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FAMILY CHARACTERISTICS OF NIGERIAN WOMEN WITH SEVERE MENTAL ILLNESS ATTENDING A PSYCHIATRIC OUTPATIENT CLINIC

M. F. Tunde-Ayinmode, MBBS, FMCPsych, Department of Behavioural Sciences, University of Ilorin Teaching Hospital, Ilorin, Nigeria

Request for reprints to: Dr. M. F. Tunde-Ayinmode, Department of Behavioural Sciences, University of Ilorin Teaching Hospital, Ilorin, Nigeria

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ABSTRACT

Objective: To assess the family characteristics of Nigerian women with severe mental illness in order to understand the clinical implication and application.

Design: A descriptive cross-sectional study.

Setting: Psychiatric clinics of University of Ilorin Teaching Hospital, Nigeria.

Subjects: One hundred severely mentally ill women in their reproductive age.

Results: Majority of the women were educated, employed and had schizophrenia. About two-third were married and co-habiting with their spouses, 71% were parents. Many reported well functioning extended family with 55% having regular contact while 38 and 7% had irregular or hardly made contact respectively. Seventy one percent of mothers had lost custody of their children at a point. Family history of mental illness was present in 19%, while 25% had fears that their children may inherit illness. Majority reported adequate spousal and relatives' support. Mothers without custody of any child were significantly more likely to have schizophrenia $p=0.001$, be currently unmarried $p=0.021$, have a non-residential marital relationship $p=0.030$; and experienced previous abortions $p=0.028$.

Conclusion: Women with severe mental illness particularly schizophrenics may have difficulties in the spheres of marriage and family living and may need help, an aggressive rehabilitation service that will assist patients in coping with family relationships and functioning is suggested.

INTRODUCTION

Family context is important in the management of patients with psychiatric illness and enormous advantages accrue when family members are considered in their medical and psychosocial management and outcome (1,2). Familial genetic predisposition remains crucial in risk factor analysis for mental disorders; for example depression is reportedly two to five times more common in first degree relatives of patients with major depression than the general population (3). Furthermore, severe mental illnesses like schizophrenia impair ability or potential to adequately form and sustain interpersonal relationships necessary for optimal psychosocial functioning (4), this could impair adequate or meaningful relationship with spouses, children and significant family members (5,6).

Although in societies with advance social and child welfare systems particularly as it relates to fostering and adoptions, the care of these children may

be more complex than presented. Child care are closely monitored and when there are evidence of abuse and serious inadequacies custody can be withdrawn even from relatives, in which case institutional caregivers get involved (7,8).

Family relationships play a great role in the psychosocial adjustment of these patients in such areas like management of the disorders, education, employment, marriage, parenthood and parenting characteristics (9-11). Decisions necessary for coping with associated problems are made within the family context; it is also within this context that the necessary social and parenting skills are learnt and transmitted. The quality and quantity of family interactions and degree of adjustments are therefore very important. Based on the level of adjustment, family interactions may either be constructive or obstructive to patient management (12). Maladjustment in family relationships has adverse consequences for the patients, children and family which may include hostility, stigma, relapse, treatment failure,

homelessness, poverty, child psychiatric disorders, child custody loss and marital dysfunction (7,8,13). Family members' attitude may serve as barrier to treatment or rehabilitation (6).

The family will have to adjust in a peculiar way to the severely mentally ill female member who has children; for this family a double burden exists that of caring for both mother and child concurrently, much more so if or when this mother is in relapse or is hospitalised. The challenge of adjustment is even greater in families with shared risk or multiple members are affected by mental illness or those who have developed psychiatric morbidity as a result of the index affected family member (14). Child custody loss is often to family member primarily but institutional care may be quite prominent in countries with advance social and child welfare systems particularly as it relates to fostering and adoptions; notwithstanding the situation can still be quite burdensome for the family.

On the whole excessive burden of care; role overload; physical and emotional burnouts may make them become dysfunctional (5,6); and may become increasingly insensitive to the patients' other physical and psychological needs or distress (7).

Within and outside of psychiatry utilising the family as a resource for care of patients is well recognised (1,2). It is reasonable to do this because it remains the basic relational unit and most intimate social environment of society. Having a family orientation to patient care is anchored on the fact that the disease process, its onset, course and management influence and is influenced by family factors (2). Physical and emotional demand of illness can be heavy and it is the family not the health care provider that takes care of the greater burden therefore their ability to cope has to be constantly reviewed.

It is therefore important to understand the family profile of patients attending outpatient clinics to take appropriate decision in assisting them cope with stresses arising from their illness and from their social environment which could affect the course and management of their disorders. Families take the major share of the burden of care. The psychiatrist should identify family strengths and weaknesses and exploit this to the benefit of the patient and his family. Social support system particularly the family should always be linked with the assessment of the patient; spousal support being about the most important with profound effect on morbidity and mortality (15). This is important to the extent that some studies suggests support provided by institutional management cannot compensates for inadequate family support as far as optimal outcome is concerned (16).

