Perceptions of Mental Illness, Obstacles and Possible Treatment Interventions in Nigerian Communities

A Literature Review

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Abstract

A mental disorder or mental illness (MI) is a syndrome characterized by clinically significant disturbances in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association, 2013, p. 20). Appropriate diagnosis, viable treatment options and prognosis of MI continue to be a significant problem in most Nigerian communities. These obstacles can be attributed to factors including grossly low numbers of properly trained clinicians able to provide adequate care, inaccessible treatment facilities, unaffordable treatment options, negative help-seeking behaviors, misunderstandings about MI, stigmatization due to a lack of understanding of treatment options and the etiology of MI, and fear of unfamiliar treatment practices. In order to bring about positive change, it is crucial that the Nigerian population and its culture be explored to better identify areas in which integration of alternative and accessible treatment is made possible hence fostering a healthier population.
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Perceptions of Mental Illness, Obstacles and Treatment Interventions in Nigerian Communities

Introduction

In order to mindfully integrate any form of change that is to affect the perception of a people, it is important to understand the history of their current cultural-traditional system. Since the goal of both orthodox and traditional psychiatric interventions is to achieve and maintain a satisfactory level of health care for a large number of the psychiatric patient populations of Nigeria, the need for integration in the form of assimilation, collaboration, and complementarity cannot be over emphasized (Chukwuemeka, 2009). Increased understanding creates avenues whereby areas of need and avenues for integration can be made accessible. To forget or disregard the history and role of colonization in Africa is to discount the legitimacy of the time before colonialism. The identity of a people plays a great role in traditions that are preserved and passed down to generations over time. Given the history of the Atlantic slave trade, when Africans were systematically acquired, distributed, and enslaved, the colonizer had to believe one “truth” in order to commit these devastating acts. The “truth” of the African being of a lesser rank hence was legitimizing the treatment that ensued in the form of slavery. Block (1980) suggested three trends relative to Blacks in psychotherapy as they were depicted as persons limited in cognitive, emotional, and social abilities who were, or should be, content with their low status because of their relative immaturity compared to the dominate white culture. The goal of the enslaver was to amass wealth, power, and control over the oppressed group of people hence the behaviors that followed. This cognitive process is exemplified in the Adlerian premise that every behavior exhibited by an individual is goal-oriented (Adler, 1979). This process can be covert or overt based on the end goal of the individual, environment and the cognitive state in which they are operating during a given period of time.
Historical Snapshot

Africa was not always colonized as historical writings of the Dutch travelers and traders in the 16th century compared the Kingdom of Benin to parts of the Western world including Amsterdam. The rhetoric took a drastic turn in the 19th century when the same Kingdom was referred to as the “City of Blood” (Bacon, 1897). The rhetoric of Africans voluntarily selling one another into slavery continues to perpetuate the idea of blame shifting from the slave traders to the indigenous people of the colonies invaded. This begs the question: “Whether societies manufacture "events" which never occurred in their history, or consciously or unintentionally change the original/actual in part, in the translation or recording process?” (Mazrui, 2013, p. 13-29). In order to perpetuate the belief of the “lesser Africa,” a perception justifying and encouraging the need to tame and domesticate was found in the history books. Promoting a discouraging rhetoric about the African ultimately served the purpose of encouraging the atrocities that stripped their identity and sense of belongingness. The common practice of renaming captured Africans meant that the generations that followed continued to struggle with their sense of security and worth. These acts laid the groundwork for disclaiming responsibility of the heinous acts against a people, their identity, and culture. The devastation of the slave trade, and invasion with advanced weapons such as guns, made the western colonization possible. As Mazrui says, “one consequence of this imperial abuse was the havoc which colonialism played with the African memory - initiating new forms of amnesia, nostalgia and false memories” (Mazrui, 2013, p. 13-29). A continent was being brutally forced to "get its history wrong," as for instance, the Igbo people. Due to the trading of the African people, the Igbos now have displaced origins in several areas of the world including Egypt, Ethiopia, Israel, Sudan and other countries in the Americas. The advancement of technology has continued to make it possible to trace the
ancestry of many in the diaspora; however, this does not make up for the time and history lost and misinterpreted over the years. In Nigeria, West Africa, there are approximately 34 million Igbos in the southeast area with more than 2000 years of culture. The Igbos are primarily Christian, sometimes merged with the indigenous Igbo religion, while a minority practice Islam.

It is important to note that the Igbos are sometimes erroneously known as the “Ibos,” and this is largely due to the Europeans having difficulty pronouncing the “ɡb” sound. This can serve as an example of a tradition of stripping one of their original name or being re-named as is observed when exploring the process of naming an African and African American child. It has become a common practice that most parents and guardians will opt to name their children a name deemed acceptable to the majority population as it is believed that having an “ethnic-Black name” automatically puts the child at a disadvantage e.g. in an application for a job. Therefore, an individual raised with this has a high probability of believing that a traditional name serves as a hindrance encouraging a faulty core belief system about non-European names. Exploring this carefully shows one of several instances where implicit messages rooted in the oppression of individuals deemed as minorities could foster inferiority feelings and self-hate in communities of strong African descent.

**Traditional Medicine**

Traditional practices of healing could also be viewed as treatments not commonly accepted within the framework of modern medical practice (Nwankwo, 2014). According to the World Health Organization (WHO), folk medicine involves health practices, approaches, knowledge, and beliefs, incorporating plant, animal, and mineral-based medicine, spiritual therapies, manual techniques, and exercises applied singularly, or in combination, to treat, diagnose, and prevent illness or maintain wellbeing (2003). A historical inquiry into folk
medicine among the Igbos of southeast Nigeria referred to the practice as ‘excessively unhygienic and crude stage’, and also as the ‘age of uncertainty (1840-1960)’ when practitioners were called heathens, pagans, and witches. In the present age of modernity (1960-to date), folk medicine not only co-exists with orthodox medicine in Igbo society, but in addition, preference for folk medicine, particularly among the lower class, is on the increase (Nwankwo, 2014). This is not entirely surprising given the level of exposure and financial burden Western medicine places on individuals in the lower class. Given the fact that some individuals desperately seek relief from their symptoms, a variety of healing sources are explored. Due to the high cost of these Western interventions in the bigger cities, most return to the familiar religious and traditional healer as they present less economic strain on the household. Folk medicines are based on social, cultural, and religious backgrounds as well as on knowledge, attitudes, and beliefs that are prevalent in the community regarding physical, mental, and social wellbeing, and the causation of disease and disability (WHO, 1978).

Iroegbu (2005) emphasized that although pharmaceutical drugs are being made available to individuals seeking help, local herbal and ritual resources can constitute assets for holistic healing. According to the Igbo culture, there are different areas of specialization in the traditional healing arts. Among the Igbos, native or traditional healers are further distinguished in accordance with their areas of specialization. They have the ‘Dibia Afa’ (diviner) and the ‘Dibia – Ogwu’ (medicine man). The former is a diagnostician, while the latter is the physician. They also have the ‘Dibiamgborogwuna-nkpa akwukwo’ (herbalist); the ‘Dibia-Okpukpu’ (bone setter); the ‘Dibia-Ogbanje’ (Pediatrician), traditional surgeons, and traditional birth attendants. The traditional healers in these communities gain a following through several factors including the subjective reality of the healer, previous successful cures, and the belief system of the
community which is usually locally and globally influenced (Nwankwo, 2014). Such acceptance or legitimacy positively legitimates traditional healers in the provision of diagnostic, curative, preventive, health promotion and rehabilitative services for people therefore remaining highly relevant in the health system despite increasing incursions by orthodox medicine into area and cultural systems that were previously their exclusive terrain (Nwankwo, 2014). Similar to the Western styles of diagnosing, the Igbo traditional healers look for the causes of illness in the following:

(a) The patient world – habits, diet, smoking, drinking and general lifestyle.

