Mental illness in some Sub Saharan African communities: the perspective of Bioethics and transcultural nursing

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ABSTRACT

In this paper, transcultural nursing is reviewed in light of bioethical issues arising from the interpretation of mental illness in some Western Sub-Saharan African communities. Four field studies were carried out by the authors of this paper in Sub-Saharan Africa (from 2016 to 2019), during which the traditional "treatment" of enchaining people considered "crazy" by local cultures was explored. These inhuman practices raise the attention of bioethics, which investigate ways to overcome this traditional practice not violating the cultural identity of the peoples who practice it. The model of Gregoire Ahongbonon and of his Association, "Saint Camille de Lellis", is reported as an example of negotiation between the respect for traditions and the guarantee of human rights. The care practice in force in the Saint Camille is related to transcultural nursing as an adequate form of treatment and strategy for restoring patients' dignity and rights.

RIASSUNTO

La malattia mentale in alcune comunità dell'Africa Sub-Sahariana: la prospettiva della bioetica e dell'assistenza infermieristica transculturale.

Il presente articolo si propone di portare all'attenzione dell'assistenza infermieristica transculturale (cd. "transcultural nursing") le questioni bioetiche derivanti dall'interpretazione e dal "trattamento" della malattia mentale secondo una certa cultura africana. Il lavoro è l'esito di quattro studi sul campo, condotti dagli autori dal 2016 al 2019 in Africa subsahariana occidentale, durante i quali è stata indagata la prassi tradizionale della contenzione dei malati mentali in catene, perpetuata dalle famiglie o da sedicenti guaritori. Queste pratiche inumane appellano la bioetica che si cimenta nel tentativo di negoziare il superamento di tale prassi tradizionale non esercitando un gesto di violenza e negazione dell'identità culturale dei popoli che in essa si riconoscono. Il modello di Grégoire Ahongbonon e della sua Associazione "Saint Camille de Lellis" viene considerato un esempio di mediazione tra il rispetto delle tradizioni culturali e la garanzia dei diritti umani. La pratica assistenziale in vigore presso i centri della Saint Camille è vista nei suoi punti di contatto con l'assistenza infermieristica transculturale, entrambe considerate idonee alla garanzia della dignità e dei diritti dei pazienti.

Keywords: transcultural nursing, bioethics, Africa, mental illness.

Parole-chiave: assistenza infermieristica transculturale, bioetica, Africa, malattia mentale.

1. Introduction

Ethnicity, culture and religion have an immense influence on the perception and interpretations of health and illness, particularly for mental illness [1].

In some African tribes, in particular the ones in which animism is still perceived in all its strength, the boundary between mental illness and demonic possessions is very thin. Hence the serious problem of the marginalization and restrain of psychiatric patients [2].

Although the word "mental illness" refers to a variety of pathologies of different grade (e.g., epilepsy, depression, and schizophrenia), its perception by local groups is often the same. In fact, usually mental illness is linked to witchcraft more than other diseases. In most cases it is believed that the mentally-ill person is possessed by evil spirits, coming from jinxes due to the jealousy of other people of the village or from the wrath of some ancestor or god wanting to punish the victim and/or his/her family for violating a divine rule or law. As the group perceives the victim as a shame, the first reaction is to try and hide him/her from the public. However, the main issue is that the mentally-ill person is perceived with fear, since the common belief is that the demon who lives in him/her can cause harm or death to the group and possess any person coming in contact with the victim [3].

The concept of collective identity [4], in force in many African cultural identities, leads the public to consider the mentally-ill as a sick factor, which triggers defence mechanisms to remove the pathogenic factor. Nevertheless, killing is not a solution to this, because it would imply contacts with the "possessed" victim and alleged spiritual contaminations or death of the executors.

However, the patient cannot be simply ostracized, since there is the risk that he/she may return and destroy everything and even endanger the life of the group in a fit of madness. Therefore, the afflicted must be kept not only afar, but also under control: hence the chaining practice.

People, independent of being a man, or a woman or a child, are chained to trees or to cement blocks and abandoned in the forest, exposed to harsh weather conditions, or locked up in tiny caves, without light or the possibility of moving [5]. Therefore, they have to coexist with their own excrements, crippled by the chains and the imprisonment and with wounds inflicted by insects and animals. These people are left with nothing, no clothes, no dignity, until, hidden from the eyes of the public, they are completely forgotten. Sometimes, someone, keeping distance, leaves them bowls with food and water, as it is usually done with animals chained outside the houses.

In some contexts, the mentally ill are entrusted to traditional healers who believe they can free the sick from demons with natural and spiritual remedies [6; 7]. Some healers, in fact, believe they can come into contact with demonic forces to try to restore the broken physical-metaphysical order [8].

