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# The Indigenous Medical Knowledge Systems, Perceptions and Treatment of Mental Illness Among the Yoruba of Nigeria

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## Abstract

Studies in African indigenous medical knowledge and the perception and treatment of illnesses require a significant intellectual concern given the interface of indigenous knowledge and health. This paper seeks to argue that there exist an indigenous peoples' medical knowledge systems and these influence their perceptions and treatment methods of mental illness. The research was conducted by using ethnography to elicit data on how indigenous knowledge is connected with the conceptualisation of mental illness, how this constructs the treatment strategy and then enhances the effectiveness of their practice. The *Yoruba people of Southwest of Nigeria* have an indigenous knowledge system that is technical. The paper concludes that indigenous medical knowledge system in the treatment of mental illness is efficacious in the treatment of different kinds of mental illnesses. It will be foolhardy to underrate and cast aspersion on this kind of practice especially among indigenous practitioners.

**Key words:** Indigenous; Treatment; Practice; Ritual

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## INTRODUCTION

Indigenous medical knowledge, in this paper refers to the knowledge system in Africa as exemplified among the Yoruba of Southwest of Nigeria, that exist in Yoruba Tradition and employed for the treatment of mental illness. It involves what the indigenous people know and do, and what they have known and done for generations Hall and Rosenburg's (2000), (Malchias, 2001). It is the knowledge of the people about how to prevent, manage and cure mental illness. This knowledge is transmitted from generation to generation. This indigenous psychiatric system is sustained by micro-level institutional arrangement vested with special responsibility that ensures mental wellness (Eyong, 2005). Unfortunately, these knowledge systems are fast eroding due to colonialism, comercialisation, globalisation, lack of proper commodification and codification. Vandana Shiva (2000) states that indigenous knowledge is a pluralistic system that has been delegitimized by western science. The neglect of this aspect of African medical knowledge systems is not only of a great loss to Africans but to the whole world. This is because a problem solving system of a people might be lost forever if proper attention is not given to it now. The World Bank (1991) holds that indigenous people are social group with a social and cultural identity distinct from the dominant society that makes vulnerability to being disadvantaged by the development process (Cobo, 1987). Estimates show that there are approximately 350 million indigenous peoples in the world representing about 5% of the total world population. It has been reported that between 300 and 500 million indigenous peoples speak a vast majority of world languages and represent the majority of cultural diversity (Melchias, 2001) and knowledge systems we must preserve for posterity

## 1. INDIGENOUS MEDICAL KNOWLEDGE AND YORUBA MENTAL HEALTH SYSTEM

Although responses to mental illness have been largely constructed only on a scaffolding of Western

, biomedical understanding of health and illness, Indigenous medical knowledge system is therefore a grey area; vast, unexplored and neglected (Jeliffe & Bennet, 1960; Abbas & Broadhead, 1997; Jenkins, 1997). According to Odejide et al. (1978), quoting Adeoye Lambo, and Ademuwagun (1973) claim that traditional healing knowledge system have survived alongside and can co-exist with Western medicine. Lambo was said to have experimented with the fusion of traditional treatment of mental illness and Western psychiatry in the first indigenous psychiatric hospital. Lambo started his own out-patient treatment services in Aro village, at the outskirts of Abeokuta, Ogun State, Nigeria, pioneering the use of modern curative techniques with traditional religion and native medicines. He travelled around and brought in a few traditional healers from different parts of Nigeria. He also sought the help of farmers near the asylum to take on some of the patients as labourers, while the patients simultaneously underwent medical treatment. The patients paid for services such as accommodation. The experiment proved to be very successful.

According to Laosebikan, Thomson, Naidoo (2000), mental illness and its treatment did not make its appearance with the coming of urbanization. Modern psychiatry began in Nigeria in the early 1900s, while the first asylum was started in 1907 (Asuni, 1986). Prior to this, traditional healers carried out treatment of psychiatric cases. Forster, (1963), Prince (1960a, 1960b) stated that traditional healers were successful in the treatment of psychoses and neuroses. According to Asuni, Schoenberg and Swift (1994), traditional healers could recognize symptoms of severe mental illness; however, such disorders were attributed to supernatural factors. The early 1900s period, witnessed the emergence of the African Psychiatric Association (APA) and its publication, the *African Journal of Psychiatry*, along with pioneering collaboration between psychiatrists and indigenous healers.

