Family Reintegration Issues of Mentally-Ill Patients Residing At Thiaroye Psychiatric Hospital.

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Abstract: *From the examinations of six mentally-ill patients who have been residing for many years inside the hospital and of two others who return to the hospital after every discharge, the authors try to investigate the factors underlying these family reintegration issues.In addition to some symptoms the neighborhood hardly condones, such as irritability and aggression, some deviant type of behavior (alcoholism, prostitution...) seclude the patient from his family. The lack of solidarity towards his family, that occurred before his relatives noticed he was suffering from a mental illness, is often called to mind to explain the exclusion to which he is subject to. The attempts to return of these patients in their family of origin are unproductive. This could be one of the reasons explaining the great number of wandering patients.*

The opportunity offered by the renewed interest of public authorities for this category of patients should be seized in order to build up hosting and reintegration structures like after-care centers with the hope that this type of institution will have an approach more comprehensive than traditional care structures such as hospitals.

Keywords: *mental illness, chronicity, family reintegration issues, long stay in hospital, Senegal*

INTRODUCTION

It is common in Senegal to meet mentally ill patients patently without family ties, wandering in the streets of towns and cities in a state of extreme unsteadiness. No town seems to be spared with their presence. Presently, this category of patients constitutes the most visible aspect of psychiatry.

The Psychiatric Hospital of Thiaroye was created about fifty years ago. One of its goals, though undeclared was to be a central element in the healthcare system of chronic patients who cannot be seen at the unique psychiatric ward of Fann University Hospital. This hospital ward of approximately 100 beds inaugurated in 1956, which has been at first operating on an asylum mode, has been quickly transformed in an open department allowing patients accompaniment, therapeutic groups, occupational activities, etc.

Nowadays, the phenomenon of wandering of mentally-ill patients even though it is more visible is not something new. Collomb's analysis of this situation was the least forbearance from the family towards mentally-ill patients which could increase with the development of the society. For Collomb (1973), the more they face rejection, the more the number of wandering patients will increase. He was linking this attitude of rejection, among others, to the fragility of the family equilibrium considering the rapid evolution of African families obliging to different live patterns compared to the traditional societies described as being more tolerant towards mentally-ill patients and is being translated by measures of protection of the population against "the dangerous mad people".

Innovations such as the accompaniment of patients by their family members, introduced in the modern techniques of healthcare were already aiming to protect them better against the rejection. As mentioned by Gbikpi (1978)**,** patient's accompaniment prevents the families to get disengaged, allows them to maintain a bond with him, and invites them to live with him in order to understand him better and by that way to change their attitude towards the one who was seen as a "dangerous and irretrievable insane man".

According to some local sources, mentally-ill patients without care are more and more present on the streets. They live there and sometimes die without assistance. Recently, a local newspaper featured the story of a mentally-ill woman wandering and carrying on her back the body of her deceased child.

It often happens that some of these sick people staying in the street find themselves hospitalized in a psychiatric ward in several circumstances: when their somatic condition deteriorates, or they are victims of traffic accidents or when their behavior becomes unbearable for people around, forcing public administrators to issue an order of provisional detention to Thiaroye's hospital. In the first two situations, to take care of the somatic pathology, officials of competent medical or surgical departments are reluctant to admit them there as soon as the underlying mental disorder is detected. Thus, once provided emergency care, a referral in a psychiatric ward is proposed. Again as with all other regular hospital patients, the staying period is limited. In fact, the conditions for the exercise of psychiatry, particularly the lack of specialized structures oblige to keep in the hospital only the patients with acute diseases and to follow as outpatients those with chronic ones with the participation of the family. In cases of involuntary confinement ordered by the judicial authority or the prefect, --- the only unit in Senegal designated for this purpose is solely the psychiatric hospital of Thiaroye --- the administrative and judicial follow-up under the current law hardly ever happens in such a way that when lifting the emergency, the psychiatrists are obliged to decide for themselves on the patient's discharge from the closed ward to an open free hospitalization in the other hospital units or make an attempt to return to the family. The return is often difficult or even impossible. So many patients end up back in the street or take up residence near or in the hospital. The hospital administration had arranged shelters to temporarily host those patients who had no family willing to reintegrate them or while waiting to find the family. It was noticed that very often, even when the family is found, the stay of these patients is short-lived as they ended up returning to the streets or come back to the hospital.