(b) The natural world – illnesses caused by microorganisms, environmental factors, animal bites.

(c) The social world – interpersonal conflicts, stresses of daily living.

(d) Supernatural world – illnesses caused by spirits, ancestors, or gods offended in course of daily living.

Remarkable successes of traditional healers in both the Igbo nation and in other developing nations are well documented by scholars like Nwankwo (2005), and WHO (1978, 2003). Furthermore, it has been argued that a strong belief in folk treatment can yield a positive outcome even where scientific treatment is known not to work. (Nwankwo, 2014). Although scientific methods might not promote the ideas of miraculous healings, religious and traditional healers have operated seamlessly in this realm for ages. In this case, striving for understanding serves no visible purpose; however, appreciating the differences in beliefs and ultimate outcomes becomes important. The World Health Organization (2003) also emphasized that up to 80% of the population of Africa uses folk medicine for primary health care. It stressed the need to harness the resources of traditional healers towards attainment of ‘health for all’ and the
millennium goals by the year 2015. The WHO also notes that the use of folk medicine is spreading in popularity in industrialized countries like America where about 158 million adults use complementary medicine—a field that incorporates traditional or folk medicine (Nwankwo, 2014). It is important to note that since 1978 when the World Health Organization declared “traditional medicine to be viewed as good as any form of science and medicine and to be helpfully employed by governments to promote health care, in particular to understand and heal illnesses, Nigerian physicians and the state health sponsored institutions have not adequately understood what to do and how to approach the provision as misconceptions and misrepresentations of the dibia continue to proliferate.” (Iroegbu, 2011, p. 8).

**Why Evidence Based Practices**

According to Sackett, Straus, Richardson, Rosenberg, and Haynes evidence-based practice (EBP) is defined as the integration of the best available evidence, with clinical expertise, client values and context (2000). Evidence Based Practices (EBPs) can be viewed as an approach that mandates the use of rigorous evidentiary standards while using it as a decision-making template (Slocum et al., 2014). This viewpoint is highlighted in the Yoruba language in the adage that states, “Gbôngbò kan ọso kò gbodò ré òjìgbón lèè pà lèèmeji” meaning “The same tree branch should not trip a smart person twice.” It further exemplifies the similarity between people regardless of location and culture as most societies strive to use previously gathered information for the advancement of their community. In this approach, evidence must work in conjunction with clinical expertise and consideration of client values and context as a basis for decisions (Detrich, Keyworth, & States, 2016). Similarly, the Adlerian Lifestyle assessment when properly completed, serves as an illuminating compass that brings clarity to a given individuals’ basic life orientation. Knowing the characteristics of the caregiver and environment
an individual was raised in plays a great role in their beliefs about the men, women, religion, self and the world. This is an assessment tool that proves useful in the treatment planning as it provides a context in the form of the individuals’ cognitive framework and how it becomes evident in their current functioning.

Given the usefulness of EBPs, it is important to look beyond actual practices to ways to implement such practices. In order to appropriately utilize a practice and assessment tool in a given area it is crucial to understand the population hence producing people-centered decisions. At the local level, decisions about how to best implement an evidence-informed policy requires professional judgment and a clear understanding of the values of the local community (Detrich, Keyworth, & States, 2016). Conceptualizing an evidence-informed policy as a decision-making framework addresses many of the concerns about the feasibility of it being realistic to address issues of context (Greenhalgh & Russell, 2009). To improve the probabilities of increased use of EBPs in Nigeria, several factors are to be explored. If evidence is to play a central role in influencing policy and available treatment models, then the challenges of overcoming personal biases, political considerations, advocacy groups, and financial incentives must be confronted (Detrich, Keyworth, & States, 2016). In order to maximize the results of any given decision in the health sector, utilizing practices that have been proven to be effective is a great component that should not be overlooked even in the face of vast differences in belief systems. Gerald Keller quoted W. Edwards Deming when he wrote, “Without data, you are just another person with an opinion” (Keller, 2009, p. 372). Implementation science has been defined as the study of how an evidence-based practice gets translated to different contexts in the “real world” (Martinez-Beck, 2013). This is a multi-staged approach with specific actions such as exploration, adoption, installation, initial implementation, and full implementation (Blasé, van
Dyke, Fixsen, Bailey, Kelly, & Perkins, 2012). One of the challenges in integrating evidence with policy is that policymakers and researchers are from two different cultures, speak different languages, and have different values (Baron, 2010). To cross the cultural divide, it will be necessary for researchers to function as cultural anthropologists so they can understand the language and values of policymakers and can interact more effectively. This could include the intricate study of African societies and how they have diagnosed and treated mental illness throughout history. This provides a framework to align and adapt new ideas while highlighting the importance of the current generational practices and norms.

**Intermingling of Western and Pre-Western Medicine**

Evidence Based Practices promise to enhance the effectiveness and ethical integrity of behavioral health outcomes, while contributing to the knowledge base crucial for the development of effective international health policies (Clark, Sprang, Freer, & Whitt-Woosley, 2012). History has shown the reluctance and eventual acceptance of people in incorporating unfamiliar ways of living into their current ways of life. Globally, professionals and indigenous healers may unintentionally or actively impede innovations designed for persons exposed to violence (Clark et al., 2012). Such challenges merit respectful and informed responses from health professionals and policy makers in these communities. Bearing in mind that culture is an ever-present reality in the therapeutic work done by clinicians, the motive needs to become “therapeutic effectiveness and not defensive practice” over time (Barnett, Doll, Younggren, & Rubin, 2007). According to Iroegbu (2011). While it is desirable to train traditional healers in a university biomedical setting, possible neo-colonialism could emerge and therefore must be understood and avoided from the outset. If appropriately managed, the unique identity of the dibia, the community, and the sharing of cultural forces, can be maintained. This could be done
by the creative portrayal and juxta-positioning of Nigerian rich cultural heritage with positive global norms (Ekeanyanwu, 2008). In order to accomplish this goal, the traditional healers foundation in their culture must never seem disregarded and should be designed in a way that it focuses on the whole community, responsibility, status, gender, and inter-intrapersonal relationships. It is important to guide against any form of de-culturation of their basic beliefs, practices, and lifestyle. By accomplishing this, the Social Interest of these traditional healers increase, which means a boost in their sense of belonging in-society and within the clinical community working to expand treatment methods and perceptions.

