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LAMBO'S MODEL OF PSYCHIATRIC CARE

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> "Psychiatry is more than a speciality of Medicine. Its scope is wider; its fundamental concepts form the essential basis of modem social Medicine. That Medicine is not concerned with individual therapy, but that it has wider social aspects, is a fact that is obtaining increasing recognition in civilize communities, for it is in primitive societies that "health and disease are a matter of the 'public' of communal concern from the start" (Lambo, 1961a).

Introduction

Perhaps the history of modem psychiatric care in Nigeria and the entire Black Africa cannot be exhaustively discussed without full recognition being given to the work of Thomas Lambo. Thomas Lambo was born in Abeokuta, Western Nigeria in 1923. After obtaining his secondary education at Baptist Boys High School, Abeokuta, he later studied Medicine at the University of Birmingham in England. Lambo subsequently specialized in Psychiatry and obtained an M. D. degree.

Lambo at fifty-three, and within a relatively short span of formally qualifying as a psychiatrist, has singularly contributed over a hundred scientific papers to various scholarly journals[1]. And several of his papers lie on the frontiers of Biological Psy-

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1 Thomas Lambo's papers which are contained in two volumes can be found in the University of Ibadan Library. The papers were compiled by Professor Alexander Boroffka, formerly head of the Department of Psychiatry, University of Ibadan, Nigeria.

chiatry, Forensic Psychiatry, Social Psychiatry and Transcultural Psychiatry.

/p. 36/ Lambo first attracted international attention in 1954 when he published a series of reports on the neuropsychiatric problems among the Yoruba of Nigeria. He later convened the first Pan-african conference on Psychiatry.

He was the Medical Director of Aro Mental Hospital between 1954 and 1962. In 1963, he was appointed to the first Chair of Psychiatry at Nigeria's Ibadan University and in 1968, he became the Vice-chancellor of the University. In recognition of his work in the field of mental health in Africa, Lambo was appointed the Deputy Director-General of the World Health Organization, a position he rose to occupy having served as an Assistant Director General of the same body. Lambo has been conferred honorary degrees from various universities including one from his alma mater.

Judging from the extent of his work; it is necessary to take a penetrating and closer look at his ideas and contribution to our understanding of the range of the mentally in African societies. This short essay focuses on: (i) his ideas in relation to the etiology of mental illness; (ii) his model of psychiatric care ; and (iii) his overall contribution to the field of Psychiatry.

Lambo's ideas and model of mental health care

To understand Lambo's conception of mental illness, one must inevitably focus on his well-known paper, published over twenty-years ago, on "The role of cultural factors in Paranoid psychosis among the Yoruba tribe"[2]. This report reveals clearly the basis of his conception of mental disorder in a non-literate society and was, in fact to guide him in the development of a specific therapeutic model in later years. He demonstrated in this report that paranoid psychosis in the westernized African

2 Source : *Journal of Mental Science*, 101. 1955.

elite does not differ qualitatively from that seen in European culture and went further to propose an alternative hypothesis based on the influence of culture on normal and abnormal psychological reaction. He elaborated this point when be argued /p. 37/ that "there is no doubt that paranoid schizophrenia (and paraphrenia) might be ubiquitous but cultural factors can play important role in its clinical manifestations and therefore have a strong bearing on the entire management of the patients" (Lambo 1955).

Lambo found that in addition to constitutional and socio-cultural factors, the Incidence of mental illness among the Yoruba of Nigeria may be linked to environmental stress resulting from rapid social and economic change. The changing social relations in an agrarian society which was hitherto rooted in magico-religious belief-system and founded on closely-knit extended family unit, as well as the gradual erosion of the socio-oeconomic and integrative functions of the institutions of the family, be contended, constitute the chief sources of mental disorder, and some of the formally documented bizarre criminal conduct of people in these societies (Lambo 1959a; 1962).

It is not therefore surprising that Lambo, in place of a custodial model of psychiatric care which was already commonplace in Euro-American psychiatric tradition, initiated a program which, he claimed was "in full recognition that the African patient must be ideally treated within a social environment" (Lambo 1964; 1968). He however conceded that the philosophy behind the program was not in itself a new one[3], but suggested that the mentally ill were more likely to benefit from a treatment which took full cognizance of be very nature of the African social structure. To this end, the Aro Community Village Experiment was established very close to the ancient city of Abeokuta in 1954. Initially, twenty-six villages were involved in

[3] Lambo points out that "this approach has been practised for some hundreds of years at Gheel. Belgium, where the mentally ill are boarded out in households surrounding a central institution. It arose apparently out of a religious foundation".

the experiment and the program was designed and equipped to cater for two to three hundred patients[4].

