herself in the river. She had spent a considerable part of her time sitting by the river, and whenever she got into this recurrent confusional state she would then obey the voice which commanded her to drown herself.

The family history was questionable. The father "died of 'apeta'" (this is the interpretation that is usually given to explain sudden deaths). She said that an enemy "called" her father when he was asleep and when her father's effigy appeared at "the other end", he was shot. Consequently, "he died in his sleep". Her mother was alive and well, but she had not got on very well with her for a number of years because of the patient's increasing interest in another religion (Obatala) instead of the usual worship of ancestral hierarchy. She was the second of seven siblings.

Two of the brothers were said to have had this type of illness. One recovered sufficiently to become a great shaman and Egungun worshipper (another form of ancestor worship) which, on close inspection, might have a therapeutic effect on schizophrenia comparable to that of Buddhism. The other brother's history was of a legendary nature. She summarized it briefly and said that "he answered the call of Odo Oya (River Niger) and disappeared". Apparently he was never found, dead or alive.

The patient was the fifth wife of an Egba-man. Everything had gone well until she and her only daughter of 17 became great worshippers of "Obatala". There were six children in the family (that is, five by the other wives).

*Personal History.* Early development was uneventful. She had sucked her big toes when she was a child. Her health in childhood had been good, except for a few bouts of malarial infection. Her early training and environment showed no deviations from the normal pattern in this culture.

She was proud of the fact that she had her first child (which was lost after six months)

three months before she actually "married" her husband. It was a few weeks after the death of the child that she had a severe infection of smallpox. Previous mental health was good.

Pre-psychotic personality traits could not be ascertained, but there were no reasons to think that she was introspective and schizoid in an environment which encourages extraversion.

*Present Illness.* Her illness started insidiously about three years before her admission. Two years prior to the beginning of her illness she changed her religion and accepted "Obatala" in place of the ancestral cult. This decision was most unpopular with her family, but in spite of this, she was prepared to carry on with it. She was so good at this religious cult that by 1947 she became a well-known figure in connection with certain aspects of it.

During this period (1948) Abeokuta was in chaos, socially, politically, and economically. The people had a few years back revolted against their tribal chief and sent him into exile. She had played a great part as a religious leader in using their influence with the spirits and the earth gods to make permanent the exile of their chief. To this end she, as well as other religious leaders, made sacrifices and other native rituals. "Unfortunately, something went wrong," she said, "and the paramount chief at Abeokuta was brought back by the Europeans." According to her, all their sacrifices and other secret devices "returned"\* to them and it was the adverse effect which had caused her illness. As a result of this conception, the voice she heard was supposed to be that of this paramount chief, who had returned from his exile.

According to her husband, she had actually started to show increasing anxiety and morbid preoccupation with her dead father's inability to grant her wishes (that is, to have more children) a few months prior to changing her religious affiliation. That was the main reason why she rejected the concept of, and belief in, ancestral cults and turned to something totally new. It was during this time that she was expressing vague ideas of reference and influence. She openly expressed that her aged mother was a witch and was influencing her inside and later suspected the presence of some people at the annual religious ceremony of Obatala as ominous.

It was not until early in 1951 that she started to make attempts at drowning herself. She at first denied hearing any voices, but later admitted hearing the voice which was commanding her to drown herself.

In comparison with other cases, the psychogenic factors are not easily demonstrable in this case. However, with a knowledge of the culture and study of the role of ancestral cult in the mental life of the native tribe, it may be possible to unravel the genesis of this disorder in this patient. Her ambivalent attitude to the ancestral cult is exemplified in her conscious hostility to her dead father. She had maintained that her father failed in his duty to solicit the spirits on her behalf for more children. This alleged "failure" on the part of her father started a chain of rationalization which in turn led to her total rejection of the concept of, and belief in, the ancestral cults. She became preoccupied with another obscure religion and later had a violent religious conversion at the initiation ceremonies.

The above formulation, which is partly based on empirical findings and partly speculative, has to be weighed against the "normal Yoruba background". A study of this particular religion (the new religion she had adopted) reveals that it subtly involved the mechanism of abreaction. It was during her violent religious conversion that she started to manifest vague ideas of reference and feelings of influence (which at a particular time might even be consistent with the normal phase of that ceremony).

