Psychiatry in Kenya:
New horizons in Medical Care

Professor J. Muhangi

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PROF. J. MUHANGI

Brief Biography

Prof. Muhangi is, in a very personal sense, a product of the interface of cultures—the old African, and the new Euro-American. Kiro, his grandfather belonged to the small, albeit, elite group of physicians that practiced pre-European medicine in "the world" of the Western hills of Ankole, Uganda. Although Muhangi's father was first a catechist, then a politician and finally a chief, young Muhangi continued to be fascinated by stories of his grandfather's exploits as a traditional doctor.

Starting at a missionary church school in the mid-forties, he always kept close to the top of the class through the various grades. Eventually he went to Nyakasura where, besides editing the school magazine and playing in the school hockey team, he chose to act the part of Artemedorus, the Doctor of Philosophy when his class staged "Julius Caesar"—a reflection of his continuing fascination with "doctors".

Graduating from Makerere Medical school in 1965, he became the first indigenous senior house officer in the local department of psychiatry, and after 9 months he went to the Institute of Psychiatry Maudsley in England, where largely under the tutelage of Dr. D. Bennett, he completed studies leading to the award of Diploma in psychological medicine in 1969.

On returning to Kampala, he briefly worked with the government before joining the then fledgeling department of Psychiatry at Makerere Medical School.

After another one year in Britain in 1972 he passed the prescribed examinations and was elected member of the Royal College of Psychiatrists of the United Kingdom.

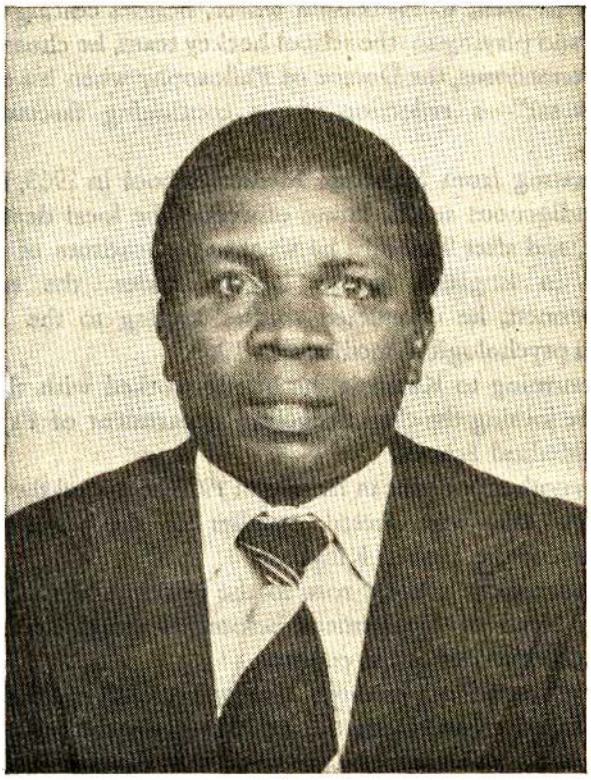
At Makerere he rapidly rose to the position of Associate Professor and Head of Department before circumstances of Amin's regime forced him out of the country.

Having started on research that was mainly geared to child psychiatry he continued along the same lines on coming to Nairobi five years ago, and currently he leads the departmental research team looking into children's problems of schooling. The project is based at Lady Northey Home in Nairobi.

A founder member of the African Association of Psychiatrists, he is the assistant chief editor of the African Journal of Psychiatry. He has published several papers both locally and abroad.

Besides Makerere and Nairobi, he has briefly lectured at the Haile Selassie I and Ibadan Universities. He is married with three sons.

He has travelled widely to various parts of the world while attending international scientific conferences.



Prof. J. Muhangi

PSYCHIATRY IN KENYA:

NEW HORIZONS IN MEDICAL CARE

"Years of struggle lie behind us,
Ceaseless labour little gain,
Ever let those years remind us
Sunshine follows after rain".
—Nyakasura School Anthem—verse 1.

These words are part of a song I repeatedly sang in the fifties. Today, looking at the psychiatric scene in Kenya, these words have a special ring in my mind and as I trace the history and future development of this discipline in this country, I find them appropriate. But before I plunge into the development of this subject, I wish us to remind ourselves that psychiatry is a medical discipline concerned with the removal of undesirable behaviour caused by genetic, congenital, constitutional, physical, psychological, psychosocial factors or a combination of any or most of these. In short, psychiatry deals with the entire personality and its aim, like in all other medical disciplines, is to bring about change in the minimum time using the minimum agents.

