

Patterns of Psychiatric Illness: A Study in Kaduna Psychiatric Facilities*

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ABSTRACT

This is a retrospective study of all first admissions to two psychiatric facilities in Kaduna from 1st January 1976 to 31st December 1979. The conclusion from the findings was that the typical individual in Kaduna State who is at most serious psychiatric risk, which may warrant admission, is a young man in his productive years. He is married, self-employed, of low or no education, and a city dweller. As expected, most patients are Hausa-Fulani-Kanuri by ethnic origin and Muslim, the prominent religion of the area.

Introduction

It is evident that, with the growing complexity of the Nigerian society, a large proportion of Nigerians are being removed from the protection of the simple traditional environments to the complex, heterogeneous and less protective modern ones. Problems such as unemployment, economic and political instability, inflation, overcrowding, crime, divorce, broken homes, prostitution, drug addiction and lack of educational opportunities now abound. These are indices of social disorganisation which have significant implications for mental health.

It is unfortunate that mental illness is not viewed with the concern it should be. Perhaps this is due to the fact that, in most instances, mental illness is a disabling rather than a killing illness, and generally poses little or no threat to public life and property, so the government and the public do not give it the attention it deserves. The mass media, for example, concentrate on reporting crimes, road accidents, etc, and have little concern for mental problems. Perhaps this is partly why a lot of psychotics roam the highways, sleep on streets, and are subjected to the perils of the elements.

Yet mental illness leads to serious socio-economic consequences for the victim, his family and society, in that mentally ill persons are unable to

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follow the pattern of their culture, perform their normal social roles, and meet the expectations of their group. Worst of all, when left without prompt and effective treatment, a mentally ill patient could become totally useless to society, wasting away in public places and street corners.

Broadly speaking, this paper is concerned with mental illness, which is becoming a serious social problem in Nigeria. Mental illness emanates from, and at the same time has, disastrous effects on the individual, family, and other societal institutions, and society in general.

There are several factors relating to the causes of mental illness in Nigeria. For instance, our cities are becoming more and more populated, congested, and heterogeneous as different ethnic groups migrate from their traditional communities to look for a means of livelihood. In these cities the degree of social disintegration is most likely to be high. Under this circumstance there is less opportunity for unstable individuals to adjust. Another factor in the etiology of mental illness is the affluence of Nigeria, as reflected in its technology, institutions, and style of living. This affluence could contribute to psychological breakdown because individuals are frequently subjected to strain and stress, in that they are constantly required to modify their behaviour to meet the demands of their socio-economic environment which, in our capitalist context, is a competitive one. They often find that they have more adjustments, and readjustments, to make in order to keep up with the pace of affluence.

Furthermore, Nigeria is a test case for Robert Merton's theory of Social Structure and Anomie. There are inherent contradictions in our society's demands upon the individual. For instance, society 'disavows' selfishness, bribery and corruption, and yet the social structures provide certain individuals with opportunities to commit these crimes and go unpunished. Our society also emphasises paper qualification and success, being somebody, but not all individuals have equal opportunity to reach these goals. Thus, students cheat in examinations and forge certificates to obtain paper qualifications; traders try to be rich overnight by hoarding, cheating, and inflating the prices of commodities; contractors try to be millionaires within the shortest time by using bribery; and youths engage in drug addiction, armed robbery and prostitution.

In other words, the same social structures and cultures that make for conforming behaviour also generate tendencies towards distinctive kinds of deviant behaviour, if mental illness can be regarded as such. Consequently, one should try to find out who are the likely victims of mental illness and where they are located in the social structure of our society. This paper, being one of a series of research reports, attempts to provide an answer to this important question.

Review of related studies in Africa

Studies of psychiatric patients based on hospital records are relatively numerous in Africa. However, the target population for such studies has often been (a) in-patient cases only, (b) a combination of in-patient and out-patient cases, or (c) out-patient cases only. Efforts to distinguish studies of new or first admissions is fraught with difficulties. This is because a case that is a first admission case may not necessarily be a new case, and vice versa, due to the practice by psychiatric patients of 'shopping' between psychiatric hospitals and traditional or non-psychiatric hospitals; and also between one psychiatric hospital and another. The tendency, therefore, is to review studies on the three categories already mentioned when undertaking a study on first psychiatric admissions.