Patients with mental illness have peculiar challenges with many areas of their family interactions. Several studies have been devoted to identifying these peculiarities (6,9,10). Obtrusively,

these studies are from the developed countries and have probably informed their welfare and rehabilitations systems and programmes put in place to help patients cope with the family and social challenges in these nations (5,6,16,17). Some of the management modalities available include: marriage and family therapy, occupational rehabilitation, parenting competence training, child welfare and fostering, specialised gynecological and reproductive health programmes and case management (8,17).

In our setting there is a pervasive assumption that the extended family system is still a protective welfare canopy for the social and family needs and problems of the severe mentally ill. The reliance on this supposed ubiquitous system may have stifled research in generating alternative social welfare and rehabilitative systems and hampered improvement of existing ones. While research in this area is progressing too slowly the family and social problems associated with severe mental illness is becoming more complex; and predictably, outcome for these patients is getting worse as indicated by the unsavory presence of homeless mentally ill or vagrants on the streets of many Nigerian cities (18). This may also be a reflection of the increasing deficiencies in the extended family system. There are indications that this system is undergoing strain and its effect is waning (19,20).

Without systematic research, effective and efficient programmes cannot be developed and utilised. Research is required firstly in establishing existence of problems, needs and impact; secondly in the development of intervention modalities and lastly in implementation and service delivery. This study is an attempt to meet the first need albeit in a limited way being a preliminary investigation to a larger study.

This study was aimed at identifying local clinic pattern of family characteristics of women with severe mental illness as way of providing evidence for making changes that will improve clinical management via modification or moderation of factors identified. It is also aimed at directing attention to family-oriented approach to psychiatric care. The specific objective is to characterise the pattern of family formation, structure, relationship and functioning of a female psychiatric outpatient population and assess association between mental illness and these factors.

MATERIALS AND METHODS

Study setting and design: The study took place at the University of Ilorin Teaching Hospital; involving the female outpatients of the departments of Behavioural Sciences and Family Medicine. The hospital is located in Ilorin, North-central Nigeria. The department of Behavioural Sciences runs outpatient clinics three times a week the family medicine being the primary care section of the hospital runs clinics everyday of the

week and is opened 24 hours. All patients attending the hospital except accidents and emergencies passed through it thus serving a primary care function.

Sample population: One hundred (100) women with severe mental illness within the reproductive age group who have been in remission or mentally stable in at least two months preceding the study and attending the psychiatric outpatient facility were studied. Severe mental illness was defined as chronic or persistent psychiatric disorders with severe functional impairment, included are schizophrenia, bipolar disorders, major depression and other psychotic disorders. Patients with significant cognitive impairment or unresolved psychotic symptoms were excluded as these may affect responses to the questions. Ethical approval for this study was obtained from the Ethics and Research Committee of the hospital.

Sampling method: Consecutive patients approached, who met the inclusion criteria and gave consent to participate were recruited.

Instrument: Participants were interviewed with a semi-structured questionnaire designed by the investigators. The questionnaire had four sections respectively on socio-demographic characteristics, family characteristics, illness-related characteristics and family planning (FP) characteristics of the subjects. The illness related characteristic section applied to only the study group.

Data collection and analysis: The questionnaire was supposed to be self-administered but they were read to the participants as pilot study showed some discrepancy between reported literacy levels and competence in correctly filling the questionnaire. EPI info 6.02 was used for data analysis. Chi-Square test and Fishers exact test for association and P value less than 0.05 was regarded as statistically significant.

RESULTS

Socio-demographics: In terms of diagnosis 74(74%) had schizophrenia; major depression (9%); bipolar affective disorders (6%); other psychotic disorders (9%), severe obsessive compulsive disorder 2%. The

mean duration of illness was eight years (SD=6.7), 45% had been ill for five or less years; 21% for six to ten years and 34% for greater than ten years. Majority (73%) had at least secondary education and for those who were married 75% of their spouses had similar level of education. Two third of these women had semiskilled or skilled employments but 10% were unemployed.

Family formation and structure: About two-thirds of the women were currently married of this, 79% were living with their spouses. Twenty two percent had had previous marriages, more than half had been married for ten or more years. Mean duration of marriage was 12.5 (SD=8.7) years (Table 1).

Family relationship and functioning: Majority of the married women had four or fewer number of children. Fifty five mothers had no custody of any child and 23 with custody of at least a child. Previous child death was reported by 32(32%) and 28 had previous unwanted pregnancy and 33 had had abortions. Extended family functioning was described as adequate by 83% with more than half having regular contact with them. Those who visited their extended families frequently were less likely to report dissatisfaction with extended family functioning, had more support from relatives and less fear of discriminations. Family history of mental illness was present in 19% while 25% feared that their children may inherit the illness (Table 2).

