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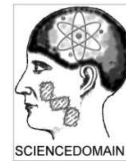

Review of the Challenges Facing Management of Patients with Psychotic Disorder and the Need for Mental Health Policies in Nigeria

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Author's contribution

The sole author designed, analyzed and interpreted and prepared the manuscript.

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ABSTRACT

Psychosis is a chronic recurrent neuropsychiatric disorder that impairs the quality of life of the individuals and represents a major public health issue. Poverty, unemployment, family instability, substance misuse and obstetric complications are the major risk factors for the rising cases of psychotic illnesses in Nigeria. However, the traditional African people still believe that the disease is due to supernatural forces at work against the mental wellbeing of the individuals and as such cure cannot be found through modern medicines. Thus, the management of the illness is mostly carried out in traditional healing centers and prayer houses without any proper regard for the human rights of the patients. The absence of comprehensive mental healthcare policy also contributes to the maltreatments and sufferings of these patients in Nigeria. Thus, this mini-review highlights the challenges facing the management of patients with psychotic disorder in Nigeria and the need for the development of comprehensive mental health policies that will specifically address these issues.

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1. INTRODUCTION

Psychosis is a mental disorder characterized by multiple symptoms affecting thought, perceptions, emotion and volition [1-3]. Delusion is a chronic disorder in thought or perceptions, as inferred from illogical or highly idiosyncratic communications and irrational behaviours that characterised patients with psychosis [1-4]. Delusions or false beliefs are attempts by the patient to deal with the confusion of reality [1-3]. The hearing of voices or hallucinations that marked this disorder is due to the inability of the patient to discriminate between external stimuli and inner mental states [1]. It is characterised by a mental state, in which the patient is no longer aware of his own thoughts and purposes. Thus, the volitional power of the individual is grossly impaired. It also accounts for the sudden blockade in the stream of thought, in which the patient expressed the sensation of somebody taking his thought from his mind, a condition known as thought withdrawal [1,4]. Catatonia and stereotyped behaviours are other major features of psychosis [1]. A patient with catatonic excitement is always in a state of extreme psychomotor agitation and talks or shouts almost continuously. His verbal productions are often incoherent and his behaviour seems to be influenced more by inner stimuli than by response to his environment. Patients in a state of catatonic excitement need urgent physical and medical attention because of their destructiveness [1,4]. However, patients in a state of catatonia with stupor are characterised by complete stupor or reduced motor activity and social withdrawal [1,4]. Stereotypy is a purposeless, compulsive or strange behaviour or gesture performed over and over again [1,4].

Although the pathogenesis of psychosis still remains unclear, hyperdopaminergic activity is generally believed to play a crucial role in the symptomatology of the disease [1-4]. This belief is based on the premise that neuroleptics, which improve psychotic symptoms, act by blocking dopamine receptors [1-4]. However, the African people have a totally different opinion about the genesis of the disease. The traditional African people believed that the disease is due to supernatural forces at work against the mental wellbeing of the individuals and as such cure cannot be found through modern medicines [5-7]. This cultural perception about the disease is a major obstacle that will continue to hinder the care and treatment of patients with psychotic disorder in Africa. Thus, necessary steps should be taken through public enlightenment about the nature of the disease and its pharmacotherapy [6-8]. In traditional African society, management of patients with psychosis are mostly carried out in traditional healing centres and prayer houses without any proper regard for the human rights of these individuals [5]. The scarcity of accessible and qualitative mental health care facilities are among the factors contributing to the increased patronage of traditional healers and prayer houses by patients with psychosis and their relatives [8]. However, most of these patients faced various maltreatments such as flogging, incarceration and food deprivation in these healing and prayer centres. This maltreatment stems from lack of a comprehensive mental health intervention policies that will care and protect the right of the mentally ill persons in Nigeria [6-9]. Thus, this mini-review highlights the challenges facing the management of patients with psychotic disorder in Nigeria and the need for the development of comprehensive mental health policies that will specifically address these issues.

This paper employs the archival method of research through the survey of literature relevant to the challenges facing the management and care of patients with psychotic disorder in Nigeria. It highlights the need for the government to develop a comprehensive mental health policy and legislation that could reduce the stigmatization, maltreatments and sufferings of these patients in Nigeria. It further suggest the adoption of the approach akin to the concept of regionalization [10], which emphasizes the utilization of resources specific to individual's community to meet the socioeconomic challenges by integrating traditional healers into the national mental health care policy in Nigeria.

