QUALITATIVE STUDY OF CAREGIVERS' PERSPECTIVES ON TRADO-RELIGIOUS MENTAL HEALTHCARE IN IBADAN, NIGERIA

BY

ALABI, Oluwatomi Temitope
B.Sc Economics
ATRICULATION NUMBER: 209509

A PROJECT SUBMITTED TO THE CENTRE FOR CHILD AND ADOLESCENT MENTAL HEALTH, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE OF THE UNIVERISTY OF IBADAN

JUNE, 2019

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DECLARATION

I declare that this research project was prepared by me and was submitted to the Centre for Child and Adolescent Mental Health, University of Ibadan. No part of this project has been previously presented or submitted anywhere else.

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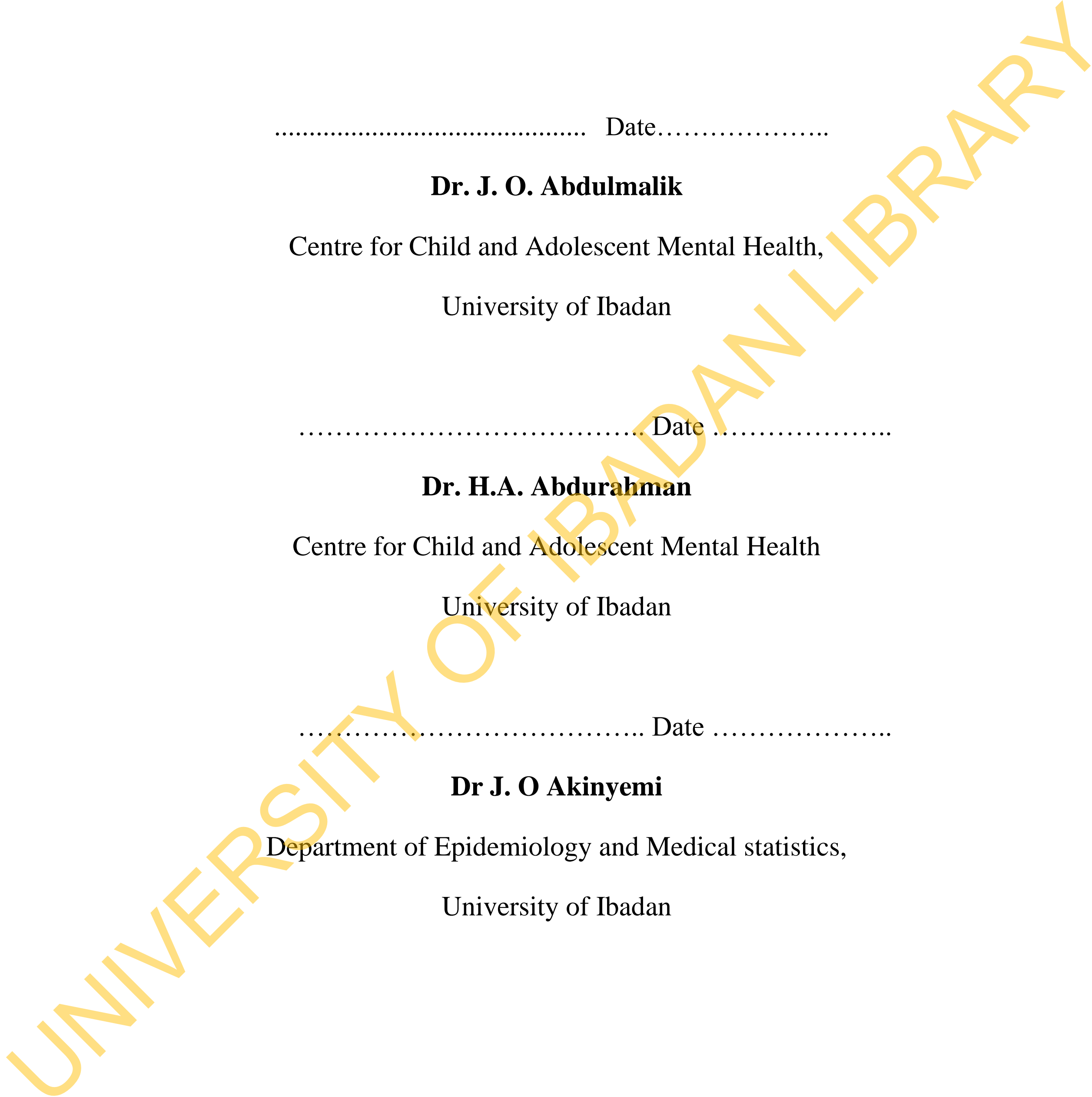
CERTIFICATION

This is to certify that this research project was carried out by Alabi Oluwatomi Temitope of the Centre for Child and Adolescent Mental Health, University of Ibadan.



.... Date………………..

Dr. J. O. Abdulmalik

Centre for Child and Adolescent Mental Health,

University of Ibadan

………………………………. Date ………………..

Dr. H.A. Abdurahman

Centre for Child and Adolescent Mental Health

University of Ibadan

……………………………….. Date ………………..

Dr J. O Akinyemi

Department of Epidemiology and Medical statistics,

University of Ibadan

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Contents

TITTLE PAGE.. i
DECLARATION ii
CERTIFICATION iii
List of tables vii
List of Appendices viii
Abstract x
CHAPTER ONE 1
1.1Background to the study 1
1.2 Definition of terms 4
1.3 Justification and relevance of the Study 5
1.4Study Aim 6
1.5Specific Objectives 6
CHAPTER TWO 8
2.1 Child and Adolescent Mental Disorders 8
2.1.1 Definitions of Mental Health and Mental disorders 8
2.1.2 Prevalence of common child and adolescent mental disorders 9
2.1.3 Burden of child and adolescent mental disorders 12
2.2 Perception and Attitude towards Mental Disorders 14
2.2.1 Perceptions of the cause of mental disorders in Sub Saharan Africa 14
2.2.2 Attitudes towards persons mental Disorder 16
2.2.3 Stigma and social distance towards persons with mental illness 17
2.3 Pathways to care 18
2.4 Trado-Religious Treatment of mental disorders/illnesses 20
2.4.1 Definition of religion and traditional medicine 20
2.4.2 Trado-Religious healers and mental healthcare service delivery 21
2.4.3 Trado-Religious treatment of mental disorders 23
2.4.4 Efficacy of Trado-Religious treatment 25
CHAPTER THREE 28
3.1 Study Location 28
3.2 Study Design: 29

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3.3 Study Population: 29

3.4 Inclusion Criteria 29

3.5 Exclusion Criteria 29

3.6 Sample Size 29

3.7 Sampling Technique: 30

3.8 Study Instruments 30

3.9 Data Management and Analysis 30

3.10 Ethical Consideration 31

CHAPTER FOUR 33

4.1 Socio-demographic Characteristics of Study Participants 34

4.1.1 Table illustrating Socio-demographic data 35

4.1.2 Table illustrating Frequency of socio-demographic variables 36

4.2 Caregivers perspectives on factors which informed the choice to engage with Trado-religious mental health care services 37

4.3 Caregivers perspectives on Trado-religious mental healthcare service providers' views on the aetiology of mental illnesses. 38

4.4 Caregivers perspectives on treatment types, attitude towards and efficacy of treatments received from Trado- religious mental healthcare service providers 40

4.4.1 Treatment types offered to caregivers' wards by Trado-religious mental healthcare providers 40

4.4.2 Caregivers attitudes/feelings on Trado-religious healing practices engaged in while seeking Trado- religious mental healthcare 43

4.4.3Caregiversperspectives on efficacy of treatment received from Trado religious mental healthcare providers 44

4.5 Caregivers perspectives on the advantages and disadvantages of engaging with Trado-religious mental healthcare services 47

4.5.1 Caregivers' perspectives on the advantages of engaging the services of Trado-religious mental healthcare providers. 47

4.5.2 Caregivers perspectives on the disadvantages of engaging with Trado-religious mental healthcare services 49

4.6 Caregivers' perspectives on the possibility of collaborations between Trado-religious and orthodox mental healthcare service providers. And barriers to these collaborations. 51

CHAPTER FIVE 54

5.1 Discussion 54

5.1.1 Socio-demographic Characteristics of Study Participants 54

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

5.1.2 Caregivers perspectives on factors which informed the choice to engage with Trado-religious mental health care services ... 57

5.1.3 Caregivers' perspectives on Trado-religious mental healthcare service providers' views on the aetiology of mental illnesses ... 60

5.1.4 Caregivers perspectives on treatment types, attitude towards and efficacy of treatments received from Trado- religious mental healthcare service providers ... 62

5.1.5 Caregivers perspectives on the advantages and disadvantages of engaging with Trado-religious mental healthcare services ... 69

5.1.6 Caregivers' perspectives on the possibility of collaborations between Trado-religious and orthodox mental healthcare service providers. And barriers to these collaborations ... 72

5.2 Conclusion ... 73

5.3 Strengths of the study ... 74

5.4 Limitations of the study ... 74

5.5 Recommendation ... 74

REFERENCES ... 75

Appendix I (Informed Consent form for Participant) ... 88

Appendix 2 (Informed Consent form for Participant: Yoruba) ... 91

Appendix 3 (Interview Guide) ... 94

Appendix 4 Socio-demographic Questionnaire ... 97

Appendix 4 Socio-demographic Questionnaire (Yoruba) ... 100

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

List of tables

Table 1: Table illustrating Socio-demographic characteristics of participants 34
Table 2: Table illustrating Frequecy of Socio-demographhic variables 35

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

List of Appendices

Appendix I: Informed consent form

Appendix II: Study Instruments (English)

Appendix III: Study Instruments (Yoruba)

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Acronyms

ADHD-Attention Deficit Hyperactivity Disorder

CAP- Complementary and Alternative mental health service providers

CMD- Common Mental Disorders

DALY-Disability Adjusted Life Years

DSM-Diagnostic and Statistical Manual

GP- General Practitioner

ICD-International Statistics Classification of Diseases

LMIC-Low and Middle Income Country

MNS- Mental, Neurological or Substance use

OMI-Opinion of Mental Illness

SPSS- Statistical Package for Social Sciences

SSA- Sub-Saharan Africa

THP- Traditional Health Practitioner

Trado-Religious- Traditional and Religious

UCH- University College Hospital

UNFP-United Nations Population Fund

WHO- World Health Organization

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Abstract

Background: Whenever children and adolescents experience ill health, their caregivers are typically saddled with the responsibility of deciding on the best course of treatment. The process of making decisions between alternative forms of treatment tends to be a complex one. Decisions regarding the most appropriate forms of care are usually informed by the interplay between a myriad of factors. This is especially so in Nigeria where persons in need of mental healthcare tend to take a pluralistic approach to care. Owing to the similar beliefs shared by users and providers regarding the nature and most culturally acceptable treatment methods the use of Trado-religious mental healthcare is prevalent. Studies show that many persons who engage with Trado-religiou mental healthcare services meet the criteria for psychiatric diagnosis. Studies also indicate that many persons engage orthodox and non orthodox mental healthcare services concurrently. In order to improve treatment adherence and outcomes, communication between service users i.e persons who engage both forms of care (Trado-religious and orthodox mental healthcare) and orthodox mental healthcare service providers on perspectives on disease aetiologies, symptoms and subjective experiences of treatment is imperative .

Objective: The study aimed at exploring perspectives of caregivers of children and adolescents with mental illnesses on Trado-Religious mental healthcare.

Method: This was a qualitative study in which 25 caregivers were recruited through the use of purposive sampling. These caregivers were all parents of children and adolescent currently receiving care at the child and adolescent psychiatric facility of the University College Hospital (UCH). Socio-demographic Questionnaires and an In-depth interview guide were used to elicit responses from study participants. The Statistical Package for Social Sciences (SPSS) version 23

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with percentages and frequencies was used to describe socio-demographic characteristics of the respondents while analysis of qualitative data was carried out through the use content analysis.

Results: Respondents indicated that the decision to engage with Trado-religious mental healthcare services were informed by their belief in spiritual causes of mental illnesses and advice from persons in their social environment. Caregivers perceived that the most common views on the aetiology of mental illnesses held by Trado- religious providers' were Spiritual causes, Biological causes, over thinking and stress. Responses from caregivers regarding the efficacy of Trado-religious treatment indicate that it is a common perception that certain forms of Trado-religious mental healthcare treatments are helpful. All participants opined that there should be collaborations between Trado-religious and orthodox mental healthcare service providers however they expressed scepticism regarding the possibility that orthodox mental healthcare service providers would be willing to do work alongside Trado-religious mental health providers.. Participants' responses indicate that many caregivers will continue to engage in a pluralistic system of care for their wards.

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Key Words: Trado-religious, Caregivers, Efficacy

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CHAPTER ONE
INTRODUCTION

1.1Background to the study

Across different countries, cultures, and contexts the use of the terms 'child' and 'adolescent' may convey different meanings and consequently have varying implications. However, the most common implication of the use of the term 'child' is to indicate some form of dependency. Whereas 'adolescent' is often used to describe the growing individual who is making a transition from childhood into adulthood (Sawyer et al 2018; Modell & Goodman, 1990).

Often times, the period of childhood and adolescence are viewed as non-mutually exclusive. This view may be attributed to the fact that there exist some overlaps in the definitions of the developmental years of both children and adolescents. The United Nations Convention on the Rights of the Child defines a child as 'an individual aged 0–18 years' (CRC, 1989). However, according to the world health organization, the period of adolescence spans from the ages of 10 - 19 years (WHO, 2001). Consequently, persons aged 10-18 may be referred to as children and adolescents at the same time.

Children and adolescents account for about a third (2.2 billion persons) of the entire human population (UNICEF, 2008). It is estimated that 90% of the worldwide child and adolescent population reside in low-income and middle-income countries (LMIC), within these countries they (children and adolescents) constitute about half of the population (Kieling et al., 2011).

Owing to the fact that neither children nor adolescents are capable of fully comprehending all the issues involved in their health care, parents are traditionally saddled with the responsibility of

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making treatment decisions on behalf of their wards (Albersheim et al., 2004*)*. The decision regarding appropriate treatment usually entails complex processes and can be difficult for families (Caron et al., 2005).

It is estimated that about 10–20% of children and adolescents worldwide are affected by various mental health problems, these problems are the leading cause of health-related disability within this group (WHO, 2003).

In order to provide effective mental health treatment, the system of care framework as promoted by Stroul & Friedman (1986) stresses the need for mental healthcare services provided to be driven by the needs of the child and his or her family. This framework has its basis in the ecological systems theory of child development which views child welfare as being hugely affected by the workings of the larger family unit. Consequently, adequate mental health treatment requires that caregivers of children and adolescents be involved in the planning, shaping, and monitoring of their child's mental health services (Hunter & Friesen, 1996; Branaan et al., 2003).