The significance of rivers to this kinship is of great cultural importance: it was their main source of spiritual life. Her kinship had worshipped the spirits (the sea deity of Yoruba mythology) inhabiting the rivers for many years. Thus this cultural factor partly formed the matrix of the psychopathology of her illness.

Physical and laboratory examinations revealed no sign of organic disease. She was well-nourished, but of asthenic habitus. She had optic atrophy of the right eye and said that it was due to an attack of smallpox at the age of 18.

Her mental state on admission was of great clinical interest, due to the prominence of anomalous features which completely dominated the basic factors of the disease. The massiveness of the symptomatology was striking. Apart from her feelings of passivity, influence (her body was being influenced by magic), and ideas of reference (she thought that certain objects on the trees outside the hospital were referring to her and indicating some obscure meanings), depersonalization-derealization phenomena (she vaguely said that since she started her new religion she had already changed and her conception of herself in human shape had altered; also that the nurses in the hospital and the world as a whole seemed altered somehow) were also prominent. She was aurally hallucinated—"I can hear that chief's voice telling me to drown myself."

She was co-operative to a reasonable degree, but her suspicions and delusions of persecution (the paramount chief and his medicine men were out to kill her if she failed to answer the call to drown herself, etc.) prevented her from answering many questions which would have thrown some light on the psychogenic factors. Her memory both for recent and remote events was good.

\* This implies the role of the aggressor in Yoruba culture, that is, if an aggressive intention fails, the psychological repercussions might be disastrous. It is a Yoruba custom in these cases to carry out several tests to determine whether a man is the victim or the aggressor. The confusion of cause and effect in Yoruba medical concept is again exemplified.



Orientation for place, person and time was good. Insight and judgment were markedly restricted, but the entire mental state was subject to fluctuations due to a mild recurrent confusional state which was usually ushered in by incoherence, hysterical outbursts and acute hallucinatory experiences (she "found a river" in the hospital grounds, stripped herself and started to make gestures as if she was in it; she spent over two hours running about "because I can see the medicine men running after me"). During some of these twilight states she struck several female nurses, saying they were her mother in disguise.

On the whole the mental state was atypical and mixed. She fluctuated between apparent normality and mild confusional state, but managed to preserve her personality integration to a fairly reasonable degree.

By early 1952 she had improved under institutional care sufficiently to be allowed to go on parole under supervision. Her main symptom was strong delusion of persecution, apart from the recurrent "hysterical" states of confusion, during which, if not properly sedated, she could cause a lot of trouble and violence. Another noteworthy finding by February, 1952, was the alteration in the affective manifestation: the earlier incongruity was later replaced by emotional lability. It was this time, when she had shown some improvement, that the history was elaborated upon, and some information was later given by her daughter. In most cases, it was seldom possible to appraise the clinical pictures with any certainty on the histories available and a single examination.

According to the medical report (communication) from Nigeria, she is still well-preserved and the host of the pathoplastic features enumerated above was still demonstrable in varying mixtures and at intervals. Her delusions of persecution were still maintained. This case, in its basic features, could be considered as paraphrenic whose qualities have been altered by the presence of pathoplastic traits.

### CASE 3

*Summary.* Paranoid schizophrenia of acute onset following an ill-defined incident in which superstition and tribal ideology formed the core of aetiological factors.

The clinical picture manifested clear-cut anomalous features comprising hypomanic traits, hysterical confusional states or cloudiness of the sensorial functions of episodic nature, and auditory hallucinations. Affect varied a great deal. Fairly "systematized" delusion of persecution at the outset, vague religious (Ifa) features and markedly bizarre behaviour.

Rapid deterioration with marked incongruity of affect and fairly prominent pathoplastic features. Remained physically fit throughout.

L.E., a Yoruba-man aged 32, married, was seen in a small village in Abeokuta Province in October, 1951. He was living in the same "compound" as his relatives with his two wives and a child of eight.

His family history was negative, especially as far as any form of epilepsy was concerned.