Developing Nigerian healers to the fullest, such that they can communicate and share their expertise and power using a scientific language, should be a trendy discourse that will face change; but also, must resist neo-colonialism, neo-arrogated-universalism…that is, the values, interests, and knowledge of indigenous peoples must be accepted as the starting point for developing meaningful social and cultural analysis. (Iroegbu, 2011, p. 9)

Similarities emerged in one study in the area of help-seeking behaviors in rural America and several African communities. Therapists in this study agreed that rurality influenced the relative significance of family and church for help seeking. Because of stigma, the church and the family continue to be the first source of help for rural people (Clark et al., 2012). Limited economic resources and longstanding cultural beliefs including gender discrimination, which is culturally embedded, thus negatively impacting female trauma clients, influence such approaches. A therapist in this study noted, “In Appalachia, one thing that struck me first (I’m not from here) was how men really do not respect women as much as they respect themselves…women are less valued” (Clark et al., 2012, p. 356). The ability to see similarities
rather than dissimilarities in the area of cultural norms and how they affect help-seeking behaviors can be useful as they highlight the traditional gender differences in society and ultimately an individuals’ role. This leads to a window of opportunity whereby the merging of cultures and new thinking is crucial to affecting perceptions of MI. Thus, to cross boundaries in psychotherapeutic relationships may be considered clinically relevant and appropriate (Barnett, Doll, Youngreen, & Rubin, 2007). The proposal of translating science into public health law and policy requires collaborating with indigenous leaders and local stakeholders (Fielding, Marks, Bradford, Nolan, Rawson, & Toomey, 2002). Recent technology transfer experiences and health policy developments in the USA, Ireland, Australia, Canada, and Sri Lanka all point to the need for developing community capacities for new behavioral health initiatives by prioritizing local participation, empowerment, and co-creative processes (Fielding et al., 2002). The current study points to the non-optional requirement for involving the persons actually delivering services. This translates into the direct involvement of the locals who live within these cultural boundaries and would benefit from a varying viewpoint. The effective response is not simply a matter of ‘educating’ ignorant workers, because therapists hold valid insights about the unfinished business of adapting EBPs into diverse local contexts – insights recently acknowledged by research scientists themselves (Clark et al., 2012). Public health researchers need to work with clinicians and policy makers to develop systematic and equitable approaches for knowledge transfer into vulnerable communities to enhance EBP adoption and utilization. Reciprocally, therapists need to respond to invitations to creatively participate in the development of EBPs in their local regions. Evidence Based Practices with cultural adaptations will be quite challenging to develop especially in the rural areas of Nigeria where cultural beliefs continue to be mostly unadulterated by Western practices. This study suggests that the interactions of cultural beliefs
and high levels of trauma exposure create synergistic processes challenging the development of ecologically valid assessment and effective treatments. These interactions are understudied phenomena, requiring researchers and therapists to collaborate by conceptualizing practice-to-science approaches utilizing pluralistic research methodologies therefore making such partnerships feasible (Clark et al., 2012). This study suggests that policy makers need to ‘begin with the end’ in mind, that is, their conceptualized positive outcomes may not correlate with those of local providers who embrace broader, colloquial definitions. Evidence Based Practices are appealing because they deliver promising, cost-effective outcomes, so consensus-building about local explanatory models of such outcomes are crucial prerequisites to their introduction into local communities, and must play an important role in developing local adaptations (Clark et al., 2012). Recent research has also revealed the importance of including consumers’ voices in the development, implementation, and adoption of behavioral health care innovations such as town hall meetings that include family units, herbalists and traditional healers, Priests of Ifa (babalawo), religious leaders, teachers and youth.

**Adlerian Psychoanalysis: Language-Culture**

For individuals who receive some form of mental health intervention, it has been discovered that they are released into a recovery environment that is not organized to encourage continued healing and reintegration into their new lives. An individual who is ill equipped to cope pre-, during, or post-MI treatment may develop what Adler termed an “inferiority complex” (Adler, 1979). This occurs when an individual is discouraged and unable to recognize their worth thereby thinking less of themselves and at times creating an environment where this individual feels the need to aggressively compensate for their perceived lack. Some patients are frequently readmitted because their relatives want them at a distance from their vicinity to avoid
“social embarrassment”, or systematic isolation that is featured in the Yoruba language as “inú igbó ni wèrè n’gbé” (the mad lives in the jungle) and “tani ofé bá wèrè gbé lé?” (Who will live with a mad man? Gbiri, Badru, Ladapo, & Gbiri, 2011). An Igbo proverb, translates, “When a drunken man meets a mad man, he learns the difference between being merely drunk and being truly mad”. Given the negative view on excessive alcohol use and public intoxication in the Nigerian culture, it is jarring that this proverb implies that an addiction to alcohol is child’s play compared to having a MI. This is an area whereby the disconnect between mental illness and addiction disorders are clearly presented. It reaffirms the need for education regarding co-occurring disorders and diagnoses, as they inform the level and quality of care provided to individuals who meet the necessary criteria. The importance of viewing an individual as part of a whole is further emphasized, thereby opening channels to integrate a variety of tools in treatment planning options. Functioning from a co-occurring viewpoint creates avenues for clinicians to utilize their unique styles and art while involving the patient and increasing their engagement in-treatment. This can be likened to one of the processes that improves outcomes of treatment like therapeutic joining, through which a clinician and a patient start to understand underlying rules and values that govern the patient’s behaviors.

In an environment where the language exposes longstanding beliefs on illness, it is no surprise that a great part of the population still operates with skewed perceptions regarding the actions to be taken after an individual is deemed “afflicted” with MI. An individual’s recovery environment plays a crucial role in their continued wellness hence investing in a system that addresses this area is important. By way of encouraging and supporting an individual in their healing process, they will be empowered to take once again their place in society (Adler, 1979). The lack of re-integration of mentally ill individuals with their families often leads to a return to
their former habits such as psycho-active substance use for self-medicating purposes and frequent relapses. Governmental policy is not currently helping to decrease this rate since most of the prescribed medicines and access to hospital facilities are not affordable for most of these patients who are often without sufficient financial means (Gbiri et al., 2011). It is important to direct significant effort toward advocating against stigmatization, misconceptions concerning the causes of MI, cultural and language insensitivity, and for the traditional African cultural model, which is based on family support. Similar to Western societies, there are certain expectations placed on an individual at certain milestones in life. These are included in the areas of work, social relationships, spirituality, love and marriage, and developing a relationship with the self. Alfred Adler proposed that the ability of an individual to excel in these areas provides an avenue to access their wellbeing or psychological wellness (Ansbacher & Ansbacher, 1964). According to Adler, in the event that an individual is discouraged in any of these tasks of life, a psychological disorder is most likely present. Alfred Adler stated that the social functioning of an individual is a barometer of his or her mental wellness. In the task of work for example, an individual who lacks avenues to be of service to others lives a useless life according to the Adlerian viewpoint. Social interest is contributing to the welfare of other people thereby forcing an individual to look outside of themselves (Ansbacher & Ansbacher, 1964).