In most cases, the family commits the mentally-ill person to religious sects or to prayer centres, where the so-called "healers" charge very high prices to imprison him/her in tree trunks, to beat him/her and to let him/her starve, in order to neutralize

the evil force. «People believe that by making the person suffer, they will drive the demon away from the body» [9, p. 44].

Life in chains weakens the sick person, until it leads them to death for malnutrition and negligence.

The link between mental illness and cultural perception is the subject of ethnopsychiatry [10-12]; however, in order to avoid digressing about such a vast discipline, it should be said that the methodological point of view presented in these pages will be that of bioethics, which allows a cross-cultural and interdisciplinary approach.

2. Bioethical issues

It is not useful to identify which communities or groups practice chaining. Unfortunately, such treatment of people with mental disorders is a very common phenomenon, not extraneous even to the past of the so-called "First World". In fact, every society has locked up their "insane", and many continue to do so. In poor countries it may mean keeping patients in chains, while in wealthier countries it may mean to sedate patients confine them. This is one of the greatest challenges for bioethics that, as an interdisciplinary subject, encourages to improve our understanding of mental illness, and promotes effective and humane treatment.

However, it is in the nature of bioethics the non-judgmental attitude of what Enghelhardt called "moral strangers" [13], so it would be too simplistic to imagine that an intervention of bioethics is limited to interrupting traditional practices.

In some communities, in fact, the practice of chaining is an *identity practice*, the denial of which could be interpreted as a form of "intellectual neo-colonialism" deriving from rationalistic and egocentric attitudes of those who believe they have rational and moral primacy. Besides, it is important to remember that the *right to cultural identity* belongs to the catalogue of fundamental human rights, the denial of which would imply the belittling of the rights and dignity of a traditional culture and a strongly anti-egalitarian approach.

Nevertheless, it is equally true that the practice of chaining itself violates other fundamental human rights (i.e., freedom, health, life etc.), so allowing the perpetration of such practice, in compliance with the right to cultural identity, is clearly a contradiction.

In addition, the low and sporadic public interest in this insane treatment of mental disorders makes one wonder how to act regarding these cultural practices still deeply rooted in some African communities, who would be completely destabilized by an imposed and sudden surrender of their traditions.

The problem is: is it really possible for African communities to give up such fundamental traditions, even if judged inhumane? Moreover, is it possible to deny their cultural specificity, their individual beliefs for universal reasons? When can the defence of traditions be overcome?

The African Charter on Human and People's Rights, already adopted in 1981, reiterated the unquestionability of both the concept of the enjoyment of rights and freedom by all individuals (art. 2) and of the inviolability of the person, even if hindered by the

respect of traditions (art. 4) [14]. Indeed, art. 17, clause 3 states: «The promotion and protection of morals and traditional principles recognized by the community constitute a duty of the state to safeguard human rights». This was given greater emphasis in the Universal Declaration on Human Rights and Bioethics-UNESCO 2005, art. 12: «The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope» [15].

Therefore, it is clear that even though the different cultures are to be respected, there is a line that cannot be crossed: any debate about pluralism should be based on the respect of human rights. Thus, how can someone overcome the impasse of denouncing the cruel tribal practice of chaining the mentally-ill people to the trees, while respecting the cultural traditions? One legitimate solution could be the request of a law that prohibits such rituals and practices, and the persecution of the mentally-ill people.

However, as afore mentioned, the prohibition of the chaining practices and of the abandonment, together with the impossibility of benefiting from public healthcare, would condemn these psychiatric patients to death.

For this reason, a cultural revolution seems urgent: this will be possible only if a mediation and negotiation strategy will be identified between the contextualism of local traditions and the universalism of human rights. Furthermore, this strategy could not be imposed, but should come from the inside of the tribal culture, as a form of endogenous recognition of the need for adaptation to contemporaneity and rights. In this way, not only mentally-ill people, but also the communities, will be in a position to state their own freedom and dignity [16].

3. Grégoire and the "Saint Camille" model

Four field studies were carried out in Benin between 2016 and 2019. During the first years of the study, the authors of this paper deepened their knowledge with respect to traditional practices related to mental illness, until they came across "Saint Camille de Lellis model", where they could experience the afore-mentioned negotiation practice.

This model respects tribal traditions, diminishing the magic-religious perceptions of the illness, while ensuring medical interventions with free health care for those affected by mental disorders. This would reduce the practice of chaining in favour of more conventional practices, in accordance with common international values of human rights. In addition, this model focuses on the reintegration of the patient in the community, presenting itself as an authentic model oriented towards the restoration of dignity [17].