2. AFRICAN PERCEPTION AND BELIEF OF MENTAL ILLNESS

Psychosis is on the increase as a neurologic disease in most developing African countries, including Nigeria. The disease impairs the quality of life of the sufferers and it remains a major medical and social problems particularly in developing countries like Nigeria [5,9]. Most Africans believed that the disease results from visitation of the devil, effect of witch-craft, the revenge of an aggrieved ancestral spirit or an

act of retribution [5,7,9]. These general beliefs has continued to influence public attitude to psychotic or manic disorder in most African countries; resulting in patients with the disease being ostracized, stigmatized and neglected [5]. Also, the rural populaces believe that psychotic illness cannot be cured by orthodox medical practitioners, but through supernatural means or syncretic religious practices like exorcism [5]. These beliefs and attitudes underlie the inadequate support and care for people living with the disease in Nigeria. This perhaps also accounts for the increased patronage of the traditional healers and prayer houses by patients with psychosis in most African countries. It is a common cultural belief that people with mental illness possess the spirit of the devil. Thus, in order to be cured, the individual has to be tied by some able-bodied men and flogged, with the belief that the evil spirit will leave the fellow [5,9]. In traditional Nigerian society, people believe that a person with psychosis who enters the market place to feed on the wastes generated from the community market place, can no longer be treated or cure [5]. This deeply held traditional myth continues to hamper the care for the mentally ill individuals in Nigeria.

3. PSYCHIATRIC PRACTICE IN NIGERIA: THE JOURNEY SO FAR

Although, the recognition and treatment of mental disorders in Nigeria pre-date written records, psychiatric service delivery was first introduced in the early 20th century [11]. The first asylum was established in Calabar in 1904 while the second was established in Yaba, Lagos in 1907 [11]. These asylums were run by medical officers, as there were no psychiatrists, and were meant to provide emergency and custodial interventions [11]. In 1954, the Aro Mental Hospital was established in Abeokuta by the British colonial government in response to the need for improved mental health care [11]. It also provided an opportunity for the country's first indigenous psychiatrist, Dr Lambo, to spearhead service delivery on his return from the United Kingdom in 1952. The hospital, later to be known as the Aro Neuropsychiatric Hospital, was to play a central role in the development of the practice of psychiatry in Nigeria [11].

The bulk of psychiatric service was provided by eight regional psychiatric hospitals and the departments of psychiatry in 12 medical schools [11]. In addition, some general hospitals also provide psychiatric services. Despite these facilities, mental health care service still remains inadequate, with the ratio of psychiatric beds being about 0.4 to 10 000 persons, while that for both psychologists and social workers is 0.02 to 100 000 persons [11]. The scarcity of accessible and quality mental health services are contributing factors to the increased patronage of traditional healers and prayer camps in Nigeria. Other factors such as the belief in spiritual influences on mental health and skepticism towards the effectiveness of biomedicines for mental disorders also result in families seeking alternatives to psychiatric treatment [11]. Psychiatric hospitals are still noted for being over-crowded and under-funded. The quality of psychiatric care is also compromised by the low numbers of qualified staff and a lack of psychosocial treatment and rehabilitation [11-12]. Additionally, psychiatric services are not readily accessible to rural communities [11-12]. This calls for an urgent intervention on the part of the health care policy makers in designing a qualitative community mental health services in the existing primary health centers in Nigeria.

4. PREVALENCE OF PSYCHOSIS IN NIGERIA

The distribution of a disorder in a given population is measured in terms of incidence and prevalence. Incidence refers to the proportion of new cases per unit of time (usually one year), while prevalence refers to the proportion of existing cases (both old and new). Three types of prevalence rate exist: *point prevalence*, which is a measure of the number of cases at a specific point in time; *period prevalence*, which is the number of cases over a defined period of time (usually six months or one year); and *lifetime prevalence,* which refers to the number of individuals who have been affected by a disorder at any time during their lives [13].

