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## Editorial Brief

**I**nternational Journal for Psychotherapy in Africa is published by the School of Psychotherapy and Health Sciences, Okija, Nigeria, with the editorial policy to address issues that border on people's psychological health and psychotherapy in African. The journal publishes contributions that advance the frontier of knowledge in psychotherapy in Africa, submitted by trained psychotherapists, psychologists, counsellors and other scholars from related disciplines, whose research works and practical experience unraveled new knowledge in the area of psychotherapy in Africa. The emphasis for the journal is on empirical papers; however, it also accepts theoretical papers, review articles, short communications and interactions containing fair commentary. Priority is given to articles that are relevant to Africa, and that address psychotherapeutic issues and methods for the enhancement of psychological wellness of Africans.

The need for psychotherapeutic intervention is very vital in many countries of Africa. In these days of corona virus (COVID-19) pandemic which locked down the whole world, the countries of Africa are least prepared to face the psychological effects of the pandemic. They are least prepared for the needed psychotherapeutic intervention during and post COVID-19. Even now that the vaccine is out, many people in Africa are skeptical about the efficacy and reliability. The trauma, stigma, depression and other forms of psychological ill-health are still likely to take many African countries unaware. In addition to that, many of the countries are being challenged by various forms of conflict and insecurity problems like terrorism, and insurgency, kidnapping, cultism, from which many innocent individuals, families and communities are displaced of their natural residences; and are physically and mentally tormented. In the face of these conditions, the International Journal for Psychotherapy in African holds it as a responsibility to invite scholars to contribute their knowledge of Psychotherapeutic intervention models that will be of great help in assisting victims of this pandemic and menace.

This seventh edition of the International Journal for Psychotherapy in African contains many scholarly and vibrant research articles in areas of Psychotherapy and trauma resilience, COVID-19 pandemic, expression and control of sexual activities, gender base violence, domestic violence, substance use, suicidal ideation, religious devotion and marriage duration, sexual dysfunctions, couple/marital therapy, individual, family and group therapies, dysfunctional families, small group versus large group psychotherapy, among others. The scholars cross-pollinated knowledge on their psychotherapy models and expressed the need for psychotherapy for mental wellness in African.

The editorial board wishes to thank all the authors of the articles and all those who helped in one way or the other to make this publication a reality.

**Prof. Sylvester Ntomchukwu Madu**  
Editor-in-Chief

## Editorial Mission and Policies

**I**nternational Journal for Psychotherapy in Africa (IJPA) is published by the School of Psychotherapy and Health Sciences (SPHS), Okija Campus, Nigeria. The institution is affiliated to Sigmund Freud University, Vienna, Austria.

The journal is geared to dissemination of research out-put and cross-pollination of ideas among psychotherapists world-wide about psychotherapy in Africa. It is a peer-reviewed indexed journal and the articles can be accessed online through Google Scholar. It accepts original articles, empirical investigations, position papers, as well as short book reviews of not more than 1500 words.

Authors interested in publishing articles in IJPA are encouraged to submit their manuscripts electronically by email attachment to the Editorial Secretary. Manuscripts should not exceed 20 typed pages, and should be accompanied by an abstract of not more than 150 words. Five key words for identifying the paper on web search should be supplied immediately below the abstract. Manuscripts should be typed in MS Word, Times New Romans, 12 font size and should be on double spaced A4 size paper. The author's named, institutional affiliation, and address should appear on the title page separated from the manuscript, to ensure anonymity in the review process. The journal adopts the latest edition of American Psychological Association (APA) format. Acknowledgement should normally come at the end of references. Contributors should ensure that papers submitted are not under consideration for publication in any other research outlet. An editorial decision on the manuscripts will be taken as soon as possible and communicated to the contributors. One complimentary copy of the journal in which the author's article appears will be forwarded to the first author immediately on publication. The journal appears once a year, but articles are welcome throughout the year. All articles for publication, requests for advertisement, and other enquiries should be forwarded to the Editorial Secretary. There is an assessment fee per article, and authors of accepted papers are also required to pay a publication fee as determined by the Editorial Board. After payment, a scanned copy of payment evidence should be forwarded to the journal's email addresses. All payments should be made to the bank account as stated below:

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# **Regression – Personality And Social Cohesion In Nigeria**

## ***Applying Analytic Psychology and Logotherapy to the Pathological Fabrics of a World in Disarray***

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### **Abstract**

*Living in a “world in disarray” and in danger, we are compelled to think and talk of the “tyranny of experts”. Finding sustainable solutions to the pivotal problems of our contemporary world involves the dimension of an infectious collective psychopathology. This article borrows therefore, the concept of “regression” in Analytic Psychology to examine how it has devastatingly eaten into the fabrics of some societies (such as Nigeria). There seems to be an undermining invisible negative principle, an unconscious force, pulling down progress in the process of nation building. This negative principle is “Regression”. It has permeated the fibre of public domain in Nigeria and requires a strategically well-calibrated approach through accredited professionals in the fields of psychiatry, psychology and psychotherapy.*

*There is not nation building without healing and this is never possible without proper diagnosis and a proper therapy. There is an urgent need for an analytic cartography of the national mental structure leading to identity-discovery and solidification as the foundation of a utopian hope. This article explores the reasonability and applicability of a structured “therapeutic approach” towards influencing the phenomenon of the psychopathology of regression in Nigeria. This is a strong advocacy for a “tragic optimism”.*

**Key words:** *Regression, Cartography of National Mental Structure, Collective Psychopathology, Tragic Optimism, Self-Transcendence.*

### **Introduction**

It is a truism that a lot is not well with our world of the 21<sup>st</sup> century, and that Nigeria epitomizes many of the anomalies ravaging the world community. Nothing could be truer as the understanding and admonition put forward by Jonathan Wilson-Hartgrove

in his book “Revolution of Values”: “In the fierce urgency of our present moral crisis, the well-being of millions and the viability of our common home are at stake” (Wilson-Hartgrove, 2019, 8). In the contemporary sociological, political and economic setting in Nigeria, where millions of people, both young and old,

are seriously struggling to balance a most difficult equation between *excruciating frustration and patience*, there is a felt need to cast a searchlight on an aspect of the reality in the country that – methinks – has not really received adequate intellectual attention for the past decades in the country's evolution to nationhood. There are prevailing feelings of *collective helplessness and hopelessness* that appear insurmountable. This assumption is exactly a major objective of this article. *Against all possible and factual objections to hope in the face of unimaginable frustration, this article stands yet for a "tragic optimism" as a fruit of a much-desired mental modulation.* From my perspective, it has long become intellectually unbearable following most of the political arguments emanating from Africa with regard to the perennial problem of socio-political underdevelopment (I prefer to call this retrogression!). With the title of his book "How Europe underdeveloped Africa", Walter Rodney offers us definitely a credible insight into many of the causes of contemporary African retrogression. Amongst others, he writes, "Most of what emerged from the colonial educational system was not unique. Educational systems are designed to function as props to a given society, and the educated in the young age groups automatically carry over their values when their turn comes to make decisions in the society. In NCOs, railroad booking clerks, for the preservation of colonial relations; and it is not surprising that such individuals would carry over colonial values into the

period after independence was regained. The colonialists meanwhile took action wherever possible to insure that persons most favourable to their position continued to man African administrations and assumed new political and state police powers" (Rodney, 2011, 260). Nobody would reasonably commit himself or herself to an intellectual dishonesty by regurgitating the well-established facts about the systematic strategy of the colonial masters to dwarf perennially the countries of Africa to their own economic and political advantage. Though decades have elapsed since the Nigerian author Areoeye Oyebola wrote his insightful and epoch-making book "Black Man's Dilemma", and, notwithstanding the fact that quite a lot has happened in Nigeria in particular in the area of the provisions of certain basic infrastructures, the tragic perspectives and realities he explored in his book have nevertheless continued to stare most Nigerians with a merciless recalcitrance in the face up till today. In his analysis, he spoke about "three intriguing facts about the black race ... which most black and 'coloured' people and some Liberal whites would prefer not to face honestly and squarely" (Oyebola, 1976, 10). On this, he did not engage himself in any self-effacing rationalizations. He wrote, "One such fact is that no black country has ever made a breakthrough to modernity. As black peoples, we have no country to be proud of in terms of its great inventions and discoveries, its technical equipment and political power. No black country has successfully developed or adapted

the technology of industrial civilisation to assure its citizens of a high standard of living. I don't know of any black country which has made any meaningful beginning in the development of, at least, parts of modern technology and science. No black country has solved the problem of poverty among a great majority of its citizens. None has found any concrete solutions to the problem of poor nutrition, endemic diseases, inadequate basic education and infrastructural facilities" (Oyebola, 1976, 10). Considering when he wrote this book, one might try to contradict him based on certain achievements in our contemporary times, both in Nigeria and in Africa in general. Such an evidence-based contradiction might however not completely lose sight of the insider-analysis given by the worldwide highly revered Nigerian author and Professor Chinua Achebe, who in his widely read book "The Trouble with Nigeria" x-rayed the devastating causes of consistent backwardness in Nigeria, pinpointing *bad leadership* as the nucleus of all socio-political and economic failures in the country. He writes unequivocally, "Nigerians are what they are only because their leaders are *not* what *they* should be" (Achebe, 1985, 10). He further explains what this article intends with the psychopathological concept of regression, "An absence of objectivity and intellectual rigour at the critical moment of a nation's formation is more than an academic matter. It inclines the fledging state to disorderly growth and mental deficiency" (Achebe, 1985, 11-12). *Therefore, this fundamental*

*historical knowledge notwithstanding, over six decades after independence, there is reason to believe that such a historical blame-game cannot and can longer stand the overwhelming evidence-based factors of self-inflicted identity destruction.*

My perception has always been – and has doubled down continuously in at least the past three decades – that most of the people with special political responsibilities in Nigeria, be they the *recycled military rulers or those presumably "democratically elected" into positions of leadership* were enmeshed in unending prevarications with regard to finding creditably sustainable solutions to the hydra-headed problems facing the country since the fateful military coup d'état of 1966. If all of life is "problem-solving", as the English scientific theorist and social philosopher, Sir. Karl Popper (1996) opined then the desired solutions will never come about by tinkering around the obvious problems. No! Serious-minded problem solving must be ready to go to the root of the known problems. For Popper, it is not possible to write history without taking a stand to the fundamental problems of a society, of politics and of customs and habits (Popper, 1996, 173). In other words, the Problem-Solver must be acquainted with the evidences of the problems he or she intends to solve. Now, such evidence-based factors, as manifested in the *widespread behavioural patterns* in the Nigerian society, *attest to the understanding of "regression"* as propounded in this contribution, with its foundation in Freudian Psychoanalysis.

