# Mental Health Care in Central Africa and China
### *Brother Stockman reports the experiences of a religious charity*

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The organisation to which I belong is the religious Congregation of the Brothers of Charity, which has been involved in mental health care since 1815 and takes care of no fewer than 30 psychiatric centres and related services in Belgium, with a total of 4500 beds. A separate association, NGO Caraes, for Rwanda, Burundi and Zaire, and another one for cooperation with China, NGO Fracaritatis, were founded for our action in these countries. Both of these associations are my responsibility.

This article outlines mental health care in the central African states of Rwanda, Burundi and Zaire; and in the People's Republic of China, with its 1100 million population. The African countries are known to us because of our participation in the founding and maintaining of practically the only psychiatric services there, whereas a cooperation and exchange programme with regard to psychiatrists and assistance to psychiatric centres are under way in China.

## Cultural backgrounds

Psychiatric health care is, in part, determined by culture, and so there are local features to the concept, the public image, and the treatment of psychiatric patients. Even in the West, treatment centres vary from being akin to prison, where the principal concern is containment, to 'high-technology' multidisciplinary care.

### The position of the individual in the community

The structure of the community determines the position of the individual within it. The family plays an essential role and is pre-eminently a normative and controlling influence in central Africa as well as in China.

### *Central Africa*

A Westerner may be conceived as egocentric and a '*homo economicus*', while a person from central Africa is 'allocentric': the emphasis is on the social environment, the family and forebears. The African is a '*homo semanticus*', who ascribes super- and paranatural dimensions to the visible world (Devisch, 1979). Thus, spirit, soul and body are strongly interconnected, and somatic and mental deficiencies are difficult to separate. The emphasis is on the perpetrator, the aggressor, who can surface in every area (Bigiruwmami, 1972; Laplantine, 1976; de Brouwer, 1979). In central Africa, the family is the core of life, and nature, religion, customs and the power game of the occult form the main sociocultural backgrounds (Baeck, 1973). Nature is a sacred space where the invisible works continuously on man and influences him (Sankale, 1969). If customs and traditions are ignored, a taboo is broken, with all its dire consequences (Kashamura, 1973). Religion is very near to daily life; the spirits of the forebears make their wishes continually known to their descendants by means of dreams and signs in man and nature. If the wish of the deceased is not followed up, the spirit may strike a descendant with sickness, bad luck and death (Secundien, 1935; de Lacger, 1961). Witchcraft still plays an important role, and poisoning is common (Heremans, 1973).

### *China*

The family system, based on Confucian principles, is the dominant social element in the structure of Chinese society (Parish, 1981), and is the basis of social life and the prototype of all other social institutions. Harmony is a central idea in the Chinese family system, with obedience to and respect for the hierarchical authorities as an important element (King & Bond, 1985). Chinese cultural norms make the family accountable for the behaviour of the individual, who will try by all means to have every member behaving as normally as possible in the public eye. If deviant behaviour appears, every attempt will be made to return the person concerned to the desirable role (Lin & Lin, 1981). First, the individual's own family will try to convince him/her that such behaviour is intolerable. If no result is obtained, advisers are called in from the circle of the acquaintances, with great solicitude about keeping the deviant behaviour hidden. If no improvement occurs, a more formal action will be commenced which may push the individual into the margin of life and distance him/her from the family. This is a

drastic intervention in the life of an individual so intimately linked with the family.

## The social situation of the mentally ill

In both the central African and Chinese communities, the threshold of tolerance to deviant behaviour is fairly high, and they have internal mechanisms in the family system to deal with deviant behaviour. In Africa, anomalous behaviour is explained by referring to supernatural powers of people and spirits (Sankalé, 1969), so that the mentally ill person acquires a social role for which respect is shown in the first phase. If, however, the patient begins to uproot the family order more and more, measures are taken. Taking that person away is always a recognition of powerlessness, of failure of the family system and, therefore, a negative event for that person as well as for the relatives. In China, there is the additional extreme feeling of shame and guilt of the family when a relative shows psychologically disordered behaviour.

Both cultures appear to recognise two phases. In a first phase, the mentally ill person is cared for by the family and the cause is looked for in the individual or the family. The external factors (real or imaginary) that are at the base of the disease are sought, be they somatic or psychic: little distinction between somatic and psychic deficiencies is made, for both can be the consequence of an external aggressor against whom an adequate remedy is being sought. In the second phase, which is characterised by an increasingly deviant behaviour and its visible negative effects, a rejection mechanism begins which leads to expulsion and confinement. The possibility of returning to the family remains, but only on condition that the individual behaves normally again, so that the former intense assistance can be restarted.