According to Lambo (1963), the Western treatment model was oriented only towards psychoanalysis, following similar or related training of the psychiatrists. After gaining the confidence of the people at Aro village, Lambo recruited traditional healers who specialized in the treatment of mental illness. It was compulsory for patients to be accompanied by a member of the family or a caregiver. Patients were made to live in the village where they were lodged by the villagers. Lambo took it upon himself to see to the welfare of the patients and of the hosts and he supervised the occupational and other therapeutic strategies by the people (Lambo, 1964). This method was reported to have been very successful as patients were made to socialise with the villagers among whom they lived instead of being hospitalised in the hospital ward. The healers were reported to have helped in the interviewing, diagnosis and treatment of patients. With this approach, Lambo realized that an average patient stayed at Aro for six months whereas those who lodged in the village or were admitted took longer before being discharged (Lambo, 1956). In the decades since Lambo's experiment, there has been an increasing recognition in many countries of the fact that orthodox and traditional medicines complement each other.

Also, an increasing concern to African scholars is the inadequately stressed missing link between culture and mental health. Since health is an important aspect of development, in Ogot's (1998, pp.140-141) words, "There is therefore a need to put cultural identity at the centre of development paradigm". Ake (1993, p.19) refers to this as the "building on the indigenous of self reliance to which there is no alternative". It is only when we come to terms with this that mental health in Africa can become sustainable; hence the need to insist on *radical* alternatives.

It is in this regard that Servaes and Arnst (1994, pp.2-4) argue that it is about time the poor and the illiterate who have always been researched, described and interpreted by the rich and the educated "became actively involved in, and why not take over, research on their predicament especially, as often, they best know their situation and have a perspective on problems and needs that no outsider can fully share". This is in line with the call for participatory research and representation systems engendered in the need for group, local and indigenous platforms in the face of increasing centralization and synchronization (UNESCO, 1980, pp.55-7).

Cross-cultural studies have revealed that many non-Western cultures have enlightened concepts of mental health which are complex and meaningful (Snowden, 2003; Fabrega, 1992). The influence of culture on people's psychiatric traditions has led to a broader range of therapeutic philosophy and culture (Good, 1993; Lopez & Guarnaccia, 2000).

## 2. MATERIALS AND METHOD

Out of the six states that comprise the south-west geopolitical zone of Nigeria, the study selected Ogun, Osun and Oyo states. The informants and the places were purposively sampled. The purposive choice of informants from specific places in Yoruba land was to engender a comprehensive generation of data. Our choice of respondents and places for this research was informed by years of experience of the practitioners and the level of patronage. Since the subject matter is based on the knowledge system of Yoruba people on the treatment of mental illness, these individuals were best positioned to speak about the subject as they were adequately equipped with knowledge of Yoruba healing tradition as embedded in practice and oral literature. In these states, we located traditional mental healing homes and their healers who

were also founders of the homes. In Osun State, we visited one home in Erin-Ijesa and another in Ilesa. In Ogun State, the Aro Mental Hospital, the first mental hospital in Nigeria was selected because of its significant contribution to mental health through the combination of the orthodox and traditional approach. Ogun State has many traditional mental healing homes. In-depth interviews with key informants and observation were used to elicit data for this research.

The investigation was conducted in five such homes—two in Abeokuta, the state capital; one in Alakija village and two in Emuren in Remo Province of Ogun State, western Nigeria. Emuren is known to be versatile in traditional healing especially in the treatment of mental illness. Emuren, a village of about 1,000 square metres, has 12 practitioners, each with his own mental healing home. In Oyo State, the research was conducted in Igbeti, a town in the western part of Nigeria which is surrounded by a hill. In Igbeti, we worked with man of 127 years of age who has been practicing traditional medicine especially the treatment of mental illness for over 80 years.