Referencing the *oral stage of developmental psychology* according to psychoanalysis, there is *no limit to the pleasure principle at this transitory level of human growth*. The child derives extreme joy from whatever it can simply put into its mouth, associating such a thing with the mother's breast that gives it milk – and succour. Surely, for the infant, it would be wrong to bracket this level of human growth as pathological! Not in the least! This stage of child growth has nothing to do with a neurotic narcissism! “For Freud the state of primary narcissism of the infant, and the later oral and anal stages of libido development, are ‘normal’ inasmuch as they are necessary stages in the process of evolution. The dependent, greedy infant is not a sick infant. Yet the dependent, greedy adult, who has been ‘fixated’ on, or who has ‘regressed’ to, the oral level of the child is a sick adult...What is normal at a certain stage is pathological at another stage” (Fromm, 1989, 58). There is room, therefore, for worries, when in any society, observable general patterns of behaviour are indicative of a stage of human growth in a child, which should belong to the past. There is then a serious *danger of a biological determinism* without regard for the necessity of an *instinctual management*, which in end effect is a most vital component of character and personality. On this individual and collective pathology, Sigmund Freud uses a striking analogy for demonstration, “Novelty is always the condition of enjoyment. But children will never tire of asking an adult to repeat a game that

he has shown them or played with them, till he is too exhausted to go on. And if a child has been told a nice story, he will insist on hearing it over and over again rather than a new one; and he will remorselessly stipulate that the repetition shall be an identical one and will correct any alterations of which the narrator may be guilty – though they may actually have been made in the hope of gaining fresh approval. None of this contradicts the pleasure principle; repetition, the re-experiencing of something identical, is clearly in itself a source of pleasure” (Freud, 1989, 42). *The author has the strong feeling that the Nigeria society is systemically guilty of this phenomenon of regressive oral stage of child-development*. Who would nevertheless, logically maintain that the Nigerian society is singularly guilty of this pathology of regression? Has the USA not demonstrated the hidden high level of such a pathological regression in the wake of the presidential elections of the ill-fated year 2020? In this sense, regression is to be understood as a psychoanalytic phenomenon with different corrosive effects on the general behavioural patterns of people in any given society.

A *phenomenological approach to the world community* reveals unavoidably what some renowned personalities in both the academic and political circles have tried to analyse lucidly in their different publications on the “State of the World”. Some of their book titles would give the reader a clear picture of the dire situation of our world in this 21<sup>st</sup> century. Franklin Foer, for example, would title his book “World

without mind. The existential Threat of big Tech” (2017). With regard to the quality of the relevance this article wants to portray, it is very significant that I am making the choice here to start with the generally neglected negative influence of the highly glorified, but nonetheless appreciated “progress” in information technology. In the prologue to his book, Foer tries to buttress what he implies with “world without mind”, “In pursuit of clicks, some of our nation’s most important purveyors of news have embraced sensationalism; they have published dubious stories; they have heaped attention on propagandists and conspiracists, one of whom was elected president of the United States. Facebook and Google have created a world where the old boundaries between fact and falsehood have eroded, where misinformation spreads virally” (Foer, 2017, 7). The concept of “world without mind” reveals that the so-called “progress” could be a “regression” in camouflage. The bottom line, a most fundamental question is, *if* the development of advanced information technology has equally led to the advancement of *personality growth*. This article would object to such an equation. The phenomenologically diagnostic approach in this article is *the claim of a collective psychopathology with regard to Nigeria* – and some other countries, including the country of the self-acclaimed exceptionalism, the USA. The implied mission with regard to Nigeria is therefore a clarion call on all involved in the Mental Health Care Sector to be (more) aggressive in the public domain by organizing and engaging the public,

but most especially the institutions of higher learning in the country, in open discussions. The example of the symposium that took place in Vienna, Austria, on the 4<sup>th</sup> of December 2009 stands out for such an engagement. It was a professional confrontation with the growing phenomenon in the social politics of the country centring on “Xenophobia, Exclusion and Violence-Readiness towards Aliens. Psychotherapy and Politics in Dialogue”. It is therefore the conviction of this article that professionals in the field of psychiatry, psychology and psychotherapy can effectively help to mould the behavioural pattern of individuals in the Nigerian society. This is my vision and mission.

#### **The smoking gun – A psychosocial “diagnosis”:**

“Regression, according to psychoanalyst Sigmund Freud, is a defence mechanism leading to the temporary or long-term reversion of the ego to an earlier stage of development rather than handling unacceptable impulses more adaptively. In psychoanalytic theory, regression occurs when an individual's personality reverts to an earlier stage of development, adopting more childish mannerisms. Freud saw inhibited development, fixation, and regression as centrally formative elements in the creation of a neurosis. Arguing that 'the libidinal function goes through a lengthy development', he assumed that 'a development of this kind involves two dangers – first, of *inhibition*, and secondly, of *regression*'. Inhibitions produced fixations; and the 'stronger the

fixations on its path of development, the more readily will the function evade external difficulties by regressing to the fixations'." (Google.com, 12.02.2022 [www.https://en.wikipedia.org/wiki/Regression\\_\(psychology\)#:~:text=Regression%20\(German%3A%20Regression\)%2C,handling%20unacceptable%20impulses%20more%20adaptively](https://en.wikipedia.org/wiki/Regression_(psychology)#:~:text=Regression%20(German%3A%20Regression)%2C,handling%20unacceptable%20impulses%20more%20adaptively))

"Neurosis for Freud was thus the product of a flight from an unsatisfactory reality 'along the path of involution, of regression, of a return to earlier phases of sexual life, phases from which at one time satisfaction was not withheld. This regression appears to be a twofold one: a *temporal* one, in so far as the libido, the erotic needs, hark back to stages of development that are earlier in time, and a *formal* one, in that the original and primitive methods of psychic expression are employed in manifesting those needs" (Google.com, 12.02.2022).

"Behaviors associated with regression can vary greatly depending upon the stage of fixation: one at the oral stage might result in excessive eating or smoking, or verbal aggression, whereas one at the anal stage might result in excessive tidiness or messiness. Freud recognised that 'it is possible for several fixations to be left behind in the course of development, and each of these may allow an irruption of the libido that has been pushed off – beginning, perhaps, with the later acquired fixations, and going on, as the lifestyle develops, to the original ones'" (Google.com, 12.02.2022).

Now, with regard to the central objective of this article, the oral phase of

child development as understood by Sigmund Freud in his theory of personality development is of an intangible importance when considering a balanced personality or even a dysfunctional one, as the case may be. The oral phase – just to refresh our collective memory – is the phase when a child engages in *an unhinged "adventure" in its environment with its mouth, trying to satisfy all its desires by putting into its mouth any- and everything that comes its way*. Literally, everything is as good as the mother's breast to suck or to lick. Immediately the child feels hungry, if the mother's breast is not readily available, it begins to suck its thumb. Because of the emotional connectedness to the mother in this phase of human development, the foundation of basic trust is laid here that plays an immense role in the development of self-esteem and social trust. Normally, it could be disastrous, if this all-important mother-child-tie is missing! Different forms of addiction as *substitution gratification* could be the dangerous outcome, reflecting the grievous deficit of early childhood. To make up for such a deficit that mutates into adulthood, *other forms of socially abnormal behavioural patterns could emerge (socio-psychopathology!)*, which constitute some socio-political and economic absurdities for any given society. *The "undefined diagnosis" here would be the unconscious mind of a grownup individual battling with the unfulfilled oral phase of human development in the spirit of Analytic Psychology.*

### A case for “tragic optimism” in Nigeria:

For an in-depth demonstration of what is meant with this ironic expression of a “tragic optimism”, I would like to borrow a leaf from one of the oldest documents in the history of humankind, the Jewish and Christian Bible, for an illustration. In the first chapter of the book of Genesis, we read the following: “In the beginning God created the heavens and the earth. Now the earth was a formless void, there was darkness over the deep, and God’s spirit hovered over the water.” (Gen 1:1-2) For purposes of the intention undergirding this write-up, our attention should centre on some key concepts in this quotation: “formless void”, “darkness” “the deep”, “water”, “hovering” and finally, “spirit”. It would not be a mistake at all, nor an exaggeration, to liken the reigning socio-political conditions in Nigeria with the Tohuwabohu state, as we know it from the Jewish-Christian Bible. Speaking picturesquely, this is called *formlessness*. For, in all sincerity of purpose, Nigeria, since its independence in 1960, through its leaders (or much more aptly, rulers!) has not succeeded in giving herself the desired functional structure of a true nation building.