Modern psychiatry in Kenya dates back to the twenties when, ironically, the present Mathare Mental Hospital was opened as a smallpox isolation centre. Unbeknown to those heroes of organic and infectious medicine, was the fact that by 1979, 7,000 shillings would be waiting for one giving information leading to the confirmation of a new case of smallpox in Kenya. More unbeknown to them was that at this stage, those of our colleagues who had specialized in the diagnosis and management of smallpox, would, in all probability be in danger of losing work by 1980. Even before the end of the twenties, under the pressure of improved hygiene, and later the development of immunization techniques, smallpox receded to the extent that Mathare was gradually changed into a mental hospital for Africans and Asians. By the forties, Mathare Mental hospital had expanded and it was to form the base for Carothers' famous, if controversial publication, "The African Mind in Health and Disease".

Reading through Carothers' (1953) monograph one cannot but sympathize with the man. The background of his training and the circumstances prevailing at his time dictated the ways in which he per-

ceived the African. There was for instance a widespread belief in the western world that Africans among other things were cannibals, a belief the African held in the reverse! In addition, amateur psychologists in the form of travellers and explorers had on returning to Europe reported that compared with the European, the status of an adult African's mind was the equivalent of that of a seven year old European child. Befogged by these concepts and the fact that psychiatry in Europe itself was still in its infancy, it is not surprising that Carothers was unable to grasp the nature and pathology of psychiatric illness among the Africans, thus making mistakes such as concluding that depression did not occur in the African and that the hallmark of African psychiatry was hysteria! With hindsight now, we can confidently say that knowledge, like radioactive material has a half-life. The half-life of Carothers' psychiatry is long over. Thus, recent studies such as those of Prince (1960) in Nigeria concerning head pains in school children, German (1972) in Uganda, concerning epidemeological distribution and prevalence of psychiatric symptoms, Giel and Van Lujik (1969), regarding the preponderance of psychiatric symptoms in a rural clinic in Ethiopia, Ibor Lopez (1972), regarding some Madrid patients presenting symptoms of depression, couched in organic language, and Ndetei and Muhangi (1979), on the prevalence of psychiatric disorders at Athi River clinics, suggest that psychiatric illnesses are not only a preserve for the developed world, but that contrary to a foreign edict that "the noble savage" meaning the African, "is free from psychiatric illness", psychiatric disorders are very common and that as war on physical disorders like smallpox succeeds, psychiatric illness will become a major public health problem.

Once, a famous physician by the name of William Osler (1849-1919) said of syphilis, "Learn ye first all about syphilis, the rest clinical shall be added unto you". Osler was worried, having discovered that syphilis was a very difficult disorder to diagnose because of the many and varied ways it manifested itself. The same thing could today, be said of psychiatry in relation to general or internal medicine. For example, in the psychiatric outpatient clinic at Kenyatta Hospital run by the academic staff, many lessons may be learned. The wise men who started this clinic meant it to be a purely referral clinic intended to cater for patients who although admitted at Kenyatta hospital primarily because of physical illness, had in addition a significant portion of psychiatric or emotional problems. Five years ago when I joined

this clinic, the most striking thing was the thickness of the case files of those patients being referred to this clinic. For many years, the patients had attended clinics like the cardiac one for complaints such as the heart beating too much and too loudly, the hypertension for high blood pressure after complaints of incessant headaches, the ophthalamology for poor vision resulting from headaches and the general medical for complaints such as vague abdominal pains, impotence, backache, general weakness and a host of other discomforts that traditional investigations such as x-rays including barium meal swallows, microscopic examinations of stools, blood, urine and even such heroic investigations as injection of radio opaque substances into the brain and electroencephalography could not help pin-point. Above all, traditional therapies like antacids, pain killers like aspirins, antihypertensive drugs, spectacles, sleeping on fracture boards or wearing neck collars appeared not to help these conditions, and in the process both the government and the patient paid heavily.

Although no prudent doctor would regard the entire 100% of these patients as suffering from purely emotional disorders, there is mounting evidence to suggest that probably as many as 95% of these cases are suffering from conditions such as depressive or anxiety states. This evidence on a local level is based on the findings that many of these patients acceded to additional symptoms of poor sleeping, poor appetite, disordered bowel function in the form of constipation or repeated episodes of diarrheoa, general dis-ease and above all, many, besides a background of psychosocial dislocation showed subtle losses in weight. This latter constellation of symptoms is strongly suggestive of a combination of depression and anxiety and as expected the patients largely and satisfactorily responded to both appropriate psychotropic and psychotherapeutic measures.

In its formative days, when Carothers was practicing in Kenya, psychiatry was only recognized if the cardinal symptoms of despair, nihilistic delusions and subjective feelings of sadness and guilt in the case of depression and fearfulness and foreboding in the case of anxiety states were present. Recent studies both in Africa and abroad, studies such as those of Binite (1975) in Nigeria, Ibor Lopez in Spain and Kielhoz (1973) in Switzerland however suggest that depression, like syphilis in the days of Osler, can manifest itself in many ways. As these studies have shown, and as my colleague Dr. Gatere has observed, it seems that there is a very large population with dep-

ressive or anxiety states presenting their dis-ease, which is really disease in "body language".