In Uselu, Benin City, Nigeria, a study of First Admissions to a University Teaching Hospital in a three year period Ichue (1981) reported 778 cases. The analysis of the data showed a predominance of male patients (55,3%) over female patients (44,7%). Patients of both sexes under the age of 30 years constituted the majority with 64,2 percent, only 3,1 percent were aged under 15 years, while 32,7 percent were 30 years and above. Regarding the occupational status of the patients, students were most frequently admitted and constituted 21,2 percent, followed by 18,1 percent housewives, and 17,9 percent from the unemployed group. The technicians, with 3,8 percent, were the least admitted of the 10 occupational groups in the study. With regard to the educational attainment of the patients, 51,5 percent did not go beyond primary education; and 54,2 percent had not been married before.

Findings in Enugu by Onyeama (1982) revealed an almost similar pattern of distribution. There was also a predominance of male over female patients by a ratio of approximately 2:1; less than 3 percent of the admissions were younger than 15 years old, while 83 percent were aged between 15 and 40 years. There was a predominance of single patients over other marital groups. The author pointed out that since the end of the Civil War in Nigeria, there has been a steady increase in the number of illiterate patients.

A study of 282 Ahmadu Bello University students in Zaria who reported psychiatric problems in the University Clinic of the Main Campus between January 15th 1978 and December 30th 1981 further revealed that males may be more often at psychiatric risk than females. Out of the 282 students, nearly all, ie 91,8%, were males and only 8,2 percent were females. There were 56,4 percent between the ages of 21 and 25 years; 66,7 percent had not been married before, 33 percent were married and ,4 percent were divorced (Umar, 1982).

In Abeokuta, Nigeria, Odejide (1981) examined a population of 226 patients admitted to Lantoro Hospital. Of the 221 cases finally analysed, 155 were male and only 66 were female. By marital status, single males had

higher rates than married males, but the reverse was the case among the females where married females predominated over single females. With respect to age, the admissions were composed mainly of young persons between the ages of 20–29 years old.

A study of admissions under a year's duration in Butabika Hospital, Uganda, had earlier revealed that males are perhaps more at psychiatric risk than their female counterparts (Orley, 1972). This was also the observation in Kaduna, Nigeria (Lergo, 1977).

From this brief literature review, three main observations can be made. First, that there tends to be a predominance of males over females in most, if not all, psychiatric admissions. Second, those who are admitted are those who are still in their productive years, ie between 15 and 30 years old. And third, persons of low educational attainment tend to be the most frequently admitted.

Methods

Hospital records were used rather than an expensive epidemiological survey. The main disadvantage of this is that the sample would not include patients who go to traditional healers and general hospitals. The second disadvantage is that the diagnostic pattern is influenced by the clinician's background. Furthermore, recent reports revealed that a disproportionately large number of psychiatric diagnoses are missed entirely by paraprofessionals (Harding et al, 1980).

Despite these drawbacks psychiatric hospital records are still useful as they highlight the problem of mental illness in the society.

Description of psychiatric facilities

The choice of location for this project was Kaduna which has two psychiatric facilities (and a referral hospital for the military which may account for the lack of military personnel in the study). Kaduna is the capital of Kaduna State which is estimated to have a population of 8 297 million. The predominant tribe is the Hausa with Islam having the largest religious following. There are divergent tribes which include Gwari, Jaba, Kaje, Kagoro, Ibo, Tiv, Yoruba, and Idoma. Kaduna town is fast growing and has a population of 478 266 people. It is a road junction, as well as a centre of commerce and establishment.

The research on which this paper is based was conducted in two hospitals in Kaduna, the Kaduna Psychiatric Hospital, owned by the state government, and the psychiatric unit of the Ahmadu Bello University Teaching Hospital. Information was obtained from records of first-admissions from January 1st 1976 to December 31st 1979.