It would not be proper, nevertheless, to invoke the spirit of defeatism regarding the known and hidden potentials in the country starting from the end of the war (1967-1970). Experience has shown repeatedly, that the most prominent characteristic of Nigeria and her citizens is *resilience*. It is within the context of this manifest resilience culture in Nigeria – amongst

Nigerians (!) – that the pragmatic meaning of “tragic optimism” comes into play in this write-up. One of the known four pathologies of the spirit of our times, as Viktor Emil Frankl, the founder of the existential theory and healing method of psychotherapy elucidated, is *fatalism*. An attitude of *giving up to fate*. According to Frankl, fatalism as an approach to life is a superstition that makes one believe in the invincible power of destiny or fate (Frankl, 1993, 138). Fatalism is however one of the symptoms of the existential vacuum, when life appears to be meaningless (cf. Graber, 2004, 143). If life is meaningless, there is then no point in making efforts to effect an existential change. Nevertheless, in an environment of a consistent and persistent political regression, a synonymous name for most Nigerians would be “struggle”. Observably, in a socio-economic and political system where the impression reigns supreme that everybody is on his or her own, it is not a rocket science to comprehend that resilience has become a national identity in Nigeria. Nigerians have proven severally that they can be dogged fighters, notwithstanding that the collective will to change has not really been prominent. This attitude might derive from the terrible experiences of the civil war that ravaged people and country in the years 1967 to 1970. Indeed a kind of collective trauma. Against this backdrop, the destructive impact of the pathology of regression appears to have increased astronomically, because most politicians tend to exploit the existing stoic individualism emanating from such a

collective trauma. Be it as it may, the existing culture of resilience in the country sustains my hope for such a “tragic optimism”, as would be demonstrated later.

***The culture of hope in Nigeria – Beyond the chains of psychopathology:***

At the end of our intellectual journey, a fundamental conclusion becomes almost incontrovertible: Democratic freedom is not – and cannot be – the same as existential freedom. It is a most willing contention of this contribution that existential freedom precedes any form of democratic freedom. What Erich Fromm wrote in his “Beyond the chains of illusion” goes to demonstrate and underpin the necessity of my logical deposition here, “I believe in freedom, in man’s right to be himself, to assert himself and to fight all those who try to prevent him from being himself. But freedom is more than the absence of violent oppression. It is more than ‘freedom from’. It is ‘freedom to’ – the freedom to become independent; the freedom to *be* much, rather than to have much, or to *use* things and people” (Fromm, 1989, 171). Any reasonable sustainable hope in Nigeria must therefore have to confront the urgent and inevitable question of psychosocial pathology. All clamours for socio-political structural reforms must – for the sake of the anticipated positive results – as of necessity, address the *structure of personalities*. This credence to structures of personalities must be the underlying motivation in all current reflections on how to build a viable Nigerian democratic society out of its

present rubbles of unimaginable dystopia. This is exactly where the educational system must come in. The persistent vulnerability of the general educational system in Nigeria to destructive psychopathological regression must constitute an enormous concern for the central government of any political party! *The desired civic responsibility can only come from individually responsible and responsive citizens!* Nigeria requires what I would like to describe as *disruptive personalities*. Not in any way because they are paranoiac sociopaths, but simply based on their willingness and decisiveness to be different, *to make a big difference by walking consciously away from the widespread habitual infantilism of the oral stage of child development*. This, in turn, implies free citizens. What do I really mean by the term “free citizens”? Well, by definition, this is not unconnected with the undefined voraciousness of the infant oral stage of personality development. Free citizens are active citizens in the sense of energy creation that influences their society. It has something to do with the *specific mode of being, which does not exhaust itself in unending material acquisitions*. Borrowing a leaf from Erich Fromm, we can describe free citizens in the following words: “The mode of being has as its prerequisites independence, freedom, and the presence of critical reason. Its fundamental characteristic is that of being active, not in the sense of outward activity, of busyness, but of inner activity, the productive use of our human powers. To be active means to give

expression to one's faculties, talents, to the wealth of human gifts with which – though in varying degrees – every human being is endowed. It means to renew oneself, to grow, to flow out, to love, to transcend the prison of one's isolated ego, to be interested, to 'list', to give" (Fromm, 1988, 76). It appears, in essence, to be an indubitable truth about all societies and nations that development and progress would never ensure unless there are many individuals who have come to the realization of the necessity of "transcending the prison of one's isolated ego". Nobody should nevertheless, underestimate the power of an already isolated ego! Habits are not easy to change. Every change, be that in a personal relationship or in a bigger whole of the society, requires as of necessity a motivational force, an object of devotion, of commitment.

The infantilism of the oral stage of Freudian developmental psychology is however abhorrent to truly free citizens! Let us reflect briefly on the very aspect of the implied *truly free citizens* in line with the thoughts of Erich Fromm: "I believe that to recognize the truth is not primarily a matter of intelligence, but a matter of character. The most important element is the courage to say no, to disobey the commands of power and of public opinion; to cease being asleep and to become human; to wake up and lose the sense of helplessness and futility" (Fromm, 1989, 170). The real power of such a defiant spirit lies however not really in objection to things that do not make for personal interests, but much more, it consists in *saying no to*

*ourselves in spite of ourselves*. What does this mean? *True test – and a true taste – of a personality consists of growing out of our infantile structure of character by saying no to our narcissism; learning to say no to our negative instincts or systemically acquired negative propensities whilst steadily growing into the culture of altruism – a caring sense of the Otherness of others*.

### **Conclusion and Recommendations**

By the constant and persistent quest for pragmatic and lasting solutions to some of the endemic problems in the Nigerian society, I subscribe to the contention that the general proclivity of both the leadership and the led towards a disparaging atavism has its major cause in a stunted personality growth. A personality growth that is engulfed in the pathology of the oral phase of child development, grabbing everything and anything that comes one's way. It is my strong belief that this form of psychopathology of societal advancement can only be attenuated through a well-calibrated *responsive consciousness by an aggressive professional disruptive strategy*. Based on the systemic theory of the *construction of reality*, it seems that the existing construction of the psychosocial pathology of the magnitude witnessed in Nigeria could only be countered through an *alternative and resilient systemic construction of a new reality, a reality that goes beyond the infantile oral stage of growth*. In this sense, there is therefore need for a deconstruction of the existing Nigerian mental

cartography. This is exactly what Jonathan Wilson Hart-Grove means, when he writes, “Deconstruction is prelude to the work of reconstruction” (Hart-Grove, 2019, 22). My belief is very strong that Mental Health Care Professionals (whether they are really practising or are tutorial) have a vital role to play in shaping the expected new systemic construction of a progressive mind-set in Nigeria. Such a conviction is underscored by a great symposium organized by the National Association of Psychotherapists in Austria on 4<sup>th</sup> December 2009, in Vienna. The central theme of the seminar was geared towards the awakening of an alternative political consciousness against the rising antagonism against foreigners. The topic speaks for itself. “Enmity towards foreigners, Readiness to Exclusion and Violence against ‘Alien People’” Now, this is the motivation and consideration: Would it not be something good for Nigeria, if all those engaged in Psycho-Professions would rise to the great challenge of trying to reconstruct the destructive mind-set that is ravaging both the democratic aspirations of the many, as well as the economic and institutional growth of the country? A fundamental way to achieve this objective would be to apply the psychoanalytic approach of exploring the subconscious mental strata of the Nigerian society and bringing such a subconscious to the level of consciousness, which would in turn create a new and more progressive social awareness. I am inclined to believe that the Freudian understanding of the individual and the society cannot be

ignored, when and if the one nagging problem in Nigeria would be solved – endemic and toxic corruption. “Sigmund Freud believed that nothing was ever forgotten by the individual. He did not through this imply that the individual consciously remembered everything. On the one hand, it is because the individual did not consciously remember everything that psychoanalysis was necessary – as a probe into the subconscious and the unconscious: on the other hand, it is because nothing was really forgotten that psychoanalysis is possible at all, for everything is there for it to probe. Thus, according to Freud, all our experiences are stored up, and they affect our overt behaviour even if we have no conscious memory of the experiences themselves” (Nkrumah, 2009, 58). It is therefore very *expedient and imperative*, while giving credence to the critical analysis given to the Nigerian self-destructive “dilemma” in his book “This House has fallen. Midnight in Nigeria” to reflect properly on the solution proffered by Karl Maier. He writes, with a strong belief in the future of the “fallen house”, as follows, “So Nigeria stands at crossroads with three probable scenarios in front of it, two of which would produce severe consequences. The most productive scenario would demand Herculean efforts by the current administration to throttle corruption and mismanagement, strengthen the judiciary and parliament, and revive the economy, giving confidence to foreigners and Nigerians alike to invest in the economy. On the political front, the government should initiative a constitutional conference to

allow a wide range of representatives from ethnic, religious, labour, women's, political, and business groups to decide how they want to live. The results should then be put to a nationwide referendum, which might create enough space for Nigerians to start talking and listening to one another. And ultimately, to fashion a political and economic order in which they feel they have a true stake" (Maier, 2000, 300). The veracity of this solution-proposition cannot be challenged even 22 years after its publication! Nevertheless, and this is the contention of this article, a reconstruction or to better use the system theoretical vocabulary, a deconstruction of the Nigerian national construction to the benefit of an accelerated social and human growth cannot take place without taking cognisance of the underlying obfuscation of the already known efforts at solutions of the recalcitrant problems in the country. *This is where the psychoanalytic theory of regression comes in.* In essence, nobody should underrate the long-term destructive effects of a psychopathological regression on any given society! Regression has the inner proclivity of turning into a collective neurosis. Who would but admit the fact that Nigeria epitomizes a study case for such a phenomenon of collective neurosis? It is infectious, toxic and unpredictable. There is a disposition to irritability, impulsiveness, hot-headed, fickle mindedness, inconsequence; ready to go to the extreme limit of any action. The Masses are open for simple passions and feelings, unimaginably suggestible, superficial in their considerations,

violent in their judgements, receptive only for the simplest and imperfect conclusions and arguments, easy to manipulate and convulse, without self-consciousness, self-respect and feeling of responsibility, nevertheless very ready with their consciousness of power to commit all forms of misgivings (cf. Freud, 2015, 25). Are these not the observable negative qualities disparaging the Nigerian society since independence?

