

WITCHCRAFT AND PSYCHIATRY IN NIGERIA TODAY

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Introduction

Over the years, several articles have been published in the area of traditional medicine in Nigeria and its implications on the practice of psychiatry. The areas considered include the practice of traditional medicine (Odejide 1978; Makanjuola *et al.* 2000), its problems and prospects (Odejide 1978; Makanjuola, 1985, 1997) and its evaluation (Adelekan *et al.* 2000). The Yoruba people of Nigeria and Africans in general, believe that the physical universe consists of the Supreme Being, deities and gods resident in heaven, and human beings, witches and spirits resident on earth. They believe in the concept of unity of life and time. More importantly, they believe in continuous communion between the dead and the living, and also in the mystical and emotional bond between the natural and supernatural worlds (Makanjuola 1997). Among the Yorubas, the causes of mental illness, even though multifactorial, could be divided into three; natural, preternatural and supernatural. Natural causes include heredity, faulty diet, high fever and toxic drugs; preternatural causes are curses and witchcraft while supernatural causes are offences against gods or ancestors (Odejide 1978; Makanjuola 1985).

The belief in witchcraft has therefore become an ideation among the average Nigerian irrespective of his/her educational and socioeconomic background. While this would constitute a grave danger to health seeking behaviour among patients/relatives

of people with mental illness, the situation is even more ominous when health workers seem to be increasingly co-opted into this belief system in witchcraft. This appears paradoxical, as an increased medical knowledge would be expected to be inversely proportional to degree of belief in superstitious forces especially in the area of medicine.

/p. 190/ This article, which dwells on belief in witchcraft and psychiatry in Nigeria today, is aimed at one, providing some insight into an issue that is not usually discussed openly (possibly for fear of retribution) even though it has a far reaching implication on the management of psychiatric patients. Two, provide a platform for further and more robust discourse about witchcraft phenomenon especially among medical colleagues and three, reinvigorate efforts to demystify a concept that seemed to have served some purpose among the early man but unfortunately now staging a more dangerous comeback to the medical/mental health scene especially among medical and paramedical practitioners.

Brief history

Witchcraft is a term for the principal means by which humans have been thought to work magic, that is, to bring about practical changes by their own will and employing supernatural means. Witchcraft needs to be distinguished from religion, in which humans are totally dependent upon divine beings to grant their wishes (Microsoft Encarta Encyclopedia 2000), and sorcery, in which supernatural skills are acquired by a process of study, usually involving books and apprenticeship to a master or the use of evil magic against others by employing herbs, medicines, charms, etc. (Neki *et al.* 1986). Witchcraft was regarded partly as an innate power, and partly as something that was handed down, by a wholly or largely unwritten tradition (Microsoft Encarta Encyclopedia 2000). It is a phenomenon

that is well rooted in the culture of most societies in the world especially in Africa. This is evidenced by the fact that various cultures in Africa have terminologies for witchcraft in their idioms and languages. For example, the Swahili¹ has the expression *ulozi* for it (Neki *et al.* 1986) while the Yorubas of Nigeria even distinguish between the male witch (*Oso*) and the female one (*Aje*).

Witchcraft seems to have developed with the existence of man. Irrespective of the society considered, it seems to have developed as a protective measure in reaction to a society's helplessness. This helplessness could be in terms of poor understanding of natural phenomena (e.g. rainbow, rainfall, drought, epidemic), poverty or economic downturn or of political sophistication.

In Africa, witchcraft phenomenon has become a subcultural belief or ideation. It was probably used as a defence mechanism to enable individuals cope with life events, especially the ego-dystonic ones. It could therefore be readily used to explain low farm yield, infertility, failure in academics, illness, complicated labour or delivery. When used to justify the existence or incidence of these events, the person usually receives pity and assistance (spiritual, financial and/or trado-medical). He/she is therefore relieved of the need to introspect, examine where he/she has contributed to the occurrence of the event and therefore take steps to prevent recurrence. The process of introspection could generate a lot of psychological phenomena ranging from projection, anger, self-blame, denial, and calm acceptance to anxiety. If these phenomena are properly resolved, it tends not only to strengthen the individual affected but also produce a better personality. Blaming someone or forces for one's woes seems easier than a careful and methodical introspection. However, it is not only intellectually lazy, but creates chance for recurrence of unwanted events. For the Afri-

