Vagrant Psychotics in Abeokuta

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OUTLINE OF STUDY PROPOSED

IN tropical African countries perhaps more than elsewhere one encounters a striking number of apparently harmless and homeless mentally ill people wandering about the towns and cities. This is particularly true of Abeokuta Town, three miles outside which my hospital is situated. One can hardly drive a mile through the town without seeing two or more of these people.

In Nigeria where the climatic condition is so warm, both day and night, living outdoors does not present the same problem as it does in older countries. The unpleasant part of the climate from the point of view of sleeping outdoors is the rainy season, and even then it is usually possible to take shelter under the eaves of houses, shops and offices, not to mention market stalls and lorry parks, which are used by many of these mentally ill people.

Most of these people do not look robust in physique. This may be due to not having enough to eat or not being able to eat what is good for them in terms of nutritive values because of their mental state. Death from hunger is not often seen here as the generosity of the people is quite sustaining. Occasionally one sees a sick person lying helplessly on the road side.

Added to the generosity of the community is their apparent tolerance of or maybe indifference to abnormal behaviour which does not threaten or disrupt the smooth running of the towns and villages. The aggressive and destructive mentally ill are therefore not often seen and it is presumed that they are taken care of in such a manner as to curb their dangerous activities.

It would appear that these vagrant mentally ill tend to congregate in townships. In recent years attention has been called to them and they have often been described as nuisances, public disgrace and eye sores. These descriptions have often come from "sophisticated" people. The question arises whether these "sophisticated" people are beginning to lose their 'tolerance' or 'indifference.'

The manner of their disposal most often suggested is segregation and removal from the cities, so that they ceased to be an eyesore, rather than removal for the sake of the mentally ill themselves. The operation often suggested is more community-centred than patient-centred. The suggestion fortunately has not been put into operation. It is suspected, however, that the socio-economic circumstances which had contributed enormously to the lack of active 'interest' in these vagrant psychotics may change so much that it may not be possible to ignore them any more.

The motivation to remove these patients is very much similar to what was stated in the report of the United Kingdom Ministry of Health:[1]

> "It is recorded that in 1750 the condition of the insane attracted much public notice and the incarceration of a considerably larger number followed, more as a measure demanded for the public safety or comfort than because of sympathy with their condition. The attitude of the public generally was one of fear and desire to put unpleasant things out of sight, or even to regard the lunatic, like a captive wild animal, as something to be stared at and bailed;"

Dorothea Lynde Dix in the United States of America also advocated the better care of the insane.[2]

It was as a result of these agitations that the monstrously large hospitals of Europe and America were built; hospitals which are now regarded a bane to the proper care of the mentally ill as we now appreciate.

If developing tropical countries are going to skip the purely custodial care stage of the evolution of psychiatry, then it is necessary to find out how best they can deal with this problem with the financial and personnel resources available to them.

In an effort to find out the best solution to this difficult problem it is proposed to carry out a pilot study over a circumscribed area for a limited period of time. To take the fullest advantage of this opportunity it is proposed to include 1) Attitude survey, 2) Distribution of these people in the town in respect of residential, commercial and administrative areas, etc.

LOCATION

Abeokuta Town, with a population of 90,000, is an ideal situation for this investigation.

a) It has both rural and urban attributes and quite a large number of the population living in the town also have villages in the neighborhood with which they maintain a considerable degree of identification.

b) The town is small and homogenous enough to be combed fairly thoroughly for the vagrant mentally ill. In this connection it is worth while to point out that the township is divided into 10 different wards. Each ward has a health-house inspector, and it has been possible through these lay inspectors to locate 40 of these mentally ill.

The word "mentally ill" is used instead of "psychotics" because it is possible that some of these may be beggars and brain damaged people rather than frank psychotics. For the same and similar reasons, the number already located may not be included in the study until psychiatric interviews have confirmed their true mental state.