Generally, several factors come into play when seeking to adequately define the concept of 'mental disorders'. Amongst these factors are cultural nuances, contexts, level of scientific knowledge and enquiry (Njenga, 2007). Therefore, in order to appropriately recognize mental disorders which may occur in an individual, one would need to cautiously evaluate the prevailing norms, beliefs and customs within said individuals' environment (Kabir et al., 2004).

In pre-colonial Africa, there existed a system of healthcare which took into account the treatment of persons with mental health problems. The methods of treatment, which at the time were administered by traditional healers, included the use of herbs, divinations, incantations and so forth. The choice of treatment engaged by the sick was informed by the beliefs commonly held

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within traditional African society; these included the belief in the existence and activities of witches, ancestral spirits, sorcerers, diviners. Such systems of belief are still pervasive in Africa today (Odejide, 1989).

In numerous developing countries, the belief that a person's ill health can be caused by another through witch craft, sorcery and the evil eye are widely held. Therefore, many individuals believe that their wellbeing can be affected through forms of manipulation carried out by persons within their psychosocial environment. Consequently, the attribution of diseases to supernatural causes is commonplace (Furnham et al., 1999; Morakinyo, 1981).

In Nigeria, it is estimated that of the country's population of 191 million people, 50% of the population is composed of Muslims, 40% are Christians while 10% of Nigerians identify as practicing indigenous religions (Central Intelligence Agency, 2018). Within the country, religion plays a pivotal role in the lives of many citizens. This is especially so as regards issues concerning health.

In terms of mental health treatment, persons with mental disorders as well as their caregivers who hold beliefs about supernatural or preternatural causes of mental illness often seek treatments or 'cures' from traditional and religious service providers (Campbell-Hall et al., 2010). Members of the clergy therefore play a major role in the care of persons with mental illnesses as they are often sought by persons with mental illness and or their families at varying stages of the illness (Igbinomwanhia et al., 2012; Gureje et al., 1995).

In Nigeria today, as is the case in several African countries, traditional and religious healing practices exist alongside more orthodox medical practices (Odejide et al., 1978). In fact, traditional and religious healers may be seen as de facto providers of mental health services to many (Agare

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et al., 2008). Approximately 70% of mental health services are delivered through unorthodox means, such as religious organizations and traditional healers (Ayorinde et al., 2004). A study conducted by Lasebikan et al., (2012) revealed that orthodox mental healthcare services are often sought as a last resort in Nigeria.

Patients who present to these traditional and religious healers often do so with symptoms that meet the requirement for a psychiatric diagnosis (Sorsdahl et al., 2010; Patel et al., 1998; Kleinman, 2004). One may therefore reasonably assume that persons with mental illnesses similar to those treated at orthodox mental health facilities patronize and receive treatment from traditional and religious healers (Nortje, 2016; Igbinomwanhia et al., 2012; Gureje et al., 1995).

As regards pathways to mental health care, which refers to a detailed description of the sources of care which a patient had made use of prior to seeking care from an orthodox mental healthcare provider as well as the factors that modify it, traditional and religious healers are often the first point of care consulted by majority of the Nigerian population before they proceed to receive orthodox care (Gater et al., 1992; Adeosun, 2013; Agara & Makanjuola, 2006). Consequently, traditional and religious healers play a key role in the pathway to orthodox mental health care (Assad et al., 2015; Igbinomwanhia et al., 2012; Milstein, 2017).

1.2 Definition of terms

1. Traditional religion is used to encompass all indigenous religious belief systems which are neither Christian nor Islamic (McGuffey, 1994).
2. Traditional healers is in describing all persons who are trained to administer locally prepared herbal medicine for the treatment of diseases, persons who explicitly appeal to spiritual, magical or religious explanations for disease and distress as well as person who

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practice healing treatments rooted in traditional religious beliefs (Crawford et al., 2004 ;Nortjie et al., 2016).

3. Traditional mental healthcare providers refer to traditional healers involved in the treatment of mental illnesses.
4. Religious mental healthcare providers refer to Christian and Muslim religious clergy involved in the treatment of mental illnesses.
5. Trado-religious mental healthcare refer to treatment offered by traditional and religious mental healthcare providers involved in the treatment of mental illnesses, to persons who met the criteria for psychiatric caseness.
6. Trado-religious mental healthcare provider was therefore used to refer to all traditional and religious mental healthcare providers.

1.3 Justification and relevance of the Study

The world health organization estimates that 1 in 4 persons will develop a mental illness within their lifetime (WHO, 2018). Therefore, many persons would require the use mental health services at some point over the course of their lives. This study focuses on Caregivers perspectives owing to the fact that they are the major decision makers regarding the types of mental health treatment received by their wards.

Awareness of caregivers' perspectives regarding Trado-religious mental healthcare would play a pivotal role in improving mental healthcare service delivery in many regards, chief amongst this is improving therapeutic rapport. Findings from the study would be useful in fostering further meaningful discussions between health users, family care givers and health providers concerning different aspects of disease including aetiologies, symptoms, diagnosis, collaborative treatment decision making, treatment adherence, and treatment outcome (Qureshi et al., 2018).

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Previous studies have attributed the use of traditional and religious mental health services to the fact that traditional and religious institutions, as opposed to orthodox mental healthcare facilities which are few and far between, are readily accessible (Odejide et al., 1978; Gureje et al., 2006).

The study also seeks to increase the body of scientific knowledge by exploring the perspectives of caregivers who have access to orthodox care but choose to engage Trado-religious mental health services alongside engaging with orthodox mental health services.

It is important to study service users' perspectives as studies in health communication show that perception plays a critical role in the healing process. This implies that a person's subjective experiences and perspectives may in fact have some influence on treatment outcomes (Stewart et al., 2000).

It is therefore imperative that we understand and take into account caregivers' perspectives, as this meets their need to be known and understood. Also, a proper understanding of caregivers' perspectives towards Trado-religious mental healthcare services with which they have engaged would also be useful in creating effective and culturally acceptable mental health advocacy plans.

1.4Study Aim

The overall aim of the study was to explore perspectives of caregivers of children and adolescents with mental illnesses on Trado-Religious mental healthcare.

1.5Specific Objectives

The specific objectives of the study were to determine perspectives of caregivers on:

1. Factors which informed the choice to engage with Trado-religious mental healthcare services.

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2. Trado-religious mental healthcare service providers' views on the aetiology of mental illnesses.

3. Treatment types, attitude towards, and efficacy of treatments received from Trado-religious mental healthcare service providers.

4. The advantages and disadvantages of engaging with Trado-religious mental healthcare services.

5. Possibility of collaborations between Trado-religious and orthodox mental healthcare service providers. And barriers to these collaborations.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Child and Adolescent Mental Disorders

2.1.1 Definitions of Mental Health and Mental disorders

According to the World Health Organization (WHO), mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Child and adolescent mental ill-health, on the other hand, is about "the inability of a child to reach the optimum level of competence and functioning, this is reflected in disorders such as depression and learning disabilities" (Patel et al., 2008).

DSM-III-R's definition of a mental disorder is as follows: "a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom".

This syndrome or pattern does not include responses which may be deemed as a normal or appropriate response to certain events, for example the loss of a loved one. Neither does it refer to deviant behavior as regards politics, religion, or sexuality, nor conflicts that are essentially between an individual and his immediate society. This syndrome or pattern, regardless of its original cause must be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person.

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Mental disorders, as defined by the ICD-10, imply "a clinically recognizable set of symptoms or behaviors associated in most cases with considerable distress and substantial interference with personal functions".

A mental disorder is therefore a "mental condition that causes significant distress or disability, it is not merely an expectable response to a particular event, and is a manifestation of a mental dysfunction" (Wakefield, 1992).

2.1.2 Prevalence of common child and adolescent mental disorders

The prevailing view in psychiatry, despite a myriad of culturally specific idioms of distress, suggests that many mental disorders are present and recognizable in every culture (Bhikha et al., 2012). Therefore, there exists no difference in the types of child and adolescent mental disorders identified in resource-poor countries as compared to those in industrialized countries (Giel et al., 1981). Consequently, culture specific mental disorders are a rarity (Nikapota, 1991).

It is however important to note that the recognition of disorders vary or have different interpretations across cultures. This fact necessitates the need for multiple informants in the diagnostic process (Paula et al., 2007). The assessment of the mental health needs of children and adolescents is therefore a complex one. Adequate assessment therefore constitutes the collection of epidemiological data from diverse locations, comparisons of the data collected as well as input from persons and agencies that provide care to the affected population (Rahman et al., 2000).

The term 'common mental disorders' (CMD), describes "disorders that are commonly encountered in community settings, and whose occurrence signals a breakdown in normal functioning" (Goldberg &Huxley, 1992). CMD are non-psychotic mental disorders or neurotic disorders which may present with a combination of somatic, anxiety and depressive symptoms (Patel et al., 1999).

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CMD are often associated with disability and about half of them become chronic (Mann et al., 1981). Consequently, they are a common cause of morbidity worldwide and pose a significant public health problem (Ormel et al., 1994; Ustun et al., 1995). CMD are prevalent among the child and adolescent population. The world health organization estimates that 20% of the world's children and adolescents experience a mental disorder at some stage in their childhood. 1 in 5 persons between the ages of 9 to 17 years currently has a diagnosable mental health disorder that causes some level of impairment. It is estimated that half of all severe mental illnesses begin before the age of 14years (Belfar, 2008). According to the American college of obstetricians and gynaecologists, the most prevalent mental disorders amongst adolescents are: anxiety, mood, attention and behaviour disorders.

Anxiety is thought to be a very common, perhaps the most common psychological disorder in childhood and adolescence (Cartwright-Hatton et al., 2006). Studies indicate that the worldwide prevalence of any anxiety disorder amongst children and adolescents is an estimated 6.5% (Talepasand et al., 2019). There is no gender disparity between the populations affected by anxiety disorders.

The prevalence rate for mood disorders amongst children and adolescents worldwide is estimated to be 3.7%. In terms of gender disparity, girls are twice as likely to develop mood disorders as boys (Merikangas et al 2010a). It is estimated that 1 in 4 children will experience a mood disorder by their late adolescence. At any given time 1 in 20 adolescents meets the clinical criteria for a mood disorder. (Tang et al 2015). In children and adolescents, the worldwide pre-valence any depressive disorder is 2.6% (Talepasand et al., 2019). Epidemiologic studies show that major depression is comparatively rare among children, but common among adolescents, with up to a

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25% lifetime prevalence by the end of adolescence. Mania is much less common, with no more than a 2% lifetime prevalence by the end of adolescence (Kessler et al., 2001).

Merikangas et al. (2010a) reported twelve-month prevalence rates of 8.6% for attention-deficit/ hyperactivity disorder in children, with boys having 2.1 times greater pre-valence of attention-deficit/hyperactivity disorder than girls. According to a report produced by the American academy of paediatrics, approximately 1 in 20 adolescents meet the criteria for a diagnosis of ADHD.

In a systematic review of the available literature on the prevalence of mental, neurological or substance use (MNS) disorder amongst children in sub-Saharan Africa, Cortina et al (2012) estimated that 1 in 7 adolescents suffers from these disorders. When using narrower diagnostic criteria, 1 in 10 children were identified as having psychiatric disorders. Commonly identified disorders in sub-Saharan Africa include behavioural disorders such as depression, anxiety disorder, conduct disorder and posttraumatic stress disorder. These disorders generally yield higher prevalence rates of 19.8% of the child and adolescent population.

A multinational study conducted by Rescorla et al. (2007) showed that girls scored significantly higher than boys on internalizing problems, whereas boys scored significantly higher than girls on externalizing problems.

Over time the prevalence of many mental disorders seem to have increased. However caution needs to be maintained in assuming that the true magnitude of any disorder is increasing as this increase may be accounted for by changes in diagnostic concepts and criteria as well as by improved identification (Belfar, 2008; Fombonne, 2005).

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2.1.3 Burden of child and adolescent mental disorders

It is of great import to state that the identification of a disorder does not in necessarily imply the magnitude of burden or degree of impairment caused by said disorder (Belfar, 2008). In order to adequately appreciate the burden associated with child and adolescent disorders, assessing the epidemiology of these disorders, as is done in the traditional sense, would not suffice (Chen et al., 2007). The magnitude of the burden of child and adolescent mental disorders should therefore be viewed from varying perspectives.

Mental disorders in children and adolescents make up one third of the global burden of disease in this age group (WHO, 2013). According to the world health report, mental disorders made up 12 per cent of the Global Burden of Disease in the year 2000, it is estimated that by the year 2020 this figure will rise up to 15 per cent. . The increasing burden of mental, neurological and substance use disorders worsens in developing countries as a result of the projected increase in the number approaching the age of risk for the onset of certain mental disorders (Flisher et al., 2007). The disability associated with mental illness contributes greatly to the global burden of disease (Chaudhury et al., 2006). Consequently, the Disability Adjusted Life Years (DALY) is largely used as a metric with which the magnitude of mental disorders on society may be measured. As at the year 2001, mental disorders accounted for 4 of the 10 leading causes of health disability. It is estimated that unipolar depression will be the second leading cause of health disability in the world by the year 2020 (WHO, 2001).

Neuropsychiatric disorders are a leading cause of health-related burden, accounting for 15–30% of the disability-adjusted life-years (DALYs) lost within the first three decades of life of young people, that is, persons aged 10 -24 (World Bank, 2006). In sub-Saharan Africa, mental and

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substance use disorders accounted for 19% of the disability-associated disease burden (Whiteford et al., 2013).

When using the DALY metric, problems are encountered with incorporating societal costs (Belfar, 2008). This implies that the existing definition of DALY is too narrow. A true reflection of 'burden of disease' ought to include other persons affected by the mental disorders, that is, family and friends as well as the need for public services (Anand & Hanson, 1997). Owing to the methodological approaches used in calculating DALYs, it can be assumed that the burden of child and adolescent psychiatric disorders far exceed what is reported.

Child and adolescent mental disorders, more so than many other illnesses, have longstanding costs to society. The societal impact is magnified by lost economic productivity and potential destabilization of communities (Belfar, 2008). Children with depression, ADHD and conduct disorder have higher rates of health care utilization (Hankin et al., 1998; Scott et al., 2001; Romeo et al., 2005). They also impose costs on society in terms of education, burden on the criminal justice system and social services (Mannuzza et al., 1998; Knapp, 2000), and need for informal care (Egger et al., 1999; Byford et al., 1999).

Family members of persons with mental illnesses are also affected by their conditions. Families do a great deal, as they provide practical help, personal care and emotional support to the family member affected by the disorder. As regards the burden such disorders place on a patients' caregiver, burden refers to "the presence of problems, difficulties, or adverse events which affect the life (lives) of the psychiatric patient's significant other(s) (Platt, 1985). This burden may either be subjective or objective. Objective burdens are defined as "readily verifiable behavioural phenomena, e.g. negative patient symptoms; caregivers' lives disrupted in terms of domestic

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routine, social activities and leisure; social isolation; and financial and employment difficulties" (Kuipers, 1993). Subjective burdens encompass "emotional strain on caregivers, e.g. fear, sadness, anger, guilt, loss, stigma and rejection" (Tsang, 2002). Studies have shown that one-third to one-half of caregivers experience significant psychological distress experience higher rates of mental ill health than the general populace (Shah et al., 2010).

