PSYCHIATRY AT A MISSION HOSPITAL IN SOUTH AFRICA

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THIS paper reviews the psychiatric presentations seen during a two month elective pupilship at a 220-bed mission hospital in a rural area of South Africa. The hospital served the medical and surgical needs of the local Bantu population of approximately 330,000, and had a staff of four full-time and five part-time doctors. An average of 300 patients were seen daily in the outpatient and casualty departments, about 50 of whom required admission. Psychiatric cases accounted for a significant proportion of the work load.

PROBLEMS IN THE PSYCHIATRIC FIELD

Because of the heavy workload and the shortage of doctors, clinical assessments had to be brief and investigations were limited by the lack of facilities. The language problems and the limited education of the patients made history taking difficult and there were frequently no relatives able to give an independent account of the

| TABLE |
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| **Range of disorders encountered** |
| Number seen |
| **Acute Organic Mental Illness** | - Toxic Confusional States | 17 |
| | - alcoholic pyrexial hypoglycaemia | 9 |
| | - Puerperal Psychosis | 3 |
| | - Head Injury | 2 |
| **Chronic Organic Mental Illness** | - Korsakov’s Psychosis | 4 |
| | - Dementias – senile pre-senile (Pick’s Disease) | 1 |
| | | 2 |
| | | pellagra | 6 |
| **Schizophreniform Psychoses** | - Paranoid Epileptic Psychosis | 5 |
| | - Schizophrenia | 29 |
| **Affective Psychoses** | - Paranoid Reactions | 8 |
| | - Manic/Hypomanic Illness | 2 |
| **Other Psychoses** | - Acute Reactive Psychotic Episodes | 6 |
| **Psychoneuroses** | - Anxiety States | 75 |
| | - ‘Brain Fag Syndrome’ | 10 |
| | - Behaviour Disorders | 4 |
| | - Depressive Reactions | 6 |
| **Mental Subnormality** | | 6 |
patient. But, despite these problems, a reasonable consensus diagnosis could usually be arrived at between staff members.

Psychiatric patients requiring admission were referred from the outpatient and casualty departments, and were admitted to the general medical wards under the care of a general physician as there was no separate psychiatric ward. Grossly disturbed patients were usually transferred to a psychiatric hospital about fifty miles away. The hospital was visited only once a fortnight by a psychiatrist; the day-to-day care of the patients was carried out by doctors who were not specialists in any field. Indeed, in the outpatient and casualty departments, much of the work was carried out without direct supervision by students.

The wide range of mental disorders encountered in the two months are shown in the table.

**Presentation of Psychiatric Disorders in This Population**

Anxiety states were common, making up about 40 per cent of all the cases seen, and typically presented with physical symptoms such as headache and abdominal pain. There were more males than females in this group, unlike European practice, and young people in educational settings such as trainee teachers and student nurses, were over-representative amongst the neurotic patients.

A number of the neurotic patients fitted the category of the ‘brain-fag syndrome’ described by Prince in 1960 in Nigeria. This condition affects young males in educational settings and is typically associated with disturbances of concentration and sensory functions, particularly visual. It is thought to be related to the imposition of European learning techniques upon the African personality.

Schizophrenia tended to present in a dramatic way with florid symptomatology; this may well be inherent in the Bantu make-up or may reflect selection in that the quieter patients whether affectively or schizophrenically ill may well stay in their village and only the grossly disturbed patients get to the hospital.

Paranoid reactions were fairly common in this sample and were typically associated with ideas instilled into the patients by witch-doctors. The witch-doctor habitually projected the explanation of evil, illness and misfortune on to spirits, relatives of the patient and so forth and hence these people developed persecutory ideas which occasionally led to their committing murder.

A number of cases of pellagra are included in this study since they initially presented with psychiatric symptoms. The condition, which is due to nicotinic acid deficiency, is fairly common in the Bantu people due to their poor diet and is classically associated with the three Ds, dermatitis, dementia and diarrhoea. The psychiatric manifestations included irritability and forgetfulness in the early stages and a late organic psychosis with memory impairment, confusion and disorientation. Treatment with nicotinic acid usually produced a dramatic improvement within 24 hours.
A significant number of psychiatric emergencies presented and were mostly acutely disturbed behavioural problems, frequently with an organic element, and the acute confusional states. Unfortunately physical restraint was used to some extent to control these patients but we found that this was unnecessary if chlorpromazine in adequate doses was given coupled with good nursing.

**Summary**

Psychiatric disorders proved to comprise a significant proportion of the workload of a busy rural hospital and their study and management proved both interesting and worthwhile.

There is no doubt that cultural differences played a part in the different presentations of the disorders seen, but nevertheless, the basic nature of the underlying conditions were similar to those seen in Northern Ireland. Many people have the idea that neurosis is a condition of the affluent Westerner, however it seems just as common in the African Bantu if you care to look for it.

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**Reference**

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