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Assessment of Household Management of the Mentally Ill in Nigeria (Pp. 267-281)

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Abstract
This study is aimed at assessing household management of the mentally ill. The participants were one hundred and fifty households purposively sampled for the study from the six geo-political zones in Nigeria. 25 households from each of the six zones. The instrument to generate data was a validated structured interview schedule reflecting Expressed Emotions of family members. The procedure was using trained research assistants who hail from the zones, to administer the person-to-person interview or conduct a focus group discussion in the zone's lingua franca. The multi-dimensional scaling analysis using simple percentages had findings to show that household members harbour significant negative emotions as a result of deeply rooted cultural myths and economic poverty which significantly hamper family care for the mentally ill. A model of household holistic coping strategies was recommended.

Keywords: Household coping strategies, Expressed Emotions, Mentally ill people, Nigeria.

Introduction

This study is aimed at assessing Nigerian households Expressed Emotions of people suffering severe mental illness characterized by a variety of symptoms including but not limited to: loss of contact with reality. In Nigeria, household members can play significant role in eliminating or reducing the frequency of psychotic symptom relapses among members with mental

illness. Many of the first studies (Brown, Bone, Dalison and Wing, 1966) used family intervention approach focused on the effects of expressed emotion. Express Emotion (EE) is a measure of emotional involvement and attitudes of household members when talking about a behaviourally disturbed family member. Aspects of EE include (a) Critical comments about family members, (b) Hostility, (c) Emotional over involvement (d) Warmth
(e) Positive remarks.

Brown, Bone, Dalison and Wing, 1966 conducted a nine – month follow-up study in London of a sample of mentally ill people who returned to live with their families after being discharged from the hospital. Interviews conducted with the parents or spouses before discharge and rated for the number of critical comments made about the patient and for expressions of hostility toward or emotional over-involvement with him or her. On the basis of this variable, called *Expressed Emotion* (EE), families were divided into those revealing a great deal, high – EE families, and those revealing little, low – EE families. At the end of the follow-up period, 10 percent of the patients returning to low – EE homes had relapsed. In marked contrast, 58 percent of the patients returning to a high – EE home had gone back to the hospital in the same period. This research has since been replicated (Vaughn and Leff, 1976; Leff, 1976, Carpenter, 1996, Leff and Vaughn, 1985, Hooley, 1985, Hooley and Richters, 1995, Hooley and Hiller, 1997, Jenkins, Karno, de la Selva, Santana, Tellis, Lopez and Mintz, 1986).

Certain as-yet-unidentified characteristics of some family members may place them at greater risk for developing critical emotions when they are exposed to the disturbed behaviour of the relative with mental illness or stigma from the environment because of the mentally ill members in the house. Expressed emotion reflects an interaction of trait-like factors, cultural and socio-economic conditions of family members.

The family system in Nigeria is still traditional with patriarchy and polygamy dominant. It used to be characterized also by communal relationship where every family member is every household member's concern. But urbanization with its attendant negative effects such as poverty (Ewhrudjakpor, 2008) has eroded this communal life style and replaced it with 'individualism'. This has broken many families' social support systems. The evidence (Kiev, 1972; Erinosho and Ayorinde, 1978; Igun, 1979; 1988) is that, among African people disturbed with mental illness, vagrancy is

much more strongly associated with treatment resistance, the consequent breakdown of family social support, and thus impact negatively on household care for the mentally ill.

Statement of Problem

Families of people suffering Mental illness suffer a great deal from social prejudices and discriminations. The problems associated with vagrant sufferers of mental illness in Nigeria, span the social, psychological, and economic spheres of living. This brings to the fore the inability of households to effect protective custody of their mentally disturbed member (Rossler, Salize and Riecher-Rossler, 1996; Matthew and Jan, 2007; Matthew and Jan, 2008; and Rose, Sonja and Rubenstein, 2008).

Household (a family consisting of, for instance parent-in-law and other relations living in the same house) play pivotal roles in mental health services. Understanding the wide roles of household and culture enables mental health prescription and the standard of behaviour of its members. Since there are different cultures so also there are different household types. The different household view mental illness from the perspective of their family structures and cultural beliefs, which inevitably influences the role of the household in care giving and support for the mentally ill (Ohacri, Adeyemi, Sunmola and Ewhrudjakpor 1992).