There is a better alternative. There is a way out of the thick woods of Nigerian retrogression orchestrated by an endemic regression. This article nurses not just the feelings of a "tragic optimism" as taught by logotherapy (the third school of psychotherapy in Vienna, as founded by the Judeo-Austrian Psychiatrist, Neurologist and Philosopher, Viktor Emil Frankl, 1915-1997). The concept of a "tragic optimism" derives from what logotherapy again calls the "defiant power of the spirit". Both imply creating meaningful possibilities out of messy circumstances, making a triumph out of a tragedy. This means – according to the counter drive of the existing general psychopathology of regression in Nigeria – to effect a kind of mental Copernican revolution (an allusion to the change of understanding from geocentrism to heliocentrism) that has the capacity of expansion with time. Just to refresh our memory, "Heliocentrism is the astronomical model in which the Earth and planets revolve around the Sun at the centre of the Universe. Historically, heliocentrism was opposed to geocentrism, which

placed the Earth at the centre” (Google.com, 05.04.2022). The realization of such an idea of a Nigerian Copernican revolution would imply a systematic shift from the “commodity-man” to a self-transcendent existence, an existence filled with meaning and the consciousness of the “Other”. Erich Fromm captures such a desirable revolution in the following words, “This commodity-man knows only one way of relating himself to the world outside, by having it and by consuming (using) it. The more alienated he is, the more the sense of having and using constitutes his relationship to the world” (1989, 48). Claiming that the Nigerian citizenry could be regarded as a “patient”, based on the thesis of collective socio-psychopathology, my conviction that all the Mental Health Professionals with their clinics or tutorial appointments can and should engage themselves in public education through organized symposia, their major challenge as compared to the role of a logotherapist “consists of widening and broadening the visual field of the patient so that the whole spectrum of potential meaning becomes conscious and visible to him” (Frankl, 1984, 115). This is to say that the way out of the overconsuming pathological narcissism and egocentricism arising mostly – as has been ostensibly demonstrated in this write-up – from the regression into the oral phase of child development, would lie in the awakening of a higher level of consciousness and personal responsibility. Finally, now, I wish to re-establish my desideratum in this article by re-echoing the concept of “self-transcendence” as it is taught and

practised by logotherapy. On this, the founder of logotherapy, Viktor E. Frankl writes, “I wish to stress that the true meaning of life is to be discovered in the world rather than within man or his own psyche, as though it were a closed system. I have termed this constitutive characteristic ‘the self-transcendence of human existence.’ It denotes the fact that being human always points, and is directed, to something, or someone, other than oneself – be it a meaning to fulfil or another human being to encounter. The more one forgets himself – by giving himself to a cause to serve or another person to love – the more human he is and the more he actualizes himself. What is called self-actualization is not an attainable aim at all, for the simple reason that the more one would strive for it, the more he would miss it. In other words, self-actualization is possible only as a side-effect of self-transcendence” (Frankl, 1984, 115).

Drawing therefore from the above quotation, this article ends with a “Mental Code”, which poses a big but nonetheless not solvable challenge to the School (Board?) of Mental Health Care Professionals in the country: Regression (a psychical infantilism, Freud, 1989, 22) leads systematically to both a self-dwarfing of the individual and to the toxic destruction of society. The prophylaxis is the culture of self-transcendence that has the capacity of breaking the chains of the illusion of regression. The reader and all Nigerians are finally invited to the motivational message of this article as illustrated by Viktor E. Frankl, who experienced excruciating years in four different

concentration camps of the Narcist leader of Austria and Germany, Adolf Hitler, and nevertheless turned those experiences into a more comprehensive human understanding for many generations – past, present and future. His uncompromising understanding of the human dignity underpins my firm belief in a “tragic optimism” for the Nigerian society bedevilled with the infantile regression that has turned into a collective neurosis. I conclude therefore with this quotation taken from his book “The Will to Meaning”: “Facts are not fate. What matters is the stand we take toward them” (Frankl, 1988, 137). Nigerians can stand up against the widespread psychopathology of regression, guided by their willing Mental Health Care Professionals in open discussions.

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# Psychological Insight Into The Impacts Of Covid-19 Pandemic In Nigeria: The Need For Psychotherapy

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## **Abstract**

*This paper focuses on the impacts of Covid-19 pandemic on mental health with attention to substance use, depression, anxiety and other forms of usual psychological challenges. The paper took a critical global review of the pandemic effect which revealed that the pandemic encouraged in some instances the use of alcohol as a relevant factor in the control of Covid-19 virus. The isolation created by the pandemic all over the world resulted in depression and some forms of anxieties. The fear of contacting the disease, self isolation and inability of the people to go out for their usual struggle for survival becomes a major concern in this paper. The usual reported cases of the disease by the media create fear or anxiety in the minds of many people. In conclusion, the current pandemic CoV-19 has badly affected lives the world over. Disease and its effect on public mental health cannot be over emphasized. The year 2020 has been characterized by a virus called Corona or COVID-19 as stated earlier. As the coronavirus pandemic rapidly sweeps across the world, it is inducing a considerable degree of fear, worry and concern in the population at large and among certain groups in particular, such as older adults, care providers and people with underlying health conditions. The researcher therefore, having reviewed the antecedence surrounding the menace, suggests that psychotherapy is key for the treatment and management of people diagnosed with mental and emotional disorders using dialogue and a variety of psychological techniques such as cognitive restructuring, counseling, emotional and behavioral management for optimal and mental wellbeing.*

**Key words:** Covid-19, Psychological insights and Psychotherapy, Nigeria

**Introduction**

Every ugly and dreadful situation poses great imbalance in the life of man especially the mental state which often results into depression, anxiety and other forms of unusual psychological challenges. Covid 19 pandemic also came with her own challenges. This paper sought to unravel the psychological insights of the pandemic, its psychological effects on mental wellbeing and the way out or solution towards having optimal adjustment in life and well-living,

Disease and its effect on public mental health cannot be over emphasized. The year 2020 has been characterized by a virus called Corona or COVID-19 as stated earlier on. As the coronavirus pandemic rapidly sweeps across the world, it is inducing a considerable degree of fear, worry and concern in the population at large and among certain groups in particular, such as older adults, care providers and people with underlying health conditions. In public mental health terms, the main psychological impact to date is elevated rates of stress or anxiety. But as new measures and impacts are introduced – especially quarantine and its effects on many people's usual activities, routines or livelihoods – levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behaviour are also expected to rise (Asmundson, Abramowitz, Richter & Whedon, 2010). The corona virus pandemic is an epidemiological and psychological crisis. The enormity of living in isolation, changes in our daily lives, job loss, financial hardship, and grief over

the death of loved ones has the potential to affect the mental health and well-being of many.

Even in this time of physical distancing, it's critical to seek social support and connection with others. It's also important to know the signs of anxiety, panic attacks, depression, and suicide so you can easily identify them, not just among your family, friends, and neighbors, but for yourself.

**Common signs associated with anxiety**

There are common signs which are evident in people suspected or diagnosed as having Corona virus. These include, persistent worry or feeling overwhelmed by emotions. Excessive worry about a number of concerns, such as health problems or finances, and a general sense that something bad is going to happen. Restlessness and irritability. Difficulty concentrating, sleep problems and generally feeling on edge.

**Panic and depressive symptoms of corona virus**

Sweating, trembling, shortness of breath or a feeling of choking. A pounding heart or rapid heart rate, and feelings of dread. Such attacks often happen suddenly, without warning. People who experience panic attacks often become fearful about when the next episode will occur, which can cause them to change or restrict their normal activities. Depressive signs include lack of interest and pleasure in daily activities. Significant weight loss or gain. Insomnia or excessive sleeping. Lack of energy or an inability to concentrate. Feelings of

worthlessness or excessive guilt. Recurrent thoughts of death or suicide. In populations already heavily affected, such as Lombardy in Italy and USA, issues of service access and continuity for people with developing or existing mental health conditions are also now a major concern, along with the mental health and well-being of frontline workers. As part of its public health response, WHO has worked with partners to develop a set of new materials on the mental health and psychosocial support aspects of COVID-19 (WHO, 2020)

This is one of the few moments in which humanity has had to deal with a virus that made us question the way how society is organized, how we relate to others, and how we work. For many people it has also had a financial impact, bringing instability to their jobs and income, particularly in Low and Middle-Income countries (LMIC) where typically there are limited social protective measures.

Mental disorders (MD) are commonly comorbid with cardiovascular, metabolic, and some infectious diseases. Understanding the burden of an outbreak on mental health is fundamental to effective action towards containing the spread of the disease, as psychopathology might reduce endurance during the lockdown. This can potentially reduce adherence to ongoing treatment resulting in avoidable recurrence of a disorder. Additionally, there is the stress caused by the eminent risk of infection or economic uncertainty, especially in low-middle income settings.

