

# **Pathways to mental healthcare in south-eastern Nigeria: Manning the crossroads**

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## **Abstract**

In sub-Saharan Africa, traditional and faith healers provide competing services alongside biomedical professionals. This may be associated with delays in reaching specialised mental health services, and hence with longer duration of untreated illness. As first line care constitutes a crucial stage in accessing of psychiatric care, investigating pathways to mental healthcare can highlight help-seeking choices. This study explored the pathways to care for mental illness preferred by a non-clinical sample of the population in south-eastern Nigeria. Multistage sampling was used to select participants (N=4706) who completed questionnaires on help-seeking. Results showed a significant preference for biomedical (90.8%) compared to spiritual (57.8%) and traditional (33.2%) pathways. Higher education predicted preference for the biomedical model, while low education was associated with traditional and spiritual pathways. Protestants preferred the spiritual pathway more than did Catholics. The use of biomedical care is potentially undermined by poor mental health infrastructure, a lack of fit between the culture of biomedical care and the deep-seated cultural/religious worldviews of the people, stigma surrounding mental illness, and the likelihood of a social desirability bias in responses. A complementary model of care is proposed.

**Keywords:** pathways to health care, mental health services, Indigenous healing, traditional, spiritual, biomedical model

## **Introduction**

Health care seeking behaviour is conceptualised as a sequence of remedial actions taken to rectify perceived ill-health (Ahmed, Adams, Chowdhury & Bhuiya, 2000). From a cognitive theory framework, three identifiable stages characterise the help-seeking pathway: defining the problem, deciding whether to seek help, and finding a source of support (Liang, Goodman, Tummala-Narra & Weintraub, 2005). While clinical factors such as symptom severity provide the impetus to the pathway, the decision to seek help and the selection of a help provider are structured by the convergence of personal, developmental, psychosocial, cultural, systemic and socio-economic factors (Cauce et al., 2002; Rogler & Cortes, 1993). Research demonstrates that pathways to psychiatric care largely follow three patterns reflecting the cultural and socio-economic characteristics of populations (Sorketti, Zuraida & Habil, 2013). The first pattern, which is typical of mainstream (Western) psychiatry, is dominated by the biomedical explanation for mental illness with emphasis on the diagnosis of symptoms, which are treated primarily through medical interventions. Here, General Practitioners (GPs) act as gatekeepers to psychiatric services. Following this pathway, the median time taken to reach specialist mental health services in Australia was 6 months, with a significantly shorter time for patients with psychotic disorders (Steel et al., 2006). In the second pattern, patients may see any care provider of their choice with the likelihood of having direct access to mental health professionals. This model is observable in parts of Asia such as Japan (Fujisawa et al., 2008) and Eastern Europe, where more than a third of patients (32 - 46%) took a direct route to specialist psychiatric care in Belgrade, Bucharest, Iasi, Strumica and Zagreb (Gater et al., 2005). Direct access to mental health professionals makes for timely intervention, thereby shortening the duration of untreated illness. However, it can equally undermine the important gate-keeping roles of GPs that ensure more cost-effective deployment of specialist services.

Traditional and faith healers play an important role alongside biomedical professionals in the third pattern, mostly observable in traditionalist (collectivist) societies of the developing world including Nigeria, where studies indicate that the majority of respondents consulted traditional and spiritual healers before

their eventual arrival at psychiatric facility (Adeosun, Adegbohun, Adewumi & Jeje, 2013; Aghukwa, 2012; Aniebue & Ekwueme, 2009; Odinka et al., 2014). Lay cultural beliefs guide help-seeking in this model and a network of personal contacts are often exhausted before contact is made with professional services. Consulting traditional or faith healers is predicated on an entrenched cultural and religious background that engenders supernatural causal attribution for mental illness, which potentially discounts the effectiveness of biomedical psychiatry in these societies. Traditional and religious healers may play important roles in addressing mental health care needs by offering culturally appropriate treatments. However, this pathway is associated with the longest delay in reaching specialized services, and hence longer duration of untreated illness (Burns, Ihazbhay & Emsley, 2011; Güner-Küçükkaya & Ünal, 2012).

Delay is exacerbated by the fact that help-seeking in these contexts often entails seeing multiple practitioners rather than seeking care through one avenue or provider. Depicting a particularly difficult pathway, a Nigerian study (Adeosun et al., 2013) found, for instance, that patients who first consulted general practitioners presented to an average of one care provider before presenting to mental health professionals while those that first consulted traditional or religious healers saw an average of about six care providers before presenting to mental health professionals. Delay is also escalated by the lack of referral skills on the part of traditional and spiritual care providers, which may be fuelled by the conception of referral as admission of incompetence. Though limited social networks predicted restricted utilisation of mental health resources in one study (Bonin, Fournier, & Blais, 2007), research also hints at the irony of the inhibitory influence of tightly meshed social networks observed in these contexts that can insulate individuals from linking up with health facilities (Birkel & Reppucci, 1983). In such close-knit networks, people can be pressured toward the acceptance of normative beliefs, and when beliefs are incongruent with the culture of services, pathways are negotiated away from reaching such facilities (Cauce et al., 2002).