The Household form (whether monogamy or polygamy) in which people live, or from which they come, plays a role in the amount of EE they show. Polygamous relatives show negative EE toward patients than that shown by relatives of monogamous homes. In the United States, Mexican Americans who live in the United States but who follow traditional cultural practices also typically show lower levels of negative EE toward their relatives than do Anglo Americans (Jenkins, Karno, de la Selva, Santana, Tellis, Lopez and Mintz, 1986; Leff and Vaughn, 1985; Rajkumar, 1991; Vaughn, and Leff, 1976).

However, despite these cultural differences, the family imposes association between negative EE and elevated risk for relapse in the mentally ill people has been replicated in many household settings (Hooley and Hiller, 1997; Gregory and Patrick, 2007; Hooley, 1985; Leff, 1976; Hooley and Richters, 1995; and Susan, Richard, Cynthia and Pamela, 2008). That these victims are sufferers of voodoo curses from aggrieved or envious relatives and

acquaintances (Igun, 1979, 1988). They are abandoned by family members completely because of the breakdown of family social support due to hard economic conditions (Oshisada, 2006) and society's negative perception of the mentally ill (Jegede, 1981; Igun, 1988; Fabrega, 1991; and Ewhrudjakpor, 2007). In recent times in order to avoid embarrassment, some states in Nigeria has decided to vacate vagrant sufferers of schizophrenia from public places into tradomedical homes owned by individual indigenous native healers.

Furthermore, there is also the problem of identifying appropriate management measures of those who are considered to have serious mental illness across households. This is against the background that, in Nigeria the cause(s) of mental illness is attributed to preternatural and supernatural forces such as, witchcraft, gods, and juju. Therefore, Africans indeed Nigerians believe that, such mental illness cannot be managed by biological or orthodox medical practitioners, but through the same witchcraft, juju, logic, magic, or gods. This study is set out to find scientific sociological explanation to households' dearth or inadequate management measures of mental illness sufferers in Nigeria.

Methods

Study Area

The Federal Republic of Nigeria is the 10th largest country in the world with a population of 140,003,542 (The Daily Champion, January 2007) There are more than 250 ethnic and linguistic nationalities that make up the 36 states and the Federal capital Tertiary. The states are grouped on the basis of ethnic homogeneity and geographical proximity into six geopolitical zones (see table 2). It is estimated that approximately 70 million Nigerians earn below US $ 1/day (one USA dollar per day). The Human Development Report 2000 ranked Nigeria among the 20 poorest countries in the world. Modern health facilities and services particularly in the rural areas are grossly inadequate. The cost of health care economically and bureaucratically is huge, encouraging impoverished natives to find an easy alternative in tradomedicine.

Instrument

This research was conducted using a structured interview for one hundred and fifty households drawn from the six geopolitical zones. (Table 1). The author adopted and modified a pre-existing (Ewhrudjakpor, 2007) interview

schedule written in English language to assess the Expressed Emotions (EE) of household members towards their mentally ill member(s) across the selected communities in the six geo-political zones in Nigeria. This interview schedule, originally with a known group method of construct validation yielded a validity score ($t = 13.22$; $df = 48$, $P < .05$; $r = 0.86$; $df = 8$, $P < .05$, known – group of households with mentally ill members. The interview schedule was divided into two sections (see table 1 and 3). Section A: contains seven questions about social demographic characteristics of household members' interviewees: Geo-political zones, Sex, Age, Marital Status, Occupation, Educational status and Religion. Section B: contains 25 questions about Expressed Emotions towards the mentally ill individual.

Sampling Technique / Sample Size

The type of sampling technique adopted was the multi-stage or cluster random sampling technique, each of the communities selected represent a cluster, 25 household each from a zone were purposively (because they have member(s) of their family who has mental illness) selected. The total sample size is 150 households with one or more mentally ill person(s). Each household consist of a family and relatives such as parent- in-laws, and other family relations.

Procedure

The type of study design used was the observational through interview (person-to-person) or focus group (F.G.D) discussion which enables the researcher to identify the impeding emotional factors towards care and social support systems for sufferers of mental illness by household members in the country. Each interview or discussion was conducted by Research Assistants who hail from the regions and can interpret English language in the dialect or Lingua Franca of the people. A single interview or F.G.D took between forty-five minutes and one hour and thirty minutes. The whole exercise of interview lasted for fourteen months, between February 2007 and March of 2008.

Each interviewee ranked the mentally ill on a five-point scale reflecting his or her Expressed Emotion about the sick in the diseased condition. In each case the interviewee was asked to select an option from among the following: "Yes, No, Maybe yes, Maybe No; don't know. The technique of multidimensional scaling analysis was used to construct, for each of the five

dimensions, an index of willingness to accept or reject the mentally ill, on the basis of their Expressed Emotions (see table 3).