The research lasted for five months. The researchers employed an emic view to evaluate and interpret the data received, which was carried out on a daily basis at the time of the interviews. For the practitioners, the treatment of mentally ill people is, on its own a profession, specialized field that emanates from the indigenous knowledge system of the Yoruba. This claim was hinged on the fact that nobody becomes a practitioner only by choice or by inspiration, he must have been trained and the knowledge can as well be passed from generation to generation. Therefore, it is important that the practice is regarded as a knowledge system that though do not follow the euro-centric epistemology but rather that of afrocentric epistemology. By implication, every people generate knowledge in accordance with their experience and environment. We can therefore claim that before the colonisation of Africa, there was indigenous psychiatry; a knowledge system that was being employed to prevent, manage and treat mental illness.

## 3. DISCUSSION

### 3.1 Mental Illness, the Dreaded Illness Among the Yoruba of South-Western Nigeria

Mental illness among the Yoruba of south west Nigeria is not regarded as one of those illlnesses such as malaria, rheumatism, stomach ache, HIV and AIDS and other pathological illnesses, it is an illness that inspires great fears. Whether it is curable or not is not the issue—the stigma affects not only the mentally sick but also his or her family. This explains the reason why in Ifa, a repository of the Yoruba oral tradition in the *odu Owunrin dagbon*, there is a prayer:

Ma je n sinwin
Ma je ka binu ti ntule
Ma je ka ni suuru ti n pa a yan
Ma je ki ori wa o daru
Ma je ki ori wa o gbona bi ologun oru
*Ma je ka ri eni ti yio fi were dan wa* wo

Do not let me be suffer of mental illness
Do not let me get angry to the extent that I will disorganize a home
Do not let me have dullness that will endanger my life
Do not let me suffer mental illness
Do not let our heads be as hot as someone with night madness
Do not let us meet a person who will inflict us with madness

The Yoruba also sing or beat the drum to the following prayer:

Bi o san ko san
Bi o san ko san
*Olorun ma fi were ba wa ja*

Whether it will be cured or not
God, do not tempt us with madness
Whether it will cure or not

The Yoruba people prefer death to being afflicted with mental illness. Hence the saying, *iku ya ju esin aye* (death is better than infamy). It is the worst of all illnesses, the ultimate shame and misery not just on the sick person but more importantly on the family. It is regarded as the most painful illness; but the ill person does not feel the pain. It can best be described as the peak of calamity. A healer described the disease as *arun ti o nsan ti oruko re ki i san* (sickness that may be curable but the stigma incurable).

Any family in which mental illness is known to have occurred stands the risk of being stigmatized and ostracized. One of the important investigations that should be made if one wants to get married into a family is to establish whether anyone of its members has suffered mental illness. If a trace of mental illness is found, every measure is taken (including the use of mysterious powers) to see that the marriage does not take place. When we asked the *Yeye Saloro* of Ijesha land, Chief Mrs. Abebi Kila, she claimed that it is not a question of stigma but that it is not good for the community. She further asseverated that if this is encouraged, it would spread madness through the land. If the indigenous Yoruba of south-western Nigeria have the official backing of the WHO and other health agencies, the illness that would be fought more vigorously is mental illness, not HIV and AIDS. They would commit more energy, time and money to the prevention,

treatment and management of mental illness as well as dealing with the question of stigma.

Although health in all forms is very important, the most important is mental health. This can be seen in the following saying:

Ko si ohun to dun leyo
Bi i ka ji ki opoplo eni o ji pere pere
Bi i ka ji kara eni o le koko bi ota.

Nothing can be more important
Than to wake up and be mentally healthy
Nothing can be more important than to wake up and be
As strong as stone

Hence the Yoruba prayer:

Ma fi'ku ba wa wi o
Ma fi were ba wa ja
Bi o san ko san ma fi were ba wa ja

Do not punish us with death
Do not fight us with madness
Whether it will be cured or not
Do not fight us with madness.

The prayer above shows that madness *(were*) is one of the evils with which the gods can punish someone who has broken a taboo. So people pray against this kind of disease even if it will be cured.

Knowing the devastating effect of mental illness, Yoruba people have devised various means of prevention, cure and management of the disease. Mental illness, treatment strategies, place and practice are couched in the peoples' norms and customs within the cultural environment, all of which influence health-seeking behaviour. In spite of the work of Lambo (1963) and Morakinyo (1983), the roles of the traditional healers in the healing of mental illness have not been widely acknowledged.