Nevertheless it is hoped that the eventual number which will be thoroughly investigated will not be less than 30.

c) Aro/Lantoro hospitals, of which I am the Medical Superintendent, are in the vicinity of, and within the town respectively, and consequently can be used as the centre of operation both from administrative and clinical aspects.

d) The Aro-Cornell Epidemiological Research project (1961) included the town of Abeokuta and the result of this and some of the material gathered may offer some basis of comparison, or corroboration of some of the findings in this study.

PROJECT

This can be briefly mentioned under two headings—Academic Enquiry and Service Orientation. These of course are not mutually exclusive as some academic findings may well be utilized in service programmes, but it is considered useful to have these classifications for the sake of clarity and operational factors.

ACADEMIC ENQUIRY

It has often been presumed that the attitude of the community towards the mentally ill is one of tolerance or indifference. No reported study is known which has concerned itself with definite evaluation of this aspect.

This study is intended to include enquiries into attitudes of a random selection of people about a specific case with which they are confronted. This will yield more reliable information than abstract opinions elicited without reference to a specific case in view.

All the attitude surveys so far recorded have been done on either pencil and paper method on hypothetical cases described, as is being done by the British Medical Research Unit in Wales under the supervision of Kenneth Rawnsley, or the interview questionnaire method as in the Trenton, N. J. Survey,[3] the Washington Survey,[4] the Louisville Survey[5] and the Baltimore Survey[6] and etc. The nearest method to that proposed here is that of Hollingshead and Redlich[7] when they inferred attitudes primarily from behaviour observed in and around psychiatric treatment situations rather than from hypothetical questions presented to persons in interview situations. Instead they drew inferences from what was done when a difficulty developed.

The respondents, it is planned, will include tradition-bound and nontradition-bound. The indices of traditionalism will include rural/urban, educated/not educated, religious affiliation and occupational distributions. This it is hoped will indicate whether a break from tradition has any effect on the attitude to mental illness.

The distribution of these mentally ill in the town in terms of residential area and public places will be of interest. It may indicate the schizophrenic drift towards the anonimity of public places, or the histrionic pattern of abnormal behaviour or the intolerance of residential areas and the consequent inhospitality of residents. It will be interesting to compare this with the work of Faris and Dunham.[8]

It will reveal such factors as origin of the mentally ill in relation to Abeokuta, distance from place of origin, what relatives have done about the illness and absence from home, what they are prepared to do with the patients if given help and support.

This last paragraph infringes on the next item Service Orientation.

SERVICE ORIENTATION

Diagnosis: A vital factor which will help in deciding the method and type of disposal is the diagnostic categories of the patients. It is expected that some will be more susceptible to treatment than others; e.g. the chronic schizophrenic as against the acute schizophrenic or depressive.

Treatment: It is proposed to submit as many of the patients as possible to definite somatic and psychiatric treatment.

This may even be made a control study, dividing the patients into two or more groups to be given only somatic treatment, or/and somatic plus psychiatric treatment and no treatment at all.

Since I personally am loath to sacrificing the welfare of patients and leaving some untreated, even for scientific excellence, and since the result is obvious any way that those given treatment—whatever sort will do better than those left untouched, I will like to have all of them treated.

It is presumed that they will all benefit from general physical examination and physical treatment and it may be possible to improve their state of health, and some may be able to function, though at a low level.

With the active interest and concern of the research group, which should later be substituted by the local authorities, the renewed fellow feeling and active interest of relatives may be restimulated and re-established.

Rehabilitation: This project can be extended to cover to some extent the scope of rehabilitation facilities. Further to handing over some improved patients to their relatives it is worthwhile to anticipate that some of the patients may have no willing relatives, or no relatives at all. It will be futile to throw these back to the street. It is proposed therefore to explore the possibility of persuading some farmers in neighbouring villages to have in their household some of the improved patients with no relatives like in Gheel, Belgium. These farmers will need to be paid some money for the patients keep. It can be observed whether these patients will become independent and self sustaining over a period of about six months.

The other possibility worth exploring is the building of a hut-hostel within a village setting to accommodate a small number of improved patients who will fend for themselves with guidance from a man who will function in the roles of nurse and rehabilitation officer. These patients will work on a farm to produce their own food which will need to be subsidized. At the initial stage of this exploration, they will need to be kept until the farm is yielding and the officer in charge will also need to be paid. It is again to be seen how long it will take these patients to branch out on their own and live independently.