2.2 Perception and Attitude towards Mental Disorders

Attitudes and perceptions are often addressed as singular interchangeable terms. However they express varying value judgments. Attitudes express a "characteristic of the individuals toward life, society and so on". Attitudes may be also be considered as a mindset or a tendency to act in a particular way based on the individual's experience and temperament (Allport, 1935; Pickens, 2005).Attitudes may also be defined as "an expression of favor or disfavor to towards a person" (Eagley et al., 1998).This plays a pivotal role in all decisions made. Perceptions on the other hand relates to "the way in which certain alternatives are perceived" (Francisco et al., 2015). Perception is pivotal to every human interaction. It is a process of "organizing, interpreting and transforming information from sense data and memory. It is a process through which humans transact with environment. It gives meaning to one's experience, represents one's reality and influences one's behaviour" (King, 1981).Perceptual functioning, past experiences, self concept and other elements of personal history all influence an individual's perception (King, 1989).

2.2.1 Perceptions of the cause of mental disorders in Sub Saharan Africa

Two main systems are generally used to explain mental illnesses. These are: the biomedical, which proposes that mental disorders are in fact brain diseases which require pharmacological intervention to treat the presumed biological irregularities; and traditional which surmises that mental illnesses are attributable to a number of causes such as witchcraft, curses or evil spirits and

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so on. The traditional system posits that mental illness is amenable to spiritual and herbal treatment (Deacon, 2013; Quinn, 2007).

Often time mental health researchers view causation as the complex interplay of biological, psychological and social factors. Conversely, the general public's perception about causation tends to be less sophisticated (Nakane et al., 2005).

It is often assumed that traditional African concepts of health views illness in a holistic way (i.e. the mind-soma dichotomy is not as distinct as in Euro-American society). However, evidence implies that such a holistic view makes a mind and body distinction. Disease causation and classification are closely linked to traditional religious beliefs which are to a large extent shared by many African people. "There are three fundamental ideas concerning causality, first, all things which exist or happen has a cause, which possesses greater 'rights' or privileges; second, occurrences which seriously affect human beings are also intentionally caused; and third, the cause of any occurrence can be ascertained through divination, memory reason and empirical judgment" (Patel,1995).

In many African societies distress is attributed to natural and supernatural causes (Landy 1977; Furnham et al.1999). Studies suggest that African villagers view every disease and misfortune as a religious experience. In Nigeria, it appears that informal education teaches that psychiatric disorders are often caused by mystical means, which include spirit possession, witchcraft, black magic (often referred to as 'poisoning') and cursing (Akighir, 1982).

A study conducted by Gureje et al (2005) reported that among the Yoruba communities in south-western Nigeria, the most frequently suggested causes of mental illnesses were drug and alcohol misuse, possession by evil spirits, traumatic event or shock, stress and genetic inheritance. In

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central Nigeria, mystical causes were reported to be the cause of mental illness amongst most people (Akighir, 1982). The misuse of drugs was believed to be the leading cause of mental illnesses in northern Nigeria.

2.2.2 Attitudes towards persons mental Disorder

The attitudes towards persons with mental illnesses are often indicative of the prevailing situation at the time. In order to appropriately understand the prevailing attitudes towards the mentally ill one would need to carefully study the past attitudes commonly held (Bhugra, 1989). The prevalent attitudes in the past involved witch hunts, present in the Europe during middle ages, creation of mental health facilities in the united states post-middle ages (Caplan, 1969; Wing 1978). Currently, the pendulum has now swung in the direction of community care (Bhugra, 1989).

Factor analyses as derived from the Opinions of Mental Illness (OMI) Questionnaire have identified two distinct clusters that reflect prejudicial attitudes about mental illness: The first and second clusters being authoritarianism and benevolence. The authoritarianism cluster as relates to attitude towards mental illness refers to the belief that persons with mental illness as a class are inferior to normal persons and therefore require coercive handling. Benevolence however refers to kindness shown to unfortunates, leading to behaviour similar to the treatment given to wards by their parents (Cohen et al., 1962).

The attitudes to any taboo group depends on: “the frequency of the actual or anticipated behavioural events, place of the behaviour in the hierarchy of the taboos, intensity of the behaviour; visibility in the open community; geographic location and distribution of the behavior in the community; and the drama of circumstances surrounding the behavior”(Frachia et al., 1976).

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However, there are factors such as familiarity with mental illness, which may be explained as ”knowledge of and experience with mental illness which have been shown to be inversely associated with prejudicial attitudes toward mental illness” (Holmes et al., 1999).

2.2.3 Stigma and social distance towards persons with mental illness

Across all cultures, the stigmatization of mental illness is likely to be present. There may however be variations in the nature and form that this stigma may take (Murthy, 2002).

Social distance is commonly used as a proxy to describe behavioural discrimination in the case of mental illness (Adewuya, 2008; More, 2014).

Stigma is “the convergence of the following four interrelated components: (i) people identify and label human differences; (ii) people associate the differences with undesirable characteristics; (iii) people accomplish some degree of separation of ‘us’ from ‘them and (iv) labelled persons experience status loss and discrimination” (Link et al 2001).

Views about causation are also strongly associated with stigmatizing attitudes to mental illness (Abiodun et al., 2008). However research shows ambivalent findings regarding the effects of certain causation on stigma towards persons with mental illnesses. The belief that mental illness is due to drug or substance misuse may result in the belief that mental illnesses are caused by self and result in the condemning of affected persons (Weiner, 1988). Also, the belief in supernatural causation of mental illness tends to make the prospect of associating with persons suffering from mental illnesses an unattractive and risky choice (Makanjuola, 1987).

Some studies report that in instances where mental illnesses are attributed to factors beyond the surfers control i.e. biological factors may reduce the tendency to reject the mentally ill. However,

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should a mental disorder be attributed to a supposed character flaw or personal defect then there exists a higher likelihood that social distance would occur (Dietrich et al 2004).

Conversely, a study carried out in New Zealand involving undergraduates reported that a belief in biological causality was related to negative attitudes, which included perceptions that persons with mental illnesses were dangerous, antisocial and unpredictable. These beliefs lead a self reported reluctance to become romantically involved with sufferers (Read et al., 2001).

2.3 Pathways to care

Pathways to care refers to "the sequence of contacts an ailing person makes with services provided by individuals or organizations, prompted by the efforts of the distressed person and those of his or her significant others, in the process of seeking treatment for the ailment".

There are various factors which inform the pathways through which patients make their way to care. These include socio-cultural and health service variables such as the organization, availability, and accessibility of health services (Adeosun et al., 2008). Pathways taken by patients may also be influenced by conventions governing referral practices, existent relationships among mental health services and other sources of help as well as the availability/ accessibility of mental health and other agencies which provide support (Gater et al., 1992).

The Goldberg & Huxley pathway to care model (1980) was created in order to assess pathways to psychiatric care. This model consists of five levels of care, that is, from the community to the hospital, as well as four filters. The first level deals with psychiatric and emotional disorders found in the community as presented in community surveys. The first filter refers to the decision made by the patient to seek care from a health professional. The second level refers to psychiatric morbidity that present in general practice. The third level assesses conspicuous psychiatric

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morbidity where the clinician recognizes and ultimately treats and refers persons with psychiatric morbidities identified. The fourth and fifth level encapsulates the patients who are referred to psychiatric services or are admitted to the hospital. The fourth filter refers to issues of secondary care.

It is however important to note that other pathways maybe used by patients seeking psychiatric care as there are cross-cultural variations in the pathways to caring for mental health problems (Gater et al., 1981). Studies conducted worldwide indicate that these variations may be as a result of the varying socio-cultural, religious, and health service contexts (Effiong& Albert, 2016).

While patients may refer themselves directly to mental health professional in some countries, others, in different countries may be referred through longer and less direct pathways, consequently dealing with several healthcare personnel (Gater et al. 1991; Reeler, 1992; Vazquez-Baraqueroet al. 1993).

It therefore follows that in order to fully grasp pathways to care for persons with mental disorders living on the African continent one would have to clearly evaluate the extent to which informal care providers feature early in the care pathway as they are more likely to provide care at the initial stages of the course of the disorder. These informal care providers may cause delays in seeking out more orthodox mental healthcare services (Burns, 2014).

Ethnicity, which encompasses factors such as language, religion, and place of origin, has a profound impact on impact on illness models, nature and direction of care pathways (Porta, 2008: Anderson et al., 2014). Across African ethnic groups factors that influence help-seeking are: personal awareness of symptoms, family members' knowledge of symptoms of mental illness and

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knowledge of mental health services (Ferrari et al., 2015). In the treatment of mental illnesses family members and relatives often mediate help seeking (Del Vecchio et al., 2015).

WHO reports that when seeking out care for mental health concerns, persons who live in countries where healthcare resources are easily available often visit hospitals as their initial point of care. These persons are then referred to mental health services. Conversely, in resources poor countries, persons with mental health concerns often seek care to an equal degree at primary care centers as well as from traditional healers. These service providers may then refer patients directly to psychiatric services (Bekele et al., 2008).

2.4 Trado-Religious Treatment of mental disorders/illnesses

2.4.1 Definition of religion and traditional medicine

No singular definition of religion has attained worldwide assent. However, religion, which at its core concerns beliefs and rituals, is a universal social phenomenon. Its root is in the belief in a Supreme Being or Supernatural power and the way by which this supreme being/power relates with that which surrounds it.

Durkheim convincingly defines religion as "A unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden, beliefs and practices which unite into one single moral community called a church, all those who adhere to them" (Durkheim, 1915). Similarly, James G. Frazer explains religion, "a belief in a power superior to man, which is believed to direct and control the course and nature of human life" (Rao, 1990).

Traditional medicine may be defined as "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or

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not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness"(WHO, 2014).

African traditional medicine may be defined as "medicine as known and practiced by Africans from time immemorial for the health need of her people; and the practitioners of the art the traditional healers are recognized by their communities" (Omonzejele, 2003)

Traditional healing is defined as "the practice of using local herbs for the treatment of diseases" (WHO, 2002).

2.4.2 Trado-Religious healers and mental healthcare service delivery

Traditional healers may be used refer to "persons who are trained to administer locally prepared herbal medicine for the treatment of diseases" (Crawford et al., 2004). One may also create an operational definition of traditional healers as "healers who explicitly appeal to spiritual, magical or religious explanations for disease and distress" (Nortjie, 2016).

Traditional healers account for a huge part of the global mental health workforce. A great deal of published work suggests that many persons living in developing countries seek out traditional healers to treat mental health concerns. In some instances these traditional healers are used alongside more orthodox psychiatric services (Alem et al., 1999; Familiar et al., 2013; Galabuziet al., 2010).

These healers appeal to many by way of the healing practices applied which often times are indigenous to the local culture. Their appeal may also be attributed the similar belief systems which are held both by the client and healer (WHO, 2002). These shared beliefs typically include spiritual and religious models of illness causation and consequently affect patterns of help-seeking (Bhikha et al., 2002).

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Religious bodies are prominent institutions across the African continent. They have a storied history of providing support to persons within the communities in which they function. The clergy by extension play an invaluable role within the community.

Religion has been discovered to influence health through four prominent pathways. They are " (1) by modifying health behaviour by prescribing certain diets, discouraging the use of alcohol and so on (2) providing social support, this is due to the fact that many people often establish relationships with other persons within their religious sect. (3) Psychological states, religious people may experience better mental health, more positive psychological states which may result in better physical health".

Koenig et al., (2012) reports that there are significant positive correlations between religion and self-esteem, hope, optimism and low scores on anxiety and suicide ideations.

Religious/ Faith healers are "religious leaders who base their treatment on the powers of God to heal sickness" (Kale, 1995). As regards the administration of mental health services, the clergy are usually at the forefront of unorthodox service delivery.

Traditional and Religious healers therefore constitute an important group of complementary and alternative mental health service providers (CAPs) in sub-Sahara Africa, that is, they provide treatment involving practices and beliefs that are not generally upheld by the dominant health system in Western countries (Jorm et al., 2004; Oluyomi et al 2017). The appeal of CAPs may be attributed to their cultural perceptions of mental disorders, the psychosocial support afforded by such healers, their availability, accessibility and affordability (Ae-Ngibise K et al 2010).

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2.4.3 Trado-Religious treatment of mental disorders

The systems of healing for mental health problems in most African countries are pluralistic. That means, both traditional and 'conventional' biomedical theories and practices exist side by side (Anyinam, 1987). Therefore, many persons patronize both orthodox health services and traditional health care providers simultaneously (Odejide et al, 1978; Ndetei, 2007). In Nigeria, as in many other African countries, traditional healing practices exist alongside orthodox medical practice (Lambo, 1959 and 1961; Harding, 1973; Ademuwagun, 1976).

The means of providing care adopted by CAPs vary from more conventional medical practice in many regards. Most notably they differ in terms of the explanatory model of disease causation/ aetiology, as well as, in the method of treatment and diagnosis applied (Fosu, 1981).

In a great many traditional healing practices there is hardly ever a distinction made between spiritual problems, physical illness, emotional illness and obstacles encountered in of everyday life (Csordas, 2008). This is evident by the fact that a disorder such as depression is not thought to be a mental illness while strange behaviours which is a key symptom of psychosis is attributed to possession or bewitching (Bhikha et al., 2002 ;Sorsdahl et al.,2010). Wellness, which as opposed to being viewed in terms of pathology, is viewed as, social and spiritual harmony (Sorsdahl et al., 2010; Portaman et al., 2002).

The form of management/treatment offered by traditional healers often times fall into two main groups, which are, herbal preparations (pharmacotherapy) and various forms of psychotherapy (Ndetei, 2006). In order to make diagnostic classifications traditional healers are hugely reliant on two major factors. They are: (1) the aetiological factors (2) the symptomatology factors. The mode of classification when considering these factors is hugely influenced by the traditional healers' conception of causation or presentation (Odejide et al 1978).

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In the course of providing mental health treatment, it is common practice for libations (sacrifices to the gods) to be made by the traditional healer (Puckree et al., 2002). Though not commonly practiced today, traditional surgical intervention, such as craniotomies, were commonly used by Kenyan people to treat psychosis. This arose due to the belief that symptoms of psychosis were caused by diseases located in the skull. Practiced today in its stead is the creation of small incisions on parts of the body to alleviate pain or for the insertion of herbal concoctions/ medicines. Traditional healers also offer what may be deemed 'spiritual therapy'. This practice seeks to bring harmony between the living and spiritual world. This treatment often results in reduced stress (Ndetei, 2006).

Religious healers mostly make use of religious practices such as praying, fasting, exorcisms, sprinkling of holy water etc as the primary means of treatment of mental health disorders (Puckree et al., 2002).