Eight patients were identified, living more or less regularly in these shelters without being formally admitted or in the surroundings of the hospital. Over time, they developed relationships with both the hospital staff and workers engaged in companies located in the vicinity of the hospital. Several attempts to bring them back to their family have failed.

The present work try to understand the circumstances that have contributed to the rupture of ties with the family through the life history of these patients including also their medical history.

STORIES OF LIFE AND DISEASE

Alcaly

Alcaly is approximately 75 years old. He left his village in Mali about the age of 11. He worked on construction sites in several countries of West Africa before immigrating to France. For several years, he did different types of work. He was diagnosed with the disease for the first time in France. It was about 30 years ago, and he was repatriated to Senegal in a condition that he hardly remembers. He lived on the street for a long time until he started to sometimes behave violently towards his vicinage. His detention was then ordered to Thiaroye hospital where the diagnosis of paranoid schizophrenia was made. After stabilization, he has not left the hospital where he stays in a shelter and grows crops on a small piece of arable land. The sale of his harvest gives him a financial stability. His medical follow-up is very irregular. The irritability and the aggressiveness he shows at times hinder its relationships with other patients and hospital staff. He claims to have no more family or friendly ties and does not see himself living outside the hospital.

Lamine

Lamine, 70 years old, has lived for 20 years in the hospital. He has chronic hallucinatory psychosis characterized by physical and verbal aggression. His speech invariably contained insults and death threats. He moves on crutches after an accident in his youth. His psychiatric care is very irregular. He lives by begging; he practices this activity around the hospital and the neighborhood mosque on Friday. Members of his family visit him at least once a week to bring him home cooked meals, clean laundry and at the same time take the opportunity to get the money and the food he has been able to collect.

He attempted several times to return to his family, but he faced opposition from his mother. He would during an aggressive outburst, dealt a blow from a cudgel to the latter. In addition, it appears that insults he uttered all day long are unbearable for those around him. The mother never comes to visit him because she fears that Lamine will still be violent with her. She has not seen him for over 10 years. His first hospitalization was motivated by the fact that Lamine has broken the windows of the neighbor's house who

happened to be an administrative officer of the Thiaroye psychiatric hospital. The latter would have taken him to the hospital and promised his family he would not come out.

Astou

Astou is 75 years old. She has spent the last 20 years of her life in the hospital. She has a chronic psychosis with significant changes in mood including irritability and dishinibition with an erotic theme. Sometimes she starts miming sexual scenes or to make caustic comments. Consultations are sometimes very difficult with the healthcare staff because of his irritability. She devotes part of her time to divination from which she can earn some money to provide for her basic needs. She still receives occasional visits from a rather distant relative. They later told us that the estrangement of Astou from her family came up before her illness. As a wealthy trader, she lived alone in her house and refused to host her relatives. This was quite surprising for the family. No one could understand how a woman could live alone, without a husband or child. Her family had concluded that her life was secretive; perhaps a life of debauchery of which they wanted to keep her away. The suspicion of love partners and alcohol consumption were even mentioned as part of the initial cause of her problem. Members of her family eventually broke off all relations with her and they do not seem to be aware of her health problems. It was her colleagues that initially saw her mental state deteriorating, took her to the hospital where she stayed up to now despite all the attempts made by social workers.