The patient's development had been normal and he was healthy until he developed left inguinal hernia soon after his marriage to the second wife. He had always been a good worker on the farm and had held a good social position in the village, being the head of the young hunters. He had lived all his life in the village, except for going to the town annually to celebrate "Odun Ogun" (the God of Iron). He was a great exponent of the theory and practice of this religion and his people said that he had saved a great number of people to the displeasure of witches and their spiritual agents. Consequently he had been in their bad books and had been watched for some years. His parents thought that all his present trouble was due to the work of revenge of these witches and shamans through the medium of sorcery. The crisis was reached after the patient's marriage. The girl was supposed to have married the son of a well-known and reputed tribal medicine man about two villages away from their own.

The fact that his sacrifices were not accepted, together with the fortune-teller's forecasts, made him think that the prognosis was hopeless. This was at the time "when they had not succeeded in draining all his brain".

The patient himself, who was a well-built man who talked fluently and at great length in connection with his delusions of persecution, related the story of this chief "in the next village" who, through his practice of sorcery, had exercised undue influence over the adjacent areas with an unusual degree of coercion. He had always "stood up to him in every way". As he said this, he looked faint but he managed to shout across to his father, who was outside his hut. His mental state changed to that of a confusional state in which cloudiness of the sensorial functions was evident and he became incoherent.

The father explained to me that almost every other day this shaman in the other village used sorcery in an attempt to kill him and it was during this period that he usually became like that, since through his own spiritual power he could foretell the attack. The father at this time repeated a few incantations and after about an hour the "evil power" was warded off and the patient resumed his history. I thought that the attack was of a hysterical nature, but that it was not wholly without clinical significance.

Three months before his illness started he married a girl as reported above. It was the Ifa oracle that "directed" this girl to him, but after their marriage he forgot to offer a sacrifice in good time according to the wishes of this great occult force (Ifa) and it was this temporary lapse which weakened his defences (he had a great number of charms around his waist and a number of rings on his fingers). The first thing he noticed was a swelling on his lower abdomen (a left inguinal hernia) which reminded him that he was in danger.



He immediately offered a sacrifice to "Igi Iroko" (Iroko Tree) soliciting its help, "but the second day the spirit left the tree" because the tree was struck by lightning. He knew then that the end had come. For a day or two afterwards he became "a new man". He said he was completely altered and it was the powerful "medicine" used by his father that brought him back to life. I was later told by the father that he was extremely excited, walked about the village looking for the "spirit" which had left the tree after refusing to accept his offering.

Careful physical examination excluded the presence of any organic disease (for example, trypanosomiasis, or post-vaccinal encephalitis, for during that year there was an epidemic of smallpox in Abeokuta province. There was also no history of head injury.)

His mental state exhibited varying degrees of paranoid symptoms which could be related to his cultural environment (ideas of reference, delusions of persecution), with other features (hysterical hypomanic behaviour, cloudiness and incoherence). He was aurally hallucinated, he could hear the voices of sorcerers at their meeting conspiring against him, and during these episodic attacks of confusion he might remain depersonalized for a considerable period afterwards, saying that he had been taken away and what is left behind was something in the nature of his effigy.

His memory both for recent and remote events was good, but during his episodic attacks, in which I have seen him on many occasions, retrospective hallucinatory experiences were interpreted in the light of the tribal general disease concept. His mood was fluctuating and on occasions showed evidence of disharmony. He was correctly oriented, except during his confusional attacks.

Within six months of seeing him regularly he deteriorated very rapidly and his delusions were less "systematized". His behaviour was much more bizarre and there were transitory religious traits in his delusions of persecution.

#### CASE 4

*Summary.* Paranoid schizophrenia of abrupt onset, with episodic manifestations and punctuated by many pathoplastic (psychoneurotic) features. Hysterical conversion symptoms, anxiety and frenzied attacks leading to multiple homicide.

Family history was clear. Great fetish religious preoccupations for a number of years. Ill-defined hallucinatory experiences at the age of 16. Recent illness probably was an acute exacerbation (Twilight States may occur as acute syndromes based on a chronic schizophrenia—Bleuler).

Some of the clinical manifestations (e.g. deafness) were definitely hysterical in nature; others simulated hysteria very closely (e.g. the recurrent confusional states). Some of the features of these confusional states are not wholly of hysterical nature as it is usually seen in the European. But, if we insist on describing these observations in physical language, then these reactions, in the rural Africans, must be conceived as abnormal psychological reactions common to a group of paranoid psychotics (and of probably cultural origin) and not as an individual disease.