Islamic healers often make use of on both physical and spiritual methods to cure disease and improve patients' wellbeing. These methods of treatment usually include recitations, devotions and supplications (Sara Al-Rawhi et al., 2002). These Islamic prayers entail external and internal meditative practices which are carried out in different postures, each with varying implications physically and psychologically (Chishti, 1991)

Islamic healers also seek to manipulate the energy around the patient's body (Mirahmadi & Mirahmadi, 2005). Ally et al., (2007) reports that during the healing process Islamic clerics often transfer positive energy to their patients by placing their hands on the patients body and reciting passages from the Qur'aan. The verses read may be blown onto the client and/or into natural products which are to be ingested by the patient.

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A study conducted by Asamoah et al., (2014) indicated that Pentecostal clergy when providing mental health treatment often begin by identifying the cause of the illness. It is a common held belief that they have the supernatural ability to distinguish if the origin of the illness is psychological, physical or spiritual. The perceived cause of the illness then informs the treatment administered. Therefore, a problem that is deemed to have non spiritual origins may lead a referral to orthodox care. However, should the problem be deemed spiritual, the healing process often requires that the evil spirit responsible be expelled through exorcism, specific religious rituals and practices such as prayer and fasting.

Christian clergy also often tend to provide counselling to persons with mental illnesses regardless of their training or feelings of adequacy in terms of providing effective treatment (Farrell, 2008). Christian clergy also provide what may be referred to as “stopgap counselling” which means they provide counselling to persons between the time they are contacted and the time they access orthodox mental healthcare (Clinebell, 1966).

Often times, both traditional and religious healers believe in the common practice of confession of sins as a pivotal part of the healing process (Puckree et al., 2002).

2.4.4 Efficacy of Trado-Religious treatment

Traditional healing practices entail a nuanced concept of healing. Consequently, the assessment of treatment efficacy is nuanced as well, even more so than is attainable within orthodox psychiatry (Nortje et al., 2016). It may therefore be argued that although traditional medicine may be compatible with orthodox medicine, a proper assessment of treatment outcomes is very difficult and that traditional healing should therefore not be made subject to western standards of scientific medicine (Tangwa, 2007; Omonzejele, 2003).

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It is however possible to assume the efficacy of traditional healing practices based on*:* "(1) Recovery based on improved functioning and reduced suffering (2) Help received by family members even though the patient does not recover (3) the affirmation of the system of medicine (this is done by engaging others in their roles as patients and participants in the healing ritual)" (Kirmayer, 2013).

A study conducted by Abbo et al., (2012) revealed that following sessions at traditional healing centers patients with mania, depression and schizophrenia experienced reduced symptoms at 3 and 6 months follow up.

As regards aspects related to physiology, treatments offered by spiritualist/traditional healers are believed to depend on trance behaviours that occur during the healing process. Kleinman (1980) believed that culturally sanctioned trances "seems to be both socially adaptive and personally therapeutic".

In some instances, spiritual healing may have effects on disorders that are not typically affected by symbolic manipulation by "cleaning" and purification, this however requires that these symbols be internalized by way of continuous reinforcement. When used, results obtained from spiritual therapy are at par with psychotherapy. This is in terms of eliminating the sick role, restoring the individual's behavioural capacities, and eliminating the feeling of "being sick" (Finkler, 1981).

Also, within the healing process, factors such as high healer and patient expectancy have been found to be strongly related to positive treatment outcomes (Wirth, 1985). Johansson (2011) indicates that "the expectancy–alliance–outcome mediational chain is a general phenomenon, not limited to subgroups of patients or modes of treatment". "Positive client expectations and the personal qualities of the healer are core ingredients of traditional healing and Western

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psychotherapy alike, suggesting that these disciplines might share some therapeutic mechanisms" (Nortje et al., 20116).

One may conclude that there are numerous ways by which disorders may intersect with various explanatory models. Lemelson (2004) reveals while studying long term treatment outcomes of patients who were formerly acutely psychotic, that traditional healing was both strongly used a very well regarded by patients.

Prayers offered by clergy have been found to be useful in treating depression and anxiety. This improvement has been found to be maintained up to 1 year following prayer intervention (Boelens et al., 2012).

In a systematic review carried out by Vander watt et al., (2018) "Spiritual and faith healing were perceived to be both effective and ineffective. Although not all spiritual and faith healing methods were perceived as effective or acceptable".

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CHAPTER THREE

METHODOLOGY

3.1 Study Location

This study was carried out in the child and adolescent psychiatric facility at the University College Hospital (UCH), Ibadan. The university college hospital is located in Ibadan, Oyo state, in the south western region of Nigeria. The University College Hospital, Ibadan was initially commissioned with 500-bed spaces. Currently, the hospital has 1,000 bed spaces and 200 examination couches with occupancy rates ranging from 65-70%.

The child and adolescent psychiatric facility, UCH, Ibadan is located within the university college hospital premises. The facility provides treatment to persons between the ages of 5 -20 years. The facility provides both in and outpatient mental healthcare services. The clinic caters to persons with mental illnesses who walk in for treatment as well as those who have been referred for treatment from other institutions as well as from with other departments in the hospital.

The mental health services provided at the outpatient clinics are provided on two separate days. They are Mondays and Thursdays. The clinic on Monday caters to children and adolescents with intellectual disabilities, while, the clinic on Thursday caters to children and adolescents who have other psychiatric disorders.

The in-patient facility provides care for children and adolescents who require hospitalization and monitoring. This facility is a ten bed facility with separate wards for male and female patients. Care at the facility is provided by a multidisciplinary team of psychiatrists, psychologists, occupational therapists and nurses.

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3.2 Study Design: This is a qualitative study of the perspectives of caregivers of children and adolescents receiving mental healthcare in a child and adolescent mental health facility to Trado-religious mental healthcare.

3.3 Study Population: The study population was caregivers, that is, parents of children who were attending weekly outpatient child and adolescent clinics as well as parents of patients who were currently receiving care at the inpatient child and adolescent psychiatric facility of the University College Hospital (UCH).

3.4 Inclusion Criteria

The following are the criteria for recruiting participants into the study;

1. Caregivers of children and adolescents who have taken their children to receive Trado-Religious mental healthcare treatment prior to engaging with orthodox mental health services as well as caregivers of children and adolescents who continue to engage their children in Trado-Religious treatment alongside orthodox mental health treatment.

3.5 Exclusion Criteria

Listed below are the exclusion criteria for the study;

1. Caregiver who are unable to communicate their experiences effectively.
2. Caregivers who are experiencing severe distress in the fulfillment of their care giving role.

3.6 Sample Size: A sample of 25 participants was recruited for the study. This is in line with the recommended qualitative research sample size as reviewed in existing literature. For phenomenological studies, a sample size of 20 – 30 study participants are suggested (Creswell et al., 1998).

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3.7 Sampling Technique: Purposive sampling was used to recruit study participants. Respondents were recruited with the help of the head matron at the child and adolescent outpatient clinic. The author worked together with the matron to recruit respondents while they were waiting for their children to be seen by the mental healthcare providers. The author also worked with the head matron at the child and adolescent in-patient facility to recruit care givers who had come to visit their children who were admitted into the facility.

3.8 Study Instruments

The instruments used for data collection in this study are as follows:

1. Socio-demographic Questionnaire: This consisted of questions relating to socio-demographic characteristics of the study participants. These characteristics included age, gender, family characteristics e.t.c. The socio-demographic questionnaire used was modified from the socio-demographic questionnaire by Omigbodun et al., (2008) which had been adapted for use in a previous study carried out in rural and urban Ibadan. The socio-demographic questionnaires were administered in both English and Yoruba (native language) so as to ensure effective communication between the researcher and research participants.
2. In-depth interview guide: this was a semi structured interview guide which consisted of questions developed by the researcher to elicit relevant information from the study participants.

3.9 Data Management and Analysis

The socio-demographic data were analyzed with the aid of SPSS software. A frequency table was used to describe the socio-demographic information of the study participants. The In- depth interviews were recorded using multiple battery operated voice recorders. The discussion were

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transcribed verbatim and coded to determine emerging themes. Analysis of qualitative data conducted by the use content analysis, this consisted of reading and re-reading texts, manual coding in the margins and through memos synthesizing and grouping data into exhaustive categories. Data gotten from non English speakers were transcribed and translated into English by an interpreter. The translated data was then re-translated to Yoruba by another translator. This was done in order to ensure that the original meaning and concepts of responses were not lost.

3.10 Ethical Consideration

Ethical approval to carry out the study was obtained from the University College Hospital/ University of Ibadan Ethics Committee. Permission to carry out the study was obtained from the head of the child and adolescent facility. Consent was sought from study participants through consent forms. These forms were designed with the aim of ensuring that participants provided informed consent.

The following ethical considerations were regarded:

1. Autonomy: Detailed information regarding the purpose of the study as well as the activities to be conducted over the course of the study period were given to study participants, this was done so as to ensure that persons who agree to be included in the study have given informed consent. Informed consent was sought from persons who are not English speakers with the aid of the Yoruba version of the consent form, questions regarding the study were answered with the aid of an interpreter.

2. Confidentiality: Persons who participated in the study were assured that confidentiality would be maintained. This was done by ensuring that there was no attribution of name to any participant or Trado- religious centers used in the study. Alternative means of

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identification such as participant initials were used as forms of identification over the course of the study.

3. Beneficience to participants: The mental health of the study participants was taken into consideration over the course of the study. Steps were taken to ensure that the welfare of the study participants took precedence over the interests of the researcher. Also, the aim of the study is to elicit information which would consequently be useful to persons who engage with the services offered by the psychiatric facility.

4. Non- maleficience to participants: No actions were taken to intentionally cause harm to the study participants over the course of the study.

5. Voluntariness: The researcher ensured that participants were not coerced or unduly induced to partake in the study. It was made clear that each study participant may choose to opt out of the study at any point in time without any associated consequences. Also care was taken to assure the caregivers of patients receiving care that refusal to participate in the study would not adversely affect the care their wards received at the facility.

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CHAPTER FOUR
RESULTS

The result section is presented as guided by the study objectives into the following sections:

- Socio-demographic characteristics of caregivers
- Caregivers' perspectives on factors which informed the choice to engage with Trado-religious mental health care services
- Caregivers' perspectives on Trado-religious mental healthcare service providers' views on the aetiology of mental illnesses
- Caregivers perspectives on treatment types, attitude towards and efficacy of treatments received from Trado- religious mental healthcare service providers
- Caregivers perspectives on the advantages and disadvantages of engaging with Trado-religious mental healthcare services
- Caregivers' perspectives on the possibility of collaborations between Trado-religious and orthodox mental healthcare service providers. And barriers to these collaborations.

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4.1 Socio-demographic Characteristics of Study Participants

A total number of 25 caregivers were included in the study. All of them were parents with 10 (40%) being male and 15(60%) being female. Participants' ages ranged from 36-61 years. The mean age of study participants was 47 years, (SD =. 5.468). 16(64%) of the caregivers practiced Christianity, 9(36%) of the caregivers practiced Islam. None of the caregivers reported that they practiced Traditional/Indigenous African religion. 6(24%) of the study participants had attained university education, 9(36%) had attained post secondary school education (non-university), 7 (28%) had attained secondary school education while 3(12%) of participants reported that they attained primary school education.

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4.1.1 Table illustrating Socio-demographic data

Identification	GENDER	AGE	RELIGION	EDUCATION	MARITAL STATUS
ID 1	Male	47	Christian	Post Secondary school	Married
ID 2	Male	41	Christian	University	Widowed
ID 3	Female	54	Christian	Secondary school	Married
ID 4	Female	48	Christian	Secondary school	Married
ID 5	Male	61	Christian	University	Married
ID 6	Female	40	Muslim	Post Secondary school	Married
ID 7	Female	41	Christian	University	Married
ID 8	Male	52	Muslim	Post Secondary school	Widowed
ID 9	Male	44	Muslim	University	Separated
ID 10	Male	52	Christian	Post Secondary school	Married
ID 11	Female	43	Muslim	Secondary School	Married
ID 12	Female	49	Christian	Primary School	Married
ID 13	Female	49	Christian	University	Married
ID 14	Male	46	Muslim	Post Secondary school	Married
ID 15	Male	48	Muslim	Post Secondary school	Married
ID 16	Male	45	Christian	Primary School	Widowed
1D 17	Female	48	Christian	Post Secondary school	Widowed
ID 18	Female	41	Muslim	University	Married
ID 19	Female	43	Christian	Primary School	Married
ID 20	Female	46	Christian	Post Secondary school	Married
ID 21	Female	44	Christian	Secondary School	Married
ID 22	Male	44	Muslim	Post Secondary school	Married
ID 23	Female	47	Christian	Secondary School	Married
ID 24	Female	36	Muslim	Secondary School	Married
ID 25	Female	54	Christian	Primary School	Married

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4.1.2 Table illustrating Frequency of socio-demographic variables

Variable	Total number	Percentage (%)
Male Caregivers	10	40
Female Caregivers	15	60
Christian Caregivers	16	64
Muslim Caregivers	9	36
Male, Christian Caregivers	5	20
Male, Muslim Caregivers	5	20
Female, Christian Caregivers	11	44
Female, Muslim Caregivers	4	16
Caregivers with University Qualification	6	24
Caregiver with Post secondary school Qualification (non- university)	9	36
Caregivers with secondary school Qualification	7	28
Caregivers with Primary school Qualification	3	12

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4.2 Caregivers perspectives on factors which informed the choice to engage with Trado-religious mental health care services

Two main themes emerged from the analysis of caregivers' responses regarding the factors which informed their choice to engage with Trado-religious mental healthcare services. These were: the belief in spiritual causes of mental illnesses and advice from persons in their social environment.

Spiritual Causes: Participants mentioned that these illnesses could be a form of punishment from God, or spiritual attack. These are illustrated below:

"Surely there is a spiritual aspect. I may be a science person but at the same time I am a Yoruba man. I know spiritually mental health problems can happen because they inflict people with it. So I use spiritual treatment too. In fact I use that one first. I go for spiritual assistance". (Male, 45)

"There is something people used to say 'Enitiibinuolorunba de si' (whoever Gods anger is extended towards). You may have offended God. That may be why it happened. So you must find spiritual help". (Female, 41)

Advice from persons in their environment: These are illustrated below

"*We even thought that it was a spiritual attack so we need to pray. Having prayed we took her to the mountain. So daddy took her to the mountain. I also took her to the mountain to pray. So having finished the spiritual aspect we realized that we still need medical advice and treatment so as not to be faulty. Daddy said we should tackle the spiritual aspect first".* (Female, 43)

"They told me that things like this cannot get treatment in hospital. They advised me to use spiritual way". (Female, 36)

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4.3 Caregivers perspectives on Trado-religious mental healthcare service providers' views on the aetiology of mental illnesses.

Four themes were generated while assessing caregivers' perspectives on Trado- religious providers' views on the aetiology of mental illnesses. These themes were: Spiritual causes, Biological causes, over thinking and stress.