The first line of care experienced by the mentally ill constitutes the most important stage of the psychiatric pathway to care as delays in the initiation of appropriate treatment are associated with worse clinical and social outcomes including the exacerbation of psychotic symptoms, poor response to treatment, and poor

quality of life in patients with schizophrenia (Adeosun et al., 2013). Investigating pathways to mental health care may shed light on popular beliefs about mental illness, the nature of accessible services and the choices that can have critical implications for eventual outcome. In a rapidly globalizing world, such research may further guide health professionals and therapists working in multi-cultural settings, helping them to situate their patients more contextually for greater therapeutic alliances. However, most research on pathways to mental health care such as the aforementioned Nigerian studies deal with clinical samples at biomedical mental healthcare facilities, where the conventional psychiatric pathway culminates. This creates a gap in our knowledge, as the pathways taken by the majority of distressed persons do not lead to or end at such formal health care centres (Ware, Manning, Duan, Wells & Newhouse, 1984). This study aims to fill this gap in knowledge by exploring the preferred pathways to care for schizophrenia by a non-clinical cross-section of the south-eastern Nigerian population and the dynamics surrounding pathway choices. An inclusive view of pathways to mental healthcare with complete mapping of care providers in the community is necessary for the planning of mental health services and the eventual evolution of a model of care that is more responsive to the cultural characteristics and contextual peculiarities of this under-researched and underserved region. Schizophrenia is a psychotic disorder - madness in lay terms (Gomez, 2013). This is the popular notion of the target population that conceptualises mental illness in terms of severe psychotic disorders (Igbinomwanhia, James & Omoaregba, 2013; Atilola & Olayiwola, 2011) with the common stereotype of the mentally ill being that of the 'unkempt psychotic vagrant' (Ewhrudjakpor, 2010).

## **Methods**

### **Participants and Sampling Technique**

This study focused on the Igbo people east of the River Niger, a culturally homogeneous and remarkably entrepreneurial people in five states of Nigeria. A multistage (random and convenience) sampling method was used to select participants from a cross-section of students, teachers, nurses and the general public ( $n = 706$ ) which included young (18 – 35 years) and old (>35 years) participants, Catholics, Protestants, participants with low education (nil – secondary education), participants with high education (post-secondary education), married and unmarried individuals, those familiar with person(s) with mental illness and those not familiar with person(s) with mental illness. The age distinction at 35 years was determined in

accordance with local culture. As Menon (2001) noted, stages of life are conceptualised differently across cultures and times. In many Nigerian cultures, the young develop a sense of adulthood through a series of age-related initiation rites such as the maturity rite among the Igbo people, performed by those between 35 and 40 years old, which symbolises the transition from youth to adulthood (Okon, 2011). The discrimination between Catholics and Protestants in the sample followed from the consideration that over 95% of the people in this region are Christians of either tradition (Agbodike, 2008), with the more independent Protestantism being arguably more indigenised than the Rome-mediated Catholic Church. Familiarity with person(s) with mental illness was considered to compare experiential with conceptive knowledge. The first stage of sampling involved a random selection of three out of the five Igbo states through a balloting process: Anambra, Enugu and Imo states were selected. The second stage of sampling involved the selection of a semi-urban locality from each of the three states based on their relative accessibility and proximity. This equally served to survey a more representative demographic with both urban and rural characteristics. The survey of the general public took place in homes, community squares and business premises. A co-educational school and a tertiary institution were further selected from each locality for the survey of students while a community hospital with a school of nursing was similarly selected for the survey of nurses. The final stage of sampling process involved the administration of questionnaires.

### **Instrument**

The quantitative instrument used in this study was developed from qualitative data collected in text form (an open ended question was asked on the possible steps respondents could take in seeking help for mental illness). The qualitative data was sourced from the same target (Igbo) population from which the data for the substantive quantitative study was later sourced. Content analysis was used to determine category scheme and to create codeable units. Predetermined 'standard' categories were used: spiritual, traditional and biomedical pathways (Adewuya & Makanjuola, 2009). Each unit was defined based on one treatment idea (preference) communicated and was coded to only one of the three pathway categories. While seven units came under the traditional pathway, five came under the spiritual pathway and six came under the biomedical pathway making up the eighteen potential items for the quantitative instrument. Each of these was articulated in a simple declarative statement framed with a four-point Likert response scale: strongly

agree, agree, disagree and strongly disagree. These were subsequently deployed in gathering the quantitative data. To further refine the scale, following data entry into SPSS version 20, the 18 items were subjected to Principal Component Analysis (PCA). Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients at .3 and above. The Kaiser-Meyer-Olkin value was .86, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) was highly significant ( $p < .001$ ), supporting the factorability of the correlation matrix. The PCA result is provided in the result section.

### **Data Collection**

Undergraduate students were recruited and trained to help with the administration of the quantitative questionnaires. Invitation to participate was extended to prospective participants and only those that consented to the study were surveyed. Those who needed help with the pragmatics of completing the questionnaires were assisted. Most of the questionnaires were completed and collected on the spot. A maximum time frame of one week was accorded those who needed time to complete the questionnaires. A characteristic high response rate of 98.5% was achieved as is typical of this collectivist culture that readily identifies with a task considered to be productive (Ikwuka et al. in press; Odinka et al. 2014). Eleven people declined participation, mostly because they were uncomfortable discussing 'madness'.

