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Contextualizing Psychotic Disorder as a Silent Epidemic from Selected Kenyan Cultural Perspectives

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Abstract

Psychotic disorder is considered as a silent epidemic throughout Kenya. However, the stigma and discrimination attributed to mental disorder has made the illness a hidden issue equated to a silent epidemic. Many households in Kenya with psychotic disorder persons conceal for fear of discrimination and exclusion from their communities. The effect of the silence on psychotic disorder is further compounded by inadequate focus at the policy level. Lack of adequate national level interventions in addressing mental health negates the understanding of the issue in the Kenyan context and the available possibilities for care and support. The social environment in many Kenyan communities does not nurture good mental health. Psychotic disorder a form of mental illness is often viewed with distress, and those who suffer from mental illnesses are mocked. This paper intends to demonstrate how the silence on psychotic disorder continues to hurt many Kenyans. The paper also discusses strategies for contextualizing mental health care approaches in Kenya. These include: intervention and protective factors; strengthening community mental health systems, cognitive-behavior therapy, family support and incorporating more culturally responsive intervention and support base. The negative attitude towards mental illness needs to change to pave way for a healthier society.

Keywords: *Cognitive, Therapy, Cultural context, Mental illness and Silent epidemic*

Introduction

Psychotic disorders are a group of illnesses that affect the mind. They make it hard for someone to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately. Mental illnesses which may feature psychotic disorders include; schizophrenia, bipolar, brief psychotic and delusional disorders (Arseneault *et al*, 2000).

Early changes associated with the development of psychotic disorders could include: difficulty in concentrating, changes in thinking, preoccupation with odd ideas, mood swings or lack of emotional response, an increase in unusual behaviour, loss of energy and loss of interest in activities, withdrawal from friends and family, and decline in performance (Brennan *et al*, 2000). Symptoms of psychotic disorders also include: disturbed thinking a 'mental block' when thoughts are interrupted completely. Muddled and disjointed thought process and memory loss. People can also experience marked changes in mood. These mood changes can cause a person's motivation to drop leading to negligence in tasks such as personal hygiene, household chores, work or study. An inappropriate response such as laughing at sad news is another symptom of psychotic disorders. People can feel numb and depressed, or sometimes be prone to bursts of intense emotion **(**Krupnick & Wade, 1999).

A substantial body of research has documented significant prevalence of psychotic disorders in Kenya. A large-scale epidemiological study conducted in Nyanza and Western Kenya has found an increase in psychotic symptoms amongst adults in rural Kenya between 2004 and 2013 (Amuyunzu, 2013). The study further revealed a rise in the prevalence of one or more psychotic symptoms from 8 per cent in 2004 to 13.9 per cent in 2013 and an increase in the presence of two or more symptoms from 0.6 per cent in 2004 to 3.8 per cent in 2013. 'The rise in prevalence of psychotic symptoms observed in this study could be partly explained by experience of violence in the Nyanza region over the last decade, an area which is known to have suffered some of the worst election violence in Kenya in 2007 (DFID, 2013).

Prior research suggests that negative life events such as sexual violence, domestic violence have a greater impact on the psychotic symptoms. For instance, election-related violence in Kenya, reported at least one episode of physical or sexual violence in at least 60 per cent of households with women affected more than men

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(Johnson, 2014). Kenya is ill-equipped to deal with these issues due to the scarcity of primary care health worker. Kenya primary care health worker looks after a population of around 10,000 as compared to 1700 in UK population. 'Similarly, in Kenya there is roughly one psychiatric nurse for 250,000 people, whereas in the UK there is one psychiatric nurse per 5-10,000 people.

Psychotic illness is considered a silent epidemic in Kenya owing to structural and systemic barriers such as inadequate health care infrastructure, insufficient number of mental health specialists, and lack of access to medical care, (Collins et al., 2011; Becker & Kleinman, 2013). Prioritizing psychotic mental illness intervention has also been difficult due to lack of resources, limited funding and ineffective mental health policies. The extent and complexity of psychotic disorders, places enormous task on treatment facilities to provide appropriate and effective interventions.

These findings indicate that there are a significant number of people in the society who are struggling with debilitating symptoms of psychotic disorders causing distress and social dysfunction. There is an identified lack of community based rehabilitation programmes that could help mitigate psychotic challenges (Mamah, 2012).