Observation of patients in treatment with traditional healers in a village setting has indicated that after a while these patients re-establish themselves within the village and become self-sustaining by farming. It is this that has given us the idea that rehabilitation in a village is quite feasible and worthy of exploration.

It is hoped that the result of this investigation will be of far reaching influence on tropical developing countries in their mental health programme, particularly in the area of care of the chronic mentally ill. Some other points of theoretical and academic value may also emerge from this study.

PRELIMINARY REPORT OF STUDY

Two agencies, the Public Health Workers and the Social Workers, were requested independently to count the number of vagrant psychotics in the town. The town of Abeokuta is divided into nine wards and each ward has a number of public health workers who comb their area as part of their schedule. The social welfare workers also know the town thoroughly by the nature of their work.

The criteria used for identifying a vagrant psychotic are those that the ordinary lay man uses—walking about naked, dressed incongruously, talking to himself, sleeping on the streets, collecting rubbish, chasing rams and goats, etc. In fact these are characteristics recorded against those that were identified.

It is a measure of the thoroughness with which the town was scoured that the two agencies identified practically identical numbers of 34 (15 F., 19 M.) and 35 (15 F., 20 M.) of the same vagrant psychotics.

The ratio of this number to the total population of 90,000 is one in 2,570. In 1958, the social welfare department of the Federal Ministry of Labour carried out a survey and found that there were 459 beggars in Lagos.. Of these, 20 were classified as insane. Six years later, in 1964, when the same exercise was repeated 1182 'beggars' were found on the streets of Lagos—an increase of 723 over the previous count. Of these 71 were categorised as 'mental'—an increase of 51 over the previous number of insane. While the ratio of these two figures of 20 and 71 to the total population of Lagos of about three quarters of a million is small compared with that in Abeokuta, it has to be pointed out that the method used may not be as fool-proof as in Abeokuta (indeed the report ad-

mits that it cannot be said with certainty the figures constitute the accurate number of beggars in the streets of Lagos); and the large number of 105 "able bodied" beggars identified in Lagos in 1964 may well include vagrant psychotics. Furthermore, other categories of beggars 'blind,' 'crippled,' 'lepruos,' etc., do not necessarily exclude the psychotics especially if the more noticeable disability is not their psychotic behaviour.

TABLE 1.—RATIO OF VAGRANT PSYCHOTICS

Population		*Psychotics*	*Ratio*
Igbo-Ora	22,000	3 men, 2 women	1.4400
Eruwa	20,000	8 men, 3 women	1.1820
Temidire and Okolo	9,000	2 men	1.4500
Lanlate	12,000	1 man	1.1200
Igangan	16,000	2 men, 1 woman	1.5333
Idere	5,600	1 man, 2 women	1.1870
Tapa and Aiyete	22,600	2 men, 5 women	1.3230
Total	107,200	32 = 19 men 13 women	1.3460
ABEOKUTA	90,000	35	1.2570

It was recorded in the Lagos Report that 53 insane persons were cleared from the streets of Lagos and admitted into the hospital for treatment in 1958. This would appear to have preceded the survey of beggars done the same year.

While the sex distribution of the vagrant psychotics in Abeokuta is 15 women and 20 men, i.e. 43 per cent women and 57 per cent men, the sex distribution in Lagos, 1964, was 71 insane (49 men, 21 women and one unclassified) i.e. 69 per cent men, 30 per cent women.

The trend for the number to increase as time goes on is supported by the finding in Abeokuta. In 1965 all the vagrant psychotics that could be found after the initial survey were taken in small groups into the psychiatric hospital. Two years later in 1967, a similar survey was carried out by the health workers and they identified 26 in the same criteria. Of these 26, only one was included in the previous survey and this one had been discharged as he was considered to be functioning fairly well before he was taken to hospital. This means that 25 fresh cases have accumulated in two years.

It will be erroneous to calculate the total number of vagrant psychotic in a given area on population basis from the sample of a particular area. It will be equally erroneous to calculate this sample of a particular town without considering the peculiarities of the town which may influence the influx of vagrant psychotics.