To further a medically informed framework, it is important to appropriately psychoanalyze and educate an individual who is able to seek treatment. Given a clinically sound setting, an individual is afforded the opportunity to learn about their lifestyle, their life movement and how it affects their trajectory. According to Ansbacher and Ansbacher (1964), the style of life of an individual is reflected in the unity of their thinking, feeling, and acting. According to Adler, an individual’s lifestyle is formed at an early age (by about 5 years old), and this becomes
the lens through which they view all of their life experiences. An individual can arrive at a
distorted perception of their life experiences based on the events that have happened to them due
to a lack of skills to properly make meaning of the purpose behind their behavior. Adler
proposed the possibility that an individual can move beyond life events and create a self-
preserving lens through which they can live a meaningful life. As claimed by Adler (1979), one
is not a product of his or her environment but rather a product of one’s interpretation (creative
power) of their particular environment; hence, he proposes re-interpretation. This is similar to
the growth of self-actualization where Abraham Maslow (1962) referred to the need for personal
growth and discovery that is present throughout an individual’s life. For Maslow, an individual is
always 'becoming' and never remains static as they continuously find a meaning to life. Maslow
expressed that self-actualization happens differently for different people. He stated, “The
specific form that these needs will take will of course vary greatly from person to person. In one
individual, it may take the form of the desire to be an ideal mother, in another it may be
expressed athletically, and in still another it may be expressed in painting pictures or in
inventions” (Maslow, 1943, pp. 382–383).

Perceptions of Mental Illness in Medical Communities

Research conducted by Adewuya and Oguntade (2007) demonstrated the realities of
deeply rooted traditional beliefs influencing medical professionals despite their exposure to
several years of Western education about mental illness, etiology, diagnosis, and prognosis. The
participants of this study were medical doctors who were randomly selected from eight health
institutions in three states in the southwestern area of Nigeria. These institutions included two
university teaching hospitals, two federal medical centers, and four general hospitals. Six
hundred medical doctors completed a semi-structured questionnaire inquiring about demographic
data such as age, sex, ethnicity, religion, marital status, department, years of practice, having managed a patient with mental illness before, and having a family member or friend who has or had a mental illness. The respondents’ attributions of the possible causal factors of mental illness were assessed by responses to 12 items: three items each from social factors, personal factors, supernatural factors, and biological factors. The respondents’ perception of the personal attributes of people with mental illness was measured by a list of nine personal attributes generated by factor analysis to cover the two important components of the stereotypes of mental illness.

The stereotype components included perceived dangerousness (dangerous, aggressive, unpredictable, lacking self-control, frightened, strange) and perceived dependency (dependent on others, needy, helpless) (Adewuya & Oguntade, 2007). Five different possibilities were suggested concerning the prognosis of mental illness: complete cure, partial remission, persistence of the problem, progressive deterioration, or do not know. The respondents were asked to choose a single category to indicate their assessment of mental illness. The findings in this study revealed the most endorsed causes of mental illness were abuse of drugs, cannabis, or alcohol; personal, financial or marital stress; evil spirits, witches and sorcery; brain injury and infections of the brain; and heredity. In addition, the four most endorsed personal attributes of the mentally ill included unpredictability, lacking self-control, aggression, and dependence on others (Adewuya & Oguntade, 2007). Most of the participants believed that if left untreated, the progression of mental illness would include deterioration and persistence and if treated, partial remission and persistence.

The findings in this study revealed that social distance towards individuals with MI was seen to increase with the level of intimacy required in the relationship. While only 10.3% would
be ashamed if people knew someone in their family has mental illness, 80.8% would not marry someone with mental illness (Adewuya & Oguntade, 2007). 78.0% of the participants would not accept a fully recovered former mental patient as a teacher of young children in a public school, and 92.0% would not hire a former mental patient to take care of their children. Unexpectedly, it was found that 67.9% of the medical doctor participants believed misuse of drugs and alcohol to be the major cause of mental illness. This was followed in succession by stress 58.3%, evil spirits/witches/sorcery 53.8%, brain injury/infections 49.4% and heredity 32.7% (Adewuya & Oguntade, 2007). Given these findings within the medical community in the southwestern area of Nigeria, it emphasizes the critical need for continuing education and agencies that are to oversee clinical practices. In an area where a medical professional’s care is sought, it is a tragedy to be faced with misinformation and the personal biases of the medical institution.

A shocking similarity was found when compared to a community based study (Adewuya & Makanjuola, 2008) in Nigeria that suggested that the most commonly endorsed causes of mental illness by the lay public were misuse of drugs and alcohol 80.8%, possession by evil spirits 30.2%, traumatic event or shock 29.9%, and stress 29.2%. The finding by Adewuya and Oguntade suggests that this belief was not limited to the public but also popular among doctors (2007). The beliefs of society about drugs serves a purpose according to the Adlerian viewpoint. A possible desired effect for the collective Nigerian culture is that it creates a negative image of drugs and chemicals hence playing a role in restricting usage. It is important to note that this does not imply the need for medical professionals to promote said beliefs without making the important distinction for medicines known to adequately manage mental illness with appropriate medical supervision. For example, although suicide and injury are more common among individuals with chronic mental illness, 60% of premature deaths in persons with schizophrenia
are due to medical conditions including heart and lung disease and infectious illness caused by modifiable risk factors such as smoking, alcohol consumption, and intravenous drug use (Parks, Svendsen, Singer & Foti, 2006). Early mortality, severity and prognosis of primary mental illnesses are worsened in the context of substance dependence (Hartz et al., 2014). The 2009-2011 National Survey on Drug Use and Health identified adults with mental illness (based on 14 items related to psychological distress and disability) and found that 36% of adults with mental illness are current smokers relative to 21% of adults without mental illness (Centers for Disease Control and Prevention - CDC, 2013). This survey found that adult smokers with mental illnesses are less likely to cease smoking than adult smokers without mental illnesses (CDC, 2013). Increased smoking among individuals with mental illness, alcohol and other substance use disorders has increased prevalence in individuals with mental illness (CDC, 2013). In a study by Hartz and her colleagues, alcohol and drug dependence were found to be more than twice as common among individuals with anxiety disorders, affective disorders, and psychotic disorders, additionally, they found evidence to support a correlation between substance abuse and other psychiatric disorders for African Americans and Hispanic individuals (Hartz et al., 2014). Based on these findings, this study concluded that individuals with severe psychotic disorders are at increased risk for smoking, heavy alcohol use, heavy marijuana use, and recreational drug use (2014). This supports the argument for ongoing efforts and resources focusing on the need to understand the comorbidity between substance use and psychotic disorders.