Persons with psychotic disorders often have their human rights violated, as a result of stigmatization and discrimination. Many are denied economic, social and cultural rights. They may also be subjected to unhygienic and inhumane living conditions, physical and sexual abuse, neglect, as well as harmful and degrading treatment practices in health facilities. They are often denied civil rights such as the right to marry and found a family, personal liberty and to participate effectively and fully in public life. As such, persons with mental disorders often live in vulnerable situations and may be excluded and marginalized from society, constituting a significant impediment in the achievement of national and international development goals (Ministry of health, 2015).

Literature

This paper reports the results of the Kenyan survey in relation to understanding psychotic disorder as a silent epidemic from Kenyan cultural context. The paper further discusses strategies to improve mental health care for people suffering from psychotic illness. The strategies encompass both professional health care and community-based care.

Accessibility of Psychotic health services in Africa

Studies indicate that psychiatrist-to-patient ratio in most African countries is less than 1 to 100, 000, and that less than 1% of the total health budget is allocated to mental health *(Bird et al., 2010; Fournier, 2011). Liberia in West Africa* has only 0.06 mental health professionals per 100,000 people in Liberia *Lupick (2012).* Similarly, in Ghana one psychiatrist is allocated to 1.5 million people. With such limited accessibility, many mental health sufferers seek treatment from traditional and faith healers *(Chambers, 2012).*

Compared with the West African countries mentioned, the situation in East Africa is similarly dire. There is an evident shortage of mental health professionals in public practice. In 2001, Tanzania recorded 10 active psychiatrists catering to a population of 30 million (*Njenga, 2002)* Though Kenya is comparatively better prepared to cater for those suffering from mental health disorders, in the region but has only 47 practicing psychiatrists in the private and public sectors against estimated over 100,000 patients. Mathare Hospital, with 750-bed facility located in Nairobi, is the national referral and teaching hospital for mental health patients *(Leposo et al*, 2012).

Cultural contexts of Psychotic mental health in Kenya

In many African societies mental illness is a taboo subject that attracts stigma. The society is often un-empathetic towards psychotic patients are often treated without empathy. The mentally ill face discrimination, social ostracism and the violation of basic human rights, due to stigma associated with mental health problems (Amuyunzu, 2013). They are put in unhygienic and inhumane living conditions, such as the use of caged beds with netting or metal bars to restrain patients. In some incidences, they are tied to trees and logs far from their communities for extended period of time without adequate food or shelter (WHO, 2003). A study conducted in Uganda revealed that the term 'depression' is not culturally acceptable amongst the population, Gordon (20118) while another study conducted in Nigeria found that people responded with fear, avoidance and anger to those who were observed to have a psychotic disorder (Kabir *et al.,* 2004). Furthermore, people with mental health problems are disadvantaged in expressing their needs and having them met. In fact, mentally ill patients are more vulnerable to abuse in society and even in the facilities and institutions that are expected to care for them (Leposo, 2012*).* The stigma linked to psychotic disorder can be attributed to a variety of factors, including lack of education, fear, religious reasoning and general prejudice (Arboleda-Florez, 2002). The effect of silence on psychotic illness is further compounded by inadequate focus at the policy level and lack of adequate national level financial and technical investments in addressing mental health issues. Keating and Robertson (2004) suggested that fear of psychotic illness and people with mental health problems discourage individuals from engaging with services. They are held back from seeking help by what is perceived as vicious circle of 'fear of psychiatric treatment.

Social beliefs that include lack of knowledge, negative attitude and perceived stigma about mental illness, may keep those who suffer from mental illness away from

treatment. Specifically, stigma has been found to contribute to discrimination from others and internalized negative self-perceptions in the form of self-stigma, both of which make people avoid treatment and hide their symptoms. Particular beliefs about the cause of mental illness often include the entire family, who may also suffer stigma, prompting them to hide their family member's illness (*Lupick, 2012).* Traditional treatment approaches used including chaining, whipping and burning patients are harmful and perpetuate stigma (Drew *et al.*, 2011). Sartorius (2007) noted that stigma extends to the health institutions and even mental health specialists. For instant, in some hospitals, patients are kept in dehumanizing environment and abuse by hospital personnel (Maj, 2011). One result is that "stigma makes community and health decision-makers see people with mental illness with low regard, resulting in reluctance to invest resources into mental health care" (Sartorius, 2007).