## Psychiatric morbidity

In countries where services for the assessment and treatment of psychiatric patients are scarce, it is not possible to make global statements about psychiatric morbidity. Only a small part of the psychiatric population is found in the psychiatric facilities; these are mainly the severest cases, so that comparisons with Western data are difficult.

## Africa

Schizophrenia is the most common psychiatric disorder for which treatment is received at mental health services in Africa (Sow, 1978). At Prince Regent Charles Hospital in Bujumbura, Vyncke (1957) found that 60% of the examined patients had a psychosis: 18% of these suffered from an affective psychosis; 11% from a schizophrenic psychosis; 7.4% from paranoid behaviour; 7.4% from acute delirious psychosis; 32.5% from an organic psychosis; 16.2% from epilepsy; 4% from mental deficiency; and 2.8% were undefinable. Vyncke found 31% suffered a neurosis. This examination was done during colonial times, so that many white patients were included in the singular psychiatric service of Rwanda and Burundi.

In 1989 patients at the same hospital service were screened (125 patients, mostly chronic) and all of them suffered a psychotic syndrome (Barancira, 1990). After the disappearance of this service, a specialised psychiatric centre was established in Kamenge (Bujumbura) in 1990 which emphasised ambulant services. The following statistics were drawn up in 1990: 18.7% of the patients were psychotic, with schizophrenia and mania, deliria being predominant; 50.6% were neurotic with headaches, sleeping and psychosomatic problems; and 27.5% were treated for neurological problems such as epilepsy, migraine and vertigo (Colpaert, 1991).

The psychiatric centre in Rwanda (Ndera), where health care has been given since 1972, provides the following data: 60% of the patients are psychotic, of whom 40% are schizophrenic and 20% manic depressive; 8% are severely epileptic due to birth traumas, infectious diseases, malnutrition, and craniocerebral traumas; 7% are neurotic, with anxiety neurosis as the most frequent. Alcohol abuse is increasing. The recent war and internecine racial fighting has led to an increasing number of young psychiatric patients (Muremyangango, 1985).

## China

In 1987, China had 1 940 000 psychiatric patients and a 100 000-bed capacity (*China News Analysis*, 1988), with one psychiatrist per 1000 patients (Lin, 1985). The number of psychiatric patients is difficult to define because of the typically protective attitude of the family, so that the official number is probably well below the real one; meanwhile, insufficient bed numbers are a significant factor. Further difficulties arise from the problems of the accessibility of the services.

## The approach to the problem

In the context of their own cultural backgrounds, central Africa and China developed their own treatment systems after models in the West. The question is, especially for Africa, whether these were

adequately adjusted to local needs. It is only after some years' experience in such services that one begins to realise that their traditional therapies are still alive, while the staff generally do not have the education to be able to tackle problems from their own cultural background.

Thus, we have to recognise that in the services in Rwanda, Burundi and Zaire, the starting point is a rudimentary Western model with a predominantly medical therapy. It would make sense to obtain more information about traditional medicine in order to integrate it with western pharmacotherapy, but research into this matter is still limited to somatic medicine (Runyinya, 1978).

In both Rwanda and Burundi it has been decided to maintain only one psychiatric centre per country, in combination with teams whose members visit the existing medical facilities (dispensaries) in order to treat patients locally. Admission to a specialised centre is envisaged only if home-based care becomes impossible. This fits with the World Health Organization's (1976) vision, which sees the training of health care personnel as a *sine qua non* for success. This requires the motivation of personnel to work in psychiatric health care, as well as the means to give them proper training. Foreign aid is indispensable.

At present, a training initiative for health care workers is under way in Belgium; it aims at sending these people as trainers to their colleagues in Rwanda and Burundi (Fracaritatis, 1994). In Rwanda, there are still some hundred, mostly chronic patients kept in Kigali Prison, who are waiting to be transferred to a new complex in the Ndera Psychiatric Centre. The internal political problems in Burundi prevent the visiting teams from starting their activities, while in Zaire the only psychiatric centre in the interior, Katuambe (Kasai), struggles with lack of staff and resources. All this and other problems cause stagnation and retard developments that were started in the 1970s; they also make us question the position of mental health care on the agenda of countries that face problems such as wars, overpopulation, extreme poverty and infectious diseases, among which AIDS takes a heavy toll.

In China the consequences of the Cultural Revolution are still felt as paralysis of the development of mental health care and suspension of training. It is only since 1984 that attention was again directed to mental health care and other forms of disability through the action of Deng Pufang, Deng Xiaoping's son, who established the China Disabled Persons Federation with the aim of stimulating and coordinating assistance and care. At the moment, there are four centres that serve as referral centres

(Changzhou, Shanghai, Hangzhou, and Shenyang), while 30 towns and 30 districts have been elected to develop special psychiatric programmes. In general the Chinese centres pay a lot of attention to somatic interventions as the basis for psychiatric problems; there is a strong personal relationship between the doctor psychiatrist and the patient, and the staff adhere to a harmonious vision of man and world from which all activities with the patients take their origin. A recent development is the introduction of rehabilitation, thoroughly Chinese in spirit, which strives for reintegration with both personal life and work. There is no other solution to the problems of the chronic patient nor to those of the severely disabled but guarding them in large groups.