Abeokuta has some peculiarities which make it different from other towns in the Western State of Nigeria. It has both urban and rural factors. The various sectors of the town have their farm stead in varying distances from the town. Perhaps it is consequent on this that the nearest town to Abeokuta is about 20 miles, whereas in another part of the Western State the towns are as close as five to 10 miles. It is significant that in the Aro-Cornell study[9] which addressed itself to the epidemiology of psychiatric disorder among the Yorubas in Abeokuta town and some neighbouring villages there was not a single vagrant psychotic found in the villages.

As long as a psychotic is not disrupting the smooth running of the village system he may be accommodated in the village without being vagrant. In view of the free and easy line of communication between the villages and the town of Abeokuta, he may tend to gravitate to the town.

Another factor that distinguished the town of Abeokuta from most other towns in the western state is the fact that the main railroad from the federal capital of Lagos into the country passes through Abeokuta—a distance of 60 miles away. In fact the next large town on the railroad from Lagos is Abeokuta and the trains often replenish their water supply in Abeokuta. All trains—even the express stop there. Until mid 1950's the motor road from Lagos to the hinterland passed through Abeokuta. A shorter road was built at this time which bypassed this town, but even then considerable amount of road traffic still goes through the town especially when some bridges on the new road are considered unfit for heavy trucks.

The third factor that may influence the number of vagrant psychotics in the town is that it is the administrative capital of the province, and also a big commercial centre.

While a thorough survey of traditional healers has never been done, this town is reputed to be an important centre of traditional healers caring for psychotics and it is known that patients are brought to them from distance places. In fact a number of psychotics—five were included in the 1967 survey of vagrant psychotics—who were currently receiving treatment from a well known traditional healer and these had to be eliminated from the number submitted by the health workers. Coincidentally the only psychiatric hospital in the whole of the western state—ARO HOSPITAL—is situated in

this town. This fact has been publicised by every medium of communication and patients are brought to the hospital not only from all over the Western State but also from other parts of the country and neighbouring countries because it is the only psychiatric hospital of its kind—with open doors and modern facilities—in the country.

All these factors may contribute to the town having more than its share of vagrant psychotics. Of the 25 psychotics who were eventually taken into hospital for treatment four came originally from outside the province. This number may be considered small, but it is significant when viewed against the background of the fact that there is considerable emigration from the town to Ibadan the capital of the western state, 48 miles north, and the federal capital of Lagos where the employment opportunities and social facilities are greater. It is of interest in this connection to point out that of the 71 'beggars' classified as insane in the Lagos 1964 survey, 23 were recorded to have come from the western region, which is the western state plus the coastal area around Lagos—the old colony province which is now the Lagos State, a small proportion of the old western region.

To test the validity of the argument that a generalisation cannot be legitimately made from a particular town without making allowance for the peculiarities of the town, a survey was done in Ibarapa area (thanks to the Medical Students who were residents there in June, 1967). The following facts emerge from this survey:

The number of vagrant psychotics to the general population, one in 3523, in Ibarapa area is smaller than in Abeokuta town one in 2570. This lends support to the statement that Abeokuta has more than its share of vagrant psychotics. Ibarapa area does not possess the number of factors already attributed to Abeokuta town.

DISTRIBUTION OF THE PSYCHOTICS IN THE TOWN

All the psychotics were found in and around the markets in the town, near the lorry and railway stations, in the commercial section of the town and the main roads passing through the town especially near the periphery. None was found in the residential areas.

The reasons for this phenomenon cannot be categorically stated, but the consideration of these has to include many sociological and psychological factors. Mere sustenance is easier to achieve in these places, especially the markets for many reasons especially flow of people, than in residential areas. It is the flow of a large number of people rather than the number itself that appears to be significant. It is as if the psychotic, especially the schizophrenic, seeks people but in small doses of the same person at a time. In residential areas the schizophrenic will be exposed for too long to the same people who may resent his presence and openly reject him and drive him away. This hypothesis of the schizophrenic's inability to tolerate contact with the same person for a long time may well apply to the normal person for different reasons. The end result of this is the drift of the schizophrenic to non-residential areas.