### **What is corona virus?**

Corona is a single stranded ribonucleic acid (RNA) virus that had its roots into the world from almost 60 years since its discovery in late 1960s. Corona viruses belong to the Corona viridae family in the Nidovirales order. The nomenclature of the Corona virus is named after the crown-like spikes on the outer surface of the virus structure. The virus has been infecting animals like chickens and pigs but there was no major human contraction to humans. Earlier, the allied viruses of the same family like the Severe acute respiratory syndrome coronavirus SARS-CoV in 2003, Human corona virus HCoV NL63 in 2004, HKU1 in 2005, Middle east respiratory (MERS) in 2012, have shown their outbreaks and now the novel version of this virus has presented a threat of unmatched severity. According to the classification of International Taxonomy of Viruses (ICTV) has referred this novel pathogen as SARS-CoV-2 (formerly known as 2019-nCoV) in 2019. The first case was identified in the city of Wuhan, a Chinese seafood market and since then it has been exponentially increasing with an evident human to human contact via respiratory droplets while sneezing and coughing. The mode and transmission and other related details about the virus continue to be updated in every few weeks, leading to enhanced uncertainty.

### **Theoretical overview**

During this period most of the research has been focused on understanding and preventing transmission; exploring treatment options and issues with global

governance. However the author of this important paper think that the psychological impact of this pandemic like stress and anxiety among the general population is also a grave concern. A study from China suggesting that more than half of the participants had a significant psychological impact of the COVID-19 pandemic. Another recent study from Denmark reported psychological well-being as negatively affected. In the United States nearly half were found to be anxious as per the survey conducted by the American Psychiatric Association. The same has not been studied in Indian population systematically; except anecdotal discussions and case reports. In Indian subcontinent, as of 30 March 2020, according to the Ministry of Health & Family Welfare (MoHFW), a total of 1071 COVID-19 positive cases (including 49 foreign nationals) were reported in 27 states/union territories. These include 99 cases that were cured / discharged, one person who has migrated and 29 deaths. Hospital isolation of all confirmed cases, tracing and home quarantine of the contacts is on-going. In India, spread of the initial disease could be traced mainly to the foreign nationals who visited the country as tourists from the disease affected countries and secondly due to the mass immigration of Indian nationals from abroad; due to the fear of infection. As the pandemic outbreak in India was on-going, the Government of India took stringent measures to limit the cases by far in that stage only, by initiating a major lockdown pan-India and also by shifting the immigrants to the special

quarantine facilities prepared by the Indian Military directly from the airports and seaports for a minimum of 14 days. Community health teams were also launched to spread awareness about the chances of spread and precautionary measures that one can use to protect themselves and others (MoHFW, 2020) During the early stages of the pandemic in India, this study was focused mainly to assess its psychological impact. The lives of people were drastically affected with lock-down and fear related to the disease's potential effects and transmission. The fear due to the contraction of COVID -19 is on the rise because of the death tolls and global spread. Hence, this study attempted to find the initial psychological impact of COVID-19 among general public; and understand its relationship with physical symptoms. This can potentially help policy makers in formulating comprehensive interventions (APA, 2020)

### **Covid 19 pandemic and substance use in some African countries**

The UNODC Kenya mentor has participated at the webinar on the impact of COVID-19 pandemic and Substance Use Disorders in Kenya on Friday, 15 May 2020. Together with Hussein Manji, Public Health Consultant at UNODC ROEA, the mentor outlines UNODC's support in the COVID-19 response among the most vulnerable groups, such as people who use drugs and who are affected by substance use disorders, people living with HIV and people living in prisons.

The webinar was an interactive 2-hours discussion with national partners such as NACADA represented by Judy Twala, Drug Dependence Treatment and Care professionals represented by Susan Gitau, Rehabilitation Centres represented by Boniface Ndirangu and UNODC. The talk was organized by ISSUP International, together with ISSUP National Chapter Kenya.

Discussions were held on the results of the COVID-10 pandemic in the country, whether essential services and programmes reaching vulnerable groups are restricted or entirely stopped. The talk continued on the topic of prevention of drug use and how the management of substance use disorders during lockdown in Kenya is handled including whether the impact of the lockdown has increased the risk of relapse or resulted in reduced cases of substance use disorders (UNODC, 2021)

A total of 209 participants were reported to attend the event and the feedback received was positive. The recording of this webinar can be access through the provided link.

The spread of COVID-19 has been slow in Nigeria compared to other countries on the continent. Nevertheless, the federal government has taken steps in readiness for a more rapid outbreak. Schools have been closed, public gatherings banned by some state governments and most public workers are required to work from home. An international travel ban has also been imposed and the country has announced a lockdown of major cities. Nigeria's health system will find a full onslaught of COVID-19 difficult to handle. The

main reasons are its lack of sufficient isolation centres and testing kits.

The other major challenge is that Nigeria has a very high dependency on imported drugs – 70% are brought in from abroad, chiefly China and India. On top of this, Nigeria relies on imported active pharmaceutical ingredients as well as equipment used in drug manufacturing.

This dependency is of particular concern in the face of a threat such as COVID-19. The reliance on foreign countries may lead to a serious medical crisis in the country if it is unable to source the drugs it needs. China and India have both been hit hard by the pandemic.

It's important for Nigeria to take stock. It needs to look at lessons learned and build on them to respond better to ensure uninterrupted pharmaceutical supply during pandemics. Most importantly, psychoactive substances should be controlled to prevent youths take advantage of the isolation and lockdown by engaging in the abuse of substances.

### **Drug security**

With the numerous health challenges that Nigeria faces – ranging from communicable to non-communicable diseases – pharmacotherapy is the mainstay for vast majority of conditions. Ensuring national sufficiency and drug security is crucial in tackling diseases, reducing mortality and catering for other health care needs. This no mean task with a growing population of over 200 million. It is important at the same time to combat falsified, substandard and

counterfeit pharmaceutical products. All pose threat to the economy and security of the nation.

There are steps the country can take to offset the very high dependency on imports. Manufacturing is one such route. The manufacture of drugs in Nigeria is on the decline. The main reasons for this are infrastructural challenges – like a lack of consistent energy supply – as well as inadequate financial support to the up-and-coming pharmaceutical scientists.

Others constraints include difficulties in the over-dependence of imported raw materials, weak technology and engineering base, weak industrial linkages and supply chain with high taxation. Nigeria nevertheless has a relatively sizeable industry. The country is home to more than 115 pharmaceutical companies. These produce for the local markets and for export to neighbouring countries. Nearly all of the local drug manufacturers purchase active pharmaceutical ingredients from other manufacturers and formulate them into finished drugs. This means that they are limited to purchasing drugs and repackaging them for use.

There is, however, some manufacturing. This includes analgesics, antimalarials, antibiotics, antiretrovirals and vitamins including tablets, capsules and syrups. Others include syrups, infusions, antacids, antiseptics/disinfectants and injectables. But there is no significant research and development activity in the country. And most of the pharmaceutical companies in Nigeria have not been able to fully navigate the

challenges which make the operation in the country sub-optimal. The overall impact of this pandemic may be felt soon, leading to shortages of active pharmaceutical ingredients. This should raise concern about the potential of an increase in fake and counterfeit medicines and drugs. Fighting the sale of fake, counterfeited and sub-standard drugs is an ongoing struggle in the country.

### **COVID-19 pandemic effect on Mental Health**

Although we have faced coronaviruses epidemics before (SARS, MERS) the current new coronavirus epidemic is unprecedented due to limited treatment options. The rapid spread on the globe has generated strain on countries' ability to keep their economies afloat. Altogether these factors constitute a recipe for anxiety and stress in the overall population, but especially among vulnerable groups. Although we will only assess the real impact of COVID-19 on mental health after the pandemic, we must now adopt strategies to mitigate its effect.

Social isolation is related to numerous symptoms. It is known that epidemics can elicit anxiety and anticipation of possible infection, which sometimes manifests itself as health anxiety. It is an exaggerated preoccupation with one's own health and usually presents itself with some type of body vigilance in which the subject focuses excessively on body signs such as, palpitations, respiratory rate, and so on. A behavioural cognitive theory model believes that it as a result of

mistaken beliefs on our own health, which leads to unreasonable interpretations of body sensations. Such psychological response to stress appeared, for example, in women during the Zika epidemic. These can persist and evolve to more intense symptoms such as anxiety and panic attacks. Naturally, this takes a higher toll on subjects, which already have a mental disorder.

Misleading information from news outlets and social media can exacerbate restlessness. We are now familiar with headlines touting the new record on infections and deaths over the last 24 hours, which is presumed since it is well known that the condition spreads at an exponential rate. This arguably increases anxiety and worsens matters for people restrained in their homes. Since this pandemic has lasted for almost five months at the time of writing this paper with several more months of some kind of social distance expected in the future, the extended hypervigilant state can potentially activate the hypothalamic-pituitary-adrenal axis and cause elevated levels of glucocorticoids. This, in turn, is related to both anxiety and depressive disorders.

It is a community ordeal. It depends on our ability of adding structure to our day in order to reduce anxiety, or perhaps for the few that can, reach out to a psychotherapist that can help ameliorate the unrealistic beliefs. It also should involve journalists, as they should attempt to be more precise on their reports and avoid click baiting. Furthermore, policymakers have the opportunity to show science will be informing their decisions in health

policies. When one of these agents are not acting cohesively during the pandemic, subjects who already have a MD are the ones most susceptible to the worsening of their illness.

In the context of the low developed countries, the epidemic will leave behind a track of recurrence of disorders. Unlike in developed countries, the prescription is usually bound to a visit to the psychiatrist, which has been considered a non-essential health service and has been severely hindered during the health crisis. The Brazilian ministry of health has issued a rule that allows prescriptions to be valid for six months, however, subjects that have been caught in-between visits and used their prescriptions are not allowed to reuse them. Furthermore, anxiety commonly needs drug adjustments in stressing moments, which would require more frequent visits and psychotherapeutic support, both of which are not possible during a lockdown.