Spiritual Causes: Participants mentioned spiritual attack and evil spirits as perceived causes of mental illness in children from the Trado religious providers. These are illustrated below

"You know there is no way when you go to a pastor…they would just say…they just said that it is attack…spiritual attack that is just what all of them are saying".(Female, 47)

"I have taken her to various Imams and even the Christian pastors. Now, they…..80% of them …..well, is it up to 80%?.....i would say maybe 60% of them says it is a spirit, in Islam we call the Jinns….Jinn nu…… okay? evil spirits aha…that is….is the evil spirit that is in her. But some are……just maybe about 20% says that the evil spirit just attacked her. But the other 80% will tell you that it is somebody….. maybe I offended somebody or something happened or….. somebody is trying to punish us…..you know….that is why the thing came into her". (Male, 44)

"Well you know spiritually, even both pastors and the herbalists…they would say a lot of things …..so farit is not my own profession too…..so I cannot argue with them. They are there they would give me explanation…….. which I believe they would give me…..that maybe someone is doing one another".(Male, 52)

Biological: Genetic causes and system imbalances were mentioned by the participants These are illustrated below

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"They prayed for him. It was then that we were informed that there is nothing wrong with him spiritually, maybe it is hereditary". (Female, 46)

"The Babalawo told me mummy let me not deceive you the thing that is doing him is not spiritual, take him to the hospital maybe something is wrong with his system". (Female, 43)

Over thinking: This is illustrated below

"Actually the fact is that, we lost his mother last year. So some of them believe that if…. He might be thinking about the loss of the mother". (Male, 52)

Stress: This is illustrated below

"Some have the belief system that maybe the sick person did something that he felt it was bad. So, maybe he was constantly under condemnation and being constantly under condemnation will definitely generate fear which is also related to stress and that can lead to other features that are related to stress". (Male, 61)

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4.4 Caregivers perspectives on treatment types, attitude towards and efficacy of treatments received from Trado- religious mental healthcare service providers

4.4.1 Treatment types offered to caregivers' wards by Trado-religious mental healthcare providers

Seven themes were generated from caregivers' responses regarding types of treatment offered by Trado-religious mental healthcare providers. These were: Prayers, Fasting Exorcism/Deliverance, Religious counselling, 'Holy water & oils', Herbal mixtures/concoctions and Incense.

1.Prayer:

"*The first church they were praying intensively. We went everyday for one week. Then I took him to another one, they said we should pray for seven days. There was no break at all. We were just praying all day, all night long. The third pace we would do it four-four hours. We would just sleep for two hours and continue praying".* (Male, 52)

"I took her to pastors and they all prayed for her. That was the only thing they were doing". (Male, 47)

2. Fasting:

"At the church they asked all of us to fast dry fast no food at all just water. They said he should not take any medication". (Male, 52)

3. Exorcism/Deliverance:

"They did deliverance for him and there is something we in the Islamic way we call it something like Talisman we call it….it is like Histiara… they used to use that thing to send evil spirit away from the child because they believe what it is because of the spirit". (Female, 41)

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"Just recent…. just very recent I have an uncle. He told me that I should take my son to an Alfa. That Alfa now do exorcism …..Ruqyah for him . He was now shaking slightly. He put his hand on my sons head. He now said that because he is shaking some jinn are coming out of him. (Male, 48)

4. "Holy water & oils":

"Normally I would take…..anytime I want to do anything spiritual……when I need spiritual assistance for her I would take her to our Alfas, the ones who are experienced in that kind of thing. They give their own verdict and then their own treatment. They gave us water in the mosque. For drinking and adding to bathing water". (Male, 44)

"Some pastors would also say okay o they would give….they have some holy water she can use. Some would give us holy oil". (Female, 41)

"With the Imams they use what we call….Hantu. That is….. they make….they write Arabic prayers and then wash it with water for her to drink. Some we will now use something and then mix it together and then say she should take". (Female, 43)

5. Counselling:

"*Initially when I noticed before this …..before she broke down I noticed. She was really irritated aggressive to the younger ones so I thought it was just being easily angered so I took here there and he spoke to her and my husband, that is, her father they also counseled her".* (Female, 48)

6. Herbal mixtures/Concoction:

"*There was one herbalist we took him to recently he too gave him 'Apaarun'(lotion). He used Adin (coconut oil) to prepare it. He also gave me something that I should be using one concoction that*

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we should mix it with pap and be drinking it because of the convulsion. They also gave him some herbs but don't know the name of the herb". (Female, 47)

"It was even his dad that took the whole thing up with all these traditionalist and their mixtures….they gave him this and that ….. they call it 'ile tutu', the mixture. It is for convulsion". (Female,48)

7. Incense:

"*The traditional healer gave him something to smoke it. He asked him to cover his head and smoke Turari (Incense). After some time he said he can't breathe very well. I don't even I don't want to go to that man again. And that Turari I ask him to just leave it".* (Male,48)

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4.4.2 Caregivers attitudes/feelings on Trado-religious healing practices engaged in while seeking Trado- religious mental healthcare

Three themes where generated while assessing responses on caregivers perspectives of Trado-religious healing practices engaged in while seeking care. They were: 'Prayer is good', 'Fasting is stressful' and 'religious counselling is important'.

Prayer is good: These are illustrated below

"Ah prayer is very very good o. If you see the prayer warrior that can pray well you will see that the spirit will leave him. You know this thing is a spirit. So they would help me to pray with him and cast the spirit out". (Male, 47)

"Without prayer nothing can happen. In fact, even before I use drugs I always pray before giving it to my daughter". (Female, 49)

Fasting is stressful: This is illustrated below

"We did the fasting ourselves. Someone that is sick we don't need to involve him in any fasting. So we made sure he was eating very well. He don't need the stress. So that at least he can be healthy and so we didn't involve him in any fasting"(Male,52)

Religious Counselling is important: This is illustrated below

***"**One should not overlook counselling because if you pray and you don't have knowledge of what you are praying upon you may not even know that God has answered. And since you don't have knowledge you will even do what caused that thing again. So counseling is very important so as not to raise that sickness again".* (Female, 54)

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4.4.3Caregiversperspectives on efficacy of treatment received from Trado religious mental healthcare providers

Three broad themes were generated while assessing caregivers' perspectives on efficacy of Trado-religious treatment. They were: 'Prayer works', 'Relapses occur', 'Exorcism does not work' and 'it depends'.

Caregivers perceived that the prayers offered by Trado-religious healers were effective. They however stated that their wards often experienced relapses.

Prayer works: These are illustrated below

"Yes actually I felt it. I won't lie because it before it was getting worster wheni came to Nigeria that a lot of people would be telling me this boy has run mad. Also, he does not sleep but now he is sleeping perfectly with the prayer. See I believe prayer is doing a lot of things in life"(Female,41)

"Prayer is effective, they prayed for her and it would go down small then later on if she sleeps again in the morning it would started. It would come back again. With prayer it would come down. He would be normal he can. He would do everything but later .... Like if he sleep again it would still started".(Male,47)

Relapses: These are illustrated below

"I have one good one…one Hausa Imam that will just use prayer. He has done it twice or thrice in my presence and the thing would just leave her like that and immediately she would be okay…..instantly. It is not something that happened behind me oh, it is something…you know…..and she would be okay.Infact, there was one time that she was okay for about fifty days. She was okay until the thing started again. The only drawback in that is that the the thing repeats itself again. It comes back". (Male, 44)

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It depends: participants felt efficacy depended on factors like specific causation of the illness, and the level of faith of the family members These are illustrated below

"Prayer can't work for her. With her case it can't work, even the bible says faith without works is dead. So you have to do some action before the prayer can work. There are some mental illnesses that you can pray and it can work. That is when it is a spiritual attack. But this one is not a spiritual attack. It is something that happened from birth that we did not notice. So this one is not a spiritual attack.. But when it comes to spiritual attacks it works with church". (Female, 44)

"For some people it is miracle that did it that remove them from the state and they are not using any drugs. It differs from people to people. I just realized that it differs. Some people's faith is stronger than others and some people's faith does not carry that type of thing so it differs". (Male, 52)

Exorcism/Deliverance not effective:

Caregivers whose wards had received exorcism opined that they did not find it to be effective

as illustrated below

"I don't think it has helped because that Alfa when he was doing that thing the ruqyah (exorcism). My son was saying he don't feel anything. He was now forcing him that he must feel it. My son now said that he feel it. Meanwhile he did not feel anything. The Alfa was saying look…. see it..the jinn is going and I was thinking ah ahn…me I do not see anything"(Male,48)

"Some would say they would exorcise the demon out of her, this has never worked". (Male,44)

"*They were thinking it is jinn so they did deliverance, nothing happened"* (Male,52)

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4.5 Caregivers perspectives on the advantages and disadvantages of engaging with Trado-religious mental healthcare services

4.5.1 Caregivers' perspectives on the advantages of engaging the services of Trado-religious mental healthcare providers.

Three themes were generated when analyzing caregivers' responses on the advantages of engaging the services Trado-religious mental healthcare. These were: provision of Financial support, Empathy and Powerful intervention.

Caregivers perceived that some Trado-religious mental healthcare providers were empathic, powerful and supportive.

Financial Support: This is illustrated below

"It is the pastor at 'orioke' mountain that gave me 5,000 naira as support". (Male, 41)

Empathy: This are illustrated below

"My pastor is like a father to me. I could remember when he was in Coma as well so when I lose my hope my pastor was like this boy God has given him to you he is going to be alive nothing will happen to him and God did it for me". (Female, 41)

"*They (pastors and Imams) are very supportive. They show a lot of empathy. They had empathy with my daughter. Maybe because they know what is wrong with her ….is affecting her is not mental".* (Male, 44)

Powerful intervention: This is illustrated below

"Religiously the man of God the woman of God…. You know why we call them the people of God? Because they are closer to God than us. Honestly I can just sit in my house and do the prayer points by myself but there are something that I won't just be able to do because of the way God

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created them. I believe…. I believe there is nothing God cannot do especially with their help. Even till now as I am coming to the hospital I don't….I'm not leaving their prayer out". (Female,41)

"After God is Jesus after Jesus is the holy spirit. After the holy spirit is pastors after pastors is doctors. So I go to pastors also". (Female, 54)

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4.5.2 Caregivers perspectives on the disadvantages of engaging with Trado-religious mental healthcare services

Caregivers perceived that there were some disadvantages of engaging Trado religious mental healthcare services. The disadvantages mentioned were the provision of improper treatment by providers, delayed treatment, Negative spiritual consequences and various forms of exploitations.

Four themes were generated from Caregivers responses. These were Improper treatment, Delayed treatment, Exploitation and Negative spiritual consequences.

Improper Treatment: This is illustrated below

"Some people take it hyper-spiritual. The disadvantage is that they may do excessive things that can bring damage to the body. Like it can leave marks on the body and damage the body."(Female,49)

Delayed Treatment: This is illustrated below

"The disadvantage is that the problem may not need church. It may need prayers but it does not necessarily need church work ....spiritual cause may not be where the problem comes from and it is in the hospital that you can receive proper treatment. If you keep going to church they may not treat the right thing. Instead of fast correct treatment they would take the person elsewhere so that is the disadvantage"(Male,52)

Exploitation: These are illustrated below

"*Well they too have to eat ....All their after is money. They would say ah.....i know what is wrong with your daughter. Ah just bring 45 thousand, 25 thousand and they know nothing but they just ……. So they … just want money".* (Male,44)

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"Spiritualism too is never concrete. There is plenty room for a lot of lies to operate. So, one is at their mercy if you go to them. So if they tell you lie you are going to live with that lie and unfortunately, 95 % of them tell lies. They don't know for sure what is going on".(Male,46)

Further Negative Spiritual Consequences: This is illustrated below

"See it is not anywhere you can take your child to. You see there are people that in the cause of seeking for spiritual help. They get more entangled into more spiritual problems". (Male, 48)

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4.6 Caregivers' perspectives on the possibility of collaborations between Trado-religious and orthodox mental healthcare service providers. And barriers to these collaborations.

All participants felt there should be collaborations as illustrated below:

"Well, I think the two can be involved together. Because medical diagnosis and medical treatment has its own way but ….it has its own issues, and prayers has its own place. So non can be isolated."

"Ithink it would be so so better…fine I don't think it has been done before. It would be so helpful for a lot of parents. If there should be an organization like that that there would be pastor alfa all these things it would be good". (Female, 41)

"*generally people need to work hand in hand. To have a whole body all the systems they work hand in hand to make the total system work well. So me I believe that medically and spiritually if they work together at least something of that nature can be cured". (Male, 45)*

"Doctors also should absolutely depend on God because if doctor should say this is the right thing I believe devil can turn the right thing before the doctor to the wrong thing. But if the doctor should rest absolutely on and believe on God that it is God that can do it and that he is just an instrument in the hands of God then the doctor would work perfectly".(Female, 54)

"As a matter of fact they are supposed to work together. Even a doctor that is working in his own profession. He needs to talk to God that God should assist him. Because no one is perfect in this world. I believe that no one is perfect. Whatever you are doing and you call God , God would surely direct you . Even before you can even make a mistake. Because if you believe in God it doesn't happen. But if you don't believe in God then you believe in yourself….Like I said no one is perfect. Surely doctors and pastors they can actually work together. It should be normal". (Male, 52)

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Barriers: The major theme identified here was Differences in beliefs &training on aetiology and management

These are illustrated below

"I think is possible but is it feasible? The people in the medical field ….You know they would always be biased. Biased in the sense that they don't believe the same things. There has to be a common ground. For example if you bring a doctor who is purely in the school of thought that believes everything is logic, that there is no spiritual dimension to things. Then there is no synergy. But having said that I think there are a lot of doctors who believe in the spiritual dimension. And I feel that there could be synergy in that direction in the sense that the doctor can also help the pastor. And If the pastors also believe in the medical field, they can refer. The doctor could as well ask for them (pastors) to come to the hospital to give words of encouragement. There could be an outreach from the ministry of the church coming to the ward to impart ministration."(Male, 61)

"It is not impossible but it would be difficult. Because they are trained differently. Like okay. If I am trained that 2+2 is 4. And you are trained that 2+2 is 8 or even 0 then definitely I would follow what I am saying. You would follow your own way". (Male, 44)

"The doctors themselves do they believe that these things are/ could be spiritual? Do they believe spiritual thing are one of the causes? So it depends on what they believe. If they believe some of these things can be spiritual that is when they can know that ah lets join hands with the faith healers to make it work. But if they don't believe there is no way. If they don't believe it as one of the causes of these conditions that we see n children in these days nothing can happen" (Female, 48)

Word Count: 4,017

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CHAPTER FIVE
DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Socio-demographic Characteristics of Study Participants

The aim of this study was to explore the perspectives of caregivers of children and adolescents with mental illnesses on Trado-Religious mental healthcare. For this reason, all participants recruited into the study were caregivers who had either sought treatment from Trado-religious mental healthcare service providers prior to seeking orthodox mental healthcare or, were currently accessing Trado-religious mental healthcare concurrently with orthodox mental healthcare.