The general name for mental illness among the Yoruba of south-western Nigeria is *were*. The sickness can also be referred to as *arun opolo,* which means sickness of the brain. A mentally ill person is known as *asinwin*. Sometimes, the words are used interchangeably, as a mad person is also known as *were*. However, a mentally ill person is not yet *asinwin* or *were* until the person's condition is a public knowledge, basically when people see the severity of his or her condition. After this initial appearance, mentally ill people are generally referred to as *were alaso*, that is, a mentally ill person who still wears clothes; and the illness cannot be identified until he or she starts to talk or behaves abnormally. Thus, it is the behaviour and the way the person talks that would make members of the public aware of their mental health—until the individual shows some anti-social behaviour, he/she is referred to as *were alaso*, but not yet *asinwin*, a state of madness that can no longer be hidden.

When a mad person goes about nude, tattered or is perpetually aggressive, the individual is referred to as *were to ja ja,* which can be translated as "the madness that has ran through the market". However, according to one of the respondents, it can be translated as "madness that is now being advertised or marketed". The patients now display their condition to the public, without the sense of shame and the connection with reality is completely lost.

The general public, especially in Ijesaland of Osun State, gives strange and funny names to mentally ill persons. Some of the names of mad people in Ilesa are *ponjolosun* (somebody who is abnormally fair in complexion or like an albino); *sokilojiji* (somebody who appears suddenly to attack or wound people); *doledole* (one who digs a hole on the ground and inserts his penis in order to have sex); *saworosasa* (one who has a string that makes noise). They are given these special names based on their physical appearances and strange behaviours. Some mentally ill persons become a public menace when they cause havoc. In 1975, for example, a mad person halted activities in Ilesa for more than four hours and kiilled nine people including an entire family. In 1984, a mentally ill person killed Aladokun, a famous healer who was also known to be a powerful medicine man. Also in 1989, it was reported that a mad person in Ilesa gruesomely murdered two of her children. The same deadly scenario took place in 2002, in Ondo State, when a mentally derailed person killed seven people. News of how mentally derailed person kill, maim their children, mothers, father or wives, neighbours abound in Yoruba land and Nigeria as whole. In one of the healing homes where our investigation took place, two of the in-patients were reported to have attempted to kill the children of the healer and three attempted suicide. At Adikuta healing home in Abeokuta, Ogun State, Nigeria, the healer narrated to us, a case of two mentally ill people who fought, and one killed the other.

When mental illness gets to this level, family members begin to dissociate themselves from the person; some mentally ill people walk away from home to exhibit their madness in distant towns. At other times, some of them come home occasionally, a situation that increases the agony of the family as well as creating fear in the people around. Mentally ill people are also generally referred to as *omo ijoba* (children of government) and seen as people without family who is responsible to nobody and nobody is responsible for them. What has made them children of the government is that they are not accountable—if they kill, steal, harm or maim, they are protected by the law. In other words, whatever they do cannot be considered good or bad as they are not subject to the law or any ethical principle. It is sometimes impossible to get a mentally ill

person to voluntarily give themselves over for treatment unless by coercion or arrest. However, if anyone kills, or beats a mad person or stea is from one, that person is liable.

This explains why families tend to hide their mentally ill members to prevent the agony of public ridicule. As a result, some benign mental problems become malignant, because patients are kept at home without adequate attention. Most Yoruba will do anything to make sure that the sickness is not known to the outsiders. When visitors come, especially when the sick person is not manifesting any form of abnormality, they can give the sickness another name such as acute malaria (*iba gannangi*, or phrenitis because it is associated with another disease) or heat (*igbona*). Family members make spirited efforts to prevent visitors or outsiders from suspecting they have a mentally ill person at home.

However, when the ill person is kept at home untreated for too long, the sickness can get unduly complicated, and the patient can force himself/herself out. We noted that when a mentally ill person constitutes a threat and the shame is becoming known, members of the family force the person to go to a distant town, village or into the bush so that the stigma is covered up. This departure is not achieved through ordinary persuasion, rather, a strong *epe* (curse) or *ase* (potent medicine) can be used to chase the ill person away, especially to the bush or forest. To do this, the family may hire the services of a medicine man to make sure that the ill person does not come near the home anymore. The healing, according to a respondent, is not as important as the stigma. Even when a mentally disturbed person is healed, the stigma is incurable.