At this stage I anticipate that someone in the audience is itching to ask as to how a doctor, particularly in a busy clinic, can rapidly discover that, despite the patient couching his symptoms in organic terms, the latter is suffering from an emotional disorder. My answer obviously lies in the time honoured art of history taking and formulation of the facts obtained from the patient. Thus, in the case of a young student who complains of the heart beating too much, enquiries about academic performance, adjustment in the family and school, the state of his love affairs, might be all that is necessary to suggest that repeated poor scores in tests, friction with parents, rivalry with siblings and fractured love affairs might be at the root of the anxiety and that palpitations of the heart are in fact a response to these anxieties.

Again, the twenties have a special, though coincidental relationship to the development of medical care in Kenya. While a smallpox centre was being established at Mathare, an Austrian by the name of Sigmund Freud was busy in Vienna giving psychiatric knowledge a facelift. In his monumental contributions to the understanding of abnormal psychology, contributions which nowadays often evoke controversy, he attempted to define what he called the unconscious or the dustbin of the mind. The dustbin described by Freud however turned out to be a dynamic one from which discarded emotional material could escape to harrass us in a physical way without our true conscious part of mind being aware. And it is no wonder that a man who has had trouble with his family, or a student strained by academic pressures will not accept or even perceive that it is because of his family trouble or his academic woes that he is experiencing palpitations respectively.

But armed with the present knowledge of psychophysiology, we need not invoke the Freudian theories to understand how emotional factors affect our physical being. Those of us who are medically qualified, will recall that, that part of the emotional nervous system called the autonomic nervous system can be capricious in converting a psychological experience into a physical one. In very basic terms for instance, it is unlikely that one will obtain an erection in the face of a lion, and that does not mean impotence. One will experience "butterfies" in the abdomen or pass urine frequently when faced with a very important examination and that does not mean dyspepsia or incontinence. Extrapolated into persistent psychosocial stresses, it seems no

longer surprising that many people will develop physical problems that we often meet at the clinic.

Depressive and anxiety states are not the only mental conditions bedevelling our society. Schizophrenic, manic depressive, drug dependence and hysterical disorders not only disrupt the normal living of the individual, but are notorious for producing effects which affect not only members of the family but other people as well. Several examples come to mind. Thus a university student who breaks down with schizophrenia, not only becomes thought disordered and insightless, thus failing to continue with his studies, but his family who emotionally and financially have spent so much on him are greatly disappointed, some spending further sums in an attempt to procure a cure for him. Again, in a primary school which is struck by a condition called "symbiotic hysteria" which commonly manifests itself as shaking of hands, uncontrollable laughing, or fainting attacks by groups of children, not only do individual children become incapacitated and therefore lose their valuable time for study, but the teachers and the parents are distressed, while running around looking for doctors.

Recently, Acuda & Muhangi (1979), have highlighted drug addiction especially regarding a potent drug called (diazepam) Valium. That paper however touched the tip of the iceberg. As the present government has correctly been pointing out, alcohol is by far the most important drug of addiction in this country and because of its physical and psychosocial ramifications, I think it is pertinent at this stage to refer to in it some detail.

Ethyl alcohol is the principle active molecule in all alcoholic beverages ranging from 'mild' beers through *chang'aa* to whiskies and brandies. I am sure everyone in this room is familiar with the immediate effects of alcohol consumption and I will therefore skip that section to deal with the long-term aspects of this drug. Like many of the addictive drugs, alcohol is a potent pan depressant of brain cells producing tranquilization and sedation. Unfortunately, once brain cells get used to functioning at reduced capacity, they are happy to stay that way although of course in the process some of these cells are dying off and the alcoholic is getting worse. Were it a matter of the individual losing his brain cells it would probably not be a matter of public concern. Unfortunately, however, the alcoholic spends money acquiring drinks, in the process depriving essential financial support to his family. Thus, school fees for children dwindle, meals for the

family become impoverished in terms of protein and even his marital obligations may suffer as a result of sexual incompetence and inefficiency.

Worse still, the alcoholic's performance at work deteriorates and he is a danger to the public at large if he gets behind a steering wheel. Because of this social fallout, the general public has been conditioned to stigmatizing alcoholics. And in the earlier stages of alcoholism when the patient still has the insight to recognize that he is becoming a social outcast, he develops guilt feelings which are sometimes of such proportions that he embarks on futile attempts of self abstinence.

In a selected group of alcoholics, these self imposed restrictions may work. In many however, these result in what medical psychophysiology terms "rebound" withdrawal symptoms when the patient within 24 hours develops symptoms of severe foreboding and anxiety sometimes ending in tremors and hallucinations, a condition that is called delirium tremens. With the rebound phenomenon, the blood pressure may shoot up, the patient sweats and may actually register a raised temperature. These latter symptoms are notorious in deceiving a busy doctor who often ends up concluding that the patient has malaria and prescribing chloroquine, itself capable of exacerbating hallucinations and general confusion.