Illness associated factors: The women with schizophrenia reported more fear of children inheriting illness ($p=0.034$); less likely to be cohabiting with spouse ($p=.049$) and to have no custody of any child ($p=0.035$). Mothers without custody of any children were significantly more likely to be schizophrenics ($p=0.001$), be currently unmarried ($p=0.021$), have non-residential marital relationships ($p=0.034$) and experienced previous abortions (0.028). They significantly had previous marriages that were unsuccessful ($p=0.000$), poor or no discussion of FP with spouse (0.016) and inadequate spousal support ($p=0.009$). Custody lost or gained was not significantly associated with maternal age, religion, type of marriage, perceived level of extended family functioning, support or frequency of contact or visits (Table 3).

Table 1
Family formation and structure characteristics of the women

Variables		n(%)
Marital status (N=100)	Currently married	67(67)
	Single	24(24)
	Divorced	5(5)
	Widowed	4(4)
Type of Marriage (N=67)	Monogamy	53(79)
	Polygamy	14(21)
Co-residential marital relationship (N=67)	Yes	53(79)
	No	14(21)
Duration of marriage in years (N=67)	≤10	34(51)
	11-20	16(24)
	>20	17(25)
Previous marriage (N=74)	Yes	16(22)
	No	58(78)
Number of siblings with same parents (N=100)	None	5(5)
	1-4	38(38)
	≥5	57(57)
Number of living children (N=100)	None	22(22)
	1-4	58(58)
	≥5	20(20)
Experience of death of children (N=100)	None	68(68)
	1	20(20)
	≥2	12(12)

Table 2
Family relationship and functioning characteristics of the women

Variables		n(%)
Extended family relationships? (N=100)	Satisfactory	83(83)
	Unsatisfactory	17(17)
Visitations to extend family (N=100)	Hardly	7(7)
	Irregular	38(38)
	Regular	55(55)
Children performance at school (N=76)	Doing well	51(67)
	Not doing well	25(33)
Children behaviour at home difficult (N=80)	Yes	7(9)
	No	73(91)
Children behaviour at school is difficult (N=80)	Yes	4(5)
	No	76(95)
Have children with similar illness (N=80)	Yes	2(3)
	No	78(97)
Have parents with similar illness (N=100)	Yes	5(5)
	No	95(95)
Have relatives with similar illness (N=100)	Yes	23(23)
	No	77(77)

Have custody of children (N=78)	All	14(18)
	only some	9(12)
	None	55(70)
Fear that the children may inherit illness (N=96)	Yes	26(27)
	No	70(73)
Suffering descrimination because of illness (N=100)	Yes	15(15)
	No	85(85)
Spousal support (N=74)	Adequate	60(81)
	Inadequate	14(19)
Relatives (N=100)	Adequate	90(90)
	Inadequate	10(10)

Table 3
Family and socio-demographic factors associated with loss of custody of children

Variables	custody absent (n ¹ =55)	custody present (n ² =23)	P value
Diagnosis of Schizophrenia			
Present	37	2	0.000
Absent	18	21	
Marital status			
Currently married	49	15	0.021*
Not currently married	6	8	
Co-residential marital relationship	(n ¹ =55)	(n ² =17)	
Yes	43	10	0.034*
No	7	7	
Previous marriage	(n ¹ =50)	(n ² =17)	
Yes	4	9	0.000*
No	46	8	
Spousal communication about family planning	(n ¹ =49)	(n ² =18)	0.016
Present	29	4	
Absent	20	14	
Perceived level of spousal support	(n ¹ =50)	(n ² =24)	0.009
Adequate	45	15	
Inadequate	5	9	

*Fisher two tailed value

DISCUSSION

In this study majority were currently married parents who were not parenting their children because they lost custody. Most enjoyed a relatively high degree of extended family involvement and support as indicated by patient-family contact frequency, perceived extended family functionality and reported spousal and family support. The remarkable trend of high prevalence of custody loss was significantly associated with schizophrenics who were married and experiencing inadequate spousal support. Women

with diagnosis of schizophrenia were also peculiar in the sense that they were less likely to be parents and to be in co-residential marital relationships.

In characterising the family of our outpatient female population we were only trying to identify pattern of formation, structure and functioning and provide evidence of need for intervention. The relatively high number of patients who were stably married parents can be explained by the fact that in our setting, cultural and religious institutions with pervasive influence make marriage and parenthood practically obligatory and discouraging separation

or divorce (21). This pronatalist factors contributes to the high fertility of 5.7 (meaning that the average Nigeria woman will bear approximately six children in her life time) (22).