### **Data Analysis**

Data management and statistical analyses were performed using SPSS software version 20.0 (SPSS Inc., Chicago, IL, USA). Descriptive statistics were provided as Frequencies, Percentages and Means (SD). There were seven demographic variables and three help-seeking pathway constructs (Traditional, Spiritual and Biomedical). Following the scale's four-point response with 'strongly agree' having the scale value of '4' and 'strongly disagree' having the scale value of '1', the scores were categorized into two groups based on the scale median of 2.5. Mean scores of constructs with values up to the scale median were categorized as endorsing a construct (agree) while mean scores with lower values were categorized as not endorsing a construct (disagree). Mean comparison of the constructs was by one-way repeated measures ANOVA. Standard multiple regression analyses were used to assess the ability of the demographic variables to predict pathways to mental healthcare. For all tests performed, the probability value of 0.05 was used as threshold

for determining statistical significance level.

### **Ethical Considerations**

The study was approved by the Ethics and Research Committee of the University of Wolverhampton, United Kingdom and that of the University of Nigeria Teaching Hospital, Enugu, Nigeria. Permissions to survey the nurses and students were sought and obtained from their respective school principals. Written or verbal consent was obtained from prospective participants prior to the administration of the questionnaires. Anonymity and confidentiality were guaranteed.

## **Results**

### **Table 1 about here**

PCA revealed the presence of four components with eigenvalues exceeding 1, explaining 26.7%, 9.6%, 8.5% and 6.4% of the variance. However, an inspection of the scree plot reveals a more prominent levelling off of the slope after the third component, although a second less prominent break could be seen after the fifth component. Given that the items were based on the 3 predetermined 'standard' categories from the qualitative data (Traditional, Spiritual and Biomedical pathways), a three-factor solution was pre-specified for the PCA for further investigation. The resultant 3 factors all had eigenvalues over 1, thus easily satisfying the Kaiser-Guttman criterion ( $\lambda > 1.0$ ), and accounted for 44.8% of the variance. Following orthogonal (varimax) rotation, items loading most strongly onto factor 1 consisted of those measuring the Traditional Pathway to mental healthcare, for example, 'If someone under my care becomes mentally ill, I will seek the advice of elders'. Factor 2 was made up of items measuring the Spiritual Pathway, for example, 'If someone becomes mentally ill, he should be exorcised,' while factor 3 consisted of items measuring the Biomedical Pathway such as, 'Mentally ill people should be taken to psychiatric hospital'. Factor loadings are shown in Table 1. Cronbach's alpha and item-total correlations were computed for each of the three factors. The first factor (Traditional Pathway) recorded a good alpha of .79. The second factor (Spiritual Pathway) recorded an alpha of .46; removal of items 13 and 14 which had item-total correlations of -.248 and -.162 respectively increased the alpha to .80. The third factor (Biomedical Pathway) recorded an alpha of .55; the removal of item 18 which had an item-total correlation of .220 increased the alpha to .60. Each of the items

had a four-point Likert response scale: strongly agree, agree, disagree and strongly disagree. Participants' responses were reclassified as agreeing to the proposition, if the response were either 'strongly agree' or 'agree' to the items, and disagreeing with the proposition, if the responses were 'strongly disagree' or 'disagree'.

### **Table 2 about here**

The demographic characteristics of the sample are summarised in Table 2. There were more female (65.4%), young (77.6%) and unmarried (68.1%) respondents. There were also more respondents with higher education (72.4%). Catholics (61.1%) outnumbered Protestants and the majority of the respondents (64.4%) were familiar with persons with mental illness.

### **Table 3 about here**

The cumulative pattern of pathway endorsements as presented in Table 3 showed that a predominant 90.8% of respondents endorsed the Biomedical Pathway while approximately half (57.8%) endorsed the Spiritual Pathway and a third (33.2%) endorsed the Traditional Pathway. Mauchly's test showed that the assumption of sphericity was violated ( $\chi^2(2) = 201.72, p < .001$ ); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ( $\epsilon = .78$ ). The results show that pathway preferences differed significantly ( $F(1.60, 912.90) = 534.06; p < .001$ ; partial eta sq. = 0.48). Post hoc Bonferroni tests confirmed that more respondents significantly preferred the Biomedical Pathway to the Spiritual ( $p < .001$ ) and Traditional Pathways ( $p < .001$ ). However, more respondents significantly preferred the Spiritual to the Traditional Pathway ( $p < .001$ ).

### **Table 4 about here**

The demographic variables were used in a standard multiple regression analyses to predict pathways to mental health care (see Table 4). The linear regression model was statistically significant in the prediction of the Traditional Pathway  $F(9, 520) = 9.10, p < .001$ , and accounted for 13.6% of the variance ( $R^2 = .136$ ). Low education made the strongest and most statistically significant unique contribution to the preference for Traditional Pathway ( $\beta = -.21, t(529) = -4.04, p < .001$ ). Occupational group was also a significant

predictor: nurses were significantly less likely to prefer the Traditional Pathway than the general public ( $\beta = -.16$ ,  $t(529) = -2.42$ ,  $p < .016$ ), but neither teachers nor students differed from the general public in their degree of preference for the Traditional Pathway. The regression model was also statistically significant in the prediction of the Spiritual Pathway  $F(9, 526) = 8.78$ ,  $p < .001$ , and accounted for 13.1% of the variance ( $R^2 = .131$ ). Low education made the strongest and most statistically significant contribution to the preference for Spiritual Pathway ( $\beta = -.26$ ,  $t(535) = -5.06$ ,  $p < .001$ ). Protestant denomination also made a statistically significant contribution to the preference for the Spiritual Pathway ( $\beta = -.08$ ,  $t(535) = -2.04$ ,  $p < .042$ ). The model was also statistically significant in the prediction of the Biomedical Pathway  $F(9, 552) = 4.52$ ,  $p < .001$ , and accounted for 7.0% of the variance ( $R^2 = .07$ ). High education made the strongest and statistically significant unique contribution to the preference for Biomedical Pathway ( $\beta = .16$ ,  $t(561) = 2.97$ ,  $p < .003$ ).