Furthermore, a chronic addict of alcohol has a greater chance of developing heart and liver disorders and besides he may develop paranoid delusions and depression, the former capable of precipitating homicidal and the latter suicidal tendencies. In general, because of poor nutritional status, alcoholics are more likely to develop both infections and other diseases than the average person.

For a long time, few medical schools offered a comprehensive course in psychiatry. In the circumstances, many of the doctors qualifying in those days had little opportunity of learning about conditions with wide ranging psychosocial implications such as alcohol. Through no fault of their own therefore, presently, there is a group of doctors who when faced with such patients are unable to understand the psychosocial implications, restricting treatment only to identifiable organic disorders. Even more alarming, newer concepts in the management of alcoholism like "drying out period" when patients have to take drugs like clormethiazole are unknown to them and cases have been seen in which a doctor has rushed to treat a patient with drugs like citrated calcium carbimide, before adequately catering for with-

drawal effects. All said, the alcoholic needs wide and extensive cera in which relatives, friends and employers are involved; but since time does not allow discussion of these aspects I must now turn to another important fact of psychiatry.

One of the things that intrigues my friends is that I also have a child psychiatric unit that I run! "How come!" they ask, "do children also get mad?". The word madness is, as far as psychiatry is concerned a misnomer. Few psychiatric patients, probably as little as 5% actually fall in the category of madness in the cultural sense the word is used. The rest, 95%, simply have behavioural disorders such as not talking, losing voice, and wandering aimlessly.

The subject of child psychiatry is even more important, if cognizance of the fact that in developing countries like Kenya, over 50% of the total population is aged 20 and below, is taken.

Child psychiatry is concerned with correction of behavioural disorders such as failure to progress at school without organic excuse, sleep-walking, anxiety states, refusal to eat, hysterical symptoms such as faints, paralysis in limbs and to a smaller extent with psychotic deterioration in the form of depression and infantile schizophrenia. As will be evident, the aeteology of many of the neurotic symptoms are tied up with such factors as sibling rivalry, friction in the family and stresses at school. Recognising these factors, it has always been my policy to involve, if possible at least, the immediate family during the course of treatment. In addition, various studies have repeatedly suggested that faulty adjustment on the part of parents may lead to neurotic disorders in children and that in many cases often a child psychiatrist ends up treating the parents instead of the child.

Thus, it is common for an irate mother to bring a 4 year old child complaining that the child wets the bed, complains of abdominal pains and headaches and that he is unable to progress at the nursery. Closer inquiries almost always reveal that the father has an additional wife, drinks heavily and that the mother has had constant headaches and abdominal pains, sleeps badly and is generally tense and irritable. In such circumstances, the mother is given an antidepressant besides psychotherapy and on a subsequent visit both child and mother are well! The trick here is that during childhood, a period in which a child is learning to socialize by identifying with adults, the likelihood that such a child will identify with the pathological processes in the adults closest to him are very high.

Related to the purely psychiatric disorders of children is the important subject of mental retardation. Again, I note with satisfaction that the present government is greatly concerned with handicapped children. This subject is of immense importance, considering that Kenya is one of the developing countries with a high birth rate.

It has been estimated that probably as many as 95% or more of our child-bearing population deliver their babies at home. Considering that factors such as cephalopelvic disproportion and poor hygiene are likely to interfere in such deliveries and the fact that complex factors such as chromosomal and metabolic disorders are likely to act unmitigated in a domestic delivery, chances are that there is a large population of mentally handicapped children.

Mental handicap is commonly associated with infections, epilepsy and a condition called hyperkinesis, i.e. extreme motor vigour. The last two of these factors are very important not only because they compound the mental handicap but because children with such ailments require extra adult care and supervision. It has for instance been estimated that if one of 5 or 6 children has hyperkinesis such a child will require 80% of parental care leaving only 20% of such time to the other 4 or 5 normal children. In other words, not only does the mentally retarded personally stand a risk of being unable to grow into an independent and useful citizen, but he has the capacity to cause similar though lesser impairment in his siblings.

Epilepsy is a condition that lies at the interface of strict internal medicine and psychiatric disorder. It arises because of abnormal electrical function of part of the brain. I mention it at this stage because as an illness it has perhaps one of the greatest fallouts on society. It is not uncommon for instance, to find parents of an epileptic child harbouring suspicious feelings against each other, each suspecting it is the other one who transmitted the disorder. In addition, psychomotor epilepsy, a name that is a misnomer since this type of epilepsy can occur repeatedly without the motor component, presents as behavioural disorders that are indistinguishable from "madness" which in the hands of a casual clinician are difficult to diagnose. And because of its "madness" component, it can result in crime, homicidal or suicidal tendencies. Furthermore, because the patient repeatedly behaves in a strange and odd way he subsequently cannot explain, he develops anxiety and depression, themselves very potent disorders. Again, in a country where obstetric care is still minimal and infection which commonly impair brain functioning

rampant, it goes without saying that this particular disorder is very common and that particular attention must be paid to this ailment.