The clinical picture exhibited multiple phases due to the presence of pathoplastic features. Spontaneous remission almost amounting to full recovery, in spite of vague depersonalization syndrome and body-image disorder at the outset of the illness—usually of bad prognosis (Langfeldt, 1937).

S.O., 29 years of age; male; peasant farmer from Ijebuland. Admitted for observation in March, 1951, after he had killed two people in his village. He had been a very sociable, gay and voluble young man. He had always worked on his father's farm, although a portion was given to him when he married.

*Family History.* There was no history of mental disease in the family. The father was a well-known figure in Ijebuland and had been a very strict disciplinarian. He was a great fetish worshipper and this religion had been traditionally accepted by the family. The patient's mother was the sixth in line of the co-wives. The siblings were all living locally in the village—four of whom were married. The patient was the only son of his mother and had been somewhat valued and spoiled as a child.

*Personal History.* The patient was born in an Ijebu village. Birth and early development were normal. He had never been to school but had received a thorough training in fetish religious principles and practice. At the age of 16 he excelled himself in forecasting certain future events which eventually happened as predicted. At this age he also had various experiences. It was revealed that he saw and talked to some spirits who finally conferred upon him a great power to foretell the future and also to manipulate the wishes of the spiritual world. His social and spiritual prestige became enhanced after these experiences.

He married the daughter of a great fetish priest who lived about twelve miles from their village, when he was 25. A child was born two years later and this child was dedicated to the fetish spirits. He married his second wife in 1949.

His previous personality is of great clinical interest. He had always had a rich phantasy life, and his hallucinatory experiences at 16, although regarded as being normal within the cultural concept, could equally be a mild schizophrenic illness around puberty. It was also at this time that he became very preoccupied with the fetish religion and its social ramifications. It can, therefore, be assumed that the fetish religious rites, which have a lot in common with the obsessional mechanism in Western culture, might have held the schizophrenic mechanism at bay. In this respect, Stengel (1945) said, "The opinion has been expressed that the obsessional

personality structure is capable of subduing and aborting schizophrenic reactions." The other alternative to the explanation of the patient's experience at 16 could be that of spontaneous remission, which is not uncommon. Hysterical hallucinatory experiences are not uncommon in this culture and could also receive consideration in this case.

*Present Illness.* His illness started suddenly with an apparent lack of psychogenic precipitating factors. According to the patient, he returned to the village one afternoon in November, 1950, after he had been working hard. He said that he was very exhausted after working during the heat of the day. After his meal he went into the fetish hut, where he had an appointment with people from another village. During this ceremony he said that half of his body, from his head to his waist, seemed to have left him, and what was left was infested by a spirit. This phenomenon is not uncommon among other religious heads in this culture, especially in those complex religious rites which are highly affectively-charged and which are potentially capable of causing some transient hysterical manifestations.

The patient said that after the ceremonial rites the spirit found it difficult to leave him, and he knew this because for several hours he was "not himself" and his "soul had left" him (a translation of which is equivalent to feelings of unreality. The concept of "soul" in Yoruba culture is synonymous with reality. This fact may account for the inability to observe the symptoms of depersonalization-derealization syndrome by foreign investigators.) Because of this he did not go out of his house for about two months, during which other medicine men did their best to ward off the work of the sorcerers. He said that during this time he could still see visions and had several conversations with his ancestors.

By early February, 1951, he suddenly "exploded" in the words of his father. For several hours he was extremely anxious and apprehensive and then went into what was described as a "trance". By the end of the day he became violent and excited and walked around the village in great confusion, but before he could be taken back to his hut he had already killed two people who were not connected with his illness or with the fetish rites in any way.