## **Discussion**

This study of a south-eastern Nigerian population was motivated by the need to develop a more responsive model of care from the current convoluted mental health care system, with its gaps in biomedical services resulting in longer duration of untreated illness. Mixed preferences were evident as respondents made endorsements across pathways. Unexpectedly, however, the study found a significant preference for the biomedical (90.8%) compared to the spiritual (57.8%) and traditional (33.2%) pathways. A possible positive interpretation of this finding would be to consider it a reflection of paradigm shift from the earlier prevalence of traditional and supernatural conceptualisations of mental illness to the more scientific (biopsychosocial) model, based on improved mental health literacy. This prospect, earlier shared by Ohaeri (1988), is supported by the finding that more education has been associated with greater biopsychosocial attribution for mental illness in this society (Ikwuka, Galbraith & Nyatanga, 2014). Possible paradigm shift in this region is similarly suggested by the findings of Furnham and Igboaka (2007) that while young Nigerians predictably endorsed supernatural causation for mental illness, they equally favoured biological and sociological explanations even more than their British counterparts. Furthermore, while the Nigerian respondents recognised traditional and religious practices as possible treatment options, they favoured

biomedical psychiatric interventions and supportive environments as treatment models more than their British counterparts.

However, as the experience of mental health services is a significant determinant of future or continued service use (Gulliver, Griffiths & Christensen, 2010), availability of functional and accessible mental health services is essential for this finding to translate into practice in this population, or else potential users will be frustrated when the need to access care arises. Given Nigeria's very poor mental health infrastructure - a total number of 0.005 mental hospitals, 2.5 psychiatric beds, 0.06 psychiatrists and 0.02 psychologists per 100,000 people (WHO, 2011) – the odds of biomedical services meeting the needs of the people are very low. While the WHO recommended 5% of Gross Domestic Product (GDP) be allocated to mental health, less than 3% of GDP is spent on health in Nigeria and of this less than 1% is allocated to mental health care (Ewhrudjakpor, 2010). Consequently, many years after its introduction into the Primary Health Care (PHC) system, which forms the bedrock of Nigeria's Health Policy, mental health care appears non-existent at this basic level of care and is scarcely existent at the secondary level (Lawani, 2008). Official referral procedures do not exist (WHO, 2011). Thus, it is likely that at the point of need, pathways will be negotiated away from biomedical health care. This has already been demonstrated in the finding that up to 80% of the population in developing countries depend on traditional medicines to help meet their health care needs (WHO, 2002).

Ideological issues constitute further potential barriers to realizing higher utilization of mental health services. In this cultural context, psychiatric treatment is a potentially difficult experience with respect to the individual's sense of self-worth and environmental homeostasis owing to the debilitating stigma surrounding mental illness. As Sartorius (2002) suggests, the stigma of mental illness begins with the attitudes and behaviour of medical professionals (iatrogenic stigma), which is most detrimental because of the belief that if a specialist says or thinks it is bad then 'it is bad'. Surveys of medical staff in Nigeria show that in spite of their relatively impressive mental health literacy, they still harbour deeply rooted cultural beliefs that discriminate against those with mental illness, resulting in their placing emphasis on custodial

care and opposing care in community (Aghukwa, 2009; Ewhrudjakpor, 2009; Adewuya, & Oguntade, 2007).

A further potential source of frustration with the biomedical model is its cultural appropriateness, which has been called into question (Vaillant, 2012). In the African context for instance, the ability to make quick and accurate diagnoses leading to timely intervention is intrinsic to the idea of an expert (e.g. a consultant). As Nzewi (1989) noted, extensive and prolonged interrogations are viewed with displeasure and usually generate lack of confidence in the therapeutic process. Thus, the bureaucracy and seemingly superfluous discourse characteristic of biomedical therapies may be met with great disappointment in this context. Conversant with their sense of urgency for results, traditional and spiritual healers, in contrast, anticipate the complaints of the clients, thereby earning their confidence, which disposes clients positively towards the therapeutic process. In times of crises, it may seem inappropriate to be kept waiting. Furthermore, there could be disparate expectations in terms of treatment outcomes. For instance, while in the biomedical model (based on individualistic Western culture), the major indicator of recovery rests on overcoming disabilities to meet goals (occupational) (Davidson, Rakfeldt, & Strauss, 2010; Liberman, 2008), in the communalistic African context, a significant step in the therapeutic process would be to help make a deviant character conform to social norms (behavioural). In the communalistic African culture, the community (family) naturally assumes the 'hands' and the 'feet' of the disabled (attending to their needs) and the disabled relishes the support and dependence (Onwuejeogwu, 1986). This explains why occupational therapy is not popular in this region, with a median rate of 0.01 occupational therapist to 100,000 population (WHO, 2011).