It is simply not possible within one hour to describe the ill-effects of all types of mental illness on society. It is only pertinent at this stage to try and outline what might be done in order to mitigate the effects of psychiatric illness.

One particular person that can with justification claim to have been part of the years of struggle in psychiatry in this country is my friend and colleague Dr. G. Mustafa, who for many years, single-handedly and patiently, treated and managed patients recognized by society as mad in the dreary and dilapidated Mathare of yesteryear. In recent years however, there has been a rapid change, I am glad to say, which came about as a result of insightful planning by both the Ministry of Health and the University authorities. And presently, besides some improvements being made on the physical aspects of Mathare, the country has a compliment of about 8 psychiatrists and again I am happy to say that within the next two to three years, when our students return from overseas courses, we will have a compliment of about 20 psychiatrists. There cannot however be much joy since 20 psychiatrists for a population of 14 million is a drop in the sea! And even if 20 psychiatrists were enough to cater for the 14 million people who are increasing at an annual rate of 3.9%, there are other prerequisites for proper psychiatric care.

First, in the delivery of psychiatric services, the watchward is the "mental health team". This team consists of a psychiatrist, other doctors, a psychiatric nurse, a clinical psychologist, an occupational therapist, a psychiatric social worker, besides the patient himself. For a long time, Kenya has had to do without some of these very essential members of the team. Again, I am pleased to note that as recently as last May, the training of psychiatric nurses at the level of state registration was started and that the Department is deeply involved in the training of these nurses. Furthermore, plans are afoot to start a local training programme for psychiatric social work. This programme will consist of 1 year's practical instruction and the minimum qualification for entry will be a bachelor's degree in Sociology.

Regarding the training of doctors, the Department of Psychiatry has lofty intentions. Thus, the 200 hours that are set aside for psychiatric instruction to undergraduate student doctors are being reconsidered and efforts will be made to increase this instruction to at least 300 hours, emphasis being laid on practical instruction. Furthermore,

efforts will be made at the Faculty level so that psychiatry becomes an independently examinable subject in the final year of undergraduate training.

In a survey carried out in 1965, Professor Linford Rees reported that more than 50% of hospital beds in England and Wales were being occupied by psychiatric patients while my colleague at Kenyatta Hospital Dr. Rees, a physician, estimates that at least 50% of his outpatient population present significant psychiatric symptoms. If these findings are true, and there is a lot of collateral evidence to suggest so, it would appear reasonable to conclude that developing countries like Kenya need as much of psychiatric services as developed countries do! Unfortunately, since the developed countries have the capacity to pay, they are presently monopolizing the psychiatrists. And because of this monopoly, it has sometimes been difficult to find adequately experienced people to man both government and University services. The long-term solution to this is to start a local training programme leading to the award of Master of Medicine in Psychiatry. Plans to start such a course are being made but will probably not materialize in the next two years simply because at present we do not have enough people to teach at that level, for instance in forensic and community psychiatry. We consider it prudent to wait that long in order to avoid a situation where we would be awarding "home-made" qualifications.

Thus far, I have talked about things concerning 95% of the psychiatric patients. The remaining 5% constitute a hard core of patients who, even if small, is the one that is better known to the general public. It consists of severely disturbed patients who are running around naked, yelling and destroying property. These patients have no insight whatsoever and are unlikely to co-operate and accept treatment. In the circumstances, there must be some legislation to enable health workers to manage these patients. Indeed, a form of such legislation exists in Kenya, but unfortunately it has been overtaken by events and there is an urgent need for a thorough revision.

Muya and Muhangi (1976), have made a number of suggestions regarding what form the new legislation should take. For instance, recognizing that 95% of psychiatric patients are likely, on adequate explanation, to understand the nature of their illness and therefore co-operate during treatment, there should be a civil part of Mathare Hospital to be organized on a walk-in-walk-out basis. In addition,

part of this civil wing should cater for patients who although may not be violent, have not the insight to know that they are unwell and therefore require treatment. Such patients would have to be sent into hospital on what the United Kingdom and some African countries call "urgency order". This means that any doctor or a police officer of the rank of Inspector and above, after satisfying himself that the person is acting oddly can sign this and get the patient delivered to hospital if necessary with the help of the police. A patient delivered in this way would be discharged at any stage of hospitalization if a "responsible" officer, in this case a consultant psychiatrist was satisfied the patient had recovered. The second and smaller part of Mathare hospital would be for forensic patients. By forensic I mean those patients who either because of the illness committed serious crimes or pleaded mental illness in the course of an ordinary trial. In normal circumstances, these patients would have come through a magistrate's court.