He was arrested by the Judicial Authorities in the area and was eventually sent to Lagos, where he was admitted for observation. He was still confused, aurally hallucinated, excited, and very difficult to manage. He was disorientated for time, place and person, and for the first time, manifested some bizarre projection symptoms. He was difficult to examine and it was thought best to sedate him, after a quick physical examination. He was confused for about two weeks, during which time the question of a concomitant organic factor was raised. All physical examinations and laboratory findings were normal. Towards the end of the tenth day he was making every effort to answer the questions put to him, but the train of thought was slow, confused and fragmentary. Affectivity was greatly disturbed. He had many terrifying but transitory hallucinatory experiences, which were accompanied by attacks of rage.

Spontaneous recovery took place about two weeks after his admission. It was discovered that the emotional factors which had played a big part in his confusional state (as evidenced by his hallucinations and contents of his utterances) were now being projected on a delusional basis. The katathymic delusional formation centred around his religious experiences. Ideas of reference and influence were evident, but his main source of anxiety (and occasional state of panic) was the persecution by the malevolent spirits whom he could hear everywhere. He denied having killed anybody and had massive amnesia for the short acute phase of his illness.

What was originally thought to be an acute phase of his illness became an episode. His (? hysterical) twilight state recurred, complicated by the states of wandering (fugues). He escaped from the hospital and was found wandering in the bush twenty miles away. The content of his twilight state was essentially one of anxiety with falsification of the environment by visual and auditory illusions and hallucinations. He recognized the people who went to fetch him as fetish gods and heard voices saying that the spirit had now left him.

Once again he recovered spontaneously from this recurrence of confusional states but he never once became normal in the intervals which varied from days to months.

During these intervals, schizophrenic features usually came more to the fore as evidenced by his bizarre mannerisms, train of thought and entire mode of expression, passivity feelings, ideas of influence and self-reference tendencies. The affects were subject to marked fluctuations due to underlying anxiety. Thus his affective states could be manipulated by touching on his religious fears. During this phase, his attention, orientation for time, place and person were unimpaired. Memory was still defective for the episodic confusional states, with a tendency to falsify his hallucinatory experiences.

In September, 1951, after several episodic confusional states, his illness remitted spontaneously and for the first time seemed normal, but he started to manifest vague hypochondriacal symptoms (pain in his abdomen, headaches, inability to hear properly, and lack of feeling over his chest) with underlying anxiety. He finally developed hysterical deafness for about two months, after which his auditory hallucinations disappeared.

The patient can be said to have fully recovered; inasmuch as he has not had a recurrence for almost a year. He is still doing very well and seems to have got over his "complexes" about the intricacies of fetish religion.

#### SPECIFIC DIAGNOSTIC FEATURES

##### I. DIAGNOSIS

The diagnosis of paranoid psychosis (whether this is paranoid schizophrenia, paraphrenia or any intermediate clinical entity) in the literate Yoruba

tribe does not present any difficulty arising from the cultural aspect. The present study presents no evidence that paranoid psychosis (within the accepted diagnostic nomenclature), among the literate (urban) Yorubas, is significantly different from the point of view of aetiology, diagnosis, psychotic manifestations or prognosis from that of paranoid psychosis in Western culture.

If the Westernized Yoruba-man has innate psychological qualities which differ from those of the Europeans, he will be expected to react differently to the same environment or similar traumatic stress, because of a different constitutional pattern. This hypothesis is not supported by the observations in this work. Morris's (1951) observation lent an indirect support to this important finding. Morris found a similarity of constitutional factors in psychotic behaviour in India, China and the United States. Clinical observations in this work have shown that the literate Yoruba-man's psychotic pattern is similar to that which is usually encountered in Europe.

If these innate mental differences exist, we should, according to psychobiological principles, expect a pattern of response with quality (and perhaps quantity) as determining factors. This work shows that the same diagnostic criteria and assessment of prognostic possibilities which hold in Western culture are equally applicable to the Yoruba patients who have been in contact with Western culture. These, however, do not seem to hold with patients whose cultural background is as different as that of the non-literate (rural) Yoruba tribe.

It is of great clinical importance to mention that the *basic* psychotic manifestations are similar in the two groups and, therefore, similar to those which are commonly described in Europeans. Furthermore, the degree of variation in the basic symptomatology in individual cases (in the two Yoruba groups) is not greater than that which exists in individual cases in Western culture. Apart from this basic similarity the pathogenic factors are essentially heterogeneous, and this is probably due to cultural variations.

