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# Family support for psychiatric patients

A psychiatric programme is reported from Ghana in which conventional medicine, with the family as the point of contact, seeks to integrate with traditional medicine in preventive, curative and promotive work.

It is widely acknowledged that recovery from illness can be greatly helped by family support. This is particularly true in the field of psychiatry. All over the world there has been a trend towards treating psychiatric patients in their family settings and their own communities rather than in mental hospitals.

The notion of primary care implies recognition of traditional or informal health systems. In Ghana, when home care for the sick fails, the affected person's family may send her or him to a traditional healing centre where the role of blood relations in care is recognized. A female relative usually stays with the patient throughout the period of treatment, acting as nurse and counsellor. Under the supervision of the traditional healer and his co-workers the relative is taught how to manage the patient after discharge.

Orthodox medical establishments have introduced comparable measures, such as rooming-in on obstetric wards, and there is clear evidence of the value of family participation in the care of highly selected

groups of patients (1). The present article outlines strategies for combining this humane feature of traditional healing with conventional medicine in an effort to implement primary care in the area of mental health. In the present context the term "family" refers to blood relations.

## Facilities

Before 1982 there was only one general psychiatrist running a private clinic in Kumasi, a city of about half a million people. A retired registered mental nurse set up a similar clinic in that year, and community psychiatric nursing, based at a health centre in the city, was started by the Ministry of Health during the early 1980s. A number of general medical practitioners also offered psychiatric services, including referrals to state psychiatric hospitals. By 1984 an aid and counselling centre for disabled persons and a halfway house for patients discharged from psychiatric institutions had been established by charitable bodies. Other conventional mental health facilities in Kumasi include a rehabilitation centre for the physically disabled, a private home and school for mentally retarded children, a corrective training centre and two orphanages.

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Formerly, if a family in northern Ghana could not pay for the treatment of a patient at one of the private psychiatric clinics in Kumasi, or for transport to the long-stay hospitals on the coast, the alternative was either management at home or recourse to a traditional healer or a spiritual church,

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where ritual, fasting and prayer are the instruments of healing, and the sick and their accompanying relatives are accommodated in nearby hostels. The availability of accommodation may account for the popularity of these churches as healing centres; there is constant contact with the healer, and the family is emotionally relieved because it is not compelled to abandon the sick person in a totally strange environment. Furthermore, feelings of acute loneliness and distress are avoided in the patient. Not surprisingly, therefore, many patients in Kumasi still use traditional healers and spiritual churches in spite of the establishment of several orthodox health facilities in the city.

Komfo Anokye Teaching Hospital, which comes under the Ministry of Health, has been used since 1981 as a teaching hospital by the School of Medical Sciences of Kumasi's University of Science and Technology. In that year a psychiatric outpatient clinic was established and in 1988 a 12-bed ward and an interview room were added, allowing the provision of better services, especially to the acutely ill and to people with chronic relapsing behavioural disorders.

## Family participation

Nearly all psychiatric outpatients at the Komfo Anokye Teaching Hospital are accompanied by a family member who can provide the staff with background information. Observations made at several adult outpatient clinics revealed that 64% of patients were accompanied by a relative who, three times out of four, was a female; 10% were accompanied by a spouse, 8% by a friend or neighbour, and 18% were unaccompanied. The family's role in care and support during illness was significant. Whether the management of patients' problems in the manner of traditional healers and religious leaders could be encouraged in an orthodox health care institution was investigated by putting certain statements to 150 randomly selected females and asking them to indicate agreement or disagreement. These statements were rated separately as indicated in the table. The responses suggested that a policy to accommodate patients' relatives would be viable.

A registered psychiatric nurse was in charge of the outpatient clinic but the general nurse in charge of the new ward had not been trained in psychiatry. A relative was obliged to stay with each admitted patient and was expected to spend as much time in the ward as circumstances permitted. At night the relative had to sleep on the floor beside the patient's bed. As the number of patients increased, most relatives preferred to spend the daytime in the ward foyer, where seats were available.

Relatives were thus on hand to answer queries from the staff and give histories or reports of their observations; they received explanations of the measures taken, took their relatives for walks, discussed progress, and were given advice on follow-up treatment. The foyer became a forum for

**Responses of 150 women to three statements on the family's role in caring for patients in hospital**

Statements <sup>a</sup>	Strong agreement	Agreement	No opinion	Disagreement	Strong disagreement
A	8	20	10	6	6
B	9	16	12	9	4
C	19	21	5	3	2

<sup>a</sup> A: patients should be admitted only if accompanied by a relative. B: you have been designated to stay in hospital by a sick relative for as long as he or she is undergoing treatment there. C: for a patient in hospital to get well quickly it is important that her or his relative be constantly present.

spontaneous group meetings at which the relatives discussed various issues, including, of course, their relatives' illnesses. When the staff situation improved a decision was taken to organize these meetings on a formal basis.