Moreover, there can be a discrepancy between attitude (as in the high endorsement of the biomedical model) and subsequent behaviour (the actual patronage of a care provider) as behaviours are triggered by a complex interaction of attitudes, values, and situational variables (Wong, 1997). Such discrepancy is exemplified in the findings from two current studies of clinical samples from this population that the majority of respondents initially followed traditional and spiritual pathways prior to arriving at the

psychiatric facility. In the first study by Odinka and colleagues (2014), while 61.1% and 14.7% initially took the spiritual and traditional pathways respectively, only 9.2% took the biomedical pathway. In the second study by Aniebue and Ekwueme (2009), the spiritual pathway led with 34.4% followed by the psychiatric pathway with 32% and traditional pathway with 13.6%. These findings corroborate reports from around Nigeria and Africa which all indicated that the majority of patients had used alternative services either alone or prior to presenting at biomedical mental health facilities. A study conducted in Akure, south-western Nigeria (Agara & Makanjuola, 2006) found that about 70% of patients had been treated by spiritual healers and 43% by traditional healers before presenting at a mental health facility. In a more recent study of south-western Nigeria (Adeosun et al., 2013), the majority of the patients (69%) consulted spiritual or traditional healers as the first contact in the process of seeking care for mental illness while psychiatrists were the first contact for only 17.4% of the patients, with 13.8% having previously consulted a non-psychiatric physician or General Practitioner. In a qualitative study of Uganda (East Africa), Nsereko and colleagues (2011) found that traditional healers were usually the first source of care people sought when faced with mental health problems and frequently the only source of care sought. In a study of an Ethiopian sample (North-east Africa), Bekele, Flisher, Alem and Bahiretebeb (2009) found that 41% patients directly contacted the mental hospital while the rest (59%) sought care from up to four different caregivers before arriving at the psychiatric hospital, with 30.9% of these consulting spiritual care providers. The median delay between onset of illness and arrival at the psychiatric hospital was 38 weeks. Another qualitative study of KwaZulu – Natal (South Africa) found that traditional and faith healers were the first port of call leading to delays in reaching specialised services (Mkize & Uys, 2004).

A possible explanation for this discrepancy lies in the sample difference between our study (non-clinical sample) and the aforementioned studies (clinical samples). As symptom severity is a major determinant of help-seeking (Biddle et al. 2004), a clinical sample will be more pragmatic in its approach and possibly more desperate too. This may play out, for example, when uninformed families are faced with the onset of a psychotic condition such as schizophrenia in a relative, with symptoms that can be very bizarre and coming at the prime of life. Such ‘strange’ occurrences would then ‘logically’ attract

supernatural attribution fuelled by the deeply religious worldview of the people (Ikwuka et al., 2014). An Igbo adage aptly captures this situation 'adighi eji anya oma eje uka Sabath' – it is desperation that drives people to healing churches. However, as Angermeyer, Matschinger and Riedel-Heller (2001) observed, if initial treatment experiences fail, the formal expert system is favoured, which explains why the clinical samples eventually turned up at the biomedical psychiatric services.

Another important situational variable capable of creating discrepancy between attitude and behaviour in this context is social desirability as observed in the responses of participants in a related Indian study (Kulhara, Avasthi & Sharma, 2000). Regardless of perceived efficacy of the biomedical interventions, the people in this region appear to have been conditioned to conceive being 'civilised' as synonymous with Western lifestyle, hence, the Western model is normally considered to be the ideal. This belief is reinforced by the seeming 'imperialisation' of mental health as evident, for example, in the Western creation of official categories of mental illnesses - The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), which has become a worldwide standard. Being associated with the Western model may therefore be the more socially acceptable choice to make, especially before an undergraduate research assistant who epitomises (Western) civilisation. Not being under the pressure of symptom severity, non-clinical samples would have the leisure of responding according to which behaviours are socially desirable.

Socially desirable responding could furthermore be fuelled in the Nigerian context by the increasing bad press and credibility problems suffered by spiritual and traditional care providers regarding their alleged shady dealings, which are furthermore exaggerated in the virtual world of the hugely popular Nigerian home movie industry - Nollywood. For instance, writing in the Guardian UK on December 9th 2007, Tracy McVeigh notes that "Evangelical pastors are helping to create a terrible new campaign of violence against young Nigerians. Innocent children and babies branded as evil are being abused, abandoned and even murdered while the preachers make money out of the fear of their parents and their communities...." Spiritual healers place themselves at the meeting point between what they refer to as the backward and

outdated traditional healers and modern, scientifically based Western medicine (Freeman & Motsei, 1992). Projecting the triumphalism of Christianity, they take their rivalry with the traditional model to the home video screens where many Evangelical Churches sponsor proselytising movies that associate traditional medicine with diabolism and excessive blood rituals, thus making it socially abhorrent. Hence, the traditional pathway is made to appear obsolete and unfashionable, which explains why traditional healing is mostly sought nocturnally. It must be recognized, though, that contempt for native systems has a structural link with the historical colonial demonization and subsequent banning of African traditional beliefs and practices.