The most important single factor in connection with the diagnosis of paranoid psychosis in the non-literate group is the variation in its phases, which is attributable to the admixture of its symptomatology.

For the sake of brevity and clarity, the most important diagnostic features will be discussed under two headings:

(a) *Mental Symptomatology of the Initial Stage (Acute Phase) of the Psychosis and its Diagnostic Significance*

During this phase, frank clinical expression of the underlying disorder is vague, unimpressive, due to an overlay of psychoneurotic phenomena. It is possible that in this phase the effective sector may be so active that the basic feature of the illness is completely overshadowed by mental confusion and projection symptoms.

Therefore the picture of mental confusion invariably dominates the acute stage of the disease. In the two improved cases which had commenced acutely, complete or partial amnesia for the acute stage was encountered. This is a very significant point, since it shows that in some of these cases we are dealing with a special group of symptoms of predominantly psychogenic origin.

The psychodynamic function of mental confusion in certain acute psychotic states appears to be that of defence; that of keeping out of awareness various affects which are conceived as intolerable to the ego and of disrupting the interpersonal relations which concurrently exists. Rosenfeld (1950), in his "Note on the psychopathology of confusional states in chronic schizophrenias", has

expressed the view that it may be that in many instances, particularly in acute psychoses, the ego is threatened with the sudden access into awareness of an overwhelmingly great intensity of affect, so that in addition to a delusional defence, mental confusion is immediately erected to reinforce the primary delusional projection. The essential feature of the acute stage, therefore, is the screening of psychotic reactions by psychoneurotic symptoms, a mental mechanism manifestly brought into play to prevent a break with reality.

Nolan D. C. Lewis (1949) has stated that the differentiation of the individual from his social environment and "the relationship of the person to the herd is an evolutionary process which has developed late". While this state has been achieved by Western culture, the primitive African largely identifies himself with his social environment.

(b) *The Diagnostic Importance of Pathoplastic Factors*

This symptom-complex, referred to above, represents the patient's elementary psychical responses in his native environment to external stimuli. The reality underlying their appearance is an activity similar to that which we know to exist in psychiatric disorder complicated by physical illness like diabetes, and phthisis.

Their cultural origin is supported by the following observations: (i) these ill-defined symptoms are present in varying degrees and severity in other psychoses in the non-literate (rural) population, with a greater predilection for paranoid psychosis or the schizophrenic group as a whole, especially those in which psychogenic factors are easily demonstrable; (ii) they may disappear at any time and leave no trace in the further process of the underlying (primary) disorder; (iii) they are not uncommon in some Westernized patients who invariably show more permanent regression to tribal beliefs and ideological concepts. This latter group is usually composed of detribalized individuals who occupy the region of no-man's-land between the "pure native" (primitive) and the Westernized group. Aggressive excitement, restlessness and bizarre psychoneurotic features are not an uncommon accompaniment of all the principal forms of schizophrenia in the rural group, especially when under observation in their home environment.

While most of these pathoplastic factors are of apparent psychoneurotic origin, they have no distinct features in themselves, that is, they are in themselves atypical. For example, the type of Anxiety State that may be associated with or precedes the psychotic manifestation in the non-literate group is multiphasic. It usually starts in the classical form, assuming a crescendo and may terminate in a hysterical hypomanic state (state of frenzy, pseudo-running amok) during which the patient is often dangerous.

Thus these contributory factors to the basic manifestations of paranoid psychosis are in themselves sources of clinical confusion.

The diagnosis of paranoid psychosis in this tribal environment should, therefore, take into consideration the important clinical finding that the psychosis includes a multiplicity of disordered states which nevertheless have a precise relation to the cultural traits of Yoruba personality structure.

## II. DIFFERENTIATION FROM ORGANIC DISEASE

It is important to point out here that when a schizophrenic psychosis in the rural (non-literate) tribe is precipitated by organic illness, it nearly always presents the classical features of schizophrenia and the pathoplastic features mentioned above are not apparent. In other words, when confronted with a paranoid schizophrenia (in the non-literate group) with symptoms that are



usually described in Europeans or in literate (Westernized) Yorubas, organic causes should be looked for. This fact had also been observed in the Gold Coast by Tooth (1950) when he said, "Among the 'bush' peoples, a typically schizophrenic picture is most likely to be due to organic illness."