Baye

Baye is a male of 75 years. He has been living in the hospital for over 25 years. He was a trader in Congo Brazzaville where he was repatriated with many other Senegalese after a diplomatic incident between Congo and Senegal. He then developed an acute psychotic episode that was stabilized since his first hospitalization. He is medically stable and no longer takes medication. Nevertheless, he continued to live in a shelter inside the hospital. He is sometimes absent for several days to visit his traditional healer or some friends. He knows all the hospital staff as well as workers of the surrounding companies. He begs in order to buy clothes, pay his travels and ensure his basic needs. Members of his family who live near the hospital no longer want to accept him back home, recalling that during his stay in Congo he had deliberately cut himself from them, not sending them any material or financial gifts as it is culturally done. Baye died accidentally by falling in an unprotected well at night while he was walking around the hospital. Even after his death, his family members were still furious with him and found it difficult to forgive him. The only effort they made was to attend his burial organized by the hospital. They did not want to bring back his personal belongings and told us to offer it to other needy patients.

Walo

Walo is 50 years old. He has been living for twenty years in a shelter inside the hospital, after he was hospitalized for suffering from schizophrenia. All attempts to bring him back to his village in the north of the country to live with his mother were unsuccessful. Only one of his distant aunts came to visit him.

Walo lost his father at a tender age. His parents were not married. He was raised by his mother and his stepfather. For Walo's family, the consumption of cannabis led to his disease; a reprehensible act that his stepfather never forgave him. He chased him away, calling him a delinquent and an outsider. Perhaps his natural child status is not foreign to this rejection even if it was never verbalized directly. It was during one of his stay to the hospital that his mother took advantage of the situation to abandon him there. Walo is engaged in small trades like washing the cars of visitors or hospital staff in order to earn some money. He befriended many patients, caregivers and even family members who live nearby the hospital.

Nafy

Nafy is a lady of 65 years old who does not live in the hospital but regularly returns there by order of internment signed by the prefect of Dakar. She comes from a village in the Sine where her siblings and her two children live. She lives downtown Dakar, where she built a makeshift shelter.

She is intermittently constrained to involuntary confinement by order of the prefect of Dakar during raids conducted by the police when they perform routine checks on public roads, especially on the eve of

international events in Dakar, or during visits of foreign dignitaries. She begs for food --such as rice and sugar-- and coins from passers-by. Members of her family pay her regular visits in order to get money and food from her and use it for their own needs. After each hospitalization, she returns to her family but she still comes back to the hospital through another internment order. We also notice that her medical treatment is discontinued without proper medical advice.

Marème

Marème is 38 years old. She's been staying in the hospital for three years now. She used to live in the backyard of a family who did not even know her. The head of family who noticed that she had obvious behavioral disorders informed the prefect, who ordered her detention in Thiaroye hospital. The psychiatric examination revealed a paranoid schizophrenia with delusional theme revolving around motherhood: she affirms to be a mother of a hundred children of European origin. She gave different home addresses but research conducted with the assistance of the police or social services has failed to find her family. After her condition improved, Marème says she does not want to talk about her family. Actually, she has severed all ties with her family for more than ten years when she, according to her words, decided to freely engage in acts of prostitution in an industrial city in northern Senegal. When her activities ceased to be profitable in that area, she went to Mali where she would have continued to be promiscuous until she has an onset of behavioral disorders. It is then that one of her compatriot met her and helped her return to Senegal. On her way back, she had no plans of finding her family, convinced that she won't succeed anymore to atone for her past conduct. She admits not to know where her family now lives.

Yacine

Yacine is a woman of 40 who lives on the street for the past ten years. She has been admitted to the hospital now for three months. Her hospitalization is arranged in collaboration with the Department of Sexually Transmitted Infections of Social Hygiene Institute of Dakar and the Maternity of Guédiawaye -- a town located in the outskirts of Dakar. In fact, the social workers who deal with sex workers recognized her in the street where she used to live, presenting obvious signs of mental illness and she was in an advanced state of pregnancy. She was objecting to be monitored in a health facility. However, social workers managed to convince her to be admitted in a maternity ward for the delivery. From there, she was transferred to Thiaroye Hospital. She is presenting signs of acute psychosis and in her delusions she revealed to have given birth to a hundred babies. Her mother was found but she is very reluctant to accept Yacine's return to the family house because she said prostitution is considered a major flaw in the family. She asserts not to be able to host her daughter even though she knows that Yacine needs support. She pays her frequent visits to the hospital. Yacine is allowed to visit her family during religious celebrations although it is very briefly. Her mother normally make sure she does not stay for long and brings her back to the hospital, pretending her condition is getting worsened.