During two group sessions it emerged that five of 30 relatives who were staying with patients in the hospital regretted not being able to take part in their usual economic activities; three were ashamed to be related to psychiatric patients. For these relatives a long-stay hospital, far away from home, where patients were cared for entirely by nurses, would have been preferable. However, 22 of the relatives were satisfied and, indeed, grateful that they were allowed to stay in the hospital.

The presence of relatives on the ward does not always simplify routines, and the sleeping arrangements and congestion have been criticized by orthodox physicians. Nevertheless, the advantages of the experiment appear to outweigh the discomforts that people, long deprived of appropriate psychiatric services, have had to suffer. By and large, relatives prefer to sleep by the patients, especially if these are on high doses of tranquillizers during the first few days after admission. The relatives can escort patients to the bathroom, provide reassurance, and so on. They appear happy to fulfil these functions, and are

undoubtedly motivated by the prospect of being able to sleep undisturbed at night when the patients return home after treatment.

**Testimony to effective action**

Before attending the clinic, a 25-year-old male had thought he was suffering from a demonic condition that would not respond to medical treatment. He had believed that his mother was a witch who had caused him to lose his mind. His illness had first appeared five years previously when he was in secondary school. A spiritualist had

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demanded that his divorced mother should make a confession but she refused. His classmates were now at university, whereas he was jobless. He said that he had been inclined to kill his mother for being the cause of his troubles but that now he knew

better. Clearly, he was beginning to gain insight into his condition. His projections and superstitions about his illness and the associated delusions were beginning to be worked on and could be expected soon to disappear.

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A student nurse who had worked in a long-stay psychiatric hospital expressed surprise that some patients were ready to leave the clinic only three weeks after admission. She had known patients with similar problems who had spent two years or more in hospital, apparently forgotten by their relatives. Indeed, for nursing and medical students in general, and even for some doctors, it was a revelation that psychiatric patients whose relatives were resident in the clinic could return home after a relatively short period and that others could be treated as outpatients.

A 15-year-old female patient remarked that the clinic looked much like her home. Her mother was with her and during daytime she had plenty of visitors. Apparently she never felt homesick. Her father, a 50-year-old head teacher, drew the analogy of someone with a broken leg in a plaster cast; the patient is taught to exercise the leg until walking becomes possible with the help of a stick, and is then discharged and continues with exercises at home until he or she can walk well again without assistance; finally, attendance for review is advised. The father noted that his daughter

had very much improved, and although she was not yet quite her former self the clinic had given her a “walking stick” to take home: drugs, advice and words of encouragement. The family would go home and do what they had learnt was necessary. If any problem arose they would return to seek further advice in the knowledge that the clinic would not begrudge helping them.

After participating in the management of patients, many relatives felt encouraged to continue giving the care at home which they had learnt about in the clinic and to confront any problems or hostility in their neighbourhoods associated with the behaviour of unwell individuals.

By April 1992, eight of 30 relatives who had stayed in hospital with patients, and six of 18 patients had returned to the clinic within eight weeks after discharge to report changed symptoms and functioning of patients. Both the patients and their relatives had clearly developed a capacity to recognize and interpret symptoms that otherwise might have passed for unruly behaviour and would probably have been attributed to magical or religious factors.

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In Ghana the last few years have seen an upsurge of interest in traditional medicine, which should be systematically integrated into orthodox medicine. Unfortunately, most attention is given to traditional herbal remedies, while other areas are neglected. The evidence shows that the maintenance of contact between sick people and their families is possible in orthodox facilities and that it can be highly effective therapeutically and in the promotion of community health. In addition to the health education aspect, the immediate distress of patients is alleviated and families are helped emotionally.

When designing psychiatric departments in general hospitals in Africa it would be beneficial to allow for the accommodation of relatives as near as possible to patients, either on the same wards or in family hostels. The strong sense of social security within families having definite traditional roles and obligations would thus be used advantageously in the management of patients. Psychotherapy is hardly possible if patients are not considered in the context of their social relationships. Individuals and their illnesses cannot be completely understood and treated unless seen against that background. Furthermore, most countries in Africa could not afford the economic commitments of large institutions, even if these were desirable.

In Ghana the three large psychiatric hospitals hardly offer the comfort and safety usually associated with orthodox health facilities, and consequently it is particularly important to introduce psychiatric services into general hospitals. Where this is desired the Kumasi model might well be adopted, or family hostels could be provided.

However, progress could be hindered by a lack of support and commitment from administrators and policy-makers in the absence of a mental health policy. Besides, despite the promise it holds for mental health care delivery in hospitals and communities the scheme raises many issues meriting further study. Comparisons with similar programmes being run in other parts of the world would be useful. □

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#### Reference

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