### 3.2 Treatment Strategies

In traditional medicine, a healer's expertise is determined not only by the efficacy of the herbs he knows but also the magnitude of his understanding of natural laws, and his ability to utilise them for the benefit of the patient and the community at large. Therefore, treatment is not limited to the use of different leaves, roots, fruits, barks, grasses and various objects such as minerals, dead insects, bones, feathers, shells, eggs, powders and smoke from different burning objects for the cure and prevention of disease

The therapeutic methods range from the simple, the bewildering and the rational to the most sublime, depending on the method of the healer was taught while in training and his spiritual inclinations. For example, Airhihebuwa (1995) observes that the prescriptions represent a fascinating combination of empiricism and sympathetic magic. Some of the herbs indeed contain some pharmacological components which determine the therapeutic relevance. For example, the orange leaf has the nature of human heart and so it is good for the cure of heart-related diseases. Treatment programmes take many forms, but specifically tailored to the needs of patients. The treatment approach is determined by the symptoms, discovered aetiology, and diagnosis. The symptoms can be classified as follows: the physical, the bio-medical and the metaphysical/spiritual. The goal of the treatment strategies is to restore a state of mental well-being, characterized by the patient's ability to interact with the world in a productive and coherent manner. It was observed that there was a strong emphasis on the healing properties of plants—leaves, bark, roots, and latex—and can be regarded as the herbal aspect of the practice. There is also the use of animals (such as chameleons, snails, vultures) and animal parts (heads of cats, snail water), besides shear butter and other items. The spiritual or metaphysical includes the use of sacrifice, incantations, divination and initiation.

### 3.3 Physical

The physical methods in the treatment of mental ill health are common. There was the use of physical methods such as beating, chaining or infliction of some form of pain. However, when a patient willingly gives himself or herself up for treatment, the physical methods are unnecessary. When patients refuse to take herbal medicine or eat food, they can be coerced into doing so. In most of the interview sessions, respondents, practitioners and caregivers alike are of the opinion that that there is no healing processes that does not involve pain and that what matters is the motive and the ultimate goal, which is for the patient to be healed. The caregivers in particular claimed that although it was very painful even for them, if that was the only available means by which their sick person could be healed, then it was quite acceptable; the most important thing was the healing. At Abeokuta, a practitioner respondent averred that these approaches help to patients quickly realise that they are sick and that they require treatment. The practitioners claimed that they were not being wicked. A young practitioner who is a son of Pa. (Dr) Awotayo of Erin-Ijesa in Osun State, Nigeria, maintained that it is not possible to treat an acute mental illness without some forms of force. He showed us some patients who had attempted to run away and escape treatment. In this same place, a patient who had been in the healing home for more than 20 years was appointed to chase after and catch anyone who attempted to run away, then help them to simmer down through beating and subsequent chaining. At Alakija village, the practitioner said he could hire hefty men in the neighbourhood to help chase and catch patients attempting to escape treatment. Sometimes, he also hired people to help in the administration of medicine to inmates. The physical form of treatment is meted out more to male patients than to female patients.

According to Edge (1999, p.281), one of the principles of the American Medical Association is that 'a physician shall respect the rights of the patient'. However, physicians and society are often faced with a dilemma.

For instance, when the mentally ill are unwilling to receive treatment for their condition, the questions that inevitably come to the fore are:

a) Should the mentally unstable be detained and compulsorily treated?
b) Should the autonomous decision of the mentally ill be respected? and;
c) When the mentally disturbed person initially consents to treatment, who decides when to stop the therapy?

It has been argued that it is paternalistic to impose any type of therapy on an adult who is capable of either consenting or otherwise to medical care. Beyond this, it has been argued on behalf of mentally and psychologically ill patients that efforts to treat them often interferes with their behaviour. According to Mason (1997, p.228), "such interference is seen as unwarranted intrusion into the mental integrity of others and may result in the manipulation of behaviour in such a way as to compromise human freedom". The problem, however, is that often, the consequences of a person's decision to reject or stop medical care affects others. This is more so as the condition of the mentally ill has implications for the community and family as well as the individual.