¹ pronounced 'kiswahili' and spoken in Kenya, Tanzania and some parts of East and Central Africa.

can, events that are unwanted and ego-dystonic are usually attributed to preternatural and supernatural forces such as gods and witchcrafts (Odejide 1978; Makanjuola *et al.* 2000). The resultant effect could be psychosocial stability among individuals and kinsmen, calm acceptance and search or hunt for the 'witchcraft'. It could also task individual's defence mechanism or coping strategies. Failure of the mechanism/strategy could result in mental illness, especially in a predisposed individual.

Factors that sustain the belief in witchcraft

Cultural factors

It is not uncommon for parents to reprimand their children by associating or coupling objectionable behaviour to a witch. For example, a mother could say to her child "Why are you staring at me like a witch?" or "You are wicked; you must be a witch!" Over time, the little child unconsciously conceptualizes the picture and attributes of a witch in his/her mind and carries it into adulthood. He/she passes the belief to her offspring and so it goes from generation to generations.

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Religion

Apart from culture and education, religion seems to be another powerful force of change in people's lives. Most religions in Africa and Nigeria today, including African Traditional Religion (ATR) that had been in existence before the advent of the modern ones such as Christianity and Islam, believe that the devil exists and brings evil to man using its agents such as witches. According to these religions, the only way to counter the power of the devil and its agents is by believing in and worshipping the Supreme God. As long as this doctrine is preached and believed in by the worshippers, the belief in witchcraft might persist.

Reinforcement by medical personnel

Medical personnel would have constituted a powerful group of role models who can ameliorate the belief in witchcraft. Unfortunately, in Africa today, an increasing proportion of medical/paramedical practitioners seem not able to draw a line between their religious/cultural beliefs and clinical practice. A significant proportion of the very group that should help in underplaying or dismissing the role of witchcraft in the causation of illnesses is currently the same one reinforcing it due to cultural/religious leanings. Two anecdotal cases are cited here as illustration.

Case 1: Mrs A is a 52-year-old trader with four-year history of hypertension. The Blood Pressure has been poorly controlled due to poor compliance with medication. She would come to the clinic on her appointment days, collect her prescription paper but will not buy the medication. On one of her appointment days, she told the attending doctor she had received divine healing and would no longer need medical treatment. The doctor then joined hands with her and prayed that her hypertension will remain 'cured' by divine healing.

Case 2: Mr B is a 35-year-old unemployed man with three-year history of paranoid schizophrenia. For a year prior to presentation, he was managed by a General Practitioner and was placed on Tabs Amitriptyline 25mg nocte, Tabs Haloperidol 10mg t.d.s, Tabs Chlorpromazine 100mg nocte and Tabs Benzhexol 5mg t.d.s. Because of poor response, patient was referred to the psychiatric unit at the University of Ilorin Teaching Hospital, Ilorin, Nigeria. On review, the diagnosis was confirmed to be paranoid psychosis and patient's drugs were readjusted to Tabs Haloperidol 10mg t.d.s and Tabs Benzhexol 2.5mg t.d.s in the first instance and to be graduated upward depending on patient's response. At a dose of Haloperidol of 20mg q.d.s, patient was not yet mentally stable and /p. 193/ extrapyramidal side effects had already started appearing. Electroconvulsive therapy could not be used because the machine was not functioning. At this point, patient was to be placed on atypical neuroleptics. While arrangement was being made to procure

the atypical neuroleptics, a resident doctor was seen praying for the patient. When asked why, he claimed there seem to be more to the patient's problem than drug resistance. That is, the devil is at work!