(i) *The Psychiatric Unit*

This is a semi-autonomous unit of the Ahmadu Bello University Teaching

Hospital. It functions as a full psychiatric hospital with facilities for in-patient and out-patient services. It is situated in an area that is easily accessible, both to motorists and pedestrians, and is near both residential and governmental establishments, the Police Barracks, Marafa Estate, the Kaduna Secretariat, and the Post and Telecommunication Headquarters. This location could be said to meet one of the requirements for an ideal location for a psychiatric hospital, as advocated by the Association of Psychiatrists in Nigeria, ie that such hospitals should be located centrally, close to people (APN, 1973).

The unit occupies part of the building of the former Kaduna General Hospital. It was initially situated in Zaria but moved to its present site in 1965. It was formerly the only unit serving the whole of the northern part of Nigeria, until 1975 when the Kaduna Psychiatric Hospital was opened. The unit has two main blocks for in-patient accommodation. One of the blocks is for female patients, the other for the male patients. The wards are never locked or closed, except at night. There are no fences separating the wards; but the whole area of the unit is fenced with two main gates. The hospital allows free movement of people. Patients could go to town and return at any time of the day. Visiting hours are at any time of the day, unlike other types of hospitals where there are restrictions.

The unit is, however, lacking in facilities. There are few beds and not enough equipment for the various forms of therapy. This may reduce the number of admissions to the hospital. Occasionally, group therapy is done, but with a shortage of qualified staff it is sometimes not conducted for months. The regular therapeutic forms are drug treatment, individual therapy, electro-convulsive therapy (ECT), and basic occupational therapy (mainly indoor games).

The unit's admission policy is to give priority to serious mental cases, regardless of proximity. Mild problems are often treated as out-patient cases. The admission policy in the unit aims at short term hospitalisation.

(ii) *Kaduna Psychiatric Hospital*

The hospital is located in Barnawa Low Cost Estate area, between the Estate and the Kaduna Borstal Institution. It is relatively isolated, compared to the psychiatric unit. It started functioning in June 1975 as the Kaduna Mental Infirmary, but was later re-named the Kaduna Psychiatric Hospital. It has two male and two female wards, with a capacity of 50 beds each.

There is no fence round the hospital but the female block is fenced. The hospital has a much larger area than the psychiatric unit. There is a kitchen and laundry, and, attached to the hospital, is the Kaduna Psychiatric Nursing School. The students' hostels and staff quarters are near the wards.

Because of a lack of staff only a few forms of therapy are given; they are

drug treatment, individual therapy, electro-convulsive therapy, and indoor games.

Like the Psychiatric Unit, the hospital aims at short term hospitalisation and gives priority to severe mental illness, treating mild cases on an out-patient basis. Relations who accompany patients to the hospital also assist in the diagnosis of the illness. There is also no restriction on visiting and on the movement of patients.

Though the two psychiatric facilities in Kaduna are not geographically isolated, they are isolated in terms of human interaction with the world outside. Few visits are made to patients and there are instances of relatives abandoning patients, not visiting them for long periods of time, or not turning up to take them home after discharge.

However, the manner in which the patients are handled by the hospital staff is a marked departure from the characteristics of total institution as outlined by Goffman (1961). In addition their lack of restrictions on people in the hospitals, and location of the hospitals, satisfies, to some extent, the requirements of a psychiatric hospital as recommended by the Association of Psychiatrists in Nigeria (APN, 1978), viz that such hospitals should be near towns and that people should be encouraged to interact with the patients. These recommendations are in line with what Lambo had earlier suggested, and put into practice, in his Aro village Scheme (Lambo, 1968), and which others have found useful (Erinosho, 1976; Jegede 1982).

Data Collection

Data was collected on age, sex, occupation, marital status, religion, tribe, educational attainment and place of residence, from all cases of first admissions to the two facilities.

There were three sources of data: patients' files, nurses' notes, and the hospital register. The files contained the demographic characteristics of patients, the history of the illness, and family background. The nurses' notes were kept in a book which gave progress reports on each patient. The register contains a summary of the socio-psychiatric characteristics of the patient. All sources were useful because they complemented each other.