It all began over 30 years ago when, in 1983, Gregoire Ahongbonon established the Saint Camille de Lellis Association with the aim to banish the superstitions that people with mental disorders are victims of witchcraft and to integrate them back into society [18].

Ahongbonon is not a psychiatrist. In fact, he was a tyre mechanic by background. He also owned a taxi company, but at a certain point he lost everything. He became so depressed that he even considered committing suicide. Because of this moment of depression, he has always considered himself very close to mentally-ill people. However, it was the rediscovery of his religious roots that turned him towards others.

In 1982 in Bouaké, in the Ivory Coast, while Grégoire was walking on the street he was struck by the sight of a naked man looking for food in the garbage: he was mentally-ill. Although during his life he had seen many, this man struck him particularly. As Grégoire said in when interviewed during the field studies in West Sub-Saharan Africa, he himself, like many, was afraid of mentally-ill people. Nevertheless, the sight of that man led him to see in him the suffering of Jesus Christ. After a series of similar encounters, Ahongbonon came to the realization that everyone needed water, food and love, without any discrimination. Ahongbonon and his wife began to walk the streets of the city at night handing out food and drinks. From there they opened a little chapel in a back room on the grounds of the general hospital in Bouaké. The results surprised everyone, including the Minister of health of Ivory Coast, who agreed to expand the space and build a centre inside the hospital. This was a major breakthrough in Ivory Coast, where, as in many other countries, mentally-ill people had been kept in institutions located far from cities for a long time [19].

In the subsequent years the Association had established a network of more than 20 centres in Ivory Coast, Togo, Burkina Faso and Benin and treated thousands of people (Gregoire estimates more than 60 thousand), 85% of whom have been reintegrated into society [20].

Grégoire has created a coherent and functional methodology for recovering mental health [21]. The rehab projects [22] promoted by Grégoire start from the "request consent" for the liberation of psychiatric patients belonging to the community. This passage is fundamental because it represents the *recognition of the cultural identity* from which the negotiation practice starts.

The request is addressed to the tribe chief who is asked, in exchange for the patient's release and care, not to interrupt the relationship between the patient and the family, who are advised to visit their relative weekly in the Saint Camille centres and to take him back in case of a full recovery or "normalization".

Afterwards, Gregoire "releases men from chains", but too often their limbs, after decades of imprisonment, are stiff and irreparably damaged. He is not afraid to touch them and he is the one approaching them first: the madmen at first appear scared, but, in a short time, a new light becomes visible in their eyes as they realize that someone is considering them as a *person*. While negotiations with the tribe continue, Gregoire asks his collaborators, nurses and assistants, often former mentally-ill people, to take *care* of the physical restoration of the patient's dignity: they shave their filthy hair, wash their dirty limbs and help them wear clothes. This rehabilitation takes place in full view of the astonished and amused villagers, enchanted by what they consider to be surreal proceedings [23].

After this Gregoire takes the patient to the closest centre to the village of origin of the victim and introduces him into a familiar environment, where people could interact and build relationships with others. Before being taken to the psychiatric consultation, mentally-ill people are visited by nurses for taking care of the wounds. The caring touch of the nurses, as they treat the sores caused by the long enchainment and the rust from the chains, soon awakens the delight of contact, as the philosopher Lévinas would say, looking in the eyes of the others, mad people glimpse a face they did not think they could still have [24].

Afterwards, they are visited by a psychiatrist, and only after a medical evaluation they receive their prescribed treatment, which, most of the time, leads to the full recovery of their mental health.

To encourage the rehabilitation of those affected by mental diseases the Saint Camille method is based on work and occupational therapies. In the centres, which are subdivided into recovery and working places, the aim is to try to fill their lives with responsible tasks, which are useful for the whole community [25]. Initially, they are requested to co-operate in supporting the community: ill people cook, clean, work in bakeries, weaving factories, or in the plantations of corn, manioc, ignam, soy, and the profits from their work goes back into the community. Sometimes they are sent to school, but in most cases, they are taught a job, and then hired so that they can receive a legitimate wage. In this context, reintegration brings about both human and professional benefits.

Moreover, many ex-patients become assistants and nurses in the centres, where they themselves have been cured, and their biggest wish is to release those still in chains. Nursing care is particularly important for the patients who have experienced social exclusion: through it they themselves can be an instrument of integration for others, a mirror of the possibility of recovery from mental illness.

The greatest merit of Grégoire's work is returning ex-patients to their communities, which, according to the collective identity typical of most African communities, means to allow them to fully appropriate one's sense of self. With Grégoire's help, many patients – "the last of the last", "forgotten by the forgotten" – return to their families, even though some still depending upon the Association for pharmacological treatments, having finally found mental stability, and become once again human beings with a social role, not to mention their newly acquired professional skill which can be useful for the tribe.