In China, psychiatric staff have a poor public image, and a strongly medicine-orientated training; there is a shortage of nurses and paramedical staff (Stockman, 1992; Simonis, 1993).

Our organisation aims in particular at providing training and other services to psychiatrists, nurses and paramedical staff; we plan to organise programmed practical work.

## Conclusion

This short survey shows clearly that in central Africa as well as in China much is still to be done in the area of mental health care. The community will have to stay alert to this care being given the priority that is its due in general health care. There is, with any Western supportive programme, a need to take into account cultural backgrounds and existing health services.

## References

BARANCIRA, S. (1990) Profil psychiatrique des patients hospitalisés dans le service de neuropsychiatrie de l'Hôpital Prince Régent Charles de Bujumbura. In *La Médicine de Bujumbura*, pp. 45–49. Bujumbura: Université National.

BIGIRUWMAMI, A. (1972) *Présentation et Commentaire des Quatre Volumes*. Nyundo.

CHINA NEWS ANALYSIS (1988) Humanitarianism: rehabilitation of the disabled. *China News Analysis*, 1–9.

COLPAERT, A. (1991) Pathologieclassificatie. *Rapport Annuel 1991 du CNPK*, p. 25. Bujumbura: CNPK.

DE BROUWER, A. (1979) *A la Rencontre de la Psychiatrie Africaine*. Université Catholique Louvain.

DE LACGER, L. (1961) *Ruanda*. Kabgayi.

DEVISCH, R. (1979) De socioculturele identiteit van de hulpbehoevende in Subsaharisch Afrika. *Psychiatrie en Verpleging*, **4**, 110–111.

FRACARITATIS (1994) *Vormingsplan Training van Trainers*. Gent: Fracaritatis.

HEREMANS, P. R. (1973) *Introduction à l'Historie du Ruanda*. Bruxelles: De Boeck.

KASHAMURA, A. (1973) *Famille, Sexualité et Culture*. Paris: Payot.

KING, A. & BOND, M. H. (1985) The Confucian paradigm of man: a sociological view. In *Chinese Culture and Mental Health* (eds W.-S. Tseng & D. Y. H. Wu), pp. 29–45. Orlando: Academic Press.

LAPLANTINE, F. (1976) *Maladies Mentales et Thérapies Traditionelles en Afrique Noire*. Paris: Delarge.

LIN, T.-Y. & LIN, M.-C. (1981) Love, denial and rejection: responses of Chinese families to mental illness. In *Normal and Abnormal Behavior in Chinese Culture*, pp. 237–272. Boston: Reidel.

——, et al (1985) The shaping of Chinese psychiatry in the context of politics and public health. In *Mental Health Planning for One Billion People* (eds T.-Y. Lin & L. Eisenberg), p. 232. Vancouver: University of British Columbia Press.

MUREMYANGANGO, B. (1985) *Profil des patients au Centre Psychiatrique Caraes à Ndera, Kigali*. Kigali: Centre Psychiatrique Caraes.

PARISH, W. L. (1981) Family and community in the People's Republic. In *Normal and Abnormal Behavior in Chinese Culture* (eds A. Kleinman & T.-Y. Lin), pp. 203–212. Boston: Reidel.

RUNYINYA, B. (1978) Quelques aspects de la systématique des plantes indigènes basée sur la médicine traditionelle au Ruanda. *Bulletin Agricole du Ruanda*, 1, 18–23.

SANKALÉ, M. (1969) *Médicine et Action Sanitaire en Afrique Noire*. Paris: Présence Africaine.

SECUNDIEN, F. (1935) *Pratiques Païennes du Ruanda-Urundi*. Astrida: Groupe Scolaire.

SIMONIS, A. (1993) *Geestelijke Gezondheidszorg in China*. Amsterdam: University of Amsterdam.

SOW, I. (1978) *Les Structures Anthropologiques de la Folie en Afrique Noire*. Paris: Payot.

STOCKMAN, R. (1992) De zorg voor gehandicapten en psychiatrische patiënten in China. In *Tijdschrift voor Ziekenverpleging*, 15, 533–538.

VYNCKE, J. (1957) *Psychoses et névroses en Afrique centrale*. Bruxelles: Académie Royale des Sciences Coloniales.

WORLD HEALTH ORGANIZATION (1976) *Les Services de Santé Mentale dans les Pays en Développement*, nr. 22. Geneva: WHO.

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