The number of people across the globe with schizophrenia has been estimated at about 29 million, of whom 20 million live in developing or least developed countries [13-14]. Point prevalence on adults ranges between 1 and 17 per 1000 population, one-year prevalence between 1 and 7.5 per 1000, and lifetime prevalence between 1 and 18 per 1000 [13-14]. However, surveys carried out in various countries including Nigeria show incidence rates per year of schizophrenia in adults between 0.1 and 0.4 per 1000 population [13]. However, its prevalence varies across the world, within countries, with higher rate in Nigeria compared to

USA and UK [11]. Lower income individuals tend to have their disorders diagnosed later after the onset of symptoms, relative to those of better economic standings [11-13]. As a result, the lower social classes are more likely to be living with their illness untreated and this may contribute to the rising rate of psychosis in most developing countries including Nigeria [9,13-15]. In Nigeria, like most other African countries, the patients with the disease are faced with challenges of being ostracized, stigmatized, neglected and becoming vagabond, thus exposing them to untold sufferings [9;16]. An immediate intervention by the government to arrest the increasing cases of disability and mortality due to the disease is indeed over due in Nigeria. The levels of successes achieved by a poorer country like Kenya in the provision of mental health services for their people at primary health care centers in the community are important lessons that can be of gain for Nigeria [17].

5. RISK FACTORS FOR THE RISING CASES OF PSYCHOSIS IN NIGERIA

Multiple factors interacting in a complex manner have been identified as the major causes for the rising cases of psychosis in Nigeria [5,18]. These factors include poverty and unemployment, family instability, substance misuse (drugs or alcohol), obstetric complications and exposure to stress or trauma [5,13-14,18]. Although, family studies have shown that the disease evolved from cluster of specific genes [19], several issues have been raised challenging the genetic predisposition to the phenomenology of psychosis or schizophrenia [20]. It is generally believe that an individual with a family history of psychosis does not necessarily mean such individual will ultimately develop psychosis, suggesting that other factors in the environment are at work for the disease to develop [21-22]. This has important policy implications that the disease is preventable and even curable if appropriate interventions are carried out to address the psychosocial risk factors.

The impact of poverty on the genesis of schizophrenia was clearly shown in a study carried out in Great Britain. The study showed that British children raised in economic deprivation were eight times more likely to grow up to be schizophrenic [13-15]. With the increasing wave of unemployment in Nigeria, most of the youths now resort to the use of illicit drugs as a coping strategy. This may perhaps have contributed to the rising cases of psychotic disorders in Nigeria. Substance misuse has been implicated as one of the major risk factors for the genesis and relapse of psychotic ailments in Nigeria [5,18]. Substance misuse (cannabis) psychosis is on the increase in Nigeria especially among young males [5,18]. Smoking of cannabis has been shown to increase the chances of developing psychosis by over 40% [18]. Cannabis has also been linked to higher rates of relapse following a psychotic episode [13-14,22]. The most common symptoms of cannabis abuse include confusion, hallucinations (usually visual) and emotional liability [13]. However, there is no yet concrete policy tailored towards the needs of these set of people in the population but the current emphasis is on regulation without systematic harm reduction strategies [8].

Family instability, obstetric complications and traumatic life events or psychosocial stress are also risk factors that are closely connected with the poor social-economic environment prevailing in the country. The increase in psychosis among urban dwellers in Nigeria has also been reported to be related to financial disadvantage, unemployment and social isolation [5]. The findings that higher cases of psychosis occur in communities that are socially impoverished and/or with low socio-economic levels further confirm that the effects of psychosocial environment are more important factors for the development of the disease [5]. The socioeconomic environment in Nigeria especially in the urban communities is stress inducing and persistent stress or life events have been shown to cause mental diseases [18,23]. Holmes and Rahe [24] define life events as changes in a person's day to day life which impose varying degrees of stress. Stress emanating from high social levels has been shown to elicit dopamine release or dopaminergic hyperactivity in mesocorticolimbic pathways [13,14,22]. Schizophrenia, the most severe forms of psychosis, has been linked to high dopamine levels in patients with the disorder [1-4,23]. It is generally believed that psychotic symptoms emerge whenever a threshold of stressors exceeds an individual's vulnerability level [13,14,23]. In indeed, heightened sensitivity to stress has been considered to play a central role in the pathogenesis of schizophrenia and studies have shown that patients with a first episode of psychosis possessed increased levels of cortisols compared with normal controls [33]. The view of stress-vulnerability model as the most critical factor in psychotic disorder will provide a

strong avenue to lobby the government to fund primary prevention programs [23]. However, emphasis on the genetic predisposition may give the government a perfect excuse to do nothing. Thus, reducing the level of stress in the social environment of the patients may likely decrease the cases and the risk of relapses of the disease in the general population.

