*A psychiatry in ascent: Nigeria revisited**

DEAR SIRS

In a recent article, Morrison[1] lamented the 'decline of psychiatry', taking his examples (except one) from the UK. Observations in the Federal Republic of Germany during the 70s and early 80s could have incited similar sighs and complaints of psychiatry's susceptibility to ideology.[2] But during a visit to psychiatric institutions in Nigeria in January 1985 I was privileged to see a psychiatry in ascent. Set against earlier experiences which extend back to 1961 and include a term as WHO Visiting Professor from 1968–1973, from ten years of working in Nigeria I found that the development of psychiatry in Nigeria since I first became acquainted with it twenty-four years ago is almost unbelievable. The increase in the numbers of professional staff speaks for itself; psychiatrists have increased from four to fifty, psychiatric nurses from less than thirty to over 1,000; psychiatric social workers and clinical psychologists from zero to several dozens each.

Despite sometimes marked differences in personalities, it is impressive to observe a distinct conformity in clinical practice: limiting the use of psychopharmacopoeia to a few brands familiar to everybody; applying ECT without hesitation when indicated by internationally accepted criteria; carrying out individual and group psychotherapy, occupational therapy; aiming at the therapeutic community; and, following the recommendations of modern developments, trying to incorporate psychiatry into primary and secondary health care services wherever feasible.

I was most impressed by the high esteem psychiatry enjoyed from the other medical specialties, including general medical practice, by the eagerness of medical students and student nurses to acquire a better understanding of mental health problems, and by the able performance of the trainees in psychiatry. I received at my request more than seventy reprints of published papers from Nigerian psychiatrists of the last decade, a fraction of those actually published in scientific journals. Some of the research, as well as questions raised in my discussions, centred around the position of traditional medicine in future health services. There seems agreement that differentiation must be made between 'real' traditional healers, knowledgeable and guarding ancient Wisdom, and the increasing number of self-appointed 'transitional healers' who often are more interested in a quick gain than in the welfare of the patient.

In addition to clinical activities and research results I was impressed by the very high professional standard of undergraduate teaching. All University departments have succeeded in extending the teaching time far beyond the posting of one week when it began in 1957 and two weeks after 1967, to eight weeks in most medical schools, including, besides formal teaching sessions, participation in in- and out-patient care as well as postings to out-posts connected with primary health care activities.

I thought remarkable the willingness to discuss openly, even controversial subjects, and the ability to contribute to a solution: this was displayed in all discussions I was privileged to hold with twenty-five of the fifty psychiatrists working in Nigeria at present.

It was a great satisfaction to learn of the regular meetings of the Association of Psychiatrists in Nigeria over more than fifteen years, a record hardly beaten by another psychiatric association in Africa south of the Sahara. Maybe most significant for a psychiatry in ascent is the opportunity for young doctors to obtain a professional qualification in Nigeria. For many years Nigerian doctors, even after being able to obtain their first degrees in Nigeria, had to go for further training to the Maudsley Hospital, to Edinburgh, to other psychiatric institutions in the UK or in the USA, or even to Australia, Germany and other countries. Now training in psychiatry can be done in Nigeria; psychiatry in Nigeria has come of age. Already it has contributed to the progress of psychiatry in the world, e.g. by Lambo's Aro Village, and it will continue to serve as an example to other Third World countries; but it may also help Western psychiatry to trust again its foundation in the sciences, natural and social. and in the humanities.

I am grateful to tate to have been connected for almost a quarter of a century with Nigeria and her 'psychiatry in ascent'.

ALEXANDER BOROFFKA

Wichernhaus
D-2300 Kiel 14, W Germany

I am grateful to the Auswartige Amt of the Fed. Rep. Germany for providing a travel grant, and to my hosts for providing board, lodging, and local transport in Nigeria.

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Pre-registration house officer posts in psychiatry

DEAR SIRS

With changes in the regulations of the General Medical Council, it has been possible to introduce a variation in the standard pattern of six months' medicine and six months' surgery during the pre-registration year. In August 1981 a rotation of four months' medicine, four months' surgery and four months' psychiatry was introduced at the Northern General Hospital, Sheffield. Following this rotation a second series of posts was introduced in August 1984. This report summarizes the views of the incumbents of the posts, their work on the wards and their future intentions concerning a medical career.