The Ganda people of central Uganda culturally ascribe psychotic illness causation to supernatural forces (Okello, 2007; Orley, 1979). They believe in highly organized systems of ancestral spirits, the top of which is Lubaale. Lubaale can be vindictive and can supposedly cause illness including severe mental illness manifesting as psychosis (Muhwezi, 2007). Psychotic illness in most communities in Kenya is highly regarded as spiritual ailment rather than a medical one. Some belief psychotic illness is a curse, thus turn to religious believers and traditional healers for divine intervention. Due to this beliefs, affected families struggle to cope with their loved ones silently receiving massive stigma from society. The silent cry of psychotic disorder is catastrophic. The victims are abused and neglected by entire society and resign to dark corners of churches or shrines, leading a life in chains. Out of sight out of mind, no funding and completely neglected (Amuyunzu, 2013).

Objectives

The present study was premised on a belief that there are cultural beliefs and practices that have stigmatized psychotic disorder thus relegating it to silent epidemic choking many people in the society in Kenya. The study was solution-focused and specifically aimed to:

- explore the content and consequences of cultural beliefs;
- identify community impediments to positive change and recommend solutions;
- identify intervention strategies and recommend solutions for mental health providers and other professionals who work alongside mental health professionals.

Adaptation of Psychotic Disorder Care

Although there has been an increase of psychotic disorders among adolescents, adults and the elderly, lack of early diagnosis and appropriate care turns them into chronic conditions. Unfortunately, the financial and human resources in the African region are insufficient to address adequately the burden of mental health disorders. The Region has fewer mental health professionals than other WHO regions (*Lupick, 2012).* For example, the median number of psychiatrists per 100,000 people is only 0.04. A similar trend is seen in the availability of psychiatric beds, whose median number per 10,000 people is 0.34. Also, only 56 per cent of African countries have community-based mental health facilities and only 37 per cent of the countries have mental health (Brickell, 2011).

In Kenya, mental health is one of the most under resourced areas of public health even though mental health problems are on the rise. Mental health is underfunded and starved of resources. For instant, Mathare Hospital, the Kenya's largest national mental health referral hospital has shortage of houses, psychiatrists, medical social workers, medicine etc. Thus, in many parts of Kenya this area of public health requires more attention than it is currently receiving. The family remains an important resource for the support of patients with mental health problems (Fournier, 2011). Although most families are willing to care for their sick relatives, severe mental disorders may deplete the resources of even the most willing and able families (Okello, 2007).

Results

Research findings indicate that 30 percent of the global population each year has a mental disorder and up to 2/3 of them will not get adequate treatment (Group, 2007). Mental disorders are associated with marginalization, social vulnerability and a range of social problems, such as homelessness and confinement (Lund *et al*., 2011; Raviola *et al*., 2011; Becker & Kleinman, 2013). A number of challenges identified as significant contributors to the problem of mental health care disparities are related to the economic and development inequalities in Kenya. For example, one of the most significant problems, the lack of mental health policy, is both an infrastructure and planning problem; poor legal protection and lack of equity for people with mental illness are also caused by a lack of effective legislation. Finally, all of these problems require comprehensive approaches and multi-level solutions in order to decrease the illness, and life disruption that result from psychotic disorders.

Conclusion

It is evident that every country should develop mental health policies and procedures that are consistent with its own social and cultural contextual - realities. Many traditional African societal beliefs of mental illness revolve around social, cultural and spiritual understandings of mental illness (Amuyunzu 2013; Akyeampong *et al.,* 2015). Many of the explanations of

mental illness are spiritual, meaning they focus on forces that are outside the physical influence, yet they have significant impact on human affairs.

Therefore, emphasize should be put on holistic and culturally responsive approaches to the mental health care gap in Kenya. This should include exploring the efficacy of traditional healers in treating psychotic illness as the cases reported in Ghana (Aniah, 2015), Sudan (Sorketti et al., 2013), Uganda (Abbo, 2011), Kenya (Mbwayo *et al*., 2013), Tanzania (Ngoma *et al*., 2003) and other countries. Further research in the area of naturalistic outcome of traditional healing is necessary. The use of biopsychosocial approach would allow researchers and practitioners to examine how spiritual beliefs and cultural practices influence individuals' help-seeking behaviors and community responses to individuals suffering from psychotic illness.