Furthermore, the psychotic has free lodging in market stalls, lorry stations and other convenient places which are deserted at night.

Perhaps for the same or similar reasons adduced by Faris and Dunham that the schizophrenics drift to the socially and culturally low part of Chicago, these psychotics also drift to the anonymity of the non-residential areas of the town.

And yet it is in such places that they attract greatest notice and are perceived as eye-sores and blemish to the towns. If they remain in the villages or in the residential areas they will not attract such notice and in any case they will be scattered over a wider area.

GENERAL FINDINGS

While it is not possible to give the details of the findings of this short paper, we shall give some of the more salient findings.

Only 25 of the total identified in the survey could be picked up for treatment. The lapse of time between the survey and picking them up was due to the difficulty in getting financial assistance for the project. In fact the project had to be pursued with little resistance and consequent meagre resources. There were 12 men and 13 women. They were picked up in small groups over a period of weeks.

Three men died within a few weeks of admission and three men escaped from the hospital. They were never seen again, not even in the town, and they were not included in the survey of late 1967.

Diagnosis: From the description of the lay observers on the streets an attempt was made to arrive at a diagnosis before we interviewed the

patient. This was done by two psychiatrists including the writer. These diagnoses were practically identical with the diagnoses made after psychiatric examination of the patients.

They were all schizophrenics of the undifferentiated type except one with schizo-affective disorder and another one with hypomanic features along with his schizophrenia. There is the suggestion of general paralysis of the insane in two cases. This suggestion is not based on clinical grounds but on the finding of positive Ide Test in the cerebrospinal fluid. It is regarded as only a suggestion since this test is not specific for syphilis, and there are other tropical conditions which give the same reaction. The period of their illness ranged from six years to over 25 years.

It is interesting to note that even though a number of the cases were schizophrenics of long standing they lack the apathy, slowness and utter disinterestedness seen in institutionalised patients. They were concerned about what they were going to eat, and they clutched their few belongings to carry with them. A number of them initially resisted being taken away in the hospital van, but settled down when told they were being taken to a place of care.

They still made efforts to fend for themselves and they were not as regressed and degenerated as those described in large long stay mental hospitals.

It is also worthy of note that they were all schizophrenics. What about the depressives? It appears that the depressives shuns the towns and people and seek oblivion while the schizophrenics, in spite of his social isolation, still seeks contact with people in a devious way. We have observed that the hallucinatory voices of the depressives tell them to, or they have the urge to, walk into the forest or the river or lagoon—away from people, a phenomenon which I call suicidal equivalent. The schizophrenics on the other hand, walk into areas where there are most people.

This observation lends support to the view that disturbance of communication is one of the salient features of schizophrenia. The schizophrenics seem to have the need to communicate with people and it may be this need that brings them into visual contact with people. His communication may be perverse, but it is still communication.

There is also the suggestion that some of them need to interact with other people—also in a perversed manner. They abuse people, they dance in public, they steal food while the vendor is looking on.

The opportunity to communicate and interact with people is considerably reduced in a large institution, when their communication and interaction may be stimuli which prevents complete personality disintegration. This may also have some influence on the relatively rapid response to treatment which was achieved in this study.

Attitude Survey: Over 300 interviews were carried out. At least 10 on each psychotic. The breakdown and analysis of this survey cannot be given here, but it tends to support the view on causation of psychosis as described by Prince and others, e.g., violation of taboo, failure to perform some rites, curse, witchcraft, heredity, etc. In spite of this locally believed idea of causation, it is remarkable that most of the responses on outcome were optimistic. The optimism was, however, expressed in religious terms of faith like "if it is the will of God." It does not appear to be based on knowledge of and confidence in psychiatric treatment—traditional or modern.

Outcome: Of the 19 who remained for treatment all but two have been discharged. One man is still psychotic. His treatment has been impeded by an associated peptic ulcer. The other still in hospital has improved considerably mentally, but she has severe contractures of her leg muscles and orthopaedic surgery does not promise much hope for her. She crawls about in the hospital.