Also, all caregivers who participated in the study were the biological parents to children and adolescents receiving mental health treatment at the child and adolescent psychiatric facility located within the university college hospital, Ibadan premises.

Of the caregivers who participated in the study, 60% were female whilst the remaining 40% were male. The female-male representation in the study was representative of a worldwide gender-biased family role assignment which tends to place women in the caregiver role rather their male counterparts. This assertion is supported by a study by Sharma et al., (2016) which reports that worldwide, women tend to play the role of caregiver and consequentially, provide informal care to family members, including those who suffer from chronic medical conditions.

The assertion is further supported by studies conducted by *Okewole et al., (2011) and* Ae-Ngibise et el., (2014). The former, *which assessed psychiatric co-morbidity among caregivers of patients attending a c*hild and adolescent clinic psychiatric clinic in Lagos, reported that females constituted 78% of all caregivers while the latter, which assessed experiences of caregivers of persons with mental illnesses in Ghana, reported findings of a 56% female caregiver constitution.

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Regarding the religious identification of the study participants, 16(72%) of the caregivers identified as Muslims, 9 (28%) identified as Christians while none identified as practitioners of any form of Traditional/Indigenous African religion. The 1963 national census (which was the last to include information on religious identification in Nigeria), revealed that the percentages of south western Muslims and Christians were, 46.3 percent and 45.5 percent respectively. At this point it is important to point out and clarify a seeming conflict with the religious demographic distribution of this study and the findings of the national census which reports a Muslim majority and therefore infers that a study such as this should majorly constitute or lean more towards a majority participant demographic of Muslims. This disparity may be reconciled by findings from a study carried out by Nolte et al., (2016) which assessed Christian-Muslim relations in south-western Nigeria, were it was reported that Christianity was most strongly represented among those between 35 and 60, an age range all the study participants' fall into, and also, that women are significantly more likely to identify as Christians than men, another socio-demographic category majority of the study participants fall into.

The level of formal education attained by the study participants varied greatly. The highest level education attained reported by the study participants was university education while the lowest level of education attained was primary school education.

6(24%) of the study participants had attained university education, 9(36%) had attained post secondary school education (non-university), 7 (28%) had attained secondary school education while 3(12%) reported that they attained primary school education. This large disparity in level of education attained is consistent with a study by Adewuya et al., (2008) which reported that educational status had no effect on the belief in supernatural causation of mental illnesses.

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5.1.2 Caregivers perspectives on factors which informed the choice to engage with Trado-religious mental health care services

Responses elicited from caregivers revealed that two main factors informed the choice to engage with Trado-religious mental health care services. These were: (1) Beliefs in spiritual causes of mental illnesses and (2) Advice received from persons within their social environment.

Spiritual causes

Caregivers frequently used the term 'spiritual attack' when discussing the view that mental illnesses could be attributed to spiritual causes. Respondents went on to explain that these 'spiritual attacks' were as a result of the workings of malevolent spirits. These spirits were commonly referred to as '*jinns'* by Muslim respondents whereas Christian respondents referred to these spirits as '*evil*' spirits.

Some caregivers opined that their wards mental illnesses could be as a result Gods displeasure with them. Caregivers who expressed this belief proceeded to explain that they considered the possibility that the mental ill-health experienced by their wards could be a form of punishment meted out to them by God.

These findings are consistent with studies such as Adewuya et al., (2008) which assessed lay persons beliefs regarding the causes of mental illnesses, the study reported that (65.5%) of study participants believed mental illnesses were caused by witchcraft/sorcery/evil spirit while (50.1%) of respondents maintained the belief that mental illnesses were as a result of God's will/divine punishment .

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This is also consistent with findings in a study conducted by Akinghir et al., (1982) which reports that in Nigeria, informal education teaches that psychiatric disorders are caused by mystical means such as spirit possessions, witchcraft and black magic.

All caregivers expressed a belief in Gods curative power. The phrase ‘God cures while doctors care’ was commonly used by respondents. This system of belief is not limited to the respondents of this study. A study conducted by Mansfield et al., (2002) to assess beliefs related to the practice of prayer in south eastern United States revealed that 80% of respondent who sought religious faith healing indicated that they believed God acts through physicians to cure illness. Expressions such as ‘I am a Yoruba man’ and ‘Because of how I was raised’ where used by respondents when explaining the rationale behind their beliefs in spiritual aetiology. This is indicative of the fact that spiritual attributions are commonly given to diseases by persons within their socio ethnic groups. Consequently, it is a commonly held belief that appropriate care would be administered by Trado-religious mental healthcare providers.

Advice from persons in their social environment

Caregivers reported that when making choices on forms of care to engage with, they took into consideration the advice offered by persons within their social environment. Responses indicated that close family and friends perceptions on the most appropriate course of treatment played pivotal roles in informing the decision to engage with Trado-religious mental healthcare.

This finding is consistent with a study by Fortunate et al., (2016) which reports that health-care seeking behaviour, that is, the decision on whom to consult and when, whether to comply with treatment or change health care service providers is influenced by traditional family values and a collective mindset

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It is note-worthy to highlight the fact that while all caregivers reported that they had received various forms of psycho-education regarding orthodox views on the causes of mental illnesses, that is, the view that mental ill health occurs as a result of the complex interplay of biological, psychological and social factors, they caregivers maintained a belief in the possibility of spiritual aetiologies of mental illnesses.

This finding is consistent with a study by Hufford (1977) which reports that complex well integrated religious beliefs tend to be stable and resistant to change.

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5.1.3 Caregivers' perspectives on Trado-religious mental healthcare service providers' views on the aetiology of mental illnesses

Caregivers reported that while some providers maintained that their wards distressing behaviours were of spiritual origins, others provided alternative explanatory models of the illness. Responses indicated that the various aetiological causes of mental illnesses acknowledged by Trado-religious mental healthcare providers were: (1) Spiritual causes (2) Biological causes (3) Over thinking (4) Stress

Spiritual Causes

Most participants indicated that the Trado-religious mental healthcare providers seen had attributed mental illnesses to 'spiritual attacks' and 'evil spirits'. It was commonly believed that the mental illnesses experienced by their wards were as a result of 'evil spirit' sent to afflict them by persons with ill intents. Phrases such as 'someone trying to punish us' and ' someone doing her' were used by caregivers to illustrate explanations offered by Trado-religious healers indicating the role of others in bringing the evil spirit upon their wards.

This finding is consistent with Morakinyo (1981) which reports that many individuals in Nigeria believe that their well being may be affected through the manipulations of persons within their psycho-social environment.

Biological Causes

Some caregivers reported that they were informed that their wards symptoms did not have a spiritual root cause. Trado-religious healers who held these beliefs posited that genetic causes and system imbalances bettered explain the distressing symptoms displayed.

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This finding is consistent with a study conducted in Kwara state by Adelekan et al (2011) which reports that (81.4%) Traditional Mental healthcare providers included in the study recognized genetics factors as a cause of mental illnesses.

Over thinking

A caregiver who had recently lost his wife reported that when his child began to withdraw and display odd behaviour the Trado-religious healer he consulted expressed the belief that his child's behaviour could be attributed to his loss of a loved one.

Stress

A caregiver reported that it was the belief of the Trado-religious healthcare provider that his wards mental ill-health was as a result of stress brought on by 'being under condemnation' for an offense he had committed

All caregivers however reported that religious mental healthcare providers sought, regardless of their varying views on the causes of the illness, offered prayer for their wards recovery. Caregivers also reported that healers who perceived that the illness had bio-medical causes went on to refer them to the hospital.

This finding on the willingness of some Trado-religious mental healthcare providers consistent with a publication by preacher Oral Roberts (1976) where he elucidated on steps to attaining better health and miracles. Here he asserts that medical treatment and prayer belong together.

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5.1.4 Caregivers perspectives on treatment types, attitude towards and efficacy of treatments received from Trado- religious mental healthcare service providers

5.1.4.1 Treatment types offered to caregivers' wards by Trado-religious mental healthcare providers

Caregivers reported that the forms of treatment offered by Trado-religious healers were: (1) Prayers (2) Fasting (3) Exorcism/Deliverance, (4) Religious counselling (5) **'**Holy water & oils', (6) Herbal mixtures/concoctions (7) Incense

Caregivers' responses revealed that the types of healthcare modality employed by service providers had its basis in aetiological view on the causes of illnesses. Consequently, perception of the cause of patients' distress and symptomatology informed the choice of treatment administered by the Trado-religious mental healthcare service providers. Caregivers reported that Trado-religious healthcare providers who perceived that symptoms displayed were as a result of 'e vil spirits' administered Exorcisms/deliverance rituals, prayers, Holy water/oil and Incense as the primary form of treatment. While Trado-religious healers who viewed patients distress as having a biological or psychological cause offered prayers, counselling and herbal concoctions as primary forms of treatment.

***Prayer,* Exorcism, Deliverance**

Caregivers reported that healers who held beliefs that the patient were exhibiting odd behaviour due to demonic possession, *jinn*, as it was commonly referred to by Muslim participants, made use of prayers, deliverance or exorcism. These religious rites were performed with the aim of expelling the malevolent spirit from the patient.

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Expressions such as 'perfect healing', 'miraculous healing' and 'prayer point' were used by Christian caregivers when refer to that prayers were offered for their wards.

This finding is consistent with Armanda (1982) which reports that many conservative churches now have groups that emphasize supernaturalistic healing practices and glossolalia.

Herbal Concoctions/ Concoction

Some caregivers reported that they received herbal concoctions as forms of treatment for neurological conditions such as seizure disorders. They went on to explain that their wards were either required to use ingest these mixtures or apply them as lotion. Caregivers of children who displayed psychotic symptoms also reported that their wards were administered herbal mixtures.

This is consistent with Harding et al., (1999) who noted that Herbal remedies were administered as a means of treating psychosis in rural Ibadan.

Holy Water& Oil

Caregivers reported that their wards had been given different types of liquids to treat their mental illnesses. These liquids were commonly referred to as 'holy water' and 'holy oil' .Caregivers went on to explain that they were instructed on how to administer these liquids to their wards. Caregivers who received 'holy oil' explained that their wards were 'anointed' with this oil, that is the oil was placed on their heads. Some care givers report that their wards were asked to ingest the liquids while others stated that they were to add the liquids to their water when taking a bath. Some caregivers reported that they were required to drink ***'Hantu'*** which is water that had been used to wash Koranic scriptures believed to have spiritual powers. Caregivers' responses indicated that these substances were administered to cleanse the body of malevolent spirits.

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These findings are consistent with Saechao et al., (2011) where it was reported that alternative mental healthcare practices performed by traditional and faith healers include performing rituals or administering holy water to cure ills.

Incense

A caregiver whose ward displayed psychotic symptoms reported that their ward was asked to inhale incense (*Turari*) as a means of expelling evil spirits from him.

Findings on the relationship between treatment administered and the perceptions of distress held by Trado- religious healers is consistent with publication by catholic priest Francis Mcnut (1974) which posits that any form of sickness may have a spiritual origin. He goes on to explain that there are three types of interrelated sicknesses. These are: (1) Sickness of the spirit which is caused by personal sin and may be remedied by penance. (2) Sickness of emotions which is caused by the original sin, that is the person has been hurt by the sins of others, this may be remedied by prayer for healing as well as spiritual counselling and (3) sickness of the body which is caused by diseases accidents and may be remedied by prayers of faith, anointing of the sick and medical healing.

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5.1.4.2 Caregivers attitudes/feelings on Trado-religious healing practices engaged in while seeking Trado- religious mental healthcare

Care givers expressed the following feelings regarding different Trado-religious healing practices engaged in while seeking Trado- religious mental healthcare. They were of the opinion that: (1) Prayer was good (2) Religious counselling was important (3) Fasting was stressful.

Prayer is good

Several caregivers expressed that maintaining an active prayer life was key to rearing healthy children. It was opined that prayer was helpful in warding off evil spirits and preventing unfortunate circumstances. Caregivers used the term 'prayer is the master key' to illustrate the fact that prayer was needed to ensure that both orthodox and non orthodox care was successful. Some caregivers reported that they employed prayer when using medication. Also commonly expressed was the fact that they continued to pray for their wards full recovery while engaging with orthodox care.

Chief amongst the 'prayer points' reported by Caregivers was for the 'miraculous healing' 'perfect healing' of their wards illnesses so that they would no longer require any form of care. Caregivers also stated that they sought the help of 'prayer warriors' to ask that God remove the 'spirit' causing the mental illness.

Fasting is stressful

Caregivers also stated that although they believed fasting, which refers to the enforced abstinence from certain or all food and drink for a defined period of time, to be advantageous the process was stressful. Caregivers often spoke on the lengths of fasting they were involved in using terms such as 'day fast' and '7day fast'. Caregivers also indicated that during some fast they were instructed

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not to eat any food. They used the term ‘dry fast’ to indicate that they only consumed water within the period of fasting. Caregivers reported that owing to the stressful nature of fasting they did not involve their wards in fasting. They stated that they ‘took up’ the fasting in their wards stead.

This finding is consistent with a study by Arias et., al (2016) which explored healing practices provided for persons with mental illnesses at prayer camps. It was reported, in this study that fasting was one of the most common healing practices used by faith healers. This was owing to the belief that fasting and prayers were the most integral parts of treating mental illnesses. At these camps relatives or pastors are required to fast in the place of those unable to fast themselves.

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5.1.4.3 Caregivers perspectives on efficacy of treatment received from Trado religious mental healthcare providers

Caregivers did not perceive that all forms of Trado-religious mental healthcare which they engaged in was successful. However, no caregiver interviewed perceived that the exorcism or deliverance rites performed on their wards were effective. Caregivers perceived that factors such as causes of illness, level of faith, ability of healer played roles in how effective treatment was.

Prayers were perceived to be helpful in the treatment of mental illnesses by some caregiver while others opined that prayers were ineffective because the root cause of their wards ill health was not spiritual. Both Christian and Muslim caregivers reported that they believed that God answered the prayers of some of the Trado-religious healers they engaged with. They all stated however that God answered 'in his time'. Christian caregivers however mentioned that for prayers to truly be effective they would be required to 'work and pray'.

Caregivers however had varying reports on how effective prayers were in treating their wards mental illnesses. Some caregivers reported that their wards were completely cured for a length of time following prayers while others reported that the symptoms of illness reduced in severity.

All caregivers who reported that that their wards were fully cured following prayer sessions stated that their wards experienced relapses. Caregivers indicated that for a length of time their wards would show no distressing symptoms however symptoms would return after some time. Some caregivers reported that symptoms aborted for as little as one day while the longest length of time reported by a caregiver where they perceived their ward to be symptom free was fifty days.

The claims regarding immediate resolution of symptoms are similar to those made in a case study by Bush el al., (2012) reports similar finding where a teen who had previously been diagnosed

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with voice hearing and pseudo- seizure experienced immediate resolution of his psychiatric symptoms following traditional healing intervention which made use of prayers. The study reports that he remained well a year post intervention despite cessation of antipsychotic treatment.