Grouping of socio-demographic characteristics

For the purpose of analysis some of the socio-demographic variables were grouped as follows:

(a) Age:

- (i) Lower group (24 years and below)
- (ii) Middle (25 to 44 years)
- (iii) Upper (45 and above).

(b) Education:

- (i) Low (no education, Koranic)

- (ii) Medium (primary and postprimary)
- (iii) High (post secondary).
- (c) **Ethnic composition:**
 - (i) Hausa/Fulani/Kanuri
 - (ii) Southern Zaria group (this includes Gwari within Kaduna State)
 - (iii) Other Northern groups (Tiv, Bachama, Birom, etc)
 - (iv) Southern tribe group.
- (d) **Occupation:**
 - (i) Unemployed
 - (ii) Employed
 - (iii) Self-employed (traders, self-employed craftsmen and artisans, and prostitutes)
 - (iv) Housewives.
- (e) **Geographical Locality:**
 - (i) Kaduna metropolis (including its surrounding villages)
 - (ii) Zaria area (with its villages and semi-towns)
 - (iii) Katsina area (with its villages and semi-towns)
 - (iv) Southern Zaria area (all villages and towns in Kachia, Jama'a and Saminaka local governments)
 - (v) Other Northern States (excluding Kaduna State)
 - (vi) Southern States.

Results

Within the four-year period of the study, a total of 1744 cases of first admissions were recorded in the two psychiatric hospitals in Kaduna. A breakdown of these cases along socio-demographic characteristics is as follows:

Age

The most frequently admitted persons, as shown in Table I, came from the productive age group (25-44 years) (4,7%), followed by the lower age group (under 25 years) (44%), while persons above 44 years (9,1%), were the least admitted. The mean age for admission was 27,6 years.

Sex status

With respect to sex, of the 1 736 cases recorded, 58,3 percent were males and 41,7 females.

Marital status

For marital status, a total of 1 701 cases were analysed, as 45 cases were counted as missing cases. Out of this number, the married persons (59%) predominated in admissions, followed by single persons (37%) while the least cases (3%) came from those who were widowed.

Educational attainment

In Table 2, in terms of educational status, of the 1 623 recorded cases, persons from the low educational group were slightly greater than those from the medium level of education, 48,6% and 46% respectively. Only 4,9% came from the high education group.

Occupational status

In terms of occupation, as shown in Table 3, housewives composed 33,3% of the 1 722 recorded cases, the largest group, followed by the self-employed and employed with 32% and 27,4% respectively. The lowest percentage was for the unemployed (7,3%).

It is important to note that when the sex and occupation compositions of the admissions are compared, the predominant female group is that of full-time housewives. It is also important to note that those not in employment in the public or private sector constitute more than half of the admissions, when those who are self-employed and housewives are grouped together.

Religious affiliation

There were 1 739 cases recorded, of which 54,4% were Muslims, 44,3% were Christians, while ,6% and ,5% came from the traditional religion worshippers and other forms of religion respectively.

Ethnic composition

The distribution according to ethnic groupings, as seen in Table 4, shows that 1 669 cases were recorded, the majority of which were from the Hausa/Fulani/Kanuri group with 46,9%; other Northern tribes next with 17%; and 14,9% from the Southern Zaria group. The Southern tribes had 21%.

Geographical locality

By residential locality, 1 704 cases were recorded. The majority of the patients (48,8%) were residing in Kaduna town (see Table 5), while 22% of the cases resided outside Kaduna State, though in the northern states. There were 14,2% from southern Zaria (south of Kaduna State), 11% came from Zaria area, 2,7% from Katsina area, and only 1,1% of the patients were residing in the southern part of the country at the time of admission. It would seem therefore that the rate of admission is also a function of proximity to the hospitals.

Conclusion

The distribution of the admissions was examined by age, sex status, marital status, educational attainment, occupation, religious affiliation, ethnic composition and geographical locality.

With regards to sex, males constituted more than half of the admissions.