6. CONSEQUENCES OF PSYCHOTIC ILLNESS: ESSENCE OF URGENT INTERVENTIONS

Although psychosis is not in itself a fatal disease, it has a lot of serious consequences on the patients and the general population. Death rates of people with the disorder have been put at least twice as high as those in the general population [21]. The high mortality in developing countries like Nigeria has been shown to be related to the poor conditions of prolonged traditional care, leading to high occurrence of infections like tuberculosis and other communicable diseases [22]. However, suicide and accidents appear to be the major leading causes of death in developed countries and some developing countries [12,24-27]. Generally, people with psychosis are known to die much earlier than their peers in the general population and about 40% of this premature death is attributed to suicide [28]. Illicit drug use, limited access to healthcare, poor quality of healthcare, fear of mental disintegration, agitation or restlessness, and poor adherence with treatment have been identified as the major factors associated with high suicide risk in patients with psychosis [28]. Thus, preventive strategies should be targeted at identifying those individuals at risk and initiation of prompt management of such patients with suicidal tendencies.

Social stigma is another major burden of the disease and it refers to a set of deeply discrediting attributes, related to negative attitudes and beliefs towards the patients [5,13,18,23]. This affects identity of the individuals and thus leading to a damaged sense of self through social rejection, discrimination and social isolation [21,25-26]. Various adverse consequences may arise from the stigmatization process: use of pejorative language, barriers to housing or employment, restricted access to social services, fewer chances for marriage, increased mistreatment and institutionalization [17,21]. Stigma is deeply rooted in the cultural background of the society and represents a major challenge with regard to the care and integration of the patients into the community [23,25-27]. Many patients with psychosis have expressed the painful experiences of stigmatization on their everyday lives [16]. Stigma also acts as a powerful barrier to treatment and a major cause of relapse [7,9,27]. The situation is quite serious in Nigeria, like most other African nations, and an urgent step need to be taken through public enlightenment and appropriate legislation to reduce the stigmatization and sufferings of schizophrenics in these regions of the world.

The socioeconomic cost of the disease is another heavy burden especially on the family of patients with psychosis and even to the nation in terms of lost of labour force. Estimates of economic costs of schizophrenia are scanty in most developing countries like Nigeria [26-29]. Economic cost includes direct costs, money spent on providing care to affected individuals and indirect cost like loss of resources and productivity due to morbidity and mortality [14,29]. Direct costs of schizophrenia in western countries range between 1.6% and 2.6% of total health care expenditures. In Nigeria, the financial cost of treatment was shown to be much more distressing to relatives than the effects of illness on their daily chores [28-29]. In Nigeria, as in most developing countries, there are no national social welfare programmes and no community-based after-care services [9,27-28]. The patients are simply left in the care of whatever support the extended family system could provide and in most cases abandoned to wander about in the streets [28-30].

7. PREVENTION OF PSYCHOSIS: THE BEST SOURCE OF INTERVENTIONS

Considering the psycho-social bases as the modifiable risk factors for the pathogenesis of psychosis, appropriate preventive strategies should drastically reduce the incidence of the disease. Preventive interventions may be carried out in two ways, namely illness prevention and health promotion. Illness prevention is aimed at establishing specific interventions such as modifying one or more risk factors, while health promotion aimed at enhancing health-promoting behaviours in the community about the causes of the disorders [13-14]. Preventive measures ‘should also aim at early identification of individuals with symptoms of the illness in order to reduce morbidity through prompt treatment [13-14]. This demands an effort from the