/p. 38/ Acceptance into the program depends on the willingness of next of tin to accompany and live with patients throughout the period of intensive care. The next of tin share pan of the responsibility in the management of patients by cooking for them, escorting the patients to the clinic, doing their laundry as well as supervising them during rehabilitation.

The life of the patients and their next of kin revolves around two main buildings which serve as the treatment blocks. The main building is small, but equipped and partitioned into seven rooms – a conference room; a consulting room; a small laboratory; a waiting room for patients and their kin; two offices and an electroconvulsive treatment room. The second building is designed as an all-purpose facility and variously serves as a recreation room; psychotherapy unit; an occupational therapy centre and so forth. The main village in the program has a number of modem facilities such as electricity, piped water and modern accommodation in contrast to other rural areas of Nigeria.

The general orientation of the experiment has influenced the existing administrative structure of the community program. For Instance, all of the consulting psychiatrists who presently participate in the program operate mainly from the outpatient clinic in the University College Hospital at Ibadan, while the day-to-day supervision of the therapeutic centre is undertaken through a nursing superintendent. But one or two psychiatrists visit the therapeutic centre once a week when the patients' progress is reviewed. As of now, the chief nursing superintendent and seven other staff members closely supervise the patients during the day, and entirely at night when the centre is closed.

Normally, the patients and their next of kin invariably be-

[4] Community-oriented program were later established in part of Nigeria and other countries in Africa since Lambo initiated and gained recognition for the village Program. Unfortunately, these other facilities have not been closely studied like the Aro experiment. Such studies would have facilitated an instant comparison with this village program.

come part of the village community during intensive care. The integrative process is facilitated by the low structural differentiation, and the highly personalized social relation which are characteristic of a village setting. Moreover, various social events and festivals are marked in the village. Kin and patients are however peripherally involved in such activities and festivals which are organized in the village from time to time. They are also opportuned to participate in the services conducted /p. 39/ in the village mosque and church. Osborne (1969) found that Aro villagers had continued to give maximum cooperation and support to the experiment.

Lambo's conception of the role of cultural factors in the etiology of mental illness among non-literate peoples, and his awareness of the scarcity of human and organizational resources needed toward the implementation of a comprehensive mental health service in Nigeria appeared to have influenced his willingness to adapt the experiment to the social situation. First, traditional healers were encouraged to participate in the therapeutic program especially during psychotherapy. In this regard, the symbolic rituals of the traditional healers were found to be particularly useful in the management of the treated patients. Second, the overhead cost borne by the program during treatment has been substantially reduced because treated patients pay nominal fees while they (i.e., the patients) and their kin assume responsibility in matters relating to meals and accommodation.

It is indeed this model of psychiatric care that Lambo established in Nigeria. His numerous reports reveal the basis of this program, its therapeutic assets, and its relevance to most non-literate societies. By 1961, Lambo was in a position to assert that: "our work in Nigeria in recent years have served to highlight the present treatment methods. In the light of our experience, we are becoming more and more convinced that the effective-ness of mental health workers in the future will depend on their ability to have their therapeutic efforts on simple approaches, that is, approaches which take into consideration local tradition, social beliefs, and forms of family structure as the basis of mental health."

The elderly appear to be the most socially, economically and emotionally vulnerable in a rapidly changing society. For this category of people, the village program had proven to be an appropriate therapeutic milieu during emotional illness Lambo (1959a) argued: "cities are rapidly growing and the rural population is declining owing to industrialization and population mobility. The growing urban society is devaluing the position of its elderly membres. The traditional family system has little or no meaning for them. The new economic order tends /p. 40/ to eliminate the role of the elderly members at the societies and make them dependent. For the first three years, the elderly senile or arteriosclerotic patients were institutionalised at Lantoro[5] and in spite of a great care and attention there was very poor survival rate. From the time they entered an institution, they seemed to deteriorate almost at will. For the past two years, deserted elderly psychotics from rural areas have been put in nearby village community and encouraged to play some roles (e.g., selling vegetables, washing clothes, weaving, raffia work etc.). The importance to the patient is that she is doing something her self-confidence, self-esteem and self-pride are born anew. Their survival rate would seem good and their morale is high and so is their emotional state. Gradually we have encouraged family interest in them again".

Moreover, the young seemed to have benefited from this experiment too. In this respect, Lambo (1961b) suggested: "the village scheme is now found to be particularly suitable for treating psychotic children who are always accompanied by a great number of relatives, usually mother, an aunt, and a sister".

Above all, an important therapeutic asset of the community program lies in the possibility of procuring the support of significant others, and, of improving the attitudes of people toward the treated patients who would otherwise have been socially stigmatized because of their illness. On this theme, Lambo (1961c) claimed: "one of the most important lessons learned

[5] Lantoro Institution also in Abeokuta, was formerly a Native Authority Prison which was converted into an asylum many years ago.

during the course of our experiment is that this form of treatment provides the best avenue of dealing satisfactorily with family attitudes to the patients from the onset of treatment".