Though it is expected that medical education should change or modify the beliefs of medical and paramedical workers about the causation of illness, recent anecdotal observations show that an increasing proportion of this group is becoming strongly influenced by religious doctrine. Some of these doctrines tend to reinforce their belief in witchcraft. While we should respect the rights of individuals to choose a religion and worship according to his faith, such religious beliefs must not be allowed to interfere with medical practice and ethics. The anecdotal cases cited above show how religious beliefs, if not properly handled, can obscure one's clinical judgment and actions. Case 1 could have needed proper individual, marital or family counseling and even social workers' intervention to ensure compliance with medications. In Case 2, could the resident's action be a reflection of his poor knowledge of psychiatry/management of drug resistant cases? Or is it a reflection of absence of humility to accept one's limitations, which should have necessitated proper referral to a more experienced colleague or a better-equipped centre? Equally important, couldn't patient's relations erroneously interpret the resident doctor's prayer as an indication that patient's case could not be helped medically and should therefore be committed to God? The relations may therefore request for discharge, present at a traditional or religious healer's home with all its attendant problems (Makanjuola 1997) or take patient home to await death. In addition, patient's relatives might erroneously inform other community members that even the western doctors said their case is beyond medical knowledge and that the doctor even prayed for them. By this action many patients who would have otherwise presented in the hospital might not do so. The resident doctor might presume he has performed 'a simple religious obligation' by praying for a patient, but its effect can be a multiplier one as shown above. Every

effort should therefore be made to encourage health practitioners to always remember to draw a line between their religious beliefs and their medical profession.

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Promotion of programmes that reinforce belief in witchcraft and sorcery

In Nigeria, most electronic and print media tend to broadcast programmes that are aimed at promoting African traditional medicine. While this effort is commendable, unfortunately the practitioners tend to use it to perpetuate issues such as witchcraft. This is done consciously or unconsciously while explaining the aetiology of illnesses. In order to stem this trend there is need to censor the programmes. Though efforts are being made by the National Council on Communications to censor these programmes, the result has not been remarkable.

Identifying and convicting a witch: what is the evidence?

Typically, witches, according to the ancient stereotype, are usually females, sometimes midwives and traditional magical healers. More often, however, the latter were among the hunters, deploying their specialist talents to detect the person responsible for bad witchcraft. Some of those executed certainly believed that they had committed the crimes alleged against them, if only in dreams, but all were totally innocent according to modern notions of how the universe operates (Microsoft Encarta Encyclopedia 2000). Previously in Europe and America, the normal pattern of prosecution was for ordinary people to denounce a suspected witch from their community, and for magistrates to arrest and try the accused person. In normal circumstances, the trial was careful and the defendant had an 80 per cent chance of acquittal. Circumstances became horribly

abnormal where the magistrates were closely associated with the local population and caught up in their fears. In that situation the proportion of acquittals to convictions was reversed, and the magistrates would employ torture to make the victim name accomplices, producing a snowballing pattern of arrests. This seems to explain why the worst areas of the hunt were Germany because of its division into many little states, and Scotland, with a decentralized system of justice. That is also why there were no executions in the Popes' own territories, and why the Spanish Inquisition banned witch-hunting in Spain; the authorities in both cases felt too secure to regard the hunt as other than a nuisance. In Europe, Asia and America, the hunt began to /p. 195/ diminish after 1632 as one set of rulers after another came to recognize that it had yielded no positive benefits, and that the struggle between Catholicism and Protestantism had been inconclusive. In one state after another the death penalty for witchcraft was abolished, and the last execution was in Switzerland (where the first had occurred) in 1782. Ordinary people continued to resort to presumed witches for magical aid all over Europe until the 20th century, when a disbelief in magic became general: many of the traditional skills of the magical healer have since been taken over by practitioners of natural therapy and complementary medicine (Microsoft Encarta Encyclopedia 2000).

In Africa, however, the belief in witchcraft does not seem to have abated much. Belief in it is the norm rather exception. This belief cuts across socio-educational and religious strata. More seriously, the belief seems to be having a relative resurgence especially among the medical personnel. The process of conviction is similar to that in Europe. When a person suspected of being a witch is mentioned as being responsible for a calamity, the accused will be confronted publicly or privately. He/she may 'agree' or 'not agree' to the accusations. More often than not, it is not the response of the individual that matters but degree of suspicion by the community that he/she is a witch. Once presumed guilty, a punishment is pronounced

which may vary from beating to eviction or even death. It is obvious that the 'trial' is unfair and based on subjective reasons rather than facts. But in these societies, the accused, the plaintiff, the jury and the community have a congenial belief in witchcraft. Nobody therefore seems to need evidence before convicting a 'witch' nay a mentally ill person or even a person with personality disorder or is it even a normal person with a little bit of eccentricity or none at all?