In the traditional African setting and to date, when there is a mentally ill person in the community, he or she is treated with or without their consent. If a patient is violent or destructive, he is sedated by the traditional healer or by family members in order to commence therapy. Therapy is continued until a cure is achieved. In some cases, the patients may be chained in order to prevent them from harming themselves or others (Ozekhome, 1990).

Caldwell-Harris and Ayçiçegi (2006) argue that human beings are both autonomous and interdependent persons with either an extreme collectivist orientation (allocentric) or extreme individualist values (idiocentric). Interdependency, therefore, will not permit anyone to refuse to be treated when the sickness of a sick person is the burden of all. Oyserman, Coon and Kemmelmier (2002) affirm that Africans are collectivistic and therefore typically have traditional values which guide and direct every aspect of their lives. A collectivistic culture encourages strong links among members of a social group, who subordinate personal needs for the good of the people. In a collectivistic society, therefore, it is not acceptable for an individual even when not in touch with reality, to be unwilling to be treated, hence the imperative of force.

It is important to note at this juncture that for the most part, the treatment of traditional healing for mental illness among the Yoruba is conducted in an arena that involves the coalescing of culture, religion, environment, ecology, spirituality and multifarious affinities. Most of the traditional healers in Nigeria inherited the practice from either their grandparents or parents.

### 3.4 Beating and Chaining

Depending on the severity of the illness, some patients were tied to a wooden post, others had chains around either their legs or hands or both. However, practitioners and care givers alike were of the view that this aspect of the healing practice was noted to be the most dangerous and delicate. This is another part of the treatment strategy that is very painful but necessary when the illness is acute. Most practitioners observed that they would not want to use this method unless the situation is compelling. The purpose of this method is to prevent the patient from running away so as to ease the administration of medication. When a patient proves stubborn or poses a danger to the healers, agile young men in the vicinity are called upon to hold and beat the patient until he or she has no strength left to resist treatment. In most cases, this happened only in the first and second week of hospitalisation. Patients who were found misbehaving or attempting to run away were arrested and re-chained. This can be so frustrating to the practitioners because the healing of a patient enhances their credibility. When patients abscond, it implies that the illness has relapsed; when they are re-arrested, practitioners have to start the treatment all over again. Newly arrested patients were immediately chained for at least two weeks depending on the level of their response to treatment. The chains restrict the patients' movements and actions. Practitioner respondents claimed that patients can pose a danger not only to the practitioners but also to themselves, to other patients and people in the vicinity. When the patients are restricted, it is easier to administer treatment.

About 90% of the healers said they use chains, ropes and other forms of restraints in order to manage the patients. Only one healer reported that in his healing home, chaining of patients with ropes was discouraged and considered to be inhuman.

### 3.5 Bio-Medical/ Phytomedical Treatment Strategy

There is a bio-medical dimension of the practitioner's treatment model. Practitioners who have well-established homes hire the services of medical doctors or nurses to help them treat wounds, malaria and other infections. It was observed that mainly antimalarials and antibiotics were dispensed when necessary. In other words, apart from the mental illness that a patient suffers, he or she is also vulnerable to other kinds of illness. Thus, there is a complementary relationship between orthodox medicine and traditional medicine even in the context of treatment of mental illness. Even though in private, and to only a small extent, there is a level at which both Western and traditional medicine cooperate in the pursuit of holistic health.

### 3.6 Tranquilizers

In the asylums where this study was conducted, patients can be divided into two categories according to the way

they responded to treatment. The first category (Category A) is regarded as consisting of problematic patients because they were over-emotional, uncooperative, constantly complaining and dependent (Lorber, 1975, p.218). Patients in this category are hospitalised between the first and second weeks of their ailment. The other category (Category B) is regarded as consisting of good patients because they were responding to treatment, they do not complain or disturb the smooth running of the asylum. At the Adikuta (in Abeokuta) and Awotayo (in Erin-Ijesa) healing centres, we noted that the problematic patients and good patients were not hospitalized in the same room, as the problematic patients posed a danger to the less violent patients. They, in many cases, pose problems to the healers themselves. As a result, they were approached with a lot of caution. Healers go to them fortified with some medicine including incantations or *ase* (potent power) or *epe* (curse). We observed three major methods in the handling of the problematic patient: the use of force, counselling, and the use of tranquilizers. The use of force could be physical or spiritual. By physical, we mean physically beating up patients, putting them in chains and using *epe* or *ase*.