Considering misuse of drugs and alcohol could be a causal factor for a number of mental disorders, and since the misuse of substances is often viewed as a moral failing in African societies, the doctors and the public may view mental illnesses as self-inflicted, and this may
elicit condemnation rather than understanding or sympathy (Adewuya & Oguntade, 2007). In addition, the study found that approximately half the doctors believed in the supernatural causation of MI, which is in agreement with the results from the studies done among the Nigerian public. The implication of this belief is that MI is viewed as a supernatural affliction that is beyond the ability of medical professionals hence needing spiritual and traditional therapy. Given these findings among medically trained personnel, it is perhaps necessary to evaluate and revise the medical curriculum on MI causes, treatment, and prognosis in Nigerian communities. This study showed that most doctor participants would not accept a former patient in a psychiatric hospital in many social situations especially when the situations are personal. 20.0% do not believe that these individuals are just as intelligent as the average person is, 77.9% would not accept a fully recovered former mental patient as a teacher of young children in a public school. While only 5.1% would feel that entering a psychiatric hospital is a sign of personal failure, 92.0% would not hire a formerly diagnosed individual as a caretaker for their children. Findings from Adewuya and Oguntade suggested that although professional ideology forces doctor participants to express “tolerant” opinions about some social acceptance and stigmatization of the mentally ill, Nigerian doctors nonetheless would not extend such tolerance to issues that personally touch their lives (2007). A high social distance, measured at 61.4% for doctor participants, was shown toward individuals with MI as comparable to 65.1% found among Nigerian university students. More than 80% of the doctors would not marry someone with mental illness, and 64.1% would be unwilling to share a room with someone with mental illness. This is comparable to 79.0% and 64.5% respectively found among Nigerian university students. This study supports the earlier findings that medical professionals including psychiatrists and the lay public do not differ in their social distance to individuals perceived to be
mentally ill. It was found that having a family member with MI lessened the social distance towards persons with mental disorders among these doctors. This finding supports earlier findings among university students. Increased contact with a family member living with a mental disorder has been shown to be associated with a lessened negative attitude about MI. Although most community studies from Western cultures have found that older people are more socially distancing, it should be noted that in these community studies, the older respondents were significantly less knowledgeable than their younger counterparts, which was not the case among the doctors in this study (Adewuya & Oguntade, 2007).

**Obstacles Preventing Adequate Awareness and Treatment of Mental Illness**

Basic obstacles in treatment interventions include frequent and intense symptoms, inadequate medication management, self-medicating, inconsistency in clinical team meetings for treatment planning, lack of consistent family support, lack of meaningful activities and structure, cognitive deficits, conflict of belief with presented treatment plan, lack of understanding-misunderstanding of diagnosis, treatment and prognosis etc. (Velligan et al., 2010). Unfortunately, some individuals experience frequent and intense mental health symptoms hence, they are driven out of their communities as it becomes highly difficult to keep their condition a secret. This is the case with many individuals seen in public places (local markets, refuse dumps scavenging for food, and seeking shelter under bridges or uncompleted buildings) and are referred to as “mad” people. Inadequate medication management is due to insufficient funds and the unavailability of psychiatrists. There are several reasons why medications may not be used as prescribed including:

a) Individuals reporting “feeling better or cured” thereby see no need to continue taking medicines.
b) Individuals reporting inability to source money to keep their prescription current.

c) Individuals reporting feeling that the medicine is making their symptoms worse.

d) Individuals reporting that their medicine is not being effective fast enough.

e) Lack of understanding about drug interactions and need to use as exactly as prescribed.

f) Lack of resources to follow up with the prescribing doctor to report side effects, which would inform the doctor’s ability to manage their medication type and dosage.

g) Individuals fearing that they would become addicted and need these medicines to function indefinitely.

Taking into account the lack of proper channels to provide information and resources, individuals are left to their own devices whereby self-medicating becomes a part of the equation thereby leading to compounding symptomology including the development of an addiction.

The absence of consistent and healthy family supports negatively affects individuals struggling with MI as over time, family members grow weary and begin to withdraw or become emotionally and physically abusive. Coupled with a misunderstanding about MI, levels of frustration increase and ultimately lead to increased struggles for everyone involved. Funding continues to be a problem when a client is deemed uncontrollable at home and transported to a general hospital where the clinicians available can suggest hospitalization with little to no explanation of diagnosis, treatment options, and prognosis. Diagnostic errors, absence of validated assessment tools, over and under diagnosing, complex trauma, and improper treatment settings, continue to be challenges faced in the African communities needing adequate and accessible treatment options. Diagnostic errors occur when the available treatment teams are not properly trained to clinically assess and diagnose an individual. Misdiagnosis leads to
unnecessary labels, utilization of wrong treatment models, alienation of a discouraged person, and in some cases, re-traumatization. Due to the current difficult process of seeking and gaining appropriate mental care by the average Nigerian, self-reports are highly unreliable as individuals can falsify their mental health history to attain the certain type of care they believe they need. For example, an individual might report lesser frequencies and intensity of their mental health symptoms as they are operating from a belief that the hospitals might “lock them up and throw away the keys” as they presume they are not seen fit to be in the general public. This is not a baseless belief as over the years, society has shunned people with MI as they have been deemed broken and a disgrace to their families. Most families try their hardest to keep these forms of illness a secret from the public as they discretely seek spiritual and traditional healing. In the case that psychiatric hospitals become involved, care is taken to have the team come to provide treatment in a discreet manner so as to avoid being shamed by the community in which they live. The lifestyle of secrecy is seen across cultures in Nigeria and is reflected in the language. An adage in the Yoruba language states, “Gbogbo aso ko ni a nsa l’Orun,” meaning, “Not all clothing should be spread to dry under the sun or in public.” The family structures in most Nigerian communities believe in the spirit of a community and maintaining a “good name” and never “disgracing the family” therefore having to speak openly about mental illness or an addiction is deemed shameful. This further deepens the feeling of reluctance to seek professional help hence forcing some to self-medicate with illicit substances in efforts to maintain one’s position within the community. The desperation to preserve the family’s dignity drives some to keeping loved ones hidden in homes and rural areas where no one would be able to identify and associate them with the person who is believed to be suffering with “arun opolo” meaning, “disease of the brain”. Over time, this could create a “perfect storm” where symptoms
of a mental illness are masked and worsened by the introduction of substances like alcohol, tetrahydrocannabinol (THC) and opiates.

It is not uncommon that individuals in African communities look to the treatment of African Americans and Africans in diaspora by the majority to determine the level of fairness in the system as a whole. The Tuskegee Syphilis Study funded by the US Public Health Service to address the epidemic of syphilis is 1932 in Macon County, Alabama is a prime example (Daugherty-Brownrigg, 2013). This was an experiment with Black sharecropper subjects that greatly benefitted the field of medicine as the development of antibiotics was achieved. The purpose of the study was to monitor the progress of untreated syphilis in African-American males under the pretense of providing free healthcare, food, and burial costs for families. None of the participating men in this study were informed of their syphilis diagnosis neither were they treated after the discovery of penicillin. The victims of this study over time included a great number of African-American men who either died, went blind, or became insane, and wives who contracted the disease along with children who were born with congenital syphilis (Planned Parenthood Advocates of Arizona, 2012). The significance of this study is that of an enduring cultural memory in Black communities. The study by Ball, Lawson, and Tanya (2013) contended that feelings of vulnerability, mistrust, and suspicion towards the healthcare system among African Americans was directly related to a history of unethical medical experimentations on the Black community such as the Tuskegee Syphilis Study. Dissemination of information of unethical events like this study intensifies problems originating from historical trauma and struggles faced by Black communities.