With the exception of the man with the peptic ulcer they all improved considerably and became socialised. The period of intensive treatment and hospitalisation was rather prolonged, perhaps more than necessary because of meagre facilities, especially frequent shortage of drugs. Hospitalisation was certainly longer than necessary because of the difficulties in locating interested relatives.

All the patients were discharged mainly to the care of relatives and friends except one case, a man, was certainly functioning at a much higher level than the others at the onset, and it was felt that it would not be proper to keep him longer than absolutely necessary. He was a farmer and he still maintained his farm. He was kept for just enough to be observed and investigated. Even this took longer than necessary. If he had to be hospitalized until his relatives could be traced, he might have been kept for too long.

Two women were removed from the hospital

temporarily to one of our villages when efforts to persuade the relatives we found to take them back failed. They both relapsed while in the village because of the waning enthusiasm of the villagers and their consequent failure to bring the patients back for follow-up and repetition of their maintenance medication. They had to be readmitted into hospital for short periods of intensive treatment. The villagers were paid little or nothing for their generous co-operation. If they were adequately paid they might have shown more sustained interest; at least they could be held more responsible. It was possible eventually to find relatives who were willing and ready to take these two female patients to their care.

One old lady was discovered to be leprous. Her mental state improved but she had to be transferred to the local leprosorium, instead of being discharged to the care of her relatives.

It was observed that while, in some cases, town relatives were rejecting and unwilling to accept patients to their care, the village relatives of the same patients were readily persuaded to accept them. In some of these cases, the patients had to be taken by us to their villages which were about 20 to 30 miles away.

The system we adopted for discharge was to invite discovered relatives to come and visit their sick member in the hospital. When they were satisfied with the mental condition of their patients they were asked to go home and prepare for the patient's resettlement after which they could come back for the patient's discharge, bringing decent clothing for the patient. On the day of the discharge the need for follow-up and maintenance medication was explained to them.

The fact that we could not contact the relatives of three of the four patients who came from outside Abeokuta province, and also the distance involved precluded us from following the procedure of discharge described above. In these cases, the patients were escorted by members of our staff to their homes 80 to 150 miles away, and they were discharged to the care of relatives with the usual warning about follow-up and maintenance medication.

FOLLOW-UP

It is distressing to find that only four of the patients came back for follow-up and these four were from the town. Not included among these four was a lady who had to be hospitalised twice again. She is alleged to be actively psychotic again but is not back with us.

Visits were paid to the homes of the patients from outside Abeokuta months after this discharge. One of the patients, an old lady, was reported to have wandered away again, and had not been found. Two others—both females—were reported to be living with some other relatives away from their original town or village.

The reason for the failure of relatives to bring the patients back for follow-up may include financial and other associated problems—especially for those in villages and those outside Abeokuta province and the belief that the patients are totally and permanently cured, which is the promise of most traditional healers, especially after the post-treatment final cleansing ceremony described by Prince.[10]

The lack of co-operation of the relatives of those patients in the town makes one wonder about the alleged sustaining and supporting factor of the extended family constellation. On the other hand it may be indicative of the breakdown of this admirable role of the extended family in the urban areas.

Moreover, the observation of Cross et al[11] that the longer a patient is in the hospital the more difficult it becomes to discharge him and that this is far more dependent on social factors than the actual condition of the patient, may also apply to the acceptance of vagrant psychotics who have wandered away from home for a long time.

The lesson to be learned from this experience on resettlement and rehabilitation is that provision has to be made for psychiatric social workers to make domiciliary visits to patients if the effort to treat these patients is not to go to waste. Secondly, psychiatric facilities, at least for follow-up, need to be provided all over the state to facilitate attendance of patients. Where relatives are rejecting the treated sick member, especially those in the urban areas, arrangement for rehabilitation in a village should be made for the illiterate and traditional patients. The time is also drawing very near, with the rapid urbanisation and industrialisation in the developing countries, that the type of progressive rehabilitation programme in terms of occupation and rehabilitation available in developed countries, will need to be provided in our developing countries.

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