### **Dementias**

Elderly subjects with cognitive impairment will require special attention. It is difficult to maintain daily care for elders in lockdown, as caregivers may be required in hospital settings as aides. Furthermore, their presence can simply prove unfeasible due to the risk of contamination while caring for more than one patient. It is highly recommended that caregivers reduce the number of subjects they care for to only one on top of maintaining all the required health measures and EPI use during their shift. Sometimes families will simply need to stand in for

the patients as replacements for the caregivers. Furthermore, too long periods without contact with familiar faces can induce acute confusion and delirium<sup>7</sup>. It is recommended that elder subjects with cognitive impairment be quarantined with a family member whenever possible. Other causes of worsening could be related to limited refilling of prescription drugs, which hinders proper adherence to treatment. This is particularly problematic in Brazil, which has numerous regulations for distinct drug classes, sometimes not entirely known by pharmacists, often leaving patients short in prescribed number of pills needed until their follow-up visit.

### **Bipolar disorder**

Subjects with bipolar disorder will face slightly distinct problems. Loneliness and boredom can trigger depressive symptoms, these patients also commonly live in financial hardship from overspending in hypomanic episodes, which might hinder their ability to acquire and store medications according to prescription. Subjects with diagnosed bipolar disorder can become stranded from their families and usually benefit from social services or caseworkers that are tightly connected to their assisting doctors. The distribution of social services in the world is unequal across the states, richer states usually having better-structured services, which is arguably a point policymakers should focus on during the later phases of the epidemic.

### **Strategies to mitigate the effect on mental health**

Most people's lives will be impacted in some way by COVID-19 over the months and maybe years to come. This paper consider that including mental health care in the national public health agenda to fight this pandemic will reduce long-lasting and expensive to treat psychological effects. In Nigeria government should wake up to her task and embrace psychological and social services available in the country whether privately owned or government owned facilities. The government is ignoring cases where mental illnesses might worsen due to the pandemic. Professional associations should be more active in relaying instructions of preventive measures for psychologists and psychiatrists.

Building strategies to guarantee that patients have access to medications and counselling during the pandemic is fundamental to avoid recurrence or worsening of the disorders. Prescription access can be addressed with rulings that extend the time allowed to fill prescriptions. Access to psychotherapy is possible through remote/online consultation methods. For instance, these are not fully regulated and are often frowned upon by professional associations in Brazil. We think that these deserve to become widely accepted strategies and should instead receive full support from government and professional associations

### **The need for psychotherapy**

The relevance of psychologists and psychotherapists at this crucial time

cannot be emphasizes. Depression, anxieties and other psychological problems requires professional attention. In order to reduce anxiety and depression symptoms widespread among the population, the World Health Organization (2019) and the Centers for Disease Control and Prevention (2020) proposed specific guidelines on the correct use of health protection with the aim to minimize the distress associated with health-care professions.

At the same time, as a consequence of the emerging issues, psychotherapists provided psychological support online, addressing the technological challenge (Greenberg *et al.*, 2020); Liu *et al.*, 2020). In line with the technological progress, professional organizations promoted specific guidelines and policies related to customer protection, privacy, screening, evaluation, and development of self-help products (Duan and Zhu, 2020; Zhou *et al.*, 2020). Technological development in mental health foreshadows future trends that include “smart” mobile devices, cloud computing, virtual worlds, virtual reality, and electronic games in addition to the traditional psychotherapy tools. In this perspective, it is important to help future generations of psychologists and patients to collaborate in the potential growth areas, through education and training on the benefits and effectiveness of telepsychology (WHO, 2020).

### **Conclusion**

In conclusion, the current pandemic CoV- 19 has badly affected lives the world over. Disease and it effect on public mental health cannot be over

emphasis. The year 2020 has been characterized by a virus called Corona or COVID-19 as stated earlier on As the coronavirus pandemic rapidly sweeps across the world, it is inducing a considerable degree of fear, worry and concern in the population at large and among certain groups in particular, such as older adults, care providers and people with underlying health conditions. In public mental health terms, the main psychological impact to date is elevated rates of stress or anxiety.

### **Implementable Recommendations**

The fact about COVID-19 remains that the trace of this pandemic and it impacts on mental wellbeing cannot be fissile out over night hence the need for Nigerian and the Nigeria government to accept this as a disease or virus that has come to stay just like malaria, typhoid among others and continue to encourage and emphasizes safety measures.

Countries of the world and Nigeria in particular most recognized the need for psychologists and psychotherapists in the emotional, substance use and mental management of the all her citizens because apart from the vulnerable groups such as elderly and the disable, every person have been affected in one way or the other, hence the need for psychotherapy.

The COVID-19 pandemic should be an opportunity for drug manufacturers to pressure government into doubling efforts to ensure local drug manufacturing and not encourage people to engage in substance use as claimed by some scientist who belief alcohol can prevent one from contacting the virus.

The federal ministry of health too needs to ensure that the medicines and drugs supply chains are well-coordinated and regulated to ensure that people who need them have access. It should ensure that all drugs listed on the national essential drug lists are readily available and well distributed across the country.

The usual media advert on the relevance of alcohol-based sanitizers has great cognitive impacts in the individuals who already have love for alcohol and other psychoactive substance, therefore, only psychotherapist, behavioural experts and counselors would provide adequate treatment.

Nigeria is blessed with thousands of medicinal herbs. This is equally an opportunity for the country to strategically improve its research on herbal medicines for diseases management and improve access to medicines. Developing a sustainable and efficient local drug industry in Nigeria would take decades of dedication by both the private sector and government. It is therefore important for the government to make the country attractive for foreign pharmaceutical companies and also to complement the development of drug manufacturing.

And more importantly, our science laboratories in our higher institutions and centers across the country should be well equipped by the government and relevant bodies to encourage research and production of vaccines at all times as obtained in many countries of the world.

But as new measures and impacts are introduced – especially quarantine

and its effects on many people's usual activities, routines or livelihoods – levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behaviour are also expected to rise hence the need for all relevant bodies to expedite actions on how to keep citizens engaged meaningfully through community or house-self programmes. These can be best achieved through good therapeutic approach such as cognitive behavioral therapy which focuses on perception of events around us and how such events could trigger abnormal behaviours

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# Utilization Of Individual, Family and Group Therapies In The Treatment of Children From Dysfunctional Families In Anambra State, Nigeria: A Case Study

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## **Abstract**

*Some families are in dysfunctional states. This dysfunctionality affects the children growing up in such families. It is for this reason that this article tried to highlight some therapeutic techniques that could be used in helping children from dysfunctional family. Hence the purpose of this study was to show how the use of individual, family and group therapies aided so much in the treatment of a child from a dysfunctional family. As a methodology, the study used a case study of a boy (Martin) from a dysfunctional family. The causes of dysfunctional families accruing from Martin's case study was highlighted. Moreover, the study underlined the negative influences the dysfunctional family of Martin had on him. The following were the negative influences Martin's dysfunctional family had on him: anger outburst, poor relationship, hypervigilance, insubordination, poor academic performance, amnesia, low self-esteem, high distractibility and low attention span. Martin went through individual, family and group therapies, each lasting for some months as indicated in the study. Findings evidenced that Martin improved greatly after some months of undergoing the above mentioned therapies. Thus he was able to develop healthy patterns in relating with himself and the outer world. He was able to control his aggressive impulses. He developed a healthy sense of self and performed much better in his academics. His inner distractibility lessened greatly. His paranoid suspicion reduced a great deal. These imply that individual, family and group therapies are good combinations in the treatment of children from dysfunctional families.*

**Keywords:** *Individual therapy, family therapy, group therapy, dysfunctional families.*

## **Introduction**

Family intends one or more persons living in the same house who are related to the household by birth, marriage or adoption. According to McGoldrick *et al*

(2011), family comprises of people who have a shared history and an implied shared future. Hence family is any unit where there is sharing of resources both material/spiritual resources, there is love

and care, each person feels supported and appreciated. The children born in the family are taken care of by their parents. Family is an important environment that is associated with a range of social and emotional behaviors of children. Family as a cell acts only with love and respect towards the members of the family (Ceka & Murati, 2016). From good families we get persons who impact positively on the society.

The concept of good families in the society today is dwindling. In the present time, many families are in shambles and in dysfunctional states. Hence it is worth noting that not all families are functional, stable and healthy. Disorganization of intra-familial relationships causes destabilization, and such family falls into the category of troubled and dysfunctional family (Astoyants & Kovalev, 2016). Many families fail to provide their children's emotional, spiritual, moral, psychological and material needs and this contributes to family dysfunction. Parents are supposed to participate actively in the education of their children. But unfortunately some parents have little or no time for their children. They tend to relegate their duties to teachers in the school. Relegation of duties to teachers in the school have both their positive and negative effects on the children and the entire family. Moreover, poor couple relationship contributes to family dysfunction. It affects negatively the relationships among the family members. Children get traumatized when their parents display some marital discord/conflicts. Research shows that family conflicts may increase

the likelihood of children committing at-risk behaviors which influence the relational pattern of the family (Borst, 2015).