“Historical trauma refers to a complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance”
Historical trauma operates through a layering of narrative turns, including trauma as a concept represented in stories, history as socially endorsed memory, and an internal logic linking history to present suffering or resilience (Crawford, 2014). The consideration of historical trauma offers a complex viewpoint on present day struggles and the development of resilience within these communities. According to Crawford, historical trauma can be understood as consisting of three primary elements: a “trauma” or wounding; the trauma is shared by a group of people, rather than an individually experienced; the trauma spans multiple generations, such that contemporary members of the affected group may experience trauma-related symptoms without having been present for the past traumatizing events (2013). This is a condition that continues to plague the Black community whereby individuals in this demographic exhibit manifestations of past trauma therefore influencing their lack of total trust in medical professionals within the healthcare system. A lack of trust and feelings of exclusion fuel the reluctance these individuals harbor toward a medical system they view negatively given its history of failing them. The transmission of information becomes a double-edged sword when African communities in Nigeria are faced with treatment proposals that are viewed as European in origin. It is not surprising that these can be met with suspicion and hesitation. Resistance to utilizing and seeking mental health services can be reduced with education about the changes that continue to take place in the field of research and medicine. In order to build and maintain trust in the healthcare system, appropriate representation of all people is necessary. The idea of using similarities in values and culture as tools to appeal to individuals who would typically avoid care becomes necessary. Although the ability to properly care for a patient may not change from clinician to clinician regardless of their racial background, seeing a clinician who looks like the patient might improve buy-in and trust. Integration of diversity within teams of
health care professionals could serve as a connector that improves participation and follow-through with treatment plans. Actively participating in community events that provide avenues to create a culturally informed treatment model may thereby encourage the use of available resources and decrease stereotypical messages about MI treatment. Lu, Russell, and Mezzich (2015) in their assessment of the differences in the diagnosis of individuals from different cultural groups, found the need to develop culturally competent attitudes, skills, and knowledge in order to avoid misdiagnosis and bias.

**Interventions for Mental Illness Awareness and Treatment**

Possible interventions with MI include: providing awareness of treatment options, affordable options, clinically informed medication evaluation and management, psycho-education classes addressing basic information on MIs and available treatment options, increasing meeting frequency and improving meeting locations, family focused therapy classes, cognitive behavioral therapy, skills-based work, and modeling behaviors to improve the engagement of participants (Velligan et al., 2010). Adopting a generalist approach of functioning whereby cultural awareness, openness, trust, mutuality, accountability, healthy boundaries, and respect are promoted and modeled is another avenue that will be useful in psycho-educational classes. In the event that an individual can be taught to improve their ability to utilize coping skills, their sense of personal safety becomes stronger; hence, skills-based work will be the foundation of the topics covered. It is crucial that everyone involved in the provision of services learn to manage expectations as this tool will also be taught to individuals and their loved ones seeking help. It is important to understand that an individual’s perceived success or failure with treatment is not directly correlated to the clinician’s abilities to provide care.
Appreciating that individuals receiving care will have varying experiences and exhibit different levels of compliance is a requirement.

Recruiting individuals from the community who are trained to consistently guide by example will play a prominent role in integrating interventions that are evidence-based. In order to avoid alienating any part of the community, it is crucial that facilitators trained to run these workshops represent individuals along the spectrum in it. Individuals who identify as Muslims, Christians, and Traditional worshippers who speak English, Pidgin-English, Yoruba and Igbo will be core members of the skills work team. Providing ongoing training for these individuals will further show the commitment, recognition, and importance placed on cultural and religious values within the communities served. In addition to creating a safe and neutral environment, it is important that the choice of language with which the information is relayed to the public be appropriate. For example, if the primary language used in a given community is Pidgin-Broken English, it is important that the workshops be taught or appropriately translated in this language to promote transparency, peer-facilitator engagement, and understanding. Facilitators need to be aware of the language barriers and find creative ways to use simple yet appropriate words and pictures that would best represent the topic being discussed. Finding ways to communicate the fact that some languages do not directly translate diagnosis or do not have words that could describe a given disorder is necessary. The message about teaching and modeling skills to cope rather than focusing on “giving” a diagnosis in these groups will be essential. More so, the materials shared to aid the teachings should be in a simple, clear, and concise format. The “What and Why – Pros and Cons” of topics covered in workshops should be outlined almost immediately at the start of each session. By the first 15 minutes of the meeting, it should be clearly stated what is being discussed and why it pertains to their day-to-day lives. It is
important to note the need to tailor these classes to the specific audiences that are being served at the time. Facilitators for these classes are to be trained to be skillful and yet able to avoid presenting as authoritarian figures. Any behavior that points to being pompous or proud is frowned upon in most Nigerian communities especially by the elderly; therefore, all appearances of self-dignification should be tempered. For example, if a class is teaching individuals who publicly claim to belong to a particular religious or traditional group, it is important that their way of life is validated and not dismissed. It is important to relay the message that the topics to be covered are designed to highlight avenues for improvement and partnership within and outside the community, to promote opportunities for advancement. No workshop should be concluded without providing a clear opportunity for the attendants to participate in a discussion of how the topic covered might affect their daily life. This is a chance to document pointers from local residents about their needs, abilities, and ideas on how to further serve them.

In the quest to understand what motivated behaviors in individuals, Abraham Maslow developed the *Hierarchy of Needs*, which outlined the needs of individuals in a five-tier pyramid model. The original pyramid by Maslow (McLeod, 2016) includes

(a) Physiological needs: food, warmth, water and rest.

(b) Safety needs: security and safety.

(c) Love and belonging needs: intimate relationships and friendships.

(d) Esteem needs: feelings of worth and achievement.

(e) Self-actualization: achieving full potential as defined by the individual

Maslow believed that people possess a set of motivational systems unrelated to rewards or unconscious desires, hence stating that people are motivated to achieve certain needs, and that some needs take precedence over others (Maslow, 1962). For example,
compared to an individual with a healthy, consistent support network, an individual who is currently homeless and hungry will have significant difficulty in fully engaging a clinical treatment process for a mental health diagnosis. In a multifaceted system, this individual’s clinical outcome can be positively affected when their basic needs are being managed with compassion and respect. According to Maslow’s theory, if and when this individual meets the basic needs of food and shelter, he or she is able to tap into the full potential of treatment thus moving to the next level on the hierarchy. This is not to imply that self-actualization in treatment intervention is impossible in the absence of basic needs; however, it is significantly harder to manage a positive outcome with several challenges being present. The important implication from Maslow’s work is that the outcome of an individual’s ability to meet their full potential is affected by the state of their physical, emotional, social, and cognitive abilities. To promote a therapeutic learning environment for psycho-education, it becomes paramount to promote an atmosphere of respect and value of the processes modeled by facilitators hence improving the engagement of the audience. Also, cultivating a process that clearly advocates for customization of interventions presented will further enhance this multifaceted approach.

To develop time- and cost-effective interventions, exploring research on tested stigma reducing plans is advisable. According to a review of intervention trials by Heyam Dalky, educational and contact-based strategies used in various stigma-reduction programs resulted in the most durable gains in knowledge as well as positive attitudinal and behavioral changes needed to decrease the stigma associated with mental illness (2012). Identifying a list of applicable barriers that affect the perception of a given population is another aspect of creating a viable ongoing plan. Racial, ethnic, familial, cultural, and stigma factors are among the most reported barriers that hinder help-seeking behaviors or maintaining treatment, which, in turn,
adds to the burden of these disorders (U.S. Department of Health and Human Services [USDHHS], 1999).