There have now been fifteen holders of the posts, selected from Sheffield graduates applying during their final year of medical training. Two common reasons for acceptance are those students who see their future in general practice and those who are considering psychiatry as a career, but would like experience at graduate level, before making a final decision. However, other factors which may govern the choice of the student include the guarantee of a twelve-month post in

one hospital, and the interest or notoriety of a new development. The posts are in one of the major teaching hospitals of the city.

Nine doctors have completed their pre-registration posts and a further six are at present completing their year. Of the nine, five have taken up vocational traineeships in general practice and the remaining four propose to continue in psychiatry. Two of them have passed the Preliminary Test of the Membership Examination and two have spent time in other departments of medicine before coming into psychiatry.

The general medicine component is seen as the most busy unit, with little time to spend with patients or on educational activities. The surgical component is less busy because of the more senior doctors who want to 'get their hands on the knife', so that much of the work is routine clerking and blood taking. The psychiatric component gives considerable individual responsibility with selected patients, but with ample access both to more senior doctors and to other professions—nurses, occupational therapists, psychologists and social workers working in the unit. There is unresolved discussion about the preferable order of the three components; each trio has their own choice of the order in which they work. The only comment was by one doctor who started with psychiatry and then was up until 2.00 am taking psychiatric histories on medical patients on transfer to the general medical section.

Each house officer is on call for the relevant unit. In medicine and surgery there are two on each firm, one doing four months and the other six months so that there is some overlap and cover for holiday periods. In psychiatry the one-in-four rota is operated to give the house officer an opportunity of being on-call covered by the duty registrar. On the remaining three days, the registrar has no junior to do the work, or, of course, to cover.

Judging by the number of applicants for the posts, the setting up of a second rotation and the general comments of those who have participated, these are seen as interesting, innovative and valuable educational posts giving a wider range of experience than normally available to a pre-registration house officer. Suggestions that newly qualified house officers are too immature to work in a psychiatric setting seem unjustified. These newly qualified doctors have the benefit of working in a multidisciplinary team with contributions from a range of professions and gain experience which will stand them in good stead in whatever branch of medicine they subsequently work.

C. P. SEAGER

Northern General Hospital
Sheffield

Psychotherapy and drug company promotion

DEAR SIRS

Psychotherapy cannot rely on the same sources of funds and support as can the rest of psychiatry and medicine given their organic basis. Research funding and drug company promotion are not easily linked with psychotherapeutic matters. On top of this, psychotherapy often faces critical attacks to which there are inherently no easy answers.

It might therefore seem to be a welcome addition to the freely distributed mass of drug promotional literature that comes through our letter boxes to find a 'newspaper' entitled *Psychotherapeutic Advances*. Unfortunately, this turns out to be the most insidious attack yet! Sponsored by Bristol-Myers, and completely free of advertisements, the paper contains journalistic articles on a number of interestig subjects, all of it with a medical scientific flavour, despite the vaguely psychotherapeutic aspects.

But scattered throughout the articles are repeated references to drug treatment, as if it was quite unremarkable to be mixing the two methods together without consideration of how they can be made compatible or be found incompatible. A choice example is: 'In psychotherapy, Buspirone should be considered in the treatment of anxiety disorders, particularly those that respond to benzodiazepines . . .' Thus, the impression is given that 'psychotherapy' is just a slightly glorified form of psychopharmacology.

Still with no easy rejoinder to this kind of propaganda, I despair.

NICK CHILD

Child and Family Clinic
49 Airbles Road
Motherwell, Lanarks

(*We invited Bristol-Myers Pharmaceuticals to reply to Dr Child's letter*—Eds.)

DEAR SIRS

Psychotherapeutic Advances includes articles on both drug and non-drug modes of therapy and is intended to provide information pertinent to those dealing with mental disorders. It is to be regretted that a publication which attempts to span several disciplines should draw such criticism from Dr Child.

B. M. GUYER

Bristol-Myers, PMS
Langley, Berks.

A chat with the other side

DEAR SIRS

I thought that the following might be of interest to *Bulletin* readers.

Bulawayo ('place of slaughter') is the second major city in Zimbabwe and one of the most beautiful sights on earth. Working in the old psychiatric hospital on the outskirts of town, I quickly discovered that many patients who came to me had either seen the *nganga* ('witch doctor') beforehand or would hasten to see him when they were through with me. The Government, as a deliberate policy, was according traditional health care recognition and the right to practise alongside 'Western' medicine. I once visited one of these 'doctors', as I felt it would be educative to see traditional health care from the inside.

He was a little slip of a man in a rather shabby white