Yet, the fact that more than half and over a third of the respondents endorsed spiritual and traditional models of care respectively, in spite of the foregoing, only goes further to illustrate how deeply socio-cultural and religious norms, beliefs and values shape the manner in which the people conceptualise and respond to experiences of psychopathology, hence the indispensability of spiritual and traditional helping models in this region. Practitioners and policy makers must therefore not assume a homogenous approach to mental health care in indigenous societies. Indeed, it would be more auspicious to heed the call of the UN Permanent Forum on Indigenous Issues (2000) for a complementary approach to health care in these contexts. It must be recognised that no health care model is self-sufficient, nor are different models equally capable of rendering help quantitatively or qualitatively. Furthermore, to facilitate therapy, causal theories and prescriptions for cure need to be meaningful to the patient in terms of the realities they understand, or else treatment compliance can be compromised. As questions have been raised regarding the extent to which biomedical psychiatric outcomes are culturally sensitive and inclusive, the traditional approach could provide a model for cultural appropriateness of service. Its grounding in a strong social network, for instance, counters the impersonal setting of psychiatric care where the patient, dislocated from strong social network bonding, is expected to bare the inner turmoil of their private life to a virtual stranger of usually higher education and/or social class. Furthermore, following Litwak's (1968) formulation, traditional kinship structures, resting on permanent relationships, can support long term commitments to care; friendship ties, resting on free choice and affectivity, can support the provision of new information;

based on geographical proximity, neighbours can deal with emergencies, while the formal mental health system, resting on trained expertise and concentrated resources, can provide specialized segmented services.

Indigenous psychiatrists recognize the need to educate and integrate spiritual and traditional healers into biomedical mental health services for maximised service delivery (Yusuf, 2010). A complementary approach to care has worked effectively in a southern African (Lesotho) context (Obioha & Molale, 2011) and equally in Europe (Sevilla-Dedieu et al., 2010). In the imaginative programme in Hungary, pastors train alongside mental health professionals because of the observed link between people's mental health, religion and spirituality (Tomcsanyi, 2000). Pakistan equally exemplifies an innovative and comprehensive strategy specifically designed to take advantage of local opportunities to meet some of the challenges faced in developing countries. The strategy includes collaborating with traditional healers who have received some training, leading to increased identification and professional referral of individuals with mental disorders (Rahman, Mubbashar, Gater & Goldberg, 1998). These examples help to debunk perceptions that biomedical mental health care and religious or traditional beliefs have nothing in common. Ignoring the beliefs of clients will cause psychiatry to miss an important psychological and social factor that may be either a powerful resource for healing or a major cause of pathology (Koenig, 2008). The need for cooperation with indigenous models was further reinforced by the findings of three cross-national studies by the World Health Organization: the International Pilot Study of Schizophrenia (IPSS) (WHO, 1979), the Determinants of Outcome of Severe Mental Disorder (DOSMeD) (Jablensky et al. 1992), and their sequel, the International Study of Schizophrenia (ISoS) (Harrison et al. 2001). These all suggest that schizophrenia has a better prognosis in non-industrialized societies, which is traceable to values in these societies such as family support and enabling styles of interaction. Moreover, it has been observed that biomedical psychiatry had no satisfactory approach for dealing with some culture bound phenomena (Roe & Swarbrick, 2007).

Meanwhile, training to promote improved cultural competency of local mental health professionals is a good starting point towards an inductive bottom-up approach that recognises the importance of local

conceptualisations of mental health difficulties. Cultural competency entails an understanding of a people's rules for behaviour, language, religion, history, traditional beliefs and values (Cross, Bazron, Dennis & Isaacs, 1989), which enables professionals to be more empathic and forge therapeutic alliances with clients. Such a professional will allay the fears of potential clients that they may be misdiagnosed by the biomedical health system or their beliefs and values dismissively pathologised. Most importantly, a culturally competent professional may be better placed to recognize and intervene when beliefs are indeed becoming pathological. Ultimately, such a professional may be better primed for work in the complementary model that envisages consultation with, referral to, or joint therapy with trained spiritual and traditional practitioners (Koenig, 2007).

This study found that higher education predicted preference for the biomedical pathway while low education was associated with the traditional and spiritual pathways. While it could logically follow that education facilitates the paradigm shift toward more scientific conceptualizations of mental illness, it is equally likely that more education, which suggests higher social status, provokes more socially desirable responses. Protestants exhibited greater preference for the spiritual pathway, consistent with the previous finding that Protestants in this region demonstrate greater supernatural causal attribution for mental illness, possibly because Protestantism is more indigenized than the Rome-(Western)-mediated Catholic denomination in Nigeria (Ikwuka et al., 2014).

### **Limitations**

The use of a convenience sampling method introduces the possibility of selection bias and the survey of given occupational variables reflected an imbalance in the representation of some demographic categories. However, given that this is a culturally homogeneous sample, generally considered, it is unlikely that these factors significantly biased the results. The cross-sectional nature of the study implies association of variables, hence caution must be exercised in drawing causal inferences. Some critical variables related to the study, such as socio-economic status and urbanicity, were not specifically investigated, which leaves an important gap for further research. A comparison of clinical versus non-clinical samples would also be

a viable priority for follow-up studies. These notwithstanding, it is hoped that the study succeeded in bringing to light the perspectives of a critical section of the society, contributing to the evolution of a more responsive model of care in this region.