Recommendations

There is need for advocacy to international, national and local stakeholders about the importance of addressing mental health care disparities in societies. Need for additional funding and research to develop and assess interventions that can be delivered by both professional and non-professionals as part of routine care for psychotic patients. This should include training for local community health workers to build mental health care capacity and develop sustainability. Prevention and intervention practices through improved general health services, such as routine mental health screening, outreach services, and comprehensive community health care.

Addressing mental health challenges in Kenya requires a focus on locally-driven and culturally responsive solutions and with integration of global best practices such policy, research and treatment improvements.

References

[1]. Abbo, C, Elialilia S Okello, E.S., Musisi, s, Waako, P & Abobe, S.E (2012). Naturalistic outcome of treatment of psychosis by traditional healers in Jinja and Iganga districts, Eastern Uganda – a 3- and 6 months follow up

[2]. Abbo, C. (2011). Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. *Global Health Action, 4*. doi:10.3402/gha.v4i0.7117.

[3]. Akyeampong, E., Hill, A.G., & Kleinman, A. (Eds) (2015). *The culture of mental illness and psychiatric practice in Africa*. Indiana University Press: Bloomington, Indiana

[4]. Amuyunzu-Nyamongo, M. (2013). The social and cultural aspects of mental health in African societies. *Commonwealth Health Partnerships,* 59-63.

[5]. Aniah, P. (2015). The contribution of indigenous health care providers to health care delivery in Rural Ghana: An exploratory study of Bongo District. *Science, 3*(1), 20-28.

[6]. Arboleda-Florez, J., (2002). What causes stigma? *World Psychiatry, 1(1)*, pp. 25–26.

[7]. Arseneault, L., Moffitt, T.E., Caspi, A., Taylor, P.J., and Silva, P.A. (2000). Mental disorders and violence in a total birth cohort: Results from the Dunedin Study. *Archives of General Psychiatry, 57:* 979-986

[8]. Becker, A.E., & Kleinman, A. (2013). Mental health and the global agenda. *New England*

[9]. *Journal of Medicine, 369*(1), 66-73.

[10]. *Bird, P., et al., 2010. The MHAPP Research Programme Consortium. Increasing the priority of mental health in Africa: Findings from qualitative research in Ghana, South Africa, Uganda and Zambia. Health Policy Plan, 26, pp. 357–365.*

[11]. Brennan, P.A., Sarnoff, A.M., and Hodgins, S. (2000). Major Mental Disorders and Criminal Violence in a Danish Birth Cohort. *Archives of General Psychiatry, 57:* 494-500.

[12]. Brickell, T. A. and McLean, C. (2011). 'Emerging Issues and Challenges for Improving Patient Safety in Mental Health: A qualitative analysis of expert perspectives'. *Journal of Patient Safety 7(1):* 39-44

[13]. *Chambers, A.,(2012). 'Mental health and the developing world', The Guardian, 10 May 2012, http://www.guardian.co.uk.*

[14]. Collins, P.Y., Patel, V., Joestl, S.S., March, D., Insel, T.R., Daar, A.S. (2011). Grand challenges in global mental health: A consortium of researchers, advocates and clinicians announces here research priorities for improving the lives of people with mental illness around the world, and calls for urgent action and investment. *Nature, 475(7354),* 27-30.

[15]. Cox J (Ed) (1988) *The life event of childbirth: socio-cultural aspects of postnatal depression*. London: Wright; 1988.

[16]. Department for International Development (DFID) (2013). Mental health. *International Journal of Environmental Research and Public Health*.

[17]. Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L., & Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet, 378*(9803), 1664-1675.

[18]. Frank Keating, K. & David Robertson, D.(2004). Fear, black people and mental illness: A vicious circle? *Health and Social Care in the Community 12(5), 439–447*

[19]. *Fournier, O.A., 2011. The status of mental health care in Ghana, West Africa and signs of progress in the greater Accra region. Berkeley Undergraduate Journal, 24(3), pp. 1-27.*

[20]. Gordon, A. (2011). 'Mental health remains an invisible problem in Africa', Think Africa Press, 8 September 2011, http://thinkafricapress.com.

[21]. Group, L.G.M.H. (2007). Scale up services for mental disorders: A call for action. *The Lancet*, *370*(9594) 1241-1252.