When force and counselling do not work, utilisation of herbal tranquilising medicine was observed to be a potent force in calming down unresponsive patients. Some of the observed reactions to herbal tranquilisers were drowsiness, sometimes reaching stupor depending on the quantity given and the constitution of the patients. Akin to drowsiness is hypertension especially among elderly patients and women, lethargy and reduction of drive were found to be most frequent. For these reasons, herbal tranquilizers are administered with great caution. Children of the practitioners and caregivers were made to keep tranquilized patients under close observation. In two big asylums in Abeokuta and Erin-Ijesa, patients who have shown tremendous signs of improvement/recovery or at least some form of rehabilitation were made to perform this task. With lower doses of tranquiliser, drowsiness tends to be transient and will pass as the patient adjusts. To control untoward drowsiness, the practitioners may reduce the dosage of herbal tranquiliser temporarily or prescribe the use of herbal stimulants. Some patients may as well be given a tranquiliser and stimulant concurrently.

When patients sleep for sixteen hours with adverse effects such as inattention, distractibility and impulsiveness, as well as apathy and lethargy, herbal stimulants were found to be important for the purpose of energising them. It was observed that the stimulant work for between three and eight hours depending on the severity of the illness and the dosage.

Many patients put under herbal stimulant medication experience a few side effects. Others experience mild allergy and some were not able to tolerate herbal stimulants. The side effects included: reduced appetite (especially among adolescent and elderly patients); headaches, jittery feelings, sleep difficulties, irritability, depression and anxiety psychosis. Because of these side effects, after carrying out a careful history and mental status investigation through divination and physical observation, a herbal stimulant can be administered to the patient. Patients who were found to react badly to stimulants were treated only with non-stimulant medication.

### 3.7 Ritual as a Healing Strategy

In the treatment of mental illness, ritual as a healing technique was found to be indispensable. When a divination is performed to get to the real cause of a mental illness, a ritual is always performed. In this technique, medicine is not directly working on the patient but it is directed towards the spiritual domain of reality. By implication, mental illness that is of spiritual or mysterious aetiology is cured with ritual. This is premised on Yoruba cosmology which accepts the presence of impersonal and dynamic forces in all beings, and that these forces are capable of causing mental illness. For these reasons, rituals are performed to appease supernatural forces. This explains why in many cases, the use of herbal preparations must be accompanied with ritual. Traditional treatment strategies are not necessarily limited to supernatural accounts of mental illness and treatment. Theoretically, the systems are open to understanding and exploring other accounts or approaches.

Ritual among the Yoruba is called *etutu*, which means a process or the art of making cool that which is hot. Mental illness as earlier mentioned is called *igbona,* that is, heat or the art of making a person hot. Ritual as a healing strategy is meant to make cool that which is *hot*. Most rituals require the use of animals, birds and herbs but the most frequently used ritual item, especially at Adikuta in Abeokuta was a cock. At Alakija village, rituals are offered periodically to *Obaluaye* on behalf of patients. Sometimes *Esu* or *Egungun,* the Yoruba divinity of the crossroads and the ancestral cult, could also be appeased. A divination session on a patient who suffered mental illness revealed that he must offer a sacrifice to his father who was long dead. As soon as the required ritual was performed, he was cured of his mental illness. However, at Erin-Ijesa, healers claim that they do not directly offer a ritual that may involve the use of animals with blood; rather, they employ the service of diviners, especially *Babalawo* (father of ancient wisdom) to perform ritual for patients.