A stigma-reduction intervention is based on adopting an entertainment education strategy, according to a study by Ritterfeld and Jin (2006). Their intervention program evaluated whether an accurate empathic media portrayal combined with an educational trailer value-added component (VAC) increased knowledge about schizophrenia and contributed to stigma reduction (Ritterfeld & Jin, 2006). In this study, viewing an accurate and empathic movie portrayal and educational trailer increased both knowledge acquisition and influenced stigma reduction; the behavioral component of stigma was the most difficult to change compared to emotional or cognitive ones (Ritterfeld & Jin, 2006). This is relevant to the entertainment structure of most Nigerian communities as in the last approximately 20 years, Nollywood has become the third largest film market in the world as well as the most innovative (The Economist, 2006).

Ekeanyanwu (2010) in his book on developmental imperatives in Nigeria stated that traditional values in Nigeria include honesty, moral rectitude, respect for elders, respect for fellow citizens, respect and loyalty to family values, hard work, resourcefulness, and education. He expressed how culture could be learned, acquired, experienced, and transferred from generation to generation in varying avenues including through communications technology (Ekeanyanwu, 2008). Nollywood, with its far reach, is capable of spreading positive cultural values that foster an environment conducive for understanding and growth. As the entertainment industry finds support in the international market, the industry now helps to champion African identity to those in the diaspora, which is consistent with Nigeria's foreign policy in which Africa is the centerpiece (Esan, 2008). According to Ajayi (2009), when science and technology are imported from outside, they remain strange and may never drive development until integrated
into the culture of the people. Similar to the Adlerian viewpoint, Ekeanyanwu (2010) postulated that a growth-conscious economy is promoted by good governance, public officials with legitimate principles, and businessmen and women with moral integrity. The behaviors driven by social interest like promoting a culture that values virtue, love for one another, integrity, diligence, and resourcefulness can serve the purpose of further integration and unity. A plan to involve the media industry in Nigeria could prove fruitful following the findings of Ritterfeld and Jin in their 2006 study using media for stigma reduction interventions on MI as outlined by Dalky (2012). They found that the inclusion of a real entertainment media in which facts and personal stories are presented to participants by watching a movie yielded positive outcomes, which were sustained over time (Ritterfeld & Jin, 2006). The addition of an educational trailer (VAC) after the movie presentation revealed more positive results than those from watching it alone or by presenting this educational trailer before the film (Ritterfeld & Jin, 2006). According to the USDHHS, additional studies with similar approaches are needed to support these findings and to promote the inclusion of such strategies in stigma-reduction programs for different target groups (1999).

Providing a variety of easy moderate-level self-improvement activities including yoga, DIYs (do it yourself-s), and dance classes will be options offered to promote the health and wellness of the people served. These classes are a great option to create a form of balance between the merging of clinical and cultural services to manage psychological wellness. Given the bustling nature of the music industry in Nigeria, dance classes using the music of Nigerian artists will further create an enjoyable and stress reducing atmosphere. Providing these classes at little or no cost, could serve as an efficient avenue that introduces people to the clinical aspects of care. Teaching simple yoga techniques allow the opportunity for individuals to learn and
experience first-hand the importance of proper stretching and breathing. This encourages the individuals in attendance to take control of their emotions, and how they are expressed, using the skills learned. These skills include box breathing, breath retention, abdominal breathing, progressive relaxation, and guided visualization that will be clearly outlined using appropriate language and simple pictures in materials to be distributed after each session to promote the continued practice and use of the skills. A study by Van der Kolk and his colleagues found that a 10-week yoga program significantly reduced posttraumatic stress disorder (PTSD) symptomatology compared with supportive therapy, well-researched psychotherapeutic and psychopharmacologic approaches (2014). Comprehensive research on the effects of mindfulness meditation like yoga has been demonstrated to positively influence several psychiatric, psychosomatic, and stress-related conditions, including anxiety, depression, chronic pain, immune function, blood pressure, cortisol levels, and telomerase activity (van der Kolk et al., 2014). Providing individuals with first-hand skills that can be practiced in their homes, while measuring effectiveness on an ongoing basis, provides the opportunity for sharing the responsibility of treatment planning and execution. This can help in relieving feelings of helplessness, discouragement, and fear, while promoting emotional awareness and feelings of belonging for the individual. In the case that individuals attend these classes with some frequency, social bonds begin to form between people within the immediate environment hence re-introducing the feeling of belonging within the community. A class that, by design, is group-driven will in ways mimic the cultural lifestyle of commitment and a united front in a Nigerian neighborhood. In time, individuals begin to feel a sense of duty to the group, which promotes the Adlerian value of social interest. This is a desired coping skill for individuals who are struggling
to manage symptoms related to daily stresses, anxiety, depression, and posttraumatic stress disorder (PTSD).

**Cultural Formulation Interview and WHODAS 2.0 as an Integrating Tool of Treatment**

_The American Psychiatric Association_ (APA) and the _Cross-Cultural Issues Subgroup_ (DCCIS) collaborated to produce and disseminate a tool at the vanguard of cultural psychiatric practice: The _Cultural Formulation Interview_ (CFI). This evidence-based tool is composed of a series of questionnaires that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning. Upon the publication of _The Diagnostic and Statistical Manual of Mental Disorders_ (DSM-5), the CFI is becoming one of the most widely used methods for implementing cultural assessment and to achieve broad dissemination of the CFI; the American Psychiatric Association provides the assessment free of charge. An Informant version of the CFI is also available and can be used to promote engagement from loved ones who are supportive of the clients’ help-seeking behavior (American Psychiatric Association, 2013). These make the CFI an ideal intervention tool to be implemented in Nigerian organizations providing mental health treatments.

At the core of the CFI is the definition of culture included in _DSM-5_ (American Psychiatric Association, 2013, p. 749):

Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience.
According to the DSM-5 (American Psychiatric Association, 2013, pp. 758-759), utilizing cultural concepts in the *Cultural Formulation Interview* (CFI) are important in the treatment process in several areas listed below:

(a) To avoid misdiagnosis: unfamiliar spiritual experiences can be misdiagnosed when misjudged for a clinical psychotic symptom.

(b) To obtain relevant clinical information: Features of risk, resilience and outcome can affect variations of symptoms presented or reported.

(c) To improve clinical rapport and engagement: “speaking the language of the served individual can assist in the joining process hence improving the treatment engagement and outcome.

(d) To improve therapeutic efficacy: It is proven that culture influences the psychological mechanisms of any given disorder therefore it is important to understand its presentation so it is appropriately addressed.

(e) To guide clinical research: gathered trends within a given culture can lead to greater understanding of comorbidity, underlying biological and environmental factors.

(f) To clarify, cultural epidemiology: understanding differences and similarities and how they affect the treatment and prognosis of an individual.


There is a crucial need to provide clinicians with clear and practical guidelines on the extent to which cultural background and context affect the expression or manifestation of
symptoms and syndromes, and of the possible existence of culturally bound syndromes (Canino & Alegría, 2008). Given the consensus that an individual is to be treated as a person and not as a list of symptoms, it is essential that information is effectively gathered from the individual in order to promote best clinical practices. The DSM-5 has now incorporated the cultural formulation interview (CFI), with the aim of defining how to ask patients about cultural issues with regard to mental health (Canino & Alegría, 2008). The adequacy of a diagnostic instrument or interview in a given culture does not guarantee its reliability or validity in another, even given a faithful translation (Canino & Bravo, 1994). Unless the assessment tool used for diagnosis is developed in the culture for which it is intended, its use requires a comprehensive adaptation process so that the instrument is capable of identifying similar phenomena to those identified by the original version but in a different culture (Canino & Alegría, 2008). The endeavor to culturally adapt a diagnostic assessment can provide clues as to the etiology of disorders and provide evidence as to whether different societal responses to mental illness affects its course thereby providing indicators for treatment improvement (Canino & Bravo, 1994).