DISCUSSION

Interpersonal issues, symptoms of the illness?

Chronicity is very frequent in the psychiatric pathology. It is closely related to the impossibility of reinsertion when it is correlated to a certain social context (Lantéri-Laura, 1972).

Irritability and aggressiveness are remarkable symptoms in most of the wandering patients. These symptoms make them to look as people with whom it is difficult to relate, to maintain consistent contact. Actually, even within the hospital, they have great relationship difficulties with the healthcare team: they threaten, insult and attack sometimes. It is not uncommon to hear a caregiver saying: "It is no wonder that he cannot live in family with this type of behavior". This expression, more than any theory, make us to understand the circularity in question in the dissolution of social ties: this is not a linear diagram of the patient's abandon by the family because of the sickness but rather interpersonal difficulties caused by the symptoms leading to a gradual dissolution of relationships. The analysis of family relationships in a systemic perspective allows most of the psychiatric caregivers in Senegal to succeed to pinpoint sequences of relational disturbance in order to avoid blaming one or the other party. The understanding that families have behavioral problems proves to be decisive in the management and the recovering process of the patients. Families live in a very

particular way some symptoms of mental illness. In a study of family impact of symptoms of manic depressive psychosis in Senegal, it was found that families seek medical care especially for signs that create trouble affecting the neighborhood such as agitation, aggression, etc. In the contrary, high psychological distress signs for the patient as depressed mood, motor inhibition, excessive guilt, are considered normal and even desired by the family (Sylla, 2009). The focus is on the signs that are clearly seen, generating a shame towards others, more than what the patient experience deeply, be it painful for him.

The breakdown of relationships is also enhanced by a lifestyle perceived as dysfunctional, deviant from social norms.

Deviant type of behavior or warning signs?

The integration into a family life implies the adherence of rules and values of which it is based on. The most important among these are the solidarity with the family members but also the respect of a number of rules and social norms as well as religious prohibitions. The use of alcohol or drugs and prostitution are all reprehensible conducts and can cause family breakdown. This type of conduct by a member of a family creates and reinforces a sense of shame in the family in front of its entourage. The offender is then as much as possible, secluded to prevent people with close ties to the family to be aware of the situation. It is common to see parents saying that their son emigrated when in actual fact, he is serving a prison sentence. In the case of some patients, this concealment of deviant behavior is achieved through the hospital. The act of believing that and to tell people that the patient is at the hospital condones at some extent the family regarding the neighborhood. This "hospitalization" is even longer since it is done through unconventional channels: it is not the psychiatrist who decides but an administrative officer who "locks". The family often uses several direct or indirect means for the patient to remain as long as possible in the hospital. Caregivers who worked in Thiaroye since the creation of the hospital have reported cases of patients who have lived many years in the structure without a single person visiting the patient. When they finally died, during their burial, several family members showed up without people knowing how they got the information. The rumor that has circulated in relation to these facts is the likelihood of a distant supervision of the patient carried out by specific persons in the hospital. The requested hospitalization, facilitated or encouraged by a person who is not a member of the patient's family often leads to a very ambiguous situation. The family did not request the hospitalization but still accepts it. It is not the family who brought the patient into the hospital but they feel relieved that he is there because his behavior will not bother them anymore. The family will sometimes go further by suggesting that the patient feels good only in the hospital and that when he comes out, his condition worsens. As described by Storper-Perez (1974), the contact with the psychiatric institution leads to rethink the interpretation of disorders. These disorders which resisted to everything are found to be cured or alleviated during the hospitalization period. Nothing then imposes the family to take care of the patient. Since he is well in the hospital, he must remain there.

The patients abandoned by their families end up seeking for refuge in the hospital which is to them, as mentioned by what Tall and Ahyi (1988-89) were describing to Jacquot as, " a place which has become open and welcoming where the patient plays with paradox of his mentally-ill status: standardized and socialized inside the hospital, dissocialized and marginalized in the outside society."