Findings

From the data analyzed (See Table 1 and 3) by the researcher, it was found significantly and unanimously among the six zones in Nigeria that breakdown of household management systems pushes the mentally ill person(s) to roam the streets. These findings (Table 1 and 3) are at the rear of this paper. However they are articulated in the discussion section.

Discussion

The findings shall be discussed under the following sub-headings: Characteristics of Household members, factors impeding Household Management of the mentally ill, and Management of the mentally ill.

Socio-demographic Characteristics of Household Members

Table one summarized the social demographic data of the 150 household of the mentally ill people interviewed in selected communities of Nigeria. The mean age of interviewees is 40.62 years, with 28 males and 92 females representing 38.67% and 61.33% respectively. The marital statuses of the respondents who are married were 121 representing 80.67% which is more than the two other categories of (Divorced and widow) that were surveyed. This reflects the nature of respondents interviewed. The six geopolitical groups were all represented equitably (See Table 1). The occupation of respondents shows that 32 representing 21.33% were farmers or fishermen. This is the major occupation of Deltans, particularly in the rural areas. The remaining 78.67% account for respondents drawn from urban areas, these are: students (6.67%), civil servants (27.33%) and business people (44.67%). The respondents educational status show that most of them are illiterates, No education were 21 (14.00%), Primary school education had 69 respondents representing 48.00%, and Secondary school had 18 people representing 12%. The tertiary educated people among these 150 interviewees were 54 representing 36.00%. Muslim was 66 or 44.00% of the interviewees. African traditional religion and Atheists had 14 and 16 respondents representing 9.33% and 10.67% respectively. Nigerians are predominantly Christians and Muslims.

Factors Impeding Household Management of the Mentally Ill in Nigeria

The Multi Dimensional Scaling Analysis (Table 3) based on the stated objectives; to assess the expressed emotions of household management for

the mentally ill in Nigeria. These factors as shown by findings in this study range form cultural concerns to economic matters and urbanization. Cultural concerns relate to beliefs about cause of mentally illness; and care of the patients. The respondents believe that 55.33% of mental illness is a curse. Linked to this, is that 43.33% believe that schizophrenia is a result of dysfunctional spirituality which dislocates the mind (47.33%) (Table 3). This finding is a confirmation of the deeply rooted unorthodox medical practices in Nigeria. It confirms earlier studies (Harding, 1973; Kiev, 1972; Jegede, 1981, Dunlop, 1975, Bichman, 1979) that mental illnesses are traditionally abhorred among Africans, despite their communal way of life. In fact in this 21st century, the analysis (Table 3) shows that belief in witchcraft and its effects, had 32%% responses that it causes mental illness. Even if natives believes that drugs such as marijuana can cause psychoses, they claim that it is the handiwork of the witches and wizards, to spiritually affect people with schizophrenia because they think that they will succeed in life. This corroborates earlier studies (Igun, 1988, Erinosho and Ayoriode, 1978; Gureja, Bamidele and Aderibigbe, 1994). Against all education and enlightenment health campaigns, only 27.33% believe that mental illness is caused by chemical or biological dysfunctionality in the sufferers. This corroborates with recent studies (Ewhrudjakpor, 2007; Susan and others, 2008). This is the more reason why people make self attribution (79.33%) as the explanation for mental illness, meaning the cause is not natural, but supernatural or preternatural, people of Delta (Igun, 1988) indeed Nigerians believe that the biological or physiological damage is a 'smokescreen' (camouflage) for the diabolical manipulations of the enemy who want to make them (household members of the mentally ill) laughing stock. Hence, 76% believe that sufferers of mental illness are incurable, and so they should be allowed to rot away in tradomedical centre or better still be allowed to roam about till they die. These seeming indigenous native healers support practices in Delta State like most parts of Nigeria were generally approved of, as shown in the results (Table 3), religious organizations, 37.33% traditional healers 50%, and mentally ill allowed to roam, 10%. It is indeed heartening to know that only 40% responded to 'yes' that the medical clinic or modern doctor is the place to turn to for help with the mentally ill.