Despite the development of the CFI over the past years, it is not a perfect system that guarantees a flawless treatment outcome, however it improves treatment experience and efficacy when used as a tool among others in practice. Both the person-centered process of conducting the CFI, and the information it elicits, are intended to enhance the cultural validity of a diagnostic assessment, facilitate treatment planning, and promote the individual’s engagement and satisfaction (American Psychiatric Association, 2013, p. 751). Therefore, it is of utmost importance to integrate information gathered from the CFI with all other available clinically sound material into a comprehensive clinical and contextual evaluation (American Psychiatric Association, 2013). The most frequent patient threats were lack of differentiation from other
treatments, lack of buy-in, ambiguity of design, over-standardization of the CFI, and severity of illness. The most frequent clinician threats were lack of conceptual relevance between intervention and problem, drift from the format, repetition, severity of patient illness, and lack of clinician buy-in (Aggarwal, Nicasio, DeSilva, Boiler, & Lewis-Fernández, 2013). As stated by Hackett and Hackett (1999), “the validity of a diagnostic system lies in whether it ultimately helps the patient, not whether it conforms to irreconcilable positions of medial anthropologists or Universalists” (p. 226). The key question, as stated by Rutter and Nikapota (2002), is “whether the associations with psychosocial functioning or disorder stem from ethnicity, from racial discrimination, from the associated social risks (e.g., poor housing, unemployment, educational disadvantage) or some complex interaction between these variables” (p. 278).

The American Psychiatric Association (2013, p. 751) outlines the following instances in which the CFI can be particularly helpful:

(a) When there is difficulty in the diagnostic assessment due to significant cultural, religious and socioeconomic background differences between the clinician and individual seeking services.

(b) When there is ambiguity between the diagnostic criteria and culturally distinct symptoms.

(c) When the clinician is experiencing difficulty in assessing illness severity or impairment.

(d) When an individual seeking services is observed to lack engagement and adherence to treatment.

*The World Health Organization Disability Assessment Schedule, Version 2.0* (WHODAS 2.0) is a self-administered assessment developed to evaluate an individual’s ability to perform activities in six specific areas: understanding and communicating; getting around; self-care; getting along with people; life activities in the areas of work/school and home; and general
participation in society (American Psychiatric Association, 2013). This is another effective tool to select interventions in Nigerian communities as it is available in several forms, can be completed on paper, easily scored, and available for print on the DSM-5 Webiste. In the case that an individual is cognitively unable to complete this assessment, a proxy-administered version is available to be completed by a knowledgeable informant. Another unique way in which this assessment can be useful in the treatment of people with MI is in tracking changes in levels of functioning through the course of treatment. Based on the findings from the DSM-5 Field Trials, the average domain and general disability scores were found to be reliable, easy to use and clinically useful to the clinicians (American Psychiatric Association, 2013, p. 746). Given the inability of the Nigerian government to provide a constant electrical supply to its population, most organizations providing services either go without a power supply or manage to rotate their funds to use generators which are expensive hence driving up the cost of services. Given the easy template of the WHODAS 2.0, providers are able to print copies in bulk that can be used during daylight hours thereby saving on cost.

**Discussion**

This paper provides an overview of the challenges faced by a special population of people in Nigeria, West Africa. The lack of clinically sound practices with diagnosis, treatment options, and prognosis for MI continue to pose a risk in Nigerian communities. These obstacles can be attributed to factors including the shortage of properly trained clinicians able to provide adequate care, inaccessible treatment facilities, unaffordable treatment options, misunderstanding about MI, and negative help-seeking behaviors fostered by stigmatization due to a lack of understanding of treatment practices and the etiology of MI. Continued exploration of these communities provides the opportunity to efficiently create awareness opportunities, consequently
benefitting its population. To work effectively, and to introduce a culturally-informed treatment model, building trust and modeling acceptance of varying perspectives in treatment approaches is necessary. Historical and current socio-economic stressors must be considered as this is directly correlated with the level of willingness to seek mental health services. This translates into further establishing an environment conducive for differences and similarities in the worldview of the community served and its caregivers. Identifying the broader base of knowledge outside of the European-based models, and committing to finding areas of possible partnership is needed in promoting trust and a sense of belonging. Focus should not be on glorifying one form of treatment over another, but rather to identify areas of similarities thus creating opportunities for partnership and increased understanding. Given that pain is a language understood across communities however far or near, continued efforts to identify the means to reduce pain and suffering is a priority. It is important to accept the fact that changes in these communities requires a consistent effort and will not be an unchallenged process. Maintaining an open mind and a long-term commitment, managing expectations, and a realistic definition of success, is important. In order to increase the effectiveness of interventions proposed in this paper, ongoing exploration and appreciation of the African cultural perspective, languages, lifestyles and culture-specific struggles, is crucial. Clinicians who work to implement interventions should prioritize gaining cultural competence by way of immersing themselves in Nigerian communities. To achieve these desired positive changes, continued commitment and partnership is key and as the Igbo language conveys; “otu onye tuo izu: o gbue ochu” – knowledge is never complete: two heads are better than one.
Glossary

Perception: a way of regarding, understanding, or interpreting (Google, 2017).

Cultural Awareness: a style of communication that accounts for varying values, beliefs and perceptions of others and self (Block, 1980).

Dibia Afa: diviner and diagnostician (Nwankwo, 2014).


Dibia-Okpukpu: bone setter (Nwankwo, 2014).

Dibia-Ogbanje: Pediatrician, traditional surgeons, and traditional birth attendants (Nwankwo, 2014).

Babalawo: Priests of Ifa (Nwankwo, 2014).

Gbòngbò kan soṣo kò gbọdọ ré ójọgbón lẹ̀ṣẹ́ pa lèjè-ṣẹ́jì: The same tree branch should not trip a smart person twice (Yoruba cultural saying).

Inú igbó ni wèrè n’gbé: The mad lives in the jungle (Yoruba cultural saying).

Tani ofé bá wèrè gbé lè: Who will live with a mad man? (Yoruba cultural saying)

Gbogbo aso ko ni a nsa l’Orun: not all clothing should be spread to dry in public (Yoruba cultural saying).

Otu onye tuo izu: o gbue ochu - knowledge is never complete: two heads are better than one (Igbo cultural saying)

Inferiority complex: an unrealistic feeling of general inadequacy caused by actual or supposed inferiority (Adler, 1979).

Discouraged: loss of confidence or enthusiasm (Adler, 1979).

Compensate: to make up for something unpleasant (Adler, 1979).
Adlerian tasks of life: work, social relationships, spirituality, love and marriage; developing a relationship with the self (Adler, 1979).

Lifestyle: An individual's unique, unconscious, and repetitive way of responding to (or avoiding) the main tasks of living (Adler, 1979).
References


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