Although the fundamental principles on which Aro community experiment is founded constitute a remarkable landmark within the context of Africa, yet two unsettling problems abound in this model of mental health care. In a recent study, Erinosho (1975) found that the handling of emergency or aggressive patients poses a problem to the organizational infrastructure of the program. Next of kin in particular and the villagers are /p. 41/ sometimes unable to manage uncontrollable and difficult patients especially at night when the treatment blocks are closed for the day. Sometimes, harm is done by such patients before staff member who live nearby are summoned for assistance.

Second, next of kin who are not necessarily from around the catchment area where the program is located, undergo tremendous stress, and may sometimes fall in during their stay in the village. The staff members automatically assume the medical care for the physically ill next of kin. This implies that admitted patients as well as some next of kin may receive care during this period.

But the latter problem may be avoided if many more regional community-oriented mental health programs are established in Nigeria. Because mental health therapeutic facilities in Nigeria today are very few and far apart, several patients and their kin usually travel great distances to Aro experimental program for care. It would seem that the nearer a community-oriented program is to the normal abode of patients, the lesser the possibility of stress for the kin who tend to assume enormous responsibility during intensive care.

Discussion

It appears that a conceptual orientation has emerged from Lambo's work. An orientation which may be succinctly described as "culture-oriented". The orientation stresses the rote

of cultural factors in the etiology of mental illness and the therapeutic assets of native healing methods. The need to integrate recognizably competent traditional healers and some of their efficacious healing techniques is strongly reinforced by available evidence which suggest that literate and non-literate psychiatric patients in Nigeria utilize the services of assorted healers at the inception of mental illness (Lambo 1963; Asuni 1968). In order to make modern mental health care effective, it might be necessary to accommodate the native healing methods because psychiatric disorder is still well placed in the magico-religious belief-system of non-literate peoples despite the modernizing Influence through western education and religion. Indeed, a case for the role which native healers can play has /p. 42/ recently been emphasized by an expert committee of the World Health Organization[6].

More important, Lambo's work can be broadly examined within the context of current development in the field of Psychiatry. Currently, the approach to the management of psychiatric patients is marked by a definite shift from a custodial therapeutic system of care to a community-oriented focus largely because previous baseline studies by JONES (1953), Stanton & Schwartz (1954), Greenblatt *et al.* (1955), Caudill (1958) and Goffman (1961) have emphasized that a psychiatric hospital is like as small encased society that is underlined by complex dynamic processes which may in fact binder patients' post-treatment performance. The unanticipated dysfunctional consequences of institutional care for treated patients have generated the proliferation of varied models of mental health car such as sheltered houses, halfway houses, distress centres and crisis centres. Also current psychiatric orientation recognizes the role which socio-cultural and environment factors play in the aetiology, course and treatment of the mentally ill.

Finally, psychiatric rehabilitation is no longer pathology-centred; rather, rehabilitation now covers the restoration of the

6 Source : *West Africa*, N° 30115, 29th March, 1976, p. 428.

social and the psychological functioning level of the impaired individuals (Myers 1965). That restoration inevitably requires the participation of next of kin and significant others. It also entails an awareness of the broader socio-cultural milieu of the mentally ill, and the modification of the attitudes of significant others toward the mentally ill in order to facilitate re-integration of the treated patients. The recognition of these important parameters in the mentally ill has proven to be particularly relevant to the existing social realities is non-literate African societies, and obviously constitutes an apparent contribution to Psychiatry.

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SUMMARY:

The paper focuses on Lambo's ideas and model of mental health care for developing African countries, and his contribution to Psychiatry. Lambo's emphasis is on the rote of socio-cultural factors in the etiology of mental illness among non-literate people of Africa. Perhaps, this perspective accounts for his adoption or a community-oriented therapeutic program rather than a custodial model of care, as well as the utilization of the services of competent traditional healers in the management or patients. Indeed, a "culture-oriented" conceptual approach is strongly revealed in Lambo's ideas and by this therapeutic mode! of care.

RÉSUMÉ:

LE MODELE DE SOINS PSYCHIATRIQUES SELON LAMBO

L'article porte sur les idées et le modèle d'institution de santé mentale conçus par Lambo pour les pays africains en voie de développement, ainsi que sa contribution à la psychiatrie. Lambo insiste sur le rôle des facteurs socio-culturels dans son étude des causes des maladies mentales chez les africains analphabètes. Cette perspective pourrait expliquer son adoption d'un programme thérapeutique orienté vers la communauté, aussi bien que le service des guérisseurs traditionnels compétents au profit des malades de préférence à un modèle de séjour dans une maison de santé mentale. En fait, les idées et le modèle de soin thérapeutique chez Lambo révèlent une approche fortement orientée vers la culture.