Some children are not taught moral behaviors at home. Some of them even as adolescents already engage themselves in unhealthy friendships with same sex or opposite sex. Research has shown that a significant number of youths and adolescents experience premarital sex (Noroozi *et al*, 2014). Sometimes these children are sexually and physically abused and molested by their care takers or relations living with them. The trauma from such abuses remains in the child hindering her full spiritual and psychological maturity throughout life. Some have joined different cults and secret societies. Some are addicted to chemical substances (Marshall, 2014). These negative experiences haunt these children and impact negatively on them and their families. There is a moral decadence because children are informed of their values no longer by their parents or the Church rather from media. Families that raise such children are dysfunctional. Some therapeutic techniques (individual, family and group therapies) can be of immense help to such children.

In individual therapy, the therapist is working with one person alone. He is trying to focus on the problems of the person, trying to help the person face his fears, problems and difficulties (Nichols, Schwartz, 2006). Family therapy on the other hand aims at providing a therapeutic experience to two or more people at the same time, who may have differing expectations about therapy,

different goals, problems and different personalities (Lawrence, 2012). This type of therapy is not predicated merely on changing the individual person alone rather it exerts change on the entire family (Nichols, Schwartz, 2006). Family being a system, a change of one person exerts a synchronous change on the other person. Group therapy is a form of therapy which involves one or more therapists working with several people at the same time. Those involved may meet once or twice a week. Group therapy treats cases like relational problems, panic attack, depression, anger problems, anxiety disorders, chronic stress, domestic violence etc. Group therapy can be categorized into different types (Cherry, 2021). The most common types are: First, cognitive behavioral groups which focus on identifying and changing inaccurate or distorted thinking patterns, emotional responses and behaviors. Second, interpersonal groups which centers on one's interpersonal relationships and social interactions and the impact these relationships have on one's mental health. Third, psychoeducational groups which focus on educating clients about their disorders and ways of coping with them. Fourth, skills development groups which center on improving social skills in people with mental disorders or developmental disabilities. Fifth, support groups which provide much benefits for people with a variety of mental health conditions. Children from dysfunctional families can benefit a lot from the above mentioned therapeutic techniques. At this juncture, an understanding of what dysfunctional family entails is very

crucial. That's the next topic to be treated below.

### **Dysfunctional Family**

Before we go into the meaning of dysfunctional family, it is pertinent to understand first what we mean when we say that a family is functional. There is a notable difference between functional and dysfunctional family. Functional family is synonymous with healthy or mature families. Functional family is one where healthy interpersonal relationships are nurtured and where problems are addressed rather than avoided. According to McGoldrick *et al* (2011), healthy family is able to reorganize and re-stabilize themselves in response to the pressure imposed by crisis. It is a model and ideal family where the needs of the children are met. Here there is love and respect among the family members (Hunt, 2001). Parents remain the role model for their children and the children obey their parents. In the healthy/functional family the members speak directly to one another about their perceptions, feelings, thoughts, dissatisfactions and needs. They are not afraid of airing their views. Here, the spiritual, emotional, and psychological growth of the members are cultivated and nurtured. The members place their trust and confidence in God. They face problematic situations with confidence in God and with support from the family members. The tendency of breaking down psychologically is very lean in a functional family because there is joy and understanding among the family members. Everyone feels at home with each other. There is respect

for individual differences and autonomy in functional family. Here, the couple relationship is characterized by mutual respect, support, equitable sharing of power and responsibilities (Ritvo & Glick, 2002).

Dysfunctional family is synonymous with unhealthy and immature family. According to Hunt (2001), dysfunctional family systems are characterized by these eight dominant traits: chaos, control, denial, inconsistency, indifference, instability, shame and unpredictability. The members of dysfunctional families adopt maladaptive coping mechanisms in dealing with everyday problems. The members are impaired emotionally, psychologically and spiritually. Thus members of a dysfunctional family can influence each other negatively. In such family, an improper and immature behaviour of at least one parent can damage the growth of the members of the family and the development of healthy relational skills among family members. Lack of peace and harmony among members are the characteristic factors in every dysfunctional family. In such family, it is very difficult to deal successfully with everyday stressors or nurture the growth of individual members. Such impairment is very detrimental to the growth of the children who must rely on the parents for support and survival. Dysfunctional family produces children who grow up to develop one psychological problem or the other. Serious academic problems and relational difficulties are areas such children are greatly affected. According to Ritvo and Glick (2002), if the

characteristic adaptive mechanisms are not available or fail to deal adequately with the situation, one or another family member may develop overt symptoms. In other words, the underlying family disturbance needs to be treated for the development of the healthy mind. Below is a case study which depicts the dysfunctionality of a family.

### **CASE STUDY**

*This is a case study of a boy of fifteen years old called Martin. Martin was a student of JSS One (Junior Secondary School, class One) in one secondary school. He was living in a boarding school. Martin came from a very severe dysfunctional family where the father was a drunkard who abused alcohol. Martin's father was a commercial driver. He learnt to consume excessive alcohol when he started driving. He left home in the morning for work and came back in the evening drunk. He would stagger and speak off point each time he was entering the family. Though he was a driver, he hardly supported his family financially. He claimed that money was not forthcoming from his transportation business. However, each time he staggered into the house he demanded for richly prepared meal. He would instantly beat up the wife and children when his need for food was not immediately and spontaneously provided. He would scold the innocent mother of Martin, accusing her of laziness. Martin's mother would respond aggressively towards the husband and sometimes these aggressive behaviors ended up in exchange of blows. Martin and siblings would cry and go to bed*

*with pain after seeing both parents fighting. Sometimes his father would abuse the children verbally and punish them for no just cause. In some occasions, Martin's mother transferred her anger towards her children. Moreover, Martin was often sent away from school due to school fees because his father never accepted that he had any money. Martin came up to the age of reason seeing his family in this miserable and dysfunctional state. With time the atmosphere in the house became very hostile and unfriendly. The children learnt to respond aggressively towards each other since they consciously and unconsciously internalized their parent's aggressive outbursts as unique ways of expressing themselves and interacting with one another. This is a typical example of a dysfunctional family.*

### **Causes of Dysfunctional Family accruing from Martin's Case Study**

#### ***a. Excessive Alcohol Consumption by Martin's Father***

Martin's father's alcohol consumption contributed to the family dysfunction. His father was constantly under the influence of alcohol during which he was not in his right sense of mind to adequately manage himself and his family. His family members were often ashamed and depressed because of their father's excessive alcohol consumption.

#### ***b. Low Economy and Financial Problems***

Low economy and financial difficulties contributed to the dysfunctionality of

Martin's father. He was not able to meet up with the financial and material needs of his family because he spent most of his money in drinking. The family lacked their basic needs and this led to quarreling and misunderstanding.

#### ***c. Aggressive and Quarrelsome Family***

There was serious conflict between Martin's father and mother. This constant quarreling increased the dysfunctionality of the family. The presence of Martin's aggressive father in the family influences negatively the relational pattern of the members. Martin's father would beat up his wife and children. The aggressive nature of Martin's family was very infectious that the children learnt to relate with each other with a lot of anger. In few occasions, Martin's mother transferred her anger to her children.

#### ***d. Punishment and Emotional Abuse***

Constant abuse and unjust punishment can lead to family dysfunction. Martin and his siblings received undeserved punishment and abuses from their father. Sometimes their mother transferred the same abuse on them especially when she was overwhelmed by her husband negative and immature behaviors.

#### ***e. Individualism and Poor Relationship***

Ideal family members live together and do some things together. The poor relational pattern in Martin's family led to serious family dysfunction. The father had no good relationship with his family. With the relationship among the family members became sour.

## **The Influence of Dysfunctional Family Background**

The parent-child relationship is the building block for individual and relational health. Views of oneself and expectations for relationships are born from early caretaker relationships. While the parent-child relationship is pivotal for early development, the couple subsystem provides fertile ground for testing and revising views of oneself, relationships and the larger world (Dunham, Dermer, Carlson, 2011). One of the things that is evidenced in dysfunctional family is poor relationship among the members of the family. Instead of loving and cordial relationships, members develop deep aggression toward the parents or towards themselves. Through modeling of aggression in the spousal or parental relationship, children come to incorporate aggression into their relationships with others. Thus the children are aggressively predisposed. They feel that life is to be lived in anger and that they get their needs through aggressive outbursts. They feel they have to assert themselves in anger. In other words, in whichever social context and environment they find themselves they try to reflect what they learnt from their family. Their Aggressive impulses affect their relationship with others wherever they go.

### **The Negative Influence of Dysfunctional Family Background on Martin**

#### **a. Anger outburst**

Martin was always seen angry with a very stern look. He had difficulty

regulating his emotions and aggressive impulses. He engaged often in quarreling and fighting with his peers both in school and outside school. He responded harshly to people even when others approached him with friendliness. Martin was sometimes depressed and in such moments he engaged in some self-destructive behaviors like cutting himself or burning himself. He hated himself and projected this hatred towards others and as a result he easily initiated interpersonal conflicts.

#### **b. Poor Relationship**

Martin had great difficulty giving and receiving affection because he didn't meet that in his family. For him, closeness meant pains as he saw between his parents and in his father's relationship with them. When Martin was in the social environments, he would be cold, withdrawing to himself. He found it difficult opening up to others because he feared that other's nearness meant aggression and bullying.

#### **c. Hypervigilance**

Martin developed some paranoid traits. He was often scared when he was around others. He easily scanned his environment in fear as if people were out to threaten or harm him. His relational ability was too poor that people started to avoid him and with that he confirmed that the outside world was hostile and unfriendly. Hence he became a loner and suspicious of other's intentions towards him. He was over sensitive and could notice problems easily even where there was none.

**d. Insubordination**

Martin had undiluted hatred for authority. This was because he felt that his parents who represented authority figures did not merit his love and obedience. He had no regard and respect for authority even in the school. He insulted his teachers and prefects at will and was often punished. The more he was punished the more he was hardened. He dominated his peers and bullied some of them who tried to near him.