Furthermore, Studies in Nigeria have documented several myths surrounding the mentally ill. Researches (Ohaeri and Others, 1992; Fabrega, 1991; Ewhrudjakpor, 2007) have shown that, if a man, traditionally married

commits incest, the man must 'run mad'; if a married woman (not the man) commits adultery, 'madness' will befall her. If a person has schizophrenia and he or she goes to the market place or Market Square to pick anything from the ground to eat, that schizophrenia will remain incurable. In fact in Delta and Edo States, it is believed to be a curse (Igun, 1988) on the household members to harbour a member of the family sick of schizophrenia. The whole family suffers socially, economically and psychologically. Nobody goes to the family to marry, they are scorned anywhere they go. The label on them is a huge and indelible stigma that literally makes them jinxed and taboo to the rest of the community. This is what actually pushes household members to reject or deny sufferer(s) of schizophrenia from re-entering their houses or homes. Stigmatization is a social construct with huge negative psychological and economic impact on the lives of the families of the mentally ill, particularly in developing economies like Nigeria. This corroborates.

Apart from the stigma that families of the mentally ill carry-on, poverty, is another huge debilitating factor hindering re-entry of sufferers of mental illness into the household.

Poverty and ignorance play a huge role in management of the mentally ill. Ewhrudjakpor, (2007) argued that economically rich families have the means of sustaining their sick member in a separate room at home or may hospitalize him or her in a government psychiatric hospital where they visit to re-socialize their family member before discharge. But this is not for over 70% of Nigerians living in poverty and rural areas where there are inadequate medical facilities.

In Nigeria, there are several hospitals ranging from, Teaching hospitals, Specialist hospitals, General hospitals, Central hospitals to Cottage hospitals. Only a few have psychiatric presence. The hospitals with full psychiatric care like psychiatric hospital in Yaba, Lagos state, the Uselu psychiatric hospital in Benin city, Edo State, and the Federal Universities Teaching Hospitals psychiatric units. These are all in urban areas, meanwhile majority of the people live in rural areas and are poor and uneducated (Ewhrudjakpor, 2008). Studies (Igun, 1979; Jegede 1981 Owumi 1983; Ewhrudjakpor, 2007) have shown that Nigerians prefer unorthodox medical practices due to poverty.

Management of the Mentally Ill

Management of the mentally ill is house socially and expensive economically. Against this background information from interviewees, the researcher recommends a blend of physical and socio-economic coping strategies by family members concerning the patient's life. This model is referred to as household copying strategies for the mentally ill. It affects the mental illness patients' physical care, social relations, lifestyle, and self-concept, financial and economic empowerment (See Figure 2).

Table 1: Social Characteristics of Interviewees (N = 150) Mean age = 40.62 Years

Social Variables	**No**	**%**
Geopolitical Zones		
North Central	25	16.67
North East	25	16.67
North West	25	16.67
South East	25	16.67
South South	25	16.67
South West	25	16.67
Sex:		
Male	58	38.67
Female	92	61.33
Age:		
Under 40 years	40	26.67
40 years < 60 years	80	53.33
60 years and above	30	20.00
Marital Status:		
Married	121	80.67
Divorced	15	10.00
Widowed	14	9.33
Occupation:		
Student	10	6.67
Farmer/fishing	32	21.33
Civil service	41	27.33
Business Person	67	44.67
Educational Status		
No Education	21	14.00
Primary School	69	46.00
Secondary School	18	12.00
Tertiary School	42	28.00
Religion:		
Christianity	54	36.00
African Traditional Religion	14	9.33
Atheists	16	10.67
Islam	66	44.00

Source: Fieldwork 2007 / 2008

Table 2: Household selection from 6 Geopolitical Zones in Nigeria

Geo Political Zones	No of Household	States and selection of Households
North East	25	Borno 5, Yobe 5, Bauchi 5, Gombe 2, Taraba 3 and Adamawa 5 States.
North West	25	Sokoto 5, Kebbi 2, Zamfara 2, Katsina 4, Kano 5, Jigawa 2 and Kaduna 5 States.
North Central	25	Plateau 5, Nassarawa 3, Niger 2, Kogi 2, Benue 5, Kwara 5 States and the Federal capital Tertiary 3.
South East	25	Anambra 5, Enugu 5, Ebonyi 5, Abia 5, and Imo 5 States.
South West	25	Ogun 5, Osun 5, Ekiti 2, Ondo 5, Oyo 5 and Lagos 5 States .
South South	25	Edo 5, Delta 5, Bayelsa 2, Rivers 5, Akwa-Ibom 3 and Cross Rivers 5 States.

Source: Fieldwork 2007/2008

Figure 1: Household coping strategies for the mentally ill.