Some caregivers reported that although they believed that mental illness could have a spiritual root cause not all mental illnesses could be attributed to spiritual causes. Some caregivers opined in order for a mental illness to be cured through Trado-religious treatment the illness had to have a spiritual cause. Conversely caregivers who held the aforementioned belief expressed skepticism about the efficacy of Trado-religious mental health treatment in tackling mental illnesses that had bio-medical causes.

Some caregivers reported that healing was dependent on the level of faith one had in Gods abilities. Caregivers often used terms like 'strong faith ' to indicate the level of faith required for Trado-religious treatment to be successful

Some caregivers perceived the efficacy of treatment to be linked with the 'spiritual power' possessed by the Trado-religious mental healthcare provider. A caregiver went on to illustrate his experience with a certain Muslim traditional healer who he believed had cured his ward for an extended period of time. This is consistent with Nortje et al., (2016) which reports that positive client expectation and personal qualities are core ingredients in perceived efficacy of both traditional healing and orthodox mental healthcare.

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5.1.5 Caregivers perspectives on the advantages and disadvantages of engaging with Trado-religious mental healthcare services

5.1.5.1 Caregivers' perspectives on the advantages of engaging the services of Trado-religious mental healthcare providers.

Caregivers perceived that there were some advantages of engaging the services of Trado-religious mental healthcare providers. Perceived advantages were: (1) Empathy showed by Trado-religious mental healthcare providers (2) Provision of financial support (3) The belief that Trado-religious mental healthcare service providers were closer to God

Empathy

Some caregivers perceived that the Trado-religious mental healthcare providers engaged were empathic towards them. These caregivers described the attitude displayed by such Trado-religious healthcare providers as 'fatherly' and 'supportive'. Caregivers who perceived the healthcare providers to be empathic reported that they felt supported during the time they received treatment.

This finding illustrates the presence of therapeutic alliance between some Trado-religious mental healthcare service users and providers. Angus et al., (2007) reports that empathy plays a pivotal in psychotherapy. This is especially so in the developing productive relational bonds as well as in patients' perception of treatment efficacy and treatment outcome.

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5.1.5.2 Caregivers perspectives on the disadvantages of engaging with Trado-religious mental healthcare services

All caregivers interviewed reported that they believed there were some disadvantages of engaging with Trado-religious mental healthcare services. The disadvantages mentioned by caregivers were: (1) Improper treatment (2) Delayed treatment (3) Exploitation (4) More Negative Spiritual consequences.

Delayed treatment

Caregivers perceived that while spiritual treatment of mental health illnesses could be effective, not all mental illnesses were as a result of spiritual causes. Caregivers therefore opined that in instance where the mental illness did not have a spiritual origin, the use of Trado-religious mental healthcare treatment would increase the duration of untreated illness.

This finding is consistent with Abdulmalik et al., (2012) which reports that 36.4% of the study participants, which were children and adolescents receiving care at a psychiatric tertiary facility in Nigeria, had initially received treatment from a Trado-religious healer. The study found that a very high proportion of children and adolescents suffering from mental and neurological disorders had not received any form of treatment prior to visiting the clinic. Of the few who had received treatment 1 in 3 patients had presented to the Trado-religious healers prior to presenting at the mental health facility. The duration of untreated illness was estimated to be at least 6 months prior to presentation at the psychiatric facility.

Improper treatment

Although no caregiver involved in the study stated that they had personal experiences at Trado-religious healing centers where various forms of abuse took place, they reported that they were

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aware that harmful practices such as beatings and scarification were practiced by some Trado-religious mental healthcare service providers.

Exploitation

Several caregivers expressed the beliefs that they had been seen by Trado-religious mental healthcare providers who were unaware of how to provide effective treatment. They were of the opinions that these mental healthcare providers willingly carried out ineffective treatment so as to amass wealth. Caregivers also reported that since they were unable to verify claims made by Trado-religious mental healthcare service providers that God had instructed them on a course of treatment they were vulnerable to being financially taken advantage off.

Further Negative spiritual consequences

Some caregivers opined engaging the services of malevolent Trado-religious mental healthcare providers could result in getting 'entangled into more spiritual problems'. It was believed that this may result in a worsened mental state of both the caregiver and their wards.

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5.1.6 Caregivers' perspectives on the possibility of collaborations between Trado-religious and orthodox mental healthcare service providers. And barriers to these collaborations.

All caregivers expressed the belief that there was the need for some form of collaboration between Trado-religious and orthodox healthcare service providers. They opined that this would address the perceived biological and spiritual aspects of mental illnesses. Caregivers also expressed the view that such collaboration would increase the efficacy of orthodox mental healthcare. A commonly expressed view amongst caregivers was that orthodox mental health care service providers ought to 'depend on God' so as to ensure that they provided error free treatment.

Barriers to collaboration

Caregivers however expressed that they believed that the differences in beliefs regarding disease aetiology would make this difficult. Caregivers reported that they were sceptical about the willingness of orthodox care providers to collaborate with Trado-religious mental healthcare providers. This closely mirrors the sentiments held by traditional healers reported by Akol et al., (2018) where these healers related that they were willing to collaborate with biomedical providers but expressed scepticism about the possibility of this occurring owing to the belief that clinicians disregarded them and would not be willing to collaborate with them.

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5.2 Conclusion

This study reveals that caregivers who believed in spiritual causes of mental illnesses prior to engaging with orthodox mental healthcare services continue to do so regardless of the fact that they have been exposed to orthodox explanations of disease causation and are currently engaging with orthodox mental healthcare services.

It is evident from participants' responses that many caregivers will continue to engage in a pluralistic system of care for their wards. Responses from caregivers regarding the efficacy of Trado-religious treatment indicate that it is a common perception that certain forms of Trado-religious mental healthcare treatments are helpful.

All respondents opined that they would find collaboration between orthodox and non- orthodox service providers helpful. Many caregivers indicate that these types of collaborations are necessary to provide appropriate and culturally acceptable mental healthcare.

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5.3 Strengths of the study

This study is one of the few studies in Nigeria to explore caregivers, who have are currently engaging with orthodox mental healthcare services, perceptions on Trado-religious mental healthcare. Owing to the fact that Nigeria is a deeply religious country it is needful to take into consideration the impact of religious leanings on systems of care used.

5.4 Limitations of the study

The author did not explore the perspective of patients who are engaging the services of both orthodox and Trado-religious mental healthcare providers. Data on this would be useful in broadening scientific knowledge as regards the comparative experiences of mental healthcare service users. Also, owing to the small sample size of the study findings cannot be generalized.

5.5 Recommendation

1. Collaboration between orthodox and non orthodox service providers should be explored.
2. Future studies should seek to explore the comparative experience of patients who are users of both orthodox and non orthodox mental healthcare services.
3. Orthodox mental healthcare providers should explore the feasibility of providing faith based therapy.

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Appendix I (Informed Consent form for Participant)

CONSENT FORM (ENGLISH)

Participant Information Leaflet and Consent Form

This leaflet must be given to all prospective participants to avail them enough information regarding the research before a decision is made whether to participate in this study or not.

Title of Research: Qualitative study of the perspectives of patients and caregivers to Trado-Religious mental healthcare.

Name and affiliation of researcher: Miss Alabi Oluwatomi Temitope of the Centre for Child and Adolescent Mental Health, University College Hospital, University of Ibadan, Nigeria.

Purpose(s) of the research: This study seeks to assess the pathway to orthodox mental healthcare by patients with child and adolescent mental disorders, the experiences of patients and caregivers at Trado-Religious mental health care centres and the perspectives of patient and caregivers towards the Trado–Religious mental health practices.

Procedure of the research: This study entails the use of focus group discussions with the aim of eliciting responses that provide insight into the perspectives of patients and caregivers to Trado-Religious Mental Healthcare.

Risk(s): The focus group discussion will take up some of the participants' time.

Benefits(s): The knowledge generated from the study would be useful in facilitating the development of services that decrease the time from first symptoms to effective treatment.

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Confidentiality: All information collected will be given number codes. No names will be recorded or used in any publication or report from this study. Data collected will not be linked to participants in any way.

Voluntariness: Your participation in this study is completely voluntary

Alternatives to participation: If you choose not to participate, this will not affect your treatment at the Child and Adolescent psychiatric facility, UCH, Ibadan, in any way.

Withdrawal from the research: You may choose to withdraw from the research at anytime, you will not be mandated to give an explanation should you choose to do so.

Consequences of withdrawal: There will be no consequence, loss of benefit or care should you choose to withdraw from this study. Please note, however, that some of the information that may have been obtained from you without identifiers (names etc.) before you chose to withdraw, may have been modified or used in analysis reports and publications. We do promise to make great effort to comply with your wishes as much as possible.

Costs/Compensation: A stipend of Five hundred Naira (500) would be given to each study participant, this amount is meant to serve as a compensation for costs accrued during participation in the study.

Statement of the person obtaining consent

I have provided information about this research to __________________________and I have provided adequate information, as well as the risks and benefits, to enable him/her make the right decision.

Name... Date..
Signature.......................................

Statement of the person giving consent

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I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it. I understand that I may freely stop being a part of the study without being required to provide explanation. I have received a copy of this information leaflet and consent form to keep for myself.

NAME:…………………………………………………………………………………….......

DATE:………………………………… SIGNATURE……………………………………………

Statement of person witnessing consent (Process for Non-Literate Participant)

I ………………………………………………….. (Name of witness) certify that the information given to ……………………………………… (Name of participant), in the local language, is a true reflection of what I have read from the study participant information leaflet attached.

Witness' Signature (maintain if participant in non-literate):……………………………….

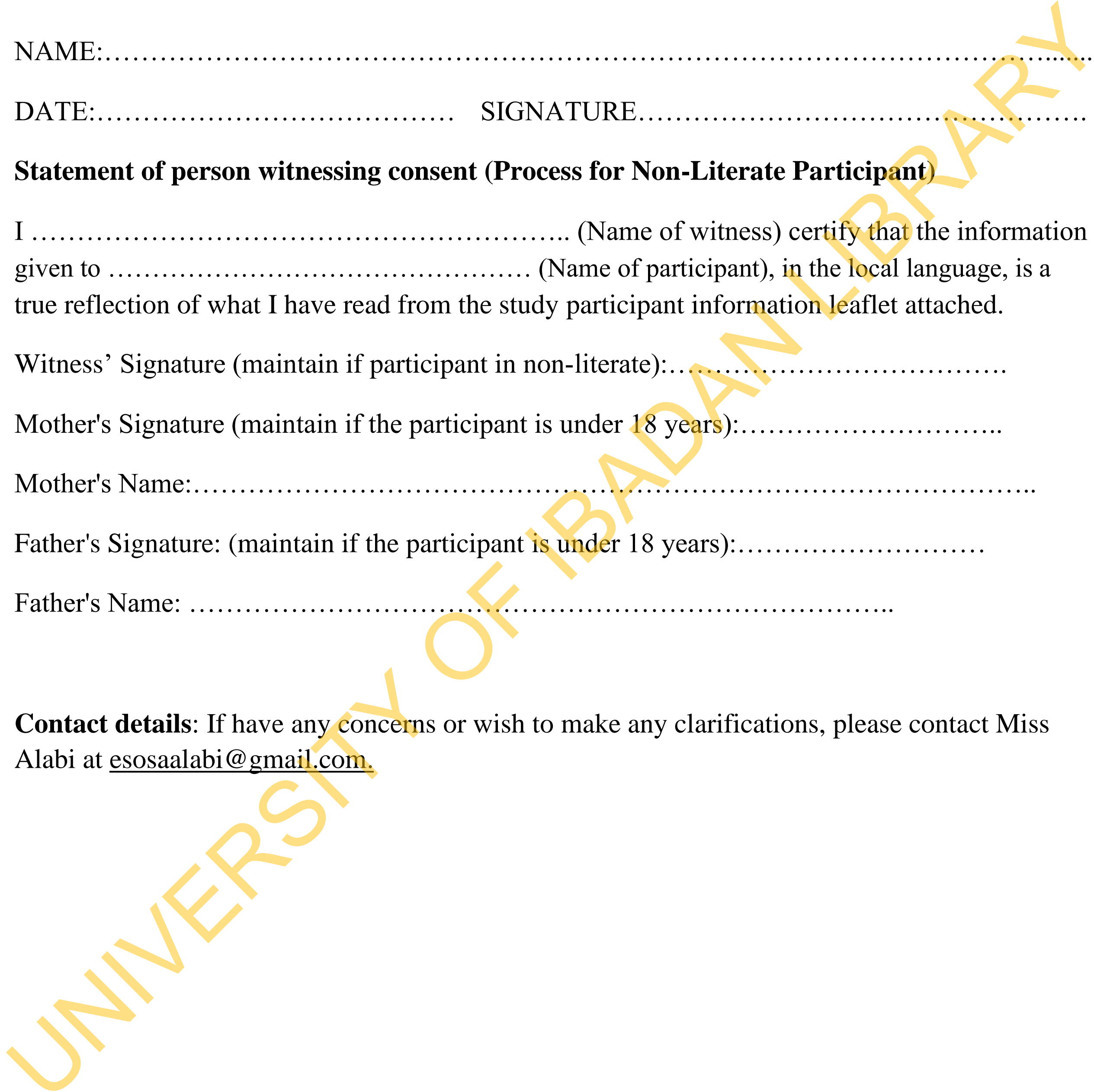
Mother's Signature (maintain if the participant is under 18 years):………………………..

Mother's Name:………………………………………………………………………………..

Father's Signature: (maintain if the participant is under 18 years):………………………

Father's Name: ………………………………………………………………..

Contact details: If have any concerns or wish to make any clarifications, please contact Miss Alabi at esosaalabi@gmail.com.



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Appendix 2 (Informed Consent form for Participant: Yoruba)

Fọ̀ọ̀mù ìlówọ̀sí

Ìwe àlàyé pélébé àti fọ̀ọ̀mù ìlówọ̀sí

O gbọdọ̀fún gbogbo ẹni tí n fojúsọ́nà lati kópa ní ìwé pélébé yìí kí wọn ó lè ní àlàyé tí ó tó nípa ìwádìí náà, kí wọn ó tó ṣe ìpinu lati kópa tàbí lati máà kópa.

Àkórí Ìwádìí: Ojúlówó ìwádìí nípa ìwòye àwọn aláìsàn àti àwọn olùtójú nípa ètò ìlera ọpọlọ ní'làna ti Ìbílẹ̀àti Ẹ̀sìn.

Orúkọ àti ibi tí olùwádìí tí n ṣ'iṣẹ́: Abilékọ Oluwatomi Temitope Alabi ti Ilé-Iṣẹ́ tíó wà fún Ìlera ỌpọlọỌmọdéàti Ọ̀jẹ̀wẹ́wẹ́, ti Ilé-Ìwòsàn Yunifásitì, Yunifásitì Ibadan, Nigeria.