Witchcraft phenomenon and aetiopsychopathogenesis of mental illness

As a manifestation of psychiatric trait

Most societies have a well-developed idea of what a witch should be like; a person living within a community but set apart from it by a reserved temperament and odd habits (Microsoft Encarta Encyclopedia 2000). Identifying someone as a witch may therefore /p. 196/ be a society's conscious or unconscious way of labeling a person with personality disorder or oddity in behaviour, especially when this behaviour is not severe enough to be labeled a psychiatric illness. This will vary from society to society depending on how permissive the society is. For example, a reserved man in a predominantly extroverted culture might be a complete gentleman in predominantly introverted one. By extension, a person labeled a witch in a community might be labeled normal in another.

As a precipitant

In Nigeria, it is not uncommon to be told that one has been bewitched or that by one's action or inaction, the witches have been offended. For these insinuations to have psychological effect, the person must believe in the concept of witchcraft and

if we are to adopt the stress-diathesis model of aetiology of mental illness (Meise *et al.* 2001), he/she must be predisposed to having mental illness with the witchcraft tales acting as stressor and precipitant (Lambo 1962).

As a symptom

The language of expression of a people is highly modified by their culture. Each person, healthy or mentally ill, expresses him/herself in the idiom of his culture (Neki *et al.* 1986). The most important issue is for patient's behaviour or complaints to be within the norms as determined by the society. It is therefore not unusual in Africa for patients to present with symptoms of mental illness in which witchcraft phenomenon is a significant manifestation either as the agent of persecution, agent of passivity (made affect, made impulse) or even agent of thought alienation (withdrawal, insertion, broadcast). Patient could also complain of witchcrafts sharing his/her flesh or having removed a vital part of the body e.g. heart and brain and yet, the patient is alive. Some patients also claim they have been initiated into witchcraft. The society tends to believe these stories and often explains some oddity in behaviour of the patients e.g. grimacing, posturing, delusion of guilt and nihilism as proof of actually being a witch. Most of these patients do not have the opportunity of receiving orthodox psychiatric care within a short period and therefore carry these symptoms, stigma and insinuations /p.197/ for a long time to the extent that people tend to believe them. The picture could have been different if the patients receive prompt care, have insight and promptly renounce the statements that were said when they were mentally unstable.

As a factor in treatment modality

Most Africans, irrespective of their educational and socio-cultural background, believe in supernatural and preternatural forces in the causation of mental illness or even other medical

illnesses. The degree to which this belief is expressed seems proportional to the degree of stress being experienced at a point time. A fairly financially comfortable and emotionally stable person might readily not acquiesce to that belief. However, when there is a downturn in fortune and social stability, which weighs down the defense mechanisms, it is not uncommon for the belief in witchcraft to be more forcefully expressed. This point must be borne in mind by a therapist practicing in Africa at all times. The therapist should therefore pay particular attention to all cues that might suggest a strong belief in witchcraft and most importantly, distinguish whether it is still at the level of subcultural belief, ideation or delusion. A careful identification, appraisal of the degree of belief in witchcraft by a patient or the relations and giving it a prompt and tactical address, will go a long way in conferring a better sick role, better insight, better drug compliance, better stay in therapy, and a better quality of life.

Witchcraft as a socio-political tool

Most human societies believe in witchcraft, and indeed the modern Western societies at various times of their development also believe in it. Traditionally, people have treated witchcraft in two very different ways. On the one hand they have resorted to specialists in it for their benefit: to be freed from suffering, to injure enemies, or to obtain what they desire. On the other, they have blamed it for their own misfortunes, and set out to identify and punish the witch responsible for using the power against them. We may therefore theorize that this dual approach to the 'myth' of witchcraft seems to create some political equation of checks and balances in traditional /p. 198/ societies. The powerful in the society exercises some caution because he/she believes some unseen groups or forces or phenomenon (witchcraft) could stem or cut him/her down. By this way the

powerful and mighty are cautious not to oppress the weak. The person who claims to be a witch is also conscious that he/she might enjoy some powers as long as he/she is identified with good or white witchcraft.