There was observation of the use of ritual bath by practitioners. For example, at Erin-Ijesa, patients take a ritual bath every Wednesday and this serves as a tranquilizer. In fact, at Emuren, the healer explained that when a patient is brought to his asylum, the first thing he does be to scrape off the hair on the patient's head and

then give him a ritual bath before any herbal medicine is administered. The bath was taken with a special, local soap and sponge that were ritually prepared. The bath can be taken in a flowing river; the belief is that a flowing river can wash away the mental illness. Hence, the saying *omi ki i san ko boju weyin* ("a river does not flow and look back"). For complex states of mental illness, the sea shore (*eti okun*) is the best place. The ocean is believed to be a storehouse where all the evil that torments humankind can be stored and *Olokun* (the ocean divinity) cannot be affected (Jegede, 2010). The bathing mode was accompanied by other forms of treatment including taking other forms of medication through the nostrils or having some of it rubbed on the skin. A female healer informed us that "there is a medication that she gives them to bathe with and another is placed in the nostril, which opens up the mind and the person will start speaking". This is commonly used when it is detected that a malevolent spirit or *jinis* is in a mentally sick person. This bath marks the start of the healing process. The medication for bathing is basically for protection.

## CONCLUSION

If the strategies of indigenous psychiatrists are judged using the Western scientific and medical paradigms, traditional psychiatric medication strategies may be seen as rather primitive. To do so, however, is to fragment otherwise holistic traditional therapeutic systems. According to Oguamanam (2006), traditional therapy transcends a narrow and reductionist view of science. It is a religion, a culture, and a belief system of a people. Direct relationships and explanations of why a certain plant or ritual has a certain effect on mental states are hard to come by. Treatment for patients with mental illness by medication mostly consists of trial and error and tweaking dosages. As noted by Leichsenring et al. (2006), the most significant factor (reality check) in any method of psychotherapy is how well the method appreciates the fact that the patient is a human being with rational faculties. Simply because those faculties are not properly expressed by their current behaviour patterns does not mean the patients have lost those powers. Enabling the person to use those faculties for his/her own benefit is how the patient gets better. However, if the method of therapy is mysterious and cannot be subjected to scientific analysis, the patient generates a new story by proposing some extravagant, improbable, and unprovable theory, as psychoanalysis often does; the method is not compatible with the reality of the patient's potential for rational thought. Making people act and think 'normally' by scaring them with something they cannot test is a great example of flouting human dignity. According to a Western psychiatrist, the effects of a drug or medicinal preparation in terms of mental states are not known. However, the reason that can be attributed is lack of adequate research into the activities of this category of healers. We are of the opinion that even the use of ritual, *ase* and *epe* as therapeutic strategies should not be dismissed as being irrational. If researchers venture into rigorous investigation of this practice, it can lead to demystification of the so-called mystical aspect of the practice and simplification of some of the complex aspects.

We observed that when medicines and rituals are administered properly, patients responded to treatment, the chains were removed and they were set free while they continued to receive treatment. Some people we found to have responded well to maintenance, management and treatment of their mental illness and therefore have no further episodes, while others may have moderate mood swings that lessen as treatment continues. Some people may continue to have episodes that are diminished in frequency and severity. Unfortunately, some manic-depressive patients may not be helped at all. There is a varied response to treatment with the use of plants, rituals and other material medicine, and it can be determined through divination beforehand who will or will not respond to treatment.

While some people have one episode of depression and then never have another or remain symptom-free for years, others have more frequent episodes or depressions that may go on for years. Some people find that their depressions become more frequent and severe as they get older. For these people, continuing (maintenance) treatment with a traditional herbal preparation that is prepared as an antidepressant can be an effective way of reducing the frequency and severity of depressions. Those that are commonly used have no known, long-term, side effects and may be continued indefinitely. The prescribed dosage of the medication may be lowered if side effects become troublesome. Some sedative preparations can be used alone for maintenance and treatment of repeated depression, whether or not there is evidence of a manic or manic-like episode in the past. Anxiety is often manageable and mild; but sometimes it can present serious problems. A high level or prolonged state of anxiety can be very incapacitating, making the activities of daily life difficult or impossible.

Some phobias (especially in children) which are persistent, with irrational fears, and are characterized by avoidance of certain objects, places, and things, sometimes accompany anxiety. To cure anxiety in children, a specially prepared medicine can be used by putting scars on the face of the child. A panic attack is a severe form of anxiety that may occur suddenly and is marked by nervousness, breathlessness, pounding heart, and sweating. Sometimes the fear that one may die is present. This is within the competence of the traditional healers and most of the patients with this kind of mental

illness respond to treatment quickly without having to be admitted

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