Ète Ìwádìí:Ìwádìí yìí nííṣe pẹ̀lúṣíṣe àgbéyẹ̀wòàwọn ọ̀nà tíàwọn aláìsàn àarun ọpọlọ n gbà rí ilera n'ilana ti igbalode; ìrírí àwọn aláìsàn àti àwọn olùtọ́jú wọn níàwọn ilé-iṣẹ́ìlera ọpọlọ n'ílànàÌbílèàti Ẹ̀sìn; àti ìwòye àwọn aláìsàn àti olùtọ́jú wọn nípa iṣẹ́ tíó ní se pẹ̀lú ìlera ọpọlọ n'ílànàÌbílèàti Ẹ̀sìn.

ÌlànàÌwádìí:Ìwádìí yìí ní nínú lílo ìjíròròàwọn ẹgbẹ́àtẹnumọ́pẹ̀lúèròàti gba àwọn ìdáhùn tí yóòṣí ni l'ójú síàwọn ìwòyeàwọn aláìsàn àti olùtójú nípa ìlera ọpọlọ n'ílànà ti ÌbílèàtiẸ̀sìn.

Ewu: Ìjíròròẹgbẹ́àtẹnumọ́náà yóò gba díẹ̀nínu àkókòàwọn olùkópa.

Ànfààní: Ìmọ̀tíó bá jẹyo lati inúìwádìí yìí yóó wúlò lati ṣe ìrànwó fún àgbékalèàwọn iṣẹ́ tí yóò múàdínkù báàkókó tó wà láàrin ìgbà tíàwọn àmìàìsàn kọ́kọ́súyọàti àkókò tíènìyàn rîìtójú tíó péye.

NíníÀṣírí: Gbogbo àlàyé tí a bá gbà ni áò fún ní nọ́mbà kóòdù. A kò ní gba orúko ẹnikẹ́ni s'ílè tàbí lòó nínu atẹjade tàbîìjábọ̀lati inúìwádìí yìí. Àkọsílẹ̀tí a bá gbà jọ ni a kò ní lè so mọ́ẹnikẹ́ni.

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Títi inú wá: Kíkópa rẹ nínú iṣẹ̀ìwádìí yìí jẹ èyí ti o ti inú rẹ wá pátápátá.

Àwọn ọ̀nà mîrán sí kíkópa: Bîiwó bá yàn lati ma kópa, eleyi kì yóò dîìtọ́jú re ní ibi tí wọ́n ti n ṣe ìtọ́júàìsàn ọpọlọàwọn ọmọdéàti ọ̀jẹ̀wẹ́wẹ́ ní ilé-ìwòsàn Yunifásitì (UCH) Ibadan, lọ́wọ́ lọ́nàkọnà.

Fífàsẹ́yìn nínu ìwádìí: Ìwọ́le yàn lati fàsẹ́yìn kúrò nínu ìwádìí yìí nîigbàkugbà; a kò ní paá ní dandan fún ọ lati ṣe àlàyé bîiwọ bá yàn lati ṣe eléyìí.

Àtunbọ̀tán Fífàsẹ́yìn: Ki yóò síàtunbọ̀tán kankan, pípàdánùànfàànì tàbîìtọ́jú bí iwọ bá yàn lati fàsẹ́yìn kúrò nínúìwádìí yìí. Jọ̀wọ́kíyèsi wípéàwọn àlàyé tí a gbà l'ọ́wọ́rẹ láì gba ìdánimọ̀kankan (fún àpẹẹrẹ, orúkọ re) kí o tó yàn lati fàsẹ́yìn ni a lè ti ọe àtúnṣe sí, tàbí lò nínúàwọn ìjábọ̀àti atẹjade wa. A ṣe ìlérí láti ṣe akitiyan pẹ̀lú inú rere láti wa ni ìbámu pẹ̀lú àwọn ohun ti o fẹ́ni bí o bá ti ṣéé ṣe.

Kóríyá: A o fun olukopa kankan ni ogorun maarun naira(500). Owo bintin yii ni yoo wa fun owo oko ti o ba na l'akoko ti iwadii naa n lo lowo.

Ọ̀rọ̀ ẹni tí ón gba lílọ́wọ́sí:

Èmi ti ṣe àlàyé nípa ìwádìí yìí fún ________________________________ tí mo sì ti pèsè àlàyé tíó tó, àti pẹ̀lú àwọn ewu àti àwọn àǹfààní, láti lè ṣe ìpinnu tí ó tọ́.

ÓJỌ́: ___________________ ÌBUWỌ́LÙ: _________________________ ORÚKỌ: ____

Ọ̀rọ̀ẹni tí ó n jẹri sí lílọ́wọ́sí (Ìlànà fún olùkópa tíó jẹ́púrùntù)

Èmi…………………………………………..(orúkọ olùjẹ́ẹ̀rí) f'ìdíi rè mú'lè wípéàlàyé tí a fún…………………………………. (orúkọ olùkópa) níede abínibí, jéàfihàn tòótó fún ohun tí mo ti kà nínùìwéàlàyé pélébé tí a so mọ́èyí.

Ìbuwọ́lù olùjẹ́ẹ̀rí (lòó bí olùkópa bá jé pùrùntù):………………………………………………..

Ìbuwólùìyá (lòó bí olùkópa kò bá tóọmọọdún méjìdínlógún):……………………………….

Orúko Ìyá:……………………………………………………………………………………

Ìbuwọ́lù bàbá (lòó bí olùkópa kò bá tóọmọọdún méjìdínlógún):……………………………..

Orúkọ bàbá:…………………………………………………………………………….

Àlàyé fún kíkànsí: Bîiwọ̀bá níàwọn ẹ̀dùn kankan tàbí bí o bá nílòàlàyé, jọ̀wọ́kàn sí abilékọAlabi l'óri esosaalabi@gmail.com.

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Appendix 3 (Interview Guide)

INTERVIEW GUIDE

CAREGIVERS PERSPECTIVES ON TRADO-RELIGIOUS MENTAL HEALTHCARE

Introduction

In pre-colonial Africa, there existed an established system of healthcare. This system included the recognition and management of persons with mental illnesses. The treatments, which at the time were provided by traditional healers, constituted of the use of herbs, incantations, divinations and so forth.

In traditional African society, there exists a strong belief in the existence and activities of witches, ancestral spirits, sorcerers and diviners. Beliefs that social factors such as blaming other people for one's ill-health, which, in developing countries, often means witch craft, sorcery and the evil eye, as well as supernatural beliefs and attributions still hold sway today.

In Nigeria, religion plays a pivotal role in the lives of many citizens, especially as it pertains to health-related concerns. The clergy are often times sought out by persons with mental illnesses and their family members at varying stages of the mental illness.

Persons with mental illnesses, as well as their caregivers, who hold beliefs about supernatural or preternatural causes for mental illness seek treatments or 'cures' from traditional and religious institutions. Studies show that traditional and religious healers are often the first point of care consulted by majority of the Nigerian populace.

It is therefore important that we understand the perspectives of caregivers of patients who have been diagnosed with mental illnesses on traditional and religious mental healthcare

The information garnered from this discussion would be helpful in broadening our understanding of this subject matter. Please be reminded that there are no right or wrong answers. You are therefore encouraged to answer the questions posed in an honest manner. You are the expert here and we are here to listen and learn from you. Thank you.

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Question 1: Views: What are your views on traditional/religious mental healthcare practices?

- ETIOLOGY: Probe for views on causes of mental illnesses i.e biological, supernatural, personal/psychological, familial/ social e.t.c*Please tell me more…*
- KNOWLEDGE ABOUT TREATMENT ALTERNATIVES: What types of mental health care services are you aware of? What forms of Trado-religious treatment are you aware of? *Please explain*
- EFFICACY: How effective are traditional religious mental healthcare practices? Does Trado-religious treatment alleviate symptoms of mental illnesses? *Please tell me more about this*
- LENGTH: How long does it take for the treatment to take effect? *Please give examples*
- Would you deem Trado-religious mental health treatment helpful or harmful? Why? *Please explain*

Question 2: Experiences: What were your experiences while at the traditional/religious mental healthcare facility?

- KNOWLEDGE OF SERVICE PROVIDER: Probe for knowledge on causes, types and treatment of mental illnesses
- ATTITUDE: Probe for attitudes of service provider towards persons with mental illnesses and their caregivers i.e benevolent, hostile…..*Please give examples*
- TREATMENT ADMINISTERED : Probe for types of treatment administered while at Trado-religious centers i.e herbs, surgery/incisions, prayers, libation, flogging, keeping in chains e.t.c*Please explain*
- ROLE PLAYED: Probe for role played by caregiver during treatment i.e fasting, prayer, libation e.t.c *Please explain*
- LENGTH OF TREATMENT SESSION: Probe for information regarding the amount of time spent administering treatment i.e how long did prayer session last. *Please give examples*
- PERIOD OF TREATMENT: Period of time solely reliant on traditional/religious mental health services

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Question 3 Recommendations

- PREFERENCE: Which form of treatment do you prefer?
- EFFICACY: Which form of treatment do you believe is more effective, Trado-religious/Orthodox? Why? *Please explain*
- Advantages and disadvantage: What are the pros and cons of both treatments? *Please give examples*
- Cultural appropriateness/ acceptability of orthodox and non orthodox treatment: Which form of treatment is most consistent with your personal beliefs? *Please explain*
- What do you believe would improve treatment (both orthodox and non-orthodox treatment)? *Please give examples and explain*
- How can awareness be raised about orthodox treatment? *Please explain*
- What steps do you believe can be taken to make orthodox care more acceptable? *Please give examples*

Thank you for participating. This has been a very successful discussion. Your opinions will be a valuable asset to the study.

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Appendix 4 Socio-demographic Questionnaire

Serial Number:

Today's Date:___/___/___

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

Please write the answers to the questions or draw a circle where it applies to you.

This is not an examination.

1. Gender (a) MALE (b) FEMALE

2. What is your date of birth? DOB: _____ ______ ________

3. How old are you? ____ ____ ____

Day Month Year

4. Where do you live? (Address of Present Abode):___________________________________

____

5. Have you received treatment from a traditional mental healthcare service provider?

6. What type of treatment did you receive?

____

7. Do you believe that this treatment is effective?

(a)Yes (b) No

8. Do you practice any religion?

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(a) No (b) Yes

9. If yes, which religion do you practice?

(a) Islam (b) Orthodox Christian (c) Pentecostal Christian (d) Traditional religion (e) Other (Specify)____

10. Please write down the exact place you attend for worship

____

____

11. How much does the teaching of your religion guide your behavior?

(a) Very much (b) much (c) Just a little (d) Not at all

12. How much does the teaching of your religion guide your family life?

(a) Very much (b) much (c) Just a little (d) Not at all

Family Information

13. Relationship with the patient:

(a) Father (b) Mother (c) Sibling (d) Relative (e) Other (specify) _____________________

14. Marital Status:

(a) Single (b) Married (c) Separated/Divorced (d) Widowed (e) Widowed Father

15. Family Type:

(a) Monogamous (b) Polygamous (c) Widowed Father (d) Widowed Mother

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16. Who do you live with presently?

(a) Parents (b) Mother (c) Father (d) Spouse (e) Alone (f) Relative/friend

17. Level of Education

(a) No Formal Education (b) Koranic School (c) Primary School (d) Secondary School

(e) Post Secondary (Non-University) (f) University Degree and above

18. Occupation: [Write the exact occupation] ______________________/I do not know

(a) Unskilled (b) Semi-skilled (c) Professional [Not University] (e) (d) Professional and University Others (Specify)____________

19. Level of Spouses Education (*if applicable*):

(a) No Formal Education (b) Koranic School (c) Primary School (d) Secondary School (e) Post Secondary (Non-University) (f) University Degree and above (e) I do not know

20. Occupation of spouse (*if applicable*):: [Write the exact occupation] _____________________/I do not know

(a) Unskilled (b) Semi-skilled (c) Professional [Not University] (d) Professional and University

(e) Others (Specify)____________

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Appendix 4 Socio-demographic Questionnaire (Yoruba)

Serial Number:

Today's Date:___/___/___

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

Jọwọ kọ idahun si awọn ibeere ti o jẹ mọ ọ, tabi ki o fa igi siabẹ eyi to ojẹmọ ọ. Eleyii kii ṣe idanwo; a kan fẹ mọ nipa rẹ ati ilera rẹ ni.

SECTION I

Personal Information

1. Ṣe ọkunrin tabi obinrin? (a) Ọkunrin (b) Obinrin

2. Kini ọjọibi rẹ?Ọjọ ibi: _____ ______ ________

3. Ọmọ ọdun melo ni ọ? ___

4. Nibo ni o n gbe? (Ibugbe):

5. Njẹ ẹ manse ẹsin kankan? (a) Bẹẹkọ (b) Bẹẹni

6. 8Kọ ibi ti o ti maa njọsin

---

7. (a) Islam (b) Orthodox Christian (c) Pentecostal Christian (d) Traditional religion (e) Other

8. Bawo ni igbagbọ rẹṣe ntọ ihuwasi rẹ?

(a) O ntọ ọ gan an (b) O ntọ ọ (c) O ntọ ọdiẹ (d) Ko tọ ọ rara

Family Information (Caregivers only/ Awon Olutoju nikan)

13. Iru ẹbi:

(a) Oniyawo kan (b) Oniyawo meji tabi ju bẹẹlọ (c) Ẹni ti iyawo rẹ ti ku (d) Opo

14. Omo melo leni?

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15. Ibagbepọ oko ati iyawo :

(a) Şe wọn gbe pọ? (b) Şe wọn ti kọ ra wọn silẹ? (d) Baba ti ku (d) Iya ti ku

16. Tani e n gbe pẹlu lọwọlọwọ?

(a) Awọn obi (b) Iyanikan (c) Baba nikan (d) oko (e) Aya

17. Iwe melo le ka?

(a) Ko kawe rara (b) Ile-keu (c) Ile-Iwe Alakọbẹrẹ (d) Ile iwe girama

(e) Ile-iwe agba(f) Yunifasiti atijubẹẹ lọ (e) Nko mo

18. Işẹwo ni e n şe: [Kọ işẹ ti wọn nşe pato lẹkunrẹrẹ] ________________________/Nko mo

(a) Unskilled (b) Semi-skilled (c) Professional [Not University] (d) Professional and University

(e) Others (Specify)______________

19. Iwe melo ni oko/iyawo yin ka?

(a) Ko kawe rara (b) Ile-keu (c) Ile-Iwe Alakọbẹrẹ (d) Ile iwe girama

(e) Ile-iwe agba(f) Yunifasiti atijubẹẹ lọ (e) Nko mo

20. Işẹwo ni oko/ iyawo yi n şe: [Kọ işẹ ti wọn nşe pato lẹkunrẹrẹ] _________________________/Nko mo

(a) Unskilled (b) Semi-skilled (c) Professional [Not University] (d) Professional and University

(e) Others (Specify)______________

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