government to address the various psychosocial factors (such as tackling the rising cases of unemployment, child abuse, drug abuse, obstetric complications and stress level or life events) that have been identified in people at risk of developing the disease [24]. Also, there is a need to establish intensive home-based interventions targeted at people at risks. Community enlightenment about the origin and nature of psychoses is also necessary, as it will reduce the evil of social stigmatization and maltreatment associated with the disorder. Social stigmatization tends to make the patients to shield themselves and their families from this discrimination, by hiding their illness and avoiding visiting mental health services [9]. The consequence of delayed treatment further creates a vicious cycle of social isolation, unemployment, abandonment, and reduces the chances of recovery and reintegration into normal life [9]. Moreover, early intervention has been shown to improve treatment outcomes and prevent relapse [31]. However, the findings that delayed intervention plays a major contribution to the severity of psychotic illness, led to the formulation of the 'critical period' hypothesis. This hypothesis states that there may be a window of opportunity for early intervention in order to prevent the occurrence of worst outcomes in patients with untreated psychosis [31]. Thus, effective and comprehensive treatment of first episode of psychosis patients is an opportunity of prevention of disability, and the target of reducing the duration of untreated psychosis should be the main objective of all interventions. In addition, the development of health-promoting coping attitudes in people at risk in their social environment could help to prevent the onset of overt schizophrenic disorders [13].

8. CHALLENGES FACING PSYCHIATRIC PRACTICES IN NIGERIA AND THE RISING CASES OF PSYCHOTIC ILLNESSES

The management of patients with psychosis in Nigeria and like most other countries in Africa falls mostly on the traditional healers [5-6]. In traditional African society, the people strongly believed that an individual's wellbeing can be influenced through the subtle manipulation of supernatural agents that constitute the psychosocial environment of the patients [5]. In most cultures in Nigeria, it is a general belief that people with schizophrenia possess the spirit of the devil [5]. As lay views of mental illness are still rooted in super-natural belief systems, and traditional illness model, the role of psychiatric services delivery in Nigeria has been grossly relegated to the background [8]. In spite of Western civilization, a large percentage of Africans irrespective of their educational level still consult traditional healers and spiritualists for guidance in time of real trouble or challenges [8]. The assessment of a number of traditional healing centres revealed that traditional healers could recognize the symptoms of severe mental illness. However, they expressed strong belief in supernatural factors as the basis of the disease [6]. Psychoeducation was found to improve their understanding of the etiology of the disease and to reduce their tendency to use corporeal interventions [6,13]. This finding is quite relevance for the national policy markers for the need to develop mental health policy that will integrate traditional medical practices since the traditional healers are often the first point of contact in most communities in Nigeria [6].

The scarcity of accessible and qualitative mental health care is another major factor contributing to the increasing popularity of traditional healers and to the high attrition from psychiatric treatment in Nigeria. However, the belief in spiritual influences on mental health and scepticism towards the effectiveness of biomedicines for mental disorders also result in families seeking alternatives to psychiatric treatment [5,32]. Above all, psychiatric hospitals in Nigeria are often over-crowded and under-funded [6-7]. The quality of care is also compromised by the low numbers of qualified staff and a lack of psychosocial treatment and rehabilitation [8-9]. If psychiatric services are to be seen by people with mental illness and their relatives as the best alternative to traditional forms of treatment, then they must not only reach out to rural communities, but also provide the highest standard of care [7,12,18].

Although pharmacological interventions have been the mainstay of treatment since the introduction of antipsychotic drugs in the 1950s, they have a number of limitations. These include high incidence of disabling side-effects, poor adherence to treatment and limited response of some patients to antipsychotic medication [15,16,29]. The issues of high cost of drugs and adulteration are also sources of limitation in the pharmacotherapy of psychosis in Nigeria [29-30].