### **Conclusion**

The finding of this study that the majority of the sample preferred biomedical to traditional and spiritual pathways to mental healthcare may be potentially undermined by the possibility of the responses being biased by social desirability effects. Moreover actual utilization of mental health services may be limited by poor mental health infrastructure, lack of fit between the culture of biomedical care and the cultural and religious worldview of the people, and stigma surrounding mental illness. A complementary model of care has been proposed as holding more promise in this particular region. While the pragmatics of such a model must still be determined, improving the cultural competence of professionals could be a starting point for a process that takes advantage of local opportunities to meet the mental health needs of the people in this deprived region.

### **Biographical Note**

**Ugo Ikwuka MA** is completing his PhD in Psychology from the University of Wolverhampton, UK. His research interest is in Mental Health in the socio-cultural context of sub-Saharan Africa. Ugo has published works on Causal Attributions for Mental Illness, and Attitudes toward Mental Illness in south-eastern Nigeria. He is also interested in psychosocial interventions for schizophrenia especially in the Cognitive Behavioural approaches.

**Niall Galbraith PhD** is a Senior Lecturer in the Department Psychology, University of Wolverhampton, UK. His areas of expertise are Individual Differences and Cognition, Cognition and Attitudes toward Mental Health, and Attitudes in Health Professionals. His current research projects include: An integrated model of the theories of delusions, Adolescent Thinking and Belief (ATAB) - an ongoing study of the role of cognitive, perceptual and emotional processes in the development of beliefs in adolescents, Factors affecting entry into and exit from sex work in the West Midlands, Cross-cultural beliefs about the causes of mental health difficulties and help-seeking.

**Ken Manktelow (Prof.)** is emeritus Professor of Psychology at the University of Wolverhampton, UK. His primary research interests are in the psychology of thinking, reasoning and rationality. He is particularly interested in the study of practical reasoning: the kind of thinking we engage in when trying to decide what to do. This is seen most clearly in the field of deontic reasoning, although there are also clear connections with the psychology of judgment and decision making. Ken is currently focusing on how we decide which rules are good rules, cultural influences on thinking, and on how we think about dilemmas.

**Josephine Chen-Wilson PhD** is a Senior Lecturer in the Department Psychology, University of Wolverhampton, UK. Her areas of expertise are Language development, Children's narratives, and

Relationship between language development and literacy. In her doctoral research, Josephine investigated the effects of language specificity on the way temporality is communicated by comparing English and Mandarin Chinese speakers' narratives. She is also working on children's expression of emotions in storytelling. Her current research projects include: Are better communicators better readers? How do children talk about emotions in narratives?

**Femi Oyebo** (Prof.) is a Professor of Psychiatry and Head of Department of Psychiatry, University of Birmingham, UK. He was the Chief Examiner of the Royal College of Psychiatrists from 2002 and 2005, and is a member of the Council of the Medical Defence Union. His interests are in clinical psychopathology, medical humanities, the application of ethics to psychiatric practice, clinical risk and medical negligence, and neuropsychological and neural correlates of abnormal phenomena.

**Rosemary Chizobam Muomah PhD** is currently working as a Principal Clinical Psychologist in the Department of Psychological Medicine, University of Nigeria Teaching Hospital, Ituku-Ozalla Enugu, Nigeria. Her special interests are in psychological testing, drug addiction and Cognitive Behavioural Therapy (CBT).

**Anulika Igboaka MBBS** works as a specialty doctor in liaison psychiatry at Northwick Park Hospital. She qualified with MBBS from Royal Free & University College Medical School and completed a Masters in Public Health at the London School of Hygiene & Tropical Medicine. She is a member of the Royal College of Psychiatrists. Her research interests include beliefs about schizophrenia amongst Nigerians.

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Table 1 Factor loadings for the Pathway to Mental Healthcare scale

Item	Factors		
	1	2	3
Item 1 A mentally ill person can get better if sacrifices are offered for his past mistakes	.733		
Item 2 People can get mental illness if they keep disregarding our culture and tradition	.700		
Item 3 If someone under my care becomes mentally ill, I will seek the advice of elders	.641		
Item 4 Mental illness is better handled in the native or traditional way	.612		
Item 5 A mentally ill person can get better if he confesses to all the evils he has done	.587	.442	
Item 6 A mentally ill person can get better if he keeps paying his tithes or making offerings to God	.537		
Item 7 Mental illness can come as a result of abomination committed against the land	.517	.389	
Item 8 If someone is mentally ill, he should be taken to a prayer house		.735	
Item 9 If someone becomes mentally ill, he should be exorcised	.345	.676	
Item 10 Mental illness can be cured through breaking of ancestral curses		.604	
Item 11 If I become troubled in spirit for a long time, I may go and see my priest or pastor		.602	
Item 12 Mental illness is a spiritual problem	.303	.561	
Item 13 Mental illness is an illness like any other illness		-.531	
Item 14 If I become troubled in spirit or depressed for a long time, I may go and see a doctor		-.447	
Item 15 Mentally ill people should be taken to psychiatric hospital			.767
Item 16 If I notice signs of mental illness in someone under my care, I will take the person to the nearest hospital			.691
Item 17 Taking mentally ill people to mental or psychiatric hospital can worsen their case	-.313		.638
Item 18 Mentally ill people can get better if they follow good advice			.412