Lest I am accused of living in the ivory tower of Nairobi, I will now turn to the question of psychiatric services of the majority of our population who live in the rural areas. The problem with Kenya is that it is a very large country, consequently the consultant services currently available in the capital cannot be readily utilized in the rural health centres. In these circumstances, I wish, if only for the long-term objectives to make the following suggestions, which I believe both the Ministry of Health and the University already have in mind.

In the next ten to fifteen years, efforts should be concentrated on having provincial psychiatric centres complete with the full mental health team I outlined. This team must be sufficiently equipped to be able to reach district health centres and thus help the rural patients. Above all, health workers, be they surgeons or obstetricians, general nurses, midwives and even psychiatrists, should be encouraged not only to shed the exotic and esoteric psychiatry that is often epitomized in such nuances as, "We are all mad, it is the degree": In its place, not only must these health workers be encouraged to learn that we are all physically abnormal and it is a matter of degree, but they should again be encouraged to grasp the more mundane facts regarding psychiatric ill-health and mental hygiene.

I say "even psychiatrists" on purpose—and that includes me. In the world of science in general, and medicine in particular, the fact that knowledge has a half life and therefore needs regular recycling is no longer a matter for dispute. In the circumstances, regular attend-

ance of clinical conferences, journal clubs, workshops, seminars and the reading of journals must not only be viewed as a luxury, but must be seen as a necessary part of the profession of medicine.

Professor Stengel in a fairly recent study, using successive fifth year classes of medical students put a simple question, namely, "Of all the medical specialities, which one deals with most pain?" Analysing the results, he found a significantly higher number of students choosing such subjects as obstetrics, presumably because of the legendary labour pains, dentistry perhaps because many of them had experienced teeth extractions, and surgery perhaps because many of them imagined with trepidation the pain of an acute appendicitis.

Recent re-examination of the nature of pain however, suggests that the way we perceive and report pain may be considerably psychologically determined. Many reports in medical journals, and cases seen in the Nairobi area strongly suggest that under extreme psychological pressure, many people may develop a psychological syndrome that is indistinguishable from the physical condition surgically called "the acute abdomen." Beleaguered surgeons, under pressure of both the urgency with which the patient presents the symptoms, and the number of patients they have to see, are forced to perform a laparatomy only to find no significant pathology. Nonetheless, because of the psychodrama of the operation and subsequent after-care, these patients experience a period of well-being. Unfortunately, since the psychological aeteological factors are not tackled, the syndrome recurs again and again, and the patient may end up with several operations and subsequently many fibrous scars on his abdomen, an abdomen which because of its inelasticity has been referred to as "the battle shield" abdomen.

Another instance in which it has been adequately demonstrated that the perception of pain is influenced by psychological factors is hypnosis, not to mention the exotic technique of acupuncture. Hypnosis in simple terms is making the patient relax and suggesting to him that he is in a trance. During such a trance it can be suggested to the patient that he will experience no pain and hypnosis has in some cases been successfully used in teeth extractions and in obstetrics.

Clearly therefore, when a patient is reporting pain, in a number of cases he may not be referring to what the organic physiology textbooks are referring to! It is to facts like these that health workers should be directing their attention. In that connection, I wish to note that the department has already taken some initiative, having organized a successful training seminar for general practitioners in Mombasa in

April last year. It is the intention of the department to hold similar seminars elsewhere in the country.

At the beginning of the sixties, when Professor Lambo, now Deputy Director of the World Health Organization was busy setting up his famous psychiatric villages around Aro Hospital in Nigeria, there was another man, Professor Raymond Prince, studying aspects of traditional healing in the same region. Visiting the psychiatric museum at Aro in 1971, I was intrigued not only by the ingenuity of the methods used by the Nigerians to physically restrict some of their violent patients, but also by the extent of that restriction. It appeared that the Nigerian psychiatric patient must, at least in the past, have been excessively vigorous. In days when a powerful tranquilizing drug called chlorpromazine had just been introduced by two French psychiatrists, Denniker and Delay, the Western psychiatrist was in a position to handle an agitated and violent patient quite easily. Professor Prince was therefore curious to find out how the traditional healer coped with such a patient. He found that on being delivered to the healer, the patient was given a bowl of herbs and roots to drink. Some 20-30 minutes later the patient was soporofic and calm and further administration of these herbs kept the patient under control. Excited, the professor picked a few of these herbs and dispatched them to London's botanical museum where they were identified as Rauwolfia Serpentina. The therapeutically active ingredient of Rauwolfia is reserpine, a drug that is still widely used at Kenyatta hospital to sedate and tranquilize patients suffering from what in medical jargon is called "essential hypertension" and actually meaning that we do not know why the patient has a raised blood pressure.

