

Editorial

What kind of in-patient psychiatry for Africa? Report from Zimbabwe

Derek Summerfield

**Summary**

The expanding global mental health field has paid little attention to evaluating the culture of psychiatry prevailing in in-patient settings across Africa. For example, in Zimbabwe in-patient psychiatry has been heavily pathologising, with over-reliance on the diagnosis of schizophrenia and on antipsychotic polypharmacy. It is not helpful that the next generation of African doctors are learning unmediated Western psychiatry, with little credence given to background cultural factors and mentalities shaping presentations. Some of the psychiatric and social consequences of this for patients in Zimbabwe are discussed.

Declaration of interest

None.

Keywords

Africa; schizophrenia; polypharmacy; ethnopsychiatry; asylums.

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Global mental health is a burgeoning field but little or no attention has been paid to evaluating already existing services, for example in-patient facilities, and the psychiatry being practised in them. Across Africa there are thousands of psychiatric in-patients in public facilities at any one time. Ingutsheni, in Zimbabwe's second city Bulawayo, is one of a handful of great psychiatric asylums built by the British in the colonial era across Africa. Its role in the regulation of a subject people was part of what in Algeria the psychiatrist Franz Fanon called the 'pathology of colonialism'.¹ Today Ingutsheni has around 725 in-patients, most admitted involuntarily, and the majority there for many years, even decades.

The schizophrenia diagnosis: a continuing legacy of colonial times

For the past 3 years I have been a visiting lecturer in psychiatry at the National University of Science and Technology School of Medicine in Bulawayo, the country's second medical school. By my observation at Ingutsheni, medical notes are often scanty but what stands out is the indiscriminate use of 'schizophrenia' as a diagnosis, and that, whatever the diagnosis or length of stay in Ingutsheni, virtually all patients are on ongoing antipsychotics – chlorpromazine, sometimes also haloperidol – and invariably also the anticonvulsant carbamazepine for unclear clinical reasons. Chronic side-effects such as Parkinsonism and dystonias are commonly visible on the wards. There are also interactions between psychiatric medication and the HIV treatment needed by many in-patients. People admitted after a time-limited event – cannabis-induced intoxication or psychosis, or an episode of family conflict and violence to property – are often discharged on open-ended antipsychotics. There is no clinical case for this. If they stop taking the medication their families bring them back to the hospital, presuming that the doctors have deemed continuing use to be crucial to their health. A further unnecessary admission to restart unnecessary medication follows.

I do not mean to point at the few doctors currently in post, rather at the continuing legacy of the psychiatric culture imported during colonial times.

The blanket use of an imported diagnosis such as 'schizophrenia' brings with it the negative reputation it has had in Western societies – the assumed association with chronicity and with disability in social roles and work. The senior sister on the 'rehabilitation' ward told me that two-thirds of her patients, typically long stay, were psychiatrically fit for discharge but that their families were reluctant to accept them back because of stigma and the assumption that they would always need medication and never be productive. These perceptions also reflect the desperate times almost everybody is living through – Zimbabwe is poverty-haunted and food-insecure, the formal employment rate 3% and public services are hollowed out, if functioning at all. These factors, in combination with the overuse of the diagnosis of schizophrenia, contribute to the manufacture of a chronic psychiatric patient, their place in the world lost as their stay in Ingutsheni lengthens.

In the 1970s the World Health Organization (WHO) international pilot study of schizophrenia (which assumed a unitary condition worldwide) found that psychosis in non-Western countries (Nigeria, India, Columbia) seemed to have a better outlook than in the West (USA, Denmark).² In Africa there are more cases of short-term, reactive psychosis or other stress-driven presentations which should not be called schizophrenia.

The consequences of Western psychiatric imperialism

Fourth-year medical students clerk patients at Ingutsheni and present them to me and another lecturer in clinical seminars. Medical training is a formal engagement with modernity and the students know implicitly that indigenous knowledge is outside modernity's limits. Their presentations thus discount patients' references to African interpretations of adversity – which emphasise external agency via bad spirits or ancestors – and to remedies such as the use of traditional healers. These are understood to be outside the framework of proper psychiatric assessment. In one case, the patient's predominant complaint was that 'my ancestors want me to suffer', a culturally unremarkable attribution for adversity in Zimbabwe, as generic here as 'it was God's will' might be elsewhere. But the student understood that there was no place for this in the (imported) psychiatric textbooks. Instead she interpreted the

complaint as evidence of formal mental illness, a paranoid psychosis, as the textbooks – not written with Africans in mind – seemed to dictate. Similarly, stand-alone ‘hearing voices’ largely reflect a culture-bound idiom of distress in Africans and not mental illness. But in Ingutsheni, and doubtless elsewhere in Africa (and, I have found, in the NHS too), auditory hallucinations alone in socially distressed people are assessed as denoting active psychosis requiring antipsychotics. This is what happens when cultural background is ignored and the Western psychiatric canon considered definitive.

A call to challenge ‘global mental health’

A crude and homogenised version of Western psychiatry may well operate across the continent in in-patient settings and elsewhere, regardless of context. This seems a pathologising system, heavy on polypharmacy, and with iatrogenic consequences that I instance above. It plays out in a continent whose central dynamic is poverty and hunger. Is this culture of psychiatry, which is passing to the next generation of African doctors, fit for purpose? Medical school curricula should legitimate the part played by indigenous forms of knowledge, getting students to see that socioculturally shaped understandings are not merely incidental and epiphenomenal but at the heart of the illness experience. There is no one schizophrenia, and no one psychology. As the Ingutsheni cases demonstrate, these issues create real consequences for patients and their families across Africa.

Framing the question of what kind of in-patient psychiatry would best suit Africa’s realities is the WHO-supported drive to

encourage the ‘scaling up’ of Western-style mental health services worldwide. African governments are urged to invest in such services, yet they have pitifully little money even for physical healthcare – in Zimbabwe per capita expenditure on health is one of the lowest in Africa. Moreover, what wider costs may accrue when non-Western mentalities carrying culturally embedded and time-honoured forms of understanding and redress, ethnopsychiatries of local value, are displaced by imported approaches based on a ‘technical’ view of mind assumed universal?^{3,4}

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