The above observation confirms the cultural origin of the atypical features mentioned above, which are almost invariably absent when the mental illness is organically precipitated. The most common causes of organic paranoid psychosis are trypanosomiasis, cerebral malaria, and neurosyphilis, especially when the temporal lobe is predominantly affected. The absence of pathoplastic features is characteristic in the organic paranoid psychoses.

The confidence with which this observation is stated should not lead the reader to believe that we are in a position to validly postulate any, even the slightest, degree of causal relationship between the observed clinical facts and mental differences which are determined by the genetic characters of the central nervous system.

Carothers's (1953) assumption that all the mental syndromes which are usually found in African psychiatry "can be envisaged in terms of frontal lobe idleness" does not in itself show, or allow us to conclude, that there are innate or racial mental structures which are characteristic of certain types of brain functional capacity and morphology.

Thus the acceptance of Carothers's assumption commits us to the view that the organization of living things (responses of the organism in development, behaviour and functional adaptation) is purely material organization.

In examining Carothers's argument we may, first, question whether, if the premises be granted that there are structural and/or functional differences in "the cortex of the native brain", the conclusion, that primitive African mentality (especially the psychiatric syndromes) "can be well linked with" this, necessarily follows; secondly, we may enquire whether the premises are well established as inductive generalizations.

Mental power in Foster Kennedy's (1911) view is an integrated function of the brain as a whole. The present work has confirmed the previous observation of Tooth (1950) that schizophrenic psychosis precipitated by a physical illness among primitive Africans, is fairly typical in its manifestations (i.e. exhibits clinical features which are commonly described in Western culture).

There is, then, no sufficient *a priori* ground for assuming that in the absence of the full functioning of the frontal lobe, "insanity takes a somewhat amorphous form".

### III. THE DIAGNOSTIC SIGNIFICANCE OF THE BASIC PSYCHOTIC MANIFESTATIONS

From what has been observed among this tribe it will be unwise to attempt to differentiate too rigidly (in terms of diagnostic categories) between the paranoid schizophrenias, the paraphrenias and the paranoias (no case was found in this investigation which could unreservedly be labelled as paranoia). Bleuler (1924), for instance, did not think that the diagnostic differentiation of the paraphrenias from the other acute or chronic paranoid forms was ever possible, in contrast to Kraepelin's view. Bleuler also believed that most of these cases bear some genetic relationship to the schizophrenias.

While we can agree with Lewis (1949) that "it is quite difficult in the light of our present knowledge, to consider schizophrenia as an entity having any definite form, function or special characteristic behaviour", the basic clinical pictures in a great majority of these cases seem to be related to the schizophrenias as they are understood today.



When paranoid psychosis in the non-literate (rural) Yoruba is devoid of its pathoplastic traits, one is confronted with a clinical picture, which is comparable to that of the Westernized group, and also in which it is almost impossible to draw any hard and fast lines of symptomatological differentiation.

#### DISCUSSION AND CONCLUSIONS

An unrestrained scientific imagination on the part of earlier and some modern investigators has led to the appearance of a number of theories on the relationship between racial factors and psychological differences. Recent research has shown more and more clearly that these theories were not borne out by the facts. We must therefore examine the alternative hypothesis of the influence of culture on normal and abnormal psychological reactions.

Obviously, the first essential pre-requisite is the application of reliable diagnostic criteria which are controlled by the consideration of the concept of the normal in that particular cultural setting. From the point of view of understanding the cultural factors and their psychological significance among primitives, the important point raised by MacCurdy (1946) is of practical significance. MacCurdy stated that "the psycho-pathologist would never expect to find that a formal description of its institutions and customs would provide adequate material for an explanation of any society. Nor would a description of group reaction be acceptable. He would, rather, expect the true nature of the culture could be found only by an analysis demonstrating both formal and behaviour phenomena as expressions of fundamental trends that were revealed in symbolic form." From a strict methodological point of view, MacCurdy's consideration shows how dangerous are the conclusions drawn by those psychiatrists who are often ready to carry over and exploit chance observations from the anthropologist's field in order to explain clinical facts.