Suggestion of marital stability in this study is based on a mean duration of marriage of 12.5 years; comparing this with the study's mean duration of illness (10years) suggests the probability that many of the women married before their illness started. The fact that contracting marriage before onset of illness is reportedly easier than after onset (9), may also have contributed to high rate in this study. Marriage being an important source of emotional and instrumental support (2) with strong association with morbidity and mortality (23), the challenge here is how to keep them adjusted via anticipatory guidance, risk identification and management.

Generally women with severe mental illness are reported to be at high risk of losing custody of their children (5,7,8,24). Custody loss prevalence rate vary widely across locality and geographical settings but rate as high as 50% have been reported among schizophrenics (24). The high prevalence of custody loss in this study is therefore not out of pattern but only indicates the high degree of burden that the extended family may have to bear. As it has been suggested custody loss has negative psychosocial implications for the patient, her child and the family (5,7,24). Some mothers are known to suffer grief, loss of self respect, desperation while some children suffer lingering feeling of rejection and desertion which can be quite traumatic (7,24).

These negative effects may occur irrespective of whether custody loss or suspension of child-parent relationship is intermittent, or permanent (25); physical or emotional (26); court mandated or family determined (7,8,24).

In Nigeria custody loss is unlikely to be permanent as it is usually to an extended family member who takes care of the child while mother is ill or recovering; in which case it is more of co-parenting or intermittent parenting (19). The affected child could also be subjected to surrogate mothering which is practiced in the extended family system where fathers send their children to live with and be raised by their grandparents (19).

There has been interest in factors associated with loss of custody for the purpose of intervention and prevention. Factors such as substance abuse, child neglect and abuse, diagnosis of schizophrenia or psychosis, homelessness and poverty are reported to elevate the risk of custody loss (7,24). In this study schizophrenics were more affected than others by loss of custody understandably probably because of the severity of the condition. Illness related variables may therefore be responsible for this trend. Apart from this, mothers likely to lose custody of their children included those not currently married, married

previously (that is divorced, separated or widowed) and those in non-residential marital relationships. It is possible that cultural and religious factors played a role in this finding; because child custody decision in our environment are most likely to be dominated by the male partner or his family (19).

Intertwined, is the issue of parenting and frequency of contact and quality of relationship between patients and family member. Despite the high level of custody loss overall it would appear that majority of the women enjoyed a reasonable degree of positive and healthy family support. This thinking is supported by the facts that virtually all of them had siblings and majority had the perception that their extended family was functioning well, contacts with family was adequate and relative and spousal support were adequate.

Because of the importance of family relationships and functioning to the care of these patients and the identified trend we decided to look at factors that influence the frequency of patient-relative contact. The frequency of patient relative contact is an important factor in management. It has been known to predict outcome in many domain of functioning (27). The frequency of patient relative contact was categorised as hardly, irregular and regular. Those who visited their extended families frequently were less likely to report, dissatisfaction with extended family functioning; support from relatives and fear of discriminations. Enquiry about relationship with family member is important. If inadequate, apart from being an indicator of social withdrawal or isolation, it may be a feature of the disease. The family is needed as a resource to improve and sustain management.

The schizophrenic subsample presented some special features that are remarkable. They were less likely to be parents, more likely to have fears that their children would inherit their illness, less likely to be in co-residential relationships and less likely to have custody of their children. These problems are most probably related to severity of the disorders. Some studies comparing schizophrenics with other disorders have reported that they have more impairment in family relationships and functioning (10,28).

Some variables were used to investigate the pattern of outcomes for the children of these patients. Most of the children were reportedly doing well at school in terms of academic performance and behaviorally and also at home, none had been admitted into any correctional institutions (also called remand homes). This study showed that majority of women had good outcomes for their children as far as these variables were concerned. This was not surprising considering the general trend that many of the women were well supported by their husbands and extended family and had adequate interaction both in quantity and quality. Quality as judged by

those who reported being satisfied with the level of functioning of their extended family and quantity by adequacy of contact or visitations. Families in relative harmony create a good environment for therapy and psychosocial development of the patients and their children.

Inconclusion, unresolved problems and needs in family relationships or interactions identified in this study can have adverse effects on patient's clinical management and the ability of the family to cope. The psychiatrists may be involved in anticipatory guidance by helping families prepare for potential stresses related to these factors before they occur. One limitation of this study is that it is clinic based which limits its applicability to the wider community. Data obtained at the clinics may help to guide the psychiatrists on how to manage the patient at the individual level. Understanding the family context of every patient's problem will improve care. Another limitation is the fact that standardised instrument was not used to assess family functioning which would have conferred greater validity on the study. This is a preliminary descriptive study intentioned to determine existence of problems it could serve as basis for a larger study with more robust instrument and methodology, by clinic-based standards it can still be considered a valuable investigation.

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