In 1970 in a demographic study of psychiatric disorders in Kasangati near Kampala, I came upon a very strange man. Wealthy and famous, he worked as a traditional healer. His technique was what I would describe as psychodrama. On certain days which appeared to be in a cyle of twenty eight days, he held his clinics. It was revealed partly by him and his entourage that during the therapeutic sessions this man saw a white female figure with whom they had a conversation in tongues. After the session which lasted about 30-45 minutes, the man lapsed in a dreamy state from which he awoke several hours later. This stereotyped behaviour suggested, and considering the late Sir Aubrey Lewis' time-tested edict that the diagnosis of epilepsy is a purely bedside matter, the man was having attacks of temporal lobe seizures. Nonetheless, the hysterical patients with paralysed limbs,

women who were infertile because of psychological problems, and men with impotence of psychological origin after witnessing these psychodramatic events, were subsequently able to use their limbs, have babies and recover their potency respectively. Of course one need not be epileptic to get into a trance. In the same study for instance, two women traditional healers appeared capable of inducing self hypnosis and in the process getting into trances during which they put on dramatic events that apparently produced therapeutic and beneficial results in patients with neurotic disorders akin to those already described.

I mention Professor Prince's observations and my own experience in order to demonstrate that traditional medicine may have a role in the practice of not only psychiatry, but medicine in general. There is an urgent need to investigate the available methods of traditional healing and where possible incorporate the relevant aspects into medicine. For instance, the example of an epileptic or hysterical patient treating others is a problematic one, posing both scientific and ethical problems: the epileptic for instance cannot "teach" another person to have epileptic trances in order to carry on when he retires. In any case he is always at risk of getting a generalised seizure that might result in considerable harm to himself if left untreated. But since there are precedents in medicine such as the advantage that was taken in studying the normal function of the stomach following a penetrating wound in "Tom's" stomach, I see no reason why psychiatry should not use these examples in obtaining insights into psychic phenomena, using similar approaches. And as it happens, my colleague, Dr. Gatere, has been making preliminary studies on traditional healing in the Murang'a region, the results of which are being used in a thesis for a Master of Philosophy degree. It is the hope of the department that these studies will form a base for more detailed research in future.

Earlier, I defined a formal mental health team. It seems however that with the techniques used by traditional healers being incorporated, a policy now encouraged by the World Health Organization, the mental health team may have to grow larger. In fact it has always been larger. It is long recognized that services offered by religious counsellors, by bodies such as alcoholic anonymous are of some value in enabling those affected to cope at least with lesser problems of mental ill-health and mental hygiene.

Although the motto in the delivery of psychiatric services is "brain and not bricks", I wish to say a few things regarding the innanimate

tools of psychiatry. At its inception some ten years ago, the department was homeless. Mercifully, Professor Gebbie, then the Chairman of the Department of Obstetrics and Gynaecology offered a wing in his department, and in the tradition of gentle-handedness of Obstetricians, his successor Professor Mati has continued to let us use that wing. Presently however, both departments are in the process of rapid expansion and I cannot see how any amount of good-will in this world will enable these two departments to continue to live under the same roof, even in the immediate future. In the circumstances, it seems, a prefab building to house the department might do the trick. Suggestions of transferring the department of psychiatry to Mathare have been, with good intensions, made. In an era when the interface between psychiatric and organic medical symptoms and syndromes is becoming inexorably blurred, and in an era when progressive medical opinion is for integration, it would be a serious setback to reinforce the dichotomy that has been existing between the two branches of medicine.

A related problem is that of physical facilities for patients. A stage seems to have been reached when integrated practice of medicine should be the rule. Recently, faced with an irate nurse demanding that a patient showing the psychiatric symptoms of restlessness be transferred to a mental hospital I was forced to muse, "supposing a patient with alcohol related disorders of hallucinosis, liver cirrhosis, depression and cardiac failure was admitted, do you suggest the head should be transferred to Mathare for the management of hallucinosis and depression, the heart to the cardiology department and the liver to the general medical ward?" Apparently mollified, the nurse cooled, presumably figuring out an answer! There is again an urgent need to set up specific beds for patients with psychiatric disorders not only at Kenyatta National Hospital, but in as many general hospitals as have access to psychiatric services, so that besides integrated medical care, health workers in other fields can gradually be introduced to the techniques of psychiatry.

Perhaps one of the psychiatric disciplines that has so far received little attention is that of child psychiatry and the related subject of mental retardation. Presently, although a child psychiatric ward exists at Mathare hospital, unfortunately it caters for only male children. Female children are therefore forced into adult female wards, wards in which there may be severely disturbed patients. It seems there is a strong need to erect a ward that will cater for both male and female

children, probably not only at Mathare hospital, but as our manpower increases in other centres.