The present work has confirmed Hallowell's (1936) hypothesis that while the specific psychogenic factors engendered by different cultures may vary and the psychopathology of individuals may reflect the traditions of their society, generally speaking, the fundamental basis of most mental disorders will remain comparable insofar as we can account for their mechanisms in terms of common psychodynamic formulations. It has also been shown in this work that when the social and cultural environments of two racial groups become similar (as it is in the case of Westernized Yoruba and the Europeans), their normal and abnormal mental reactions show corresponding similarities.

It has been stated by some investigators that paranoid schizophrenia is not as common in primitive society as the catatonic sub-type. Carothers (1953) stated, "Paranoia, paraphrenia, and even paranoid schizophrenia are relatively rare in Africans" and he quoted Gordon (1936) and Minde (communication) to support his findings. The present writer's experience has not confirmed this finding among the Yoruba tribe and, furthermore, the distribution of all the sub-types of schizophrenia does not seem to vary among the Westernized and the primitive (non-literate rural) group. The observations made by Tooth (1950) and Yap (1951), who worked among the West African tribes and the Chinese respectively, do not support Carothers's impressions. Yap commented that Carothers's impressions "could only be true if the people concerned were so primitive as to have only the rudiments of language".

Carothers, however, gave a plausible explanation of this alleged rarity. He said, "The criteria used in separating paranoid form from other types of

schizophrenia were a tendency to chronicity in the delusions and a fairly good preservation of the personality in the former." Having argued that systematization is essentially a function of the frontal lobes, and also that the preservation of the personality and chronic delusions must be based on some degree of systematization, he concluded, "... it is precisely this quality which the primitive African and the leucotomized European tend to lack". Yap (1951) argued that the most likely explanation, "supposing it were true, is that the observer cannot understand what the patient says, and that possibly the patient is thereby discouraged from communicating his thoughts to him in speech".

The more acquainted one becomes with simpler society, the greater the conviction that man is an evasive entity, very rarely caught in difficult situations in which he would be willing to surrender to a complete and unreserved study as a personality. Usually the difficulty involved is greatly enhanced in the presence of socio-cultural barriers (e.g. the problem of language) when an attempt is made by foreign observers to penetrate the inner quality of the native mind and to supply some information on (often an interpretation of) his responses.

In their quest for facts some, unfortunately, are apt to offer a series of apparent assumptions. For instance, Carothers's (1953) thesis on the absence of obsessional neurosis states that "it seems that rural Africans, children and adults, seldom or never develop such reactions on individual lines, since this behaviour is the normal pattern of their lives", but this is questionable. (See also quotation from Davidson by Carothers, *ibid.*, p. 151.) There is no doubt that certain aspects of primitive ways of life are full of prohibitions and rituals but the present writer has seen true severe obsessional neurosis in rural Africans. Tooth (1950) also recorded two cases on the Gold Coast.

Obsessional neurosis in primitive Africans is usually masked by, or mistaken for, normal native religious rituals. Therefore, the essential pre-requisites for sound diagnosis are thorough knowledge of the language and the sub-cultural group to which the patient belongs, for example, his religion. From the diagnostic standpoint, obsessional neurosis seems to be the most formidable of all the varieties of psychoneurosis among primitives. This is probably due to the fact that the apparent elasticity of the cultural environment to accommodate the symptoms is great. However, certain recognizable qualities of the reactions and the disproportionate degree of anxiety provoked by failure to carry out these reactions contrast sharply with the ordinary prohibitions and rituals in the culture.

All the previous observations concerning the nature and relative incidence of psychosis and psychoneurosis in the primitives were made mostly by foreign investigators (usually anthropologists) and the nature of their inferences in view of the difficulties involved in the diagnosis should suffice to convince anyone of their untenable ground.

Intensive study and analysis of a body of clinical materials from a specific (primitive) culture is still needed to validate some of the interesting hypotheses that have been advanced by various investigators before definite conclusions can be made. Our phenomenological studies have not been completed and the existing cultural institutions and ideals may have to be wholly revised. However, there is no doubt that paranoid schizophrenia (and paraphrenia) might be ubiquitous, but cultural factors play an important role in its clinical manifestation and therefore have strong bearing on the entire management of the patient.

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