This sex difference is consistent with other studies of hospital populations in different African towns (Orley, 1972; Onyema, 1980). But if one examines prevalence studies in industrial societies, there is no consistent difference by sex in mental illness in general. These studies only reveal that sex differences are consistent and apparent only in specific types of mental illness (see Dohrenwend and Dohrenwend, 1976; and Dohrenwend, 1974). Various hypotheses could be put forward to explain the predominance of males in this present study. The females, more than their male counterparts, in most Northern States, tend to have protection from factors that lead to stress. For instance, men are more socially and physically mobile and seem to take on more strenuous occupations that are hazardous to physical health than their female counterparts. The Muslim custom of keeping women in purdah may be psychologically and physically protective of women, in the sense that males are more exposed to the possibilities of getting involved in drug addiction, alcoholism, accidents, crimes, etc, that might predispose to mental illness, in general, and some organic and personality types of mental illness, in particular. Furthermore, the cultural expectations of females to be gentle and avoid certain social activities (such as violence, drinking and smoking) buttress their protection from mental illness, vis-a-vis the males.

As for age, the majority of admitted persons were young, with a mean age of 27.6 years. Indeed, the rate of admissions decreased with age. These age-related findings could be accounted for by factors of mobility and social behaviour. For example, youth are more mobile, migrating to the towns, moving about in search of jobs and fun, and trying to establish their identities so as to prepare themselves for life. However, some of the elders have economically and socially settled and found their life identities. In terms of other forms of behaviour, the youth seem to be more competitive and aggressive, still exhibiting youthful exuberance. Furthermore, the effects of social change from the traditional to the modern are most likely to affect the youth who are in the process of making life-long commitments to the future. Undoubtedly, these activities of the youth expose them to factors that precipitate mental problems.

More patients belonged to the Muslim religion, a fact explained by their predominance in the state.

The educational characteristics of the admissions were also considered. This is vital, because level of educational attainment is generally one of the indicators of socio-economic position. In this study the admissions were predominantly composed of persons with little or no education. However, it might be argued that there are more non-literate persons in the state than literates and therefore they will be more represented in the admissions than literates.

In addition to considering these occupational groupings and educational

levels separately, a combined observation of the two variables revealed that admissions were composed of persons from the lower social class in the society. This is consistent with other studies conducted in Europe, which have shown a relationship between mental illness and social class (Faris and Dunham, 1939; Hollingshead et al, 1958; Srole et al, 1962).

The ethnic composition revealed that the Hausa/Fulani/Kanuri group predominated. This could be explained in terms of the predominance of this group in the population of the area in which the psychiatric hospitals are situated. There is no doubt that this group is the majority in Kaduna State.

The typical individual, therefore, in a psychiatric hospital in Kaduna State is a young man in his productive years, he is married, self-employed, of low or no education and is a city dweller. It is to this category of persons that psychiatric services should be seriously directed.

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Table 1

Distribution of Admissions by Age

Age in Years	No	%
Lower (24 and below)	768	44,0
Middle (25-44)	828	47,4
Upper (45+)	148	9,1
TOTAL*	1 744	100

*Mean Age = 27,6

Table 2

Distribution of Admissions by Education

Level of Education	No	%
Low	798	48,6
Medium	746	46,0
High	79	4,9
TOTAL*	1 623	100

*121 unspecified cases.

Table 3

Distribution of Admissions by Occupation

Occupation	No	%
Unemployed	129	7,8
Employed	472	27,4
Self-Employed	548	32,0
House-Wife	573	33,8
TOTAL*	1 722	100

*22 unspecified cases.

Table 4**Distribution of Admissions by Ethnic Affiliation**

Ethnic Group	No	% of Total
Hausa/Fulani/Kanuri	783	46,9
Southern Zaria	249	14,9
Other Northern Tribes	284	17,0
Southern Tribes	358	21,0
TOTAL*	1 669	100

*75 unspecified cases.

Table 5**Distribution of Admissions by Residential Locality**

Residential Locality	No	% of Total
Kaduna Area	832	48,8
Southern Zaria Area	243	14,2
Zaria Area	189	11,0
Katsina Area	46	2,7
Other Northern States	375	22,0
Southern States	19	1,1
TOTAL*	1 704	100

*40 unspecified cases