Mendicancy: a factor for integration or familial exclusion?

Mendicancy is encouraged in poor countries by the economic, social, cultural and religious context constitute a survival activity for a specific population. It concerns people who are "weak" because of their physical or mental disability that prevents them to seek out paid jobs. In Senegal, mendicancy is visible around places of worship, health facilities, restaurants and resorts as well as on the busy streets of big cities. It is considered a profitable business that it is common to see people with no disability, who are able to work but prefer to become beggars next to the lepers, the disabled persons, the victims of industrial injury and the mentally defective persons.

It has been and remains a brain-teaser for the authorities responsible to maintain public order. In fact, since the 1970s, with the massive exodus of rural populations to Dakar, sanitation of public space has become a major challenge for the authorities. A vast movement of eviction of slums from Dakar to the suburbs was organized in the first place (Vernière, 1974).

Despite the fact that raids are becoming more regular, the phenomenon is more visible than ever in the arteries of the cities. Thiaroye Hospital as Guèye (1998) puts it, built with the unspoken idea to unclog Fann was from the beginning an element of the device developed against the "human encumbrance" since they were receiving patients under a detention order. It is with the same concern that it still keeps on admitting patients at odds with their family, those who are raided on the pretext of treating them and reintegrate them in their families. Actually, the first goal is to remove them from public spaces where their presence is remarkable and embarrassing.

Mendicancy is on one hand an income generating activity for the patients and on the other hand a factor that keeps them in a paradoxical position in relation to their family of origin. These patients who are considered beggars earn money but most of the time their families do not hesitate to collect the money, using visits as a pretext. Besides, begging cannot be practiced if the patient lives with his own family because of the shame that it can generate and also in relation to the neighborhood where people would be aware of this. There is news of reported cases of patients who have built rooms for their family members and who continued to live in the street. This assistance to the family by the chronic mentally-ill and homeless people is also reported by Guèye (1998).

Whether begging or doing other activities such as gardening, car washing, and divination, patients are engaged in an activity that makes them more or less autonomous. Aside from their accommodation and medication they receive from time to time, they are not too dependent on the hospital.

With the current management style of health facilities, the prolonged presence of this kind of patients in the hospitals will cause problems. Since 2000, hospitals have become public health facilities with management autonomy. Increasingly, this type of management leaves no room for "informal" initiatives especially when a third party who can offer a financial support is not found.

Looking for host families everywhere, where patients are forcibly brought back is a precarious solution; a way to delay the progress of a system provider of wandering patients on the streets.

Hope still comes from the free health care policy for some diseases and certain categories of patients in this context of hospital reform, as well as day care centers opened by non-governmental organizations which accommodate patients of a particular profile. Families invest in these shelters and we notice a sort of pride related to the fact that the patient has a place where he spends his days and reintegrates with the family in the evening.

The interest shown by the authorities on the homeless mentally-ill patients could trigger a reconsideration of the issue. Indeed, more and more voices rise to prevent this handicap. The Senegalese Association Psy, ASPsy organized a dinner debate chaired by the Minister in charge of Health about the family exclusion and the wandering of mentally-ill people.

CONCLUSION

The mentally ill patients in a situation of family exclusion, whether wandering, living in the streets or staying in the courtyard of the psychiatric hospital that they are unable to leave after hospitalization, represent a population that the current Senegalese healthcare system cannot deal with effectively.

Nowadays, for the treatment of mental illnesses in Senegal, it is just psychiatric departments that treat temporary disorders or an acute situation. However, for patients with chronic illnesses or who are excluded of a structuring social environment in particular, the management should include rehabilitation and reintegration programs.

This necessarily implies the creation of structures where after care and psychological stability will be provided. Patients will be supervised in order to regain skills that will facilitate their reintegration in an environment that is structured. In this perspective, helping the progressive reestablishment of the broken relationship with the family must be the number one priority. Day care centers could contribute substantially to this goal.

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