[22]. Johnson, K.; Scott, J.; Sasyniuk, T.; Ndetei, D.; Kisielewski, M.; Rouhani, S.; Bartels, S.;Mutiso, V.; Mbwayo, A.; Rae, D.; *et al.* (2014*)* A national population-based assessment of 2007–2008 election-related violence in Kenya. *Conflict Health*, *8*, doi:10.1186/1752-1505-8-2.

[23]. Kabir, M., et al., 2004. Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *Bio Med Central International Health and Human Rights, 4(3),* pp. 1-5.

[24]. .Kebede, D.; Alem, A.(1999). Major mental disorders in Addis Ababa, Ethiopia: I. Schizophrenia,schizoaffective and cognitive disorders. *Acta Psychiatr. Scand.* 1999, *100 (S397)*, 11–17

[25]. Krupnick, S.L.W. & Wade, A. (1999). Psychiatric Care Planning, Second Edition. Springhouse

[26]. Leposo, *L., McKenzie, D. and Ellis. J., (2012) 'Kenya doctor fights mental health stigma*

in"traumatizedcontinent"',CNN,31January2012,http://www.cnn.com.

[27]. Lewis, G.; Bebbington, P.; Brugha, T.; Farrell, M.; Gill, B.; Jenkins, R.; Meltzer, H.(1998)

[28]. Socioeconomic status, standard of living, and neurotic disorder. *Lancet* 1998, *352*, 605–609

[29]. Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., Knapp, M., & Patel, V. (2011). Poverty and mental disorders: Breaking the cycle in low-income and middle-incomecountries. *The Lancet*, *378*(9801), 1502-1514.

[30]. *Lupick, T., (2002). 'Liberia mental health services: Building from the ground up', Think Africa Press,29August2012,http://thinkafricapress.com.*

[31]. Maj, M. (2011). The rights of people with mental disorders: WPA perspective. *The Lancet,378*(9802), 1534-1535.

[32]. Mamah, D.; Mbwayo, A.; Mutiso, V.; Barch, B.M.; Constantino, J.N.; Nsofor, T.; Khasakhala, L.; Ndetei, D.M. (2012). A survey of psychosis-risk symptoms in Kenya. *Compr. Psychiatr. 53*, 516–524.

[33]. Mbwayo, A.W., Ndetei, D.M., Mutiso, V., & Khasakhala, L.I. (2013). Traditional healers and provision of mental health services in cosmopolitan informal settlements in Nairobi, Kenya. *African Journal of Psychiatry, 16*(2), 134-140.

[34]. Ministry of health (2015) Kenya mental health Policy 2015 - 2030Towards Attaining the Highest Standard of Mental Health

[35]. Muhwezi, W.W. (2007). The Interface between Family Structure, Life Events and Major Depression in Uganda, in Department of Clinical Neuralscience, and Department of Psychiatry. Stockholm, Sweden and Kampala, Uganda: Karolinska Institute and Makerere University; 2007.

[36]. Ngoma, M.C., Prince, M., & Mann, A. (2003). Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. *The British Journal ofPsychiatry, 183*(4), 349-355.

[37]. *Njenga, F., (2002). Focus on psychiatry in East Africa. British Journal of Psychiatry, 181, pp.354–59.*

[38]. Okello ES, Neema (2007). Explanatory models and help-seeking behavior: pathways to psychiatric care among patients admitted for depression in Mulago hospital, Kampala, Uganda. Qualitative Health Research 2007, 17(1):14–25.

[39]. Orley J, Wing J:(1979). Psychiatric disorders in Two African villages. Arch. Gen. Psychiatry 1979, 36:513–5.

[40]. Patel, V.; Simbine, A.P.F.; Soares, I.C.; Wiess, H.A.; Wheeler, E (2007). Prevalence of severe mental disorder and neurological disorders in Mozambique: a population-based survey. *Lancet* 2007,*370*, 1055–1060.

[41]. Sartorius, N. (2007). Stigma and mental health. *The Lancet*, 370(9590), 810-811.

[42]. Sorketti, E.A., Zainal, N.Z., & Habil, M.H. (2013). The treatment outcome of psychotic disorders by traditional healers in central Sudan. *International Journal of Social Psychiatry, 59*(4), 365-376.

[43]. Raviola, G., Becker, A.E., & Farmer, P. (2011). A global scope for global health–including mental health. *The Lancet, 378*(9803), 1613-1615.

[44]. World Health Organization (2003). Investing in mental health'http://www.who.int.