9. URGENT NEED FOR EFFECTIVE MENTAL HEALTH CARE POLICY IN NIGERIA

The role of the central government as the custodian of the nation's resources to develop a comprehensive mental health policy and legislation that could reduce the stigmatization, maltreatment and burdens or sufferings of the mentally ill persons cannot be over emphasized. The World Health Organization (WHO) endorsed mental health care as a universal human right and a fundamental goal for health care systems for all countries [32-33]. Easily accessibility to quality mental health care, manpower development, psychoeducation and the protection of rights of the mentally ill individuals are the major components of the mental health policy [34]. Mental health was adopted into the nation's Primary Health Care in 1991, which became her first mental health intervention policy [9,32]. Since its adoption, the policy has not been fully implemented and overdue for revision [9]. However, there was a draft Mental Health Bill that was sent to the National Assembly in 2003 but instead of being pass into law, was later withdrawn in 2009 [32]. The draft Mental Health Legislation Bill, when passed into law will protect the rights of persons with mental disorders, ensure easy access to treatment, discourage stigma and discrimination and set standards for psychiatric practice in Nigeria [9,32]. Thus, with this background, Nigeria as a nation is yet to have a well-delineated mental health policy and still practicing mental health service delivery system inherited from her colonial master, Great Britain [9,32,35]. Unlike South Africa, which had adopted a new mental health policy since 2002, Nigeria still follow the same mental health law that was in operation before independence in 1960 [32]. This law was originally called the Lunacy Ordinance that was first enacted in 1916 and last amended in 1958 [32]. According to the Lunacy Act, a lunatic includes an idiot and any other person of unsound mind that may require involuntary confinement to prisons called asylums [32]. However, this term was grossly abuse, as many families that find it too difficult or expensive to copy with their relatives' mental health issues simply pass the responsibility to the prisons [32]. The lunatics instead of being treated at hospitals or mental health institutions; they are rather jailed in asylums without any forms of medical interventions [25]. Moreover, the definition of a lunatic as a person of unsound mind also has abuse potentials, which may result in a wrongful confinement of mentally healthy individuals [32].

Nigeria's mental health facilities consist of eight federally funded psychiatric hospitals and six state-owned mental hospitals financed and managed by various state governments, which are grossly inadequate for a population of over 150 million people [36]. Moreover, none of the facilities have beds for children and adolescents [36]. However, a privately owned community residential facility with 10 beds administered by a religious organization for rehabilitation of persons with drug problems was reported to be available in Lagos State [36]. Many reasons such lack of human resources and difficulty in retaining staff, particularly in rural areas as well as poor federal or state funding of mental health services have been advanced for failure of the primary mental health care program in Nigeria [36]. In Nigeria, 95% of professionals who are psychiatrically trained are known to work in tertiary institutions and the other 5% work in non-mental health care facilities [36].

Primary health care services for the mentally ill persons are absent in the rural communities, making early identification and treatment of mental health cases difficult to achieve in Nigeria [36]. Also, information about the level of mental health services in Nigeria is limited and thus, making it difficult to identify areas of need that could influence policy direction [36]. The consequence of this information gap is the continued neglect of mental health issues and the increasing burden of patients with psychotic disorders in the country [36]. This calls for a comprehensive revision of the draft Mental Health Bill Legislation that was initially brought to the National Assembly for adoption and its full implementation after enactment into law. However, mental health advocates should continue to dialogue with the policy markers until mental health received the desired attention and priority in Nigeria. The adoption of the suggestions of Jenkins, [37] may be helpful in persuading our politicians of the need to give adequate attention to the plights of the mentally ill persons, particularly of their disabilities and economic hardships. Thus, every opportunity should be used to influence the politicians of the need for comprehensive mental health policy.

Furthermore, civil servants and professionals in the relevant sectors, who are in direct contact with politicians, should also be persuaded of the need to make mental health a priority in Nigeria.

10. CONCLUSIONS AND RECOMMENDATIONS

A comprehensive mental healthcare system should be developed by the Nigerian government that will focus more on the rural people who are the poorest in the population. There should be a coordinated effort to improve rural infrastructure and design behavioral health promotion campaigns to inform and educate the public about the etiology and nature of psychotic disorders. Policy makers should develop appropriate policies and legislation that could protect the human right of patients with psychosis. The government should also regulate the practice of traditional healers and establish a working relationship between them and orthodox medical counterparts. Government should provide financial support to the relatives of psychotic patients and pay stipends to the mentally ill persons to support them economically. Relevant government agencies should extend social work services to household members of the mentally ill individuals. Trained psychiatrists and clinical psychologists should on regular basis, visits the homes of patients with psychotic disorders to attend to them and encourage other family members to care for them. More importantly, government should protect the right of people with mental illnesses and offer them a sense of dignity as citizens of the nation. They should not be left to themselves to wander in the streets but should be rehabilitated and given the much needed assistance.

COMPETING INTERESTS

Author has declared that no competing interests exist.

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