Strategies aimed at Health care	Strategies aimed at raising and supplementing income to maintain household expenditure patterns	Strategies aimed at destigmazing the family.
Government agencies should extend social work services to household members of the mentally ill. Government psychiatrists and clinical psychologists' regular visits to the household, to attend medically to the sick member of the household and encourage other household members to care.	Government and non government organizations should provide paid employment to unemployed household members. Pay a stipend to the mentally ill to support the households economically.	Reconstruction of cultural negative beliefs. Media campaign against negative myths. Quarantine settlements should be dismantled

Table 3: Expressed Emotions of 150 Households to Questions about Mental illness

S/No.	Questions	Yes	No	May be yes	May be No	Don't Know
1.	Mental illness is caused by a disorder of one's spiritual life.	65 43.33%	24 16.00%	30 20.00%	14 9.33%	17 11.33%
2.	Mental illness is caused by a disorder of one's mind	71 47.33%	23 15.33%	22 14.67%	06 4.00%	28 18.67%
3.	Mental illness is caused by a curse from an enemy or an envious friend or neigbour or family member	83 55.33%	19 12.67%	28 18.67%	0 (00.00) %	20 13.33%
4.	Mental illness is caused by an incest/engaging in sexual acts contrary to one's culture	34 22.67%	30 20.00%	20 13.33%	4 2.67%	62 41.33%
5.	Is caused by breaking a taboo	120 80.00%	20 13.33%	9 6.00%	0 (00.00) %	01 0.67%
6.	Mental illness is caused by stressful social relationships with others particularly loved ones.	30 20.00%	61 40.67%	25 16.67%	0 (00.00) %	34 22.67%
7.	Mental illness is caused by a genetic or biological disorder of one's body	41 27.33%	63 42.00%	11 7.33%	20 13.33%	15 10.00%
8.	Mental illness is caused by drug (marijuana, alcohol) consumption	131 87.33%	7 4.67%	0. (00.00 %)	6 4.00%	6 4.00%
9.	Mental illness is caused by witchcraft	48 32.00%	39 26.00%	21 14.00%	2 1.33%	40 26.67%
10.	Patients are to blame for their illness	119 79.33%	18 12.00%	0 00.00%	0 00.00%	13 8.67%
11.	Other people are to blame for causing a person's mental illness.	121 80.67%	16 10.67%	0 00.00%	4 2.67%	9 6.00%
12.	The Government is to blame for causing a person mental illness.	9 6.00%	128 85.33%	0 00.00%	0 00.00%	13 8.67%
13.	Do you show your dislike to a mental illness relative with phrases such as "it annoys me" or "I don't like it"	127 84.67%	8 5.33%	6 4.00%	0 00.00%	9 6.00%
14.	Mental illness are unkempt, they make the environment smell. I hate them.	106 70.67%	0 00.00%	10 6.67%	30 20.00%	4 2.67%

15.	Mental illness are sick, they must be cared for in as they request.	40 26.67%	110 73.33%	0 00.00%	0 00.00%	0 (00.00 %)
16.	Sometimes when he/she realizes himself, he/she can be so nice, apologetic as if he caused it for himself or herself.	32 21.33%	113 75.33%	0 00.00%	0 00.00%	5 3.33%
17.	Its good to shower praises and approval through empathy and show of love for a mental illness relative.	113 75.33%	24 16.00%	5 3.33%	0 00.00%	8 5.33%
18.	A person can be cured of his or her mental illness.	12 8.00%	114 76.00%	3 2.00%	4 2.67%	17 11.33%
19.	Friends are people to turn to for help with mental illness.	0 00.00%	133 88.67%	0 00.00%	0 00.00%	17 11.33%
20.	Relatives or family are people to turn to for help with mental illness.	13 8.67%	130 86.67%	0 00.00%	0 00.00%	7 4.67%
21.	A medical clinic or modern doctor is a place to turn to for help with mental illness	60 40.00%	72 48.00%	0 00.00%	0 00.00%	18 12.00%
22.	Religious organizations like church groups are the best places to turn to for help with mental illness	56 37.33%	38 25.33%	17 11.33%	6 4.00%	33 22.00%
23.	Native or witch doctors are persons to turn to for help with mental illness	75 50.00%	39 26.00%	15 10.00%	0 (00.00 %)	21 14.00%
24.	Sufferers of mental illness roam the streets until they die.	15 10.00%	109 72.67%	4 2.67%	0 (00.00 %)	22 14.67%
25.	Treated mental illness can be rehabilitated by Government Job	122 81.33%	00 (0.00%)	06 4.00%	00 (0.00%)	22 14.67%

Source: Fieldwork 2007 / 2008

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