The need to have specific facilities for the education of mentally retarded children unwittingly began to emerge in 1905 when the city of Paris commissioned Alfred Binet to devise a test or tests that would separate children that were capable of following a normal school career from those who could not. That of course was the beginning of the controversial "Intelligence Quotient" popularly known as "I.Q." and purporting to measure a child's present and future performance in a nutshell. Over the years however, collateral observations have suggested that a child's development of the various attributes of intelligence is not uniform. Thus it is common for instance to find a child having considerable verbal facility while other attributes of intelligence such as motor co-ordination, writing and reading are considerably backward. In fact extreme cases in which a child may for example have a reasonably well developed sense of numbers to the exclusion of all other intellectual attributes are known, such a child having been given the unflattering name of "idiot savant". In these circumstances, although Kenya has in the last few years taken the lead in black Africa in educating the mentally handicapped, it seems there is a need to have a second look at the policy of attaching a "speciall class" to a normal school for all the children under the blanket name of "mentally handicapped". While the prime object of this policy has the apparent advantage of the abnormal child keeping close to the normal, these special classes appear to have been a bottleneck, unable to develop the individual child's talents to a maximum. The obvious result has been that several children have attended such a class for several years without attaining the desirable goal of being reasonably independent at an older age. It would seem that we have reached a stage where several schools modelled along the Jacaranda school, in which a combination of psychological and teaching skills in various fields of intellectual development on the part of teachers are urgently needed to help develop a comprehensive educational programme for these children who probably form more than 1% of children aged 5-15 years, many of of whom as the department's pilot study at Lady Northey Home has shown cannot even be absorbed in the present "special classes".

Clinical care apart, there is the important aspect of a University department, namely, research. For the greater part, most of the concepts used in psychiatry in Kenya originate from studies in the Euro-American cultures. Professor Lambo (1960) has for instance demon-

strated that certain clinical pictures in African patients differ from those of Euro-American patients at least in style. Thus, Lambo spoke of pathoplastic phenomena, meaning cultural additions which on a glance, for example, suggested that schizophrenia in Africans was different from that found in Caucasians. Lambo's work was therefore important in proving that despite the apparent differences, ultimately the condition was the same everywhere.

Similar studies must be carried out in Kenya. Furthermore, studies on demographic and epidemeological aspects of psychiatry must be made. And as a department we must not stop there. The more biological aspects of psychiatry such as response of local patients to drugs tested on European patients, genetic and chromosomal effects, protein deprivation in childhood on the brain and the whole field of psychophysiology and psychochemistry must ultimately be studied in our local population. This will of course require certain tools. For instance, epidemiological studies will require transport, data processing equipment and proper typewriters for the researchers, relatively sophisticated equipment such as electroencephalogram for the study of brain function, and certain reagents and photomicroscopes for the study of genetic abnormalities. Many of these tools can easily be obtained so long as the Ministry of Health process our request to the World Health Organization.

Having said all this, I wish to conclude by noting that in a few month's time, the Department of Psychiatry will be celebrating ten years of existence at the University of Nairobi. The ten years have probably been years of ceaseless labour and little gain! Gazing in my crystal bowl however, I can see the dark clouds gradually being swept away, and even if it may mean some years to come, there is a strong possibility of sunshine following after rain.

REFERENCES

1. ACUDA, S.W. & MUHANGI, J. (1979) Diazepam Addiction in Kenya. E.A. Med. J. *56* No. 2 76-79.

2. BINITE, A. (1975) "Recognition of Depression in the African". Proc. of Round Table Discussion. Abidjan. Ed. T. Asuni. pp 31-35.

3. CAROTHERS, T.C. (1953) "The African Mind in Health and Disease: A Study of Ethinopsychiatry". Monograph series WHO, Geneva 17.

4. GERMAN, G.A. (1972) "Aspects of Clinical Psychiatry in Sub-Saharan Africa." Brit. J. Psychiat. 121 4161-79.

5. GIEL, R. & VAN LUJIK, J.N. (1969) "Psychaitric Morbidity in a Small Ethiopian Town". Brit. J. Psychiat. 115, 149-61.

6. KIELHOLZ, P. (1973) "Psychosomatic Aspects of Depressive Illness—Masked Depression and somatic equivalents". In: Masked Depression. Ed. P. Kielholz. Basle.

7. LAMBO, T.A. (1955) "The Role of Cultural Factors in Paranoid Psychoses Among the Yorubas." J. Ment. Sci. 101, 239-65.

8. LOPEZ IBOR, J.J. (1972) "Masked Depression and Depressive Equivalents.". In: Depressive Illness, Diagnosis, Assessment and Treatment.

9. MUYA, W.J. & MUHANGI, J. (1976) "Mental Health Services in Kenya". Proc. African Association of Psychiatrists. LUSAKA, Zambia.

10. NDETEI, D.M. & MUHANGI, J. (1979) "The Prevalence and Clinical Presentation of Psychiatric Illness in a Rural Setting in Kenya". Brit. J. Psychiat, 135, 269-72.

11. PRINCE, R. (1960) "The 'Brain fag' Syndrome in Nigerian Students'. J. Ment. Sci. 106 599-70.

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