Table 2 Socio-demographic Characteristics of the Sample

<b>Characteristics</b>	<b>N</b>	<b>%</b>
<b>Gender</b>		
Male	244	34.6
Female	462	65.4
<b>Age</b>		
Young	544	77.6
Old	156	22.3
<b>Marital Status</b>		
Not married	472	68.1
Married	221	31.9
<b>Educational Status</b>		
Low education	193	27.6
High education	507	72.4
<b>Religious Denomination</b>		
Protestant	262	38.9
Catholic	411	61.1
<b>Familiarity with Mental Illness</b>		
Not familiar	216	34.3
Familiar	405	64.4
<b>Occupation</b>		
General public	196	28.3
Students	190	27.4
Teachers	92	13.3
Nurses	215	31.0

Table 3 Descriptive Statistics for Pathways to Mental Health Care

Demographic Variables		Pathways to Mental Health care																	
		Traditional						Spiritual						Biomedical					
		N		%		Mean	SD	N		%		Mean	SD	N		%		Mean	SD
Agree	Disagree	Agree	Disagree			Agree	Disagree	Agree	Disagree			Agree	Disagree	Agree	Disagree				
Gender	Male	88	138	38.9	61.1	2.38	.57	140	84	62.5	37.5	2.59	.57	206	32	86.6	13.4	2.9	.50
	Female	124	289	30.0	70.0	2.25	.54	240	193	55.4	44.6	2.50	.55	419	31	93.1	6.9	3.0	.44
Age	Young	150	349	30.1	69.9	2.27	.54	290	215	57.4	42.6	2.52	.57	488	43	91.9	8.1	3.0	.46
	Old	59	77	43.4	56.6	2.38	.61	85	62	57.8	42.2	2.52	.55	133	19	87.5	12.5	2.9	.44
Marital Status	Not Married	133	303	30.5	69.5	2.27	.55	248	186	57.1	42.9	2.51	.56	425	37	92	8.0	3.0	.46
	Married	73	119	38	62	2.34	.57	122	88	58.1	41.9	2.53	.55	189	25	88.3	11.7	2.9	.44
Educational Status	Low Educ.	96	81	54.2	45.8	2.54	.50	137	43	76.1	23.9	2.80	.53	161	28	85.2	14.8	2.80	.47
	High Educ.	114	342	25.0	75.0	2.20	.55	239	232	50.7	49.3	2.42	.53	459	35	92.9	7.1	3.0	.44
Religious Denomination	Protestant	71	167	29.8	70.2	2.22	.55	143	100	58.8	41.2	2.56	.56	223	29	88.5	11.5	2.92	.47
	Catholic	129	245	34.5	65.5	2.32	.57	218	163	57.2	42.8	2.51	.56	372	32	92.1	7.9	2.95	.46
Familiarity with Mental Illness	Not Familiar	56	141	28.4	71.6	2.25	.50	106	100	51.5	48.5	2.51	.52	195	11	94.7	5.3	2.94	.40
	Familiar	140	231	37.7	62.3	2.34	.60	233	141	62.3	37.7	2.54	.59	355	43	89.2	10.8	2.93	.48
Occupation	Teachers	19	57	25.0	75.0	2.29	.46	53	33	61.6	38.4	2.53	.43	83	6	93.3	6.7	2.90	.37
	Students	84	93	47.5	52.5	2.50	.48	126	46	73.3	26.7	2.73	.50	171	15	91.9	8.1	2.88	.45
	Gen. public	68	106	39.1	60.9	2.36	.60	103	80	56.3	43.7	2.53	.57	158	30	84.0	16.0	2.9	.47
	Nurses	36	163	18.1	81.9	2.05	.57	88	115	43.3	56.7	2.31	.58	203	10	95.3	4.7	3.06	.45
<b>Cumulative Score</b>		<b>212</b>	<b>427</b>	<b>33.2</b>	<b>66.8</b>	<b>2.29</b>	<b>.56</b>	<b>380</b>	<b>277</b>	<b>57.8</b>	<b>42.2</b>	<b>2.52</b>	<b>.56</b>	<b>625</b>	<b>63</b>	<b>90.8</b>	<b>9.2</b>	<b>2.94</b>	<b>.45</b>

Table 4 Standard Multiple Regression of Demographic Variables as Predictors of Pathways to Mental Health Care

	Traditional pathway			Spiritual pathway			Biomedical pathway		
	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Constant	17.50	1.57		17.25	1.19		9.363	0.66	
Gender	-0.42	0.38	-.05	-0.15	0.29	-.02	0.05	0.16	.01
Age	0.47	0.57	.05	-0.12	0.43	-.02	-0.44	0.24	-.11
Marital Status	0.25	0.52	.03	-0.50	0.39	.00	-0.19	0.22	-.05
Educational Status	-1.81	0.46	-.21***	-1.79	0.35	-.26***	0.58	0.20	.16**
Religious Denomination	0.57	0.34	.07	-0.52	0.26	-.08*	0.02	0.14	.01
Familiarity	0.27	0.34	.03	0.08	0.26	.01	-0.04	0.15	-.01
General Public vs. Students	0.70	0.54	.08	0.58	0.41	.09	0.32	0.23	.09
General Public vs. Teachers	0.40	0.57	.00	0.71	0.43	.08	0.19	0.24	.04
General Public vs. Nurses	- 1.28	0.54	.16*	-0.62	0.41	-.10	0.40	0.23	.11

Note  $R^2 = .14$ , \* $p < .05$  \*\* $p < .01$  \*\*\* $p < .001$