Conclusion

The concept of witchcraft can be regarded as a myth. But like most things developed by man, the concept was not totally useless as it served the early man in organizing his society and in coping with stress when used as a defense mechanism. However, it was a concept that hindered the development of man by stunting his appreciation of the scientific basis of illness. It also led to untimely death of many during the witch-hunt era. Like most things in the history of man, witchcraft should, by now, be confined to medical history. Unfortunately, the belief is still rife in Nigeria and seems to be staging a dangerous comeback among medical and paramedical personnel. This trend should be discouraged through mass education, inclusion of witchcraft as a topic (with specific aims and objectives e.g. history, demystification etc.) into the curricula of medical schools, postgraduate medical colleges, schools of nursing and other paramedical schools. Non-governmental organizations with specific programmes on eradication of non-health promoting beliefs and traditions in our societies should be promoted and assisted. Where applicable, programmes that reinforce non-health promoting beliefs and traditions should be censored.

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SUMMARY:

The article dwells on belief in witchcraft and psychiatry in Nigeria today. It is aimed at one, providing some insight into an issue that is not usually discussed openly (possibly for fear of retribution) even though it has a far-reaching implication on the management of psychiatric patients. Two, provide a platform for further and more robust discourse about witchcraft phenomenon especially among medical colleagues and three, reinvigorate efforts to demystify

the phenomenon of witchcraft. It examined, briefly, the history of witchcraft, factors that tend to sustain the belief, the relationship between it and aetiopathogenesis of mental illness and its implication on management. It concludes that witchcraft phenomenon is a myth and offered suggestions on how to stem down the belief in the society at large /p. 200/ and most especially, among health professionals. It is hoped that the article will improve the understanding of aetiology of mental illness among the public, caregivers, policy makers, patients and health workers. This would go along way in improving early presentation, early referral, better scientifically oriented treatment approach, better stay in treatment and finally a better quality of life of mentally ill patients.

Key words: • Witchcraft • Psychiatry • Nigeria

RÉSUMÉ :

LA SORCELLERIE ET LA PSYCHIATRIE AU NIGÉRIA AUJOURD'HUI

Cet article insiste sur les rapports entre la croyance à la sorcellerie et la psychiatrie au Nigeria aujourd'hui. Il a pour objectif : 1) de proposer une réflexion sur une question qui n'est généralement pas discutée ouvertement (peut-être en raison de la crainte de représailles), bien que cette question aie des implications fort importantes pour divers aspects du traitement qui est proposé aux malades mentaux ; 2) de proposer une plate-forme pour un débat à poursuivre et une prise de parole plus ferme sur le phénomène de la sorcellerie, particulièrement parmi les collègues médecins ; et 3) de tenter des efforts revigorés pour démystifier le phénomène de la sorcellerie. Il examine brièvement l'histoire de la sorcellerie, les facteurs qui tendent à soutenir et conforter la croyance, la relation entre elle et l'étiopathogénie de la maladie mentale et ses implications dans son traitement, dans sa gestion. Il conclut que le phénomène de la sorcellerie est un mythe et avance des suggestions pour lutter contre la croyance dans la société en général, et plus particulièrement dans le milieu des professionnels de la santé. L'auteur espère que l'article contribuera à faire progresser la compréhension de l'étiologie de la maladie mentale dans le public, parmi les soignants, les décideurs politiques, les patients et travailleurs de la santé. Cela serait de nature à favoriser une présentation plus rapide des patients aux services de soins, une approche des soins mieux scientifiquement fondée, un meilleur suivi des soins et enfin une meilleure qualité de vie pour les patients malades mentaux.

Mots clés : • Sorcellerie • Psychiatrie • Nigeria