3. Transcultural nursing

The extraordinary nature of the Saint Camille model lies in the fact that transcultural nursing, in this case referred to mental health [26], is a double-help tool: for the former mentally-ill people, now mental health nurses or mental health professionals, as they become more aware of the causes of mental illness and keep away from traditional restraint practices, and also for the mentally-ill people who have before their eyes an example of redemption and "healing", which is motivational factor for the treatment path.

In addition, a further advantage of the

reported method is that mental health nurses or professionals are perfectly familiar with the local cultures to which they themselves belong. This allows them to cross the boundaries of Western medical frameworks, and to better approach mental problems, contextualising them in the culture and tradition of origin.

If in Europe or in the so-called First world the theme of transcultural nursing is related to migration [27], this is not extraneous to the African universe itself: it often happens to mental health nurses to find themselves in front of immigrants from other African countries, whose ethnicity, culture, religion and language or dialect are very different from their own.

As in Europe, also in Africa migrants, especially the first generations, suffer because they left their country of origin to settle permanently in another country for a variety of reasons (i.e., persecutions, seeking political or religious freedom, and poverty). Upon arrival, they are challenged to adapt themselves to the new cultures, beliefs, values, languages while preserving their traditions. In addition, they not only face problems when accessing the health care system due to cultural and linguistic differences, but also because they are discriminated by the health care services of the arrival countries.

According to Leininger's [28] definition, transcultural health care is "formal areas of study and practice in the cultural beliefs, values and life ways of diverse cultures and in the use of knowledge to provide culture-specific or culture-universal care to individuals, families and groups of particular cultures". For this reason, transcultural mental health services are challenged not only to understand cultures of migrants, but also their illness perceptions and interpretation [29-31].

This is stated by the Universal Declaration of Human Rights of United Nations which advocates for equal treatment and opportunity for all, regardless of cultures, ethnicity or social-economic status, and including refugees, mentally ill persons and women [32].

However, this is certainly not a problem for ex-mentally-ill people who, in this way, put into practice the important tool of transcultural nursing. Working with different cultures can help enhance their understanding of their self-construction and that of the migrants and their families, and of the expression of emotions across cultures and how this impacts on the nurse-client therapeutic relationship.

Saint Camille's approach is a mixture of what Leininger had already explained in his theories, including: ethnonursing, ethnographic qualitative methods, the theory of findings, and the qualitative criteria related to credibility, confirmability, meaning-in-context, saturation, recurrent patterns and transferability [33-38].

It can be said, therefore, that Saint Camille is also the garrison of transcultural mental health units in West Sub-Saharan Africa, probably the only one, considering that many states, such as Benin, pay little attention to the problem of mental health, considering other diseases as priorities or continuing to practice restraint, albeit unofficially.

All professional codes of ethics, including those of today's nurses, recognize that restraint is not a therapeutic act, however, it is expected that it may be implemented,

in case of need, by the medical team or even by the nurse if necessary, to protect the safety of the assisted person, other people and operators. Nonetheless, the restraint must be motivated and noted in the clinical care documentation, it must be temporary and monitored over time to check if the conditions that justified its implementation are still metand if it has negatively affected the health conditions of the assisted person [i.e. 39, art. 35].

Still, it would be a paradox if the former mentally-ill, rescued from the practice of chaining, practiced it on their own kind.

After all, this is one of the flaws of Leininger's method, which insists on incorporating traditional approaches to treatment into professional ones, running the risk of perpetuating stereotypes and practices to be overcome [40].

Certainly, with respect to the restraint practices, the conditions of necessity require radical interventions, however, according to fundamental human rights it is common sense that the practice of chaining is a barbarism to be universally banned. The practice of chaining, if authorized by the codes and in force according to tradition, risks to return in all its strength.

Having an approach oriented to taking care of the patient in a wider way, with a caring that becomes aware of the differences among patients and is ready to tailor the approach to each individual would be preferable.

Mental health nurses and professionals need to work towards being a good cultural mediator to enhance the bridging, linking or mediating between them and the migrants and their families so as to reduce any conflict and bring about a positive change in the mental health of the migrant and their families.

One of the future expectations is that more transcultural mental health units are set up urgently in the near future to plan and organize transcultural mental health nursing for migrants and the general population of West sub-Saharan Africa and, generally, of low-income countries that are the most affected by mental illness [41].

In this direction, the hope is that local policies and no longer private initiatives, such as Ahongbonon's, are concerned with developing transcultural health care practices, in particular for mental health [42].

Indeed «transcultural mental health nursing and cultural brokering are the pinnacles of providing effective and culturally congruent and sensitive mental health services for the ethnically, culturally and linguistically diverse populations and traditions» [27], particularly of Africa.

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