**e. Academic Challenges**

In JSS One Martin was 15 years old and he was the oldest student in their class. Many of his class members were within the range of 9-10 years old. He repeated classes several times while in primary school. He found it difficult to comprehend simple things taught in class. He spoke poorly and his mathematical ability was too low. Though he was 15 years, he performed at below average intelligence.

**f. Amnesia**

Research has shown that dysfunctional families lead to a number of psychological disorders including anxiety, memory lapses, forgetfulness, fear, attention deficit, hyperactivity, mood disorder and substance abuse (Stien, Kendall, 2004). Martin suffered from disruption of cognitive capacities. He experienced serious forgetfulness and loss of memory. He was not able to retain the things he learnt in class. Inability to retain what was taught in class made it very difficult for him to pass his exams. Messages given to him

by teachers for his parents were often forgotten and never delivered.

**g. Low Self-Image**

His self-concept and self-image were very low. He didn't believe in himself and he felt very little before others though he tried to dominate others defensively. He was not out to compete with his peers in terms of academics rather he competed with them in moments of aggressiveness. Low academic performance contributed to his depressive feelings and low sense of self.

**h. High Distractibility and Low Attention Span**

He lacked the ability to concentrate in class for a long time. In other words, his attention span was very short. He was easily distracted by little things. He found it difficult sitting and reading for long.

**Therapeutic Techniques used in Helping Martin**

From the case study of Martin above, it is crystal clear that children from dysfunctional families develop a lot of psychological problems, challenges and personality disorders (Mathews, 2020). Apparently, Martin exhibited some psychological difficulties and paranoid personality disorder. Martin went through individual, family and group therapies. These therapies took place at Mater Christi Human Development and Religious Formation Centre, Amawbia. This centre is a multi-purpose center with different departments like counselling centre department, music

department, family light of the nation department, catechetical department, skill acquisition department and youths animation department. However, the therapies were conducted in counselling centre department. This department has been in existence since December 13<sup>th</sup>, 2014. It is a centre where we assist clients/persons with different kinds of problems and disorders. We conduct psychological evaluation for lay persons, candidates in formation houses, priests and religious. We also organize family and group therapies. Most clients continue with therapy after the psychological evaluation while some others go with their psychological reports after the test.

Below are some therapeutic techniques that were employed in helping Martin:

**a. Individual Therapy**

Martin was engaged in individual therapy for about nine months. He came for therapy once in two weeks. In other words, he attended about 18 sessions. Initially Martin was resistant and defensive, lacking in openness. As time went on he relaxed and was open to engage in therapy. There was a good therapeutic alliance. The individual therapy helped him to be in touch with himself and his problems. Supportive and cognitive behavioral therapies were mostly used during the therapy sessions.

**b. Family Therapy**

The family of Martin was greatly wounded by their father's addiction and the consequent negative behaviors from other members of the family. The family therapy was proposed to them since the

family atmosphere influenced Martin a lot even as he went through individual therapy. It was a short term family therapy so that it could accommodate those who were working and going to school. The family therapy comprised of six people: Martin, his parents and three brothers of Martin. The family therapy lasted for a period of three months. The family was meeting once every week. In other words, the family had about twelve sessions. During the therapy sessions one therapist was involved. With the family therapy each person saw how dysfunctional their family has been. They also saw how each other's attitudes and behaviors influenced the behavior of the other. Thus each member of the family learned how to contribute positively to the rebuilding of the family. During the therapy sessions, there were moments of conflicts as a result of pointing accusing finger on others. However, the therapist was able to control the sessions so as to minimize the conflicts.

**c. Group Therapy**

Martin had overt relational difficulties. He often felt inferior whenever he was in any social environment. He could not relate adequately with others instead his relationships were marked with high aggression. In sum, he didn't know how to comport himself when he appeared in the group. He had to go through interpersonal group therapy from which he benefitted a lot. The group therapy lasted for a period of nine months. The group met once in two weeks. In other words, there were 18 sessions. The group therapy was scheduled the same

day he had his individual therapy but at different hours. Two female therapists were present during the group therapy. At the initial stage of the group therapy, Martin communicated very little due to timidity and low self-esteem. But as the therapy progressed, Martin was able to express himself in the public. He mastered courage to ask questions and he learnt how to relate with others. He was able to control his aggressive impulses during the sessions. He realized his interpersonal deficits and worked on himself.

The group was heterogenous in nature in the sense that it was made up of males and females with different problems and psychological difficulties. The participants of the group therapy were twelve in number, seven males and five females. Their age range was between 14-25 years. Three participants were in junior secondary school, two were in senior secondary school while five were in the university and two have finished university and are working class. Seven participants came from dysfunctional families while five of them came from functional families though with peculiar problems. Most of them were victims of emotional and sexual abuses who exhibited similar symptoms like that of Martin. Their general characteristic problems/symptoms were interpersonal deficits, poor impulse control/anger problems, avoidance/withdrawal syndrome, hypervigilance, suspicion, lack of trust, low self-image and poor academic performance. The language of the therapy was English though two participants mixed up both English and

Igbo languages as they expressed themselves.

### **The Result**

The result showed that after some definite number of months engaged in individual, family and group therapies, Martin showed great improvement. The combination of the three therapeutic techniques helped him a lot. Martin got more insight into his problems and the psychogenesis of his problems. His relationship with others improved greatly. He developed healthy and functional patterns of dealing with life. His anger outbursts reduced impressively. He could relate with others without much anger and projection. He developed good esteem of himself and was able to express himself before others. He learnt to be more attentive to the group without much distractions.

### **Conclusion**

Many factors lead to family dysfunctionality. Without systematic interventions resulting in changed behavior, dysfunctional behaviors will continue to beget dysfunctional behaviors. Applying some therapeutic methods or systematic interventions in helping such children and their families is of utmost importance. In dysfunctional families, the academic and relational aspects of the children are adversely affected to the extent that they relate poorly with others and do poorly in their academics. This was evidenced in the case of Martin. Helping Martin go through individual therapy helped him deal with his intrapsychic and interpersonal conflicts. Furthermore,

family therapy served a great deal because family being a system, everyone in the family is adversely affected because the relational pattern is a very toxic one. Interpersonal group therapy helped Martin learn to manage better his relationship with others since this aspect of himself was greatly damaged because of his dysfunctional family of origin. With the group therapy, Martin realized that he was not alone rather there were others with similar problems which he had. The insight he gained from group therapy hastened his healing, leading to healthier and adaptive behavioral patterns.

In order to curb the damaging effects of dysfunctional families, every family is encouraged to cultivate positive attitudes that encourage functional family styles. Families should be places of joy, harmony and peace instead of places of chaos and inconsistency. Parents are encouraged to ensure that their families remain functional, healthy and ideal. Not only the parents, children are encouraged to behave in consistent ways that promote good and healthy living. Families are advised to seek for therapy when they show traits of dysfunctionality instead of allowing the maladaptive patterns of behaviors to ruin the lives of the members. Finally, further research is needed to discover more therapeutic approaches that can be combined in helping children from dysfunctional families.

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## Gender Base Violence Behaviour: Interaction Between Psychological Operations And Psychotherapy Intervention In Africa

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### **Abstract**

*This study contributes to the understanding of the influence of violence against women in patriarchal cultural practices and its effect on the emotional, behavioral and psychosocial wellbeing of women. An increasing body of research demonstrates that negative family relationships can cause violence, stress, and impact on women's mental health or even contribute to physical symptoms related to psychosomatic syndrome. Many women do not say no to abusive relationships, because they live in prison of peril within their own homes in such a victimized behavior; while up till today nothing have seem to change their predicament. Sequel to this, women continue to be exposed with all sorts of violence in which they often don't know what to do or where to turn to as a result of the cultural practices which identify complete obedience to certain rights that gives men more power than women within their homes and society at large. **Results:** This study has brought about some revolutionary changes in the way women cope with the patriarchal practices in Africa such as dehumanization of their rights and privileges, multiple oppressions in family arrangement and reproductive right as well as access to healthcare. In addition, it is safe to assume that the law and health policy considers women's mental health to be a pivotal concern. In western part of the world women are observed to exercise their fundamental human rights than their counter parts in Africa. But in a society like Africa where male-centrism has dominated every aspect of the basic human needs. For at least two decades now, it has been widely observed that women in the patriarchal culture have significantly higher rates of psychological distress than African men. **Conclusion:** The relevance of psychotherapy in this study will establish the linkage of violence by identifying the risk behavior in women population and target psychotherapy model of intervention, for women exposed to violence. Advocacy on a change of behavior on the way women maintain their psychosocial well being and being able to interpret and relate to the persistent patriarchal practices in Africa. The need here is the implications for psychotherapy in addressing and rebuilding sustainable mental health in the aftermath of violence on women.*

**Key words:** *Patriarchal practice, violence on women, psychosocial well-being and psychotherapy*

### **Introduction**

The trajectory usage of psychotherapy cannot be over emphasized when we look at patients centered approach. psychotherapy is used today for a variety of treatment related to the elimination of people's pain and suffering. The intervention serves for multi purposes across cultures including: addiction, oppression, pain/guilt, anxiety, grieving coping with loss and depression. (Madu, 2021) in his unpublished lectures note stated that psychotherapy provides varieties of purposes, it involves reaching out and working with patients as well as victims in their conditions. The intervention mainly is to eliminate pain as reduction of harm and control. It addresses clinical issues related to existential problems into psychotherapy while promoting a positive psychology of meaning towards life. (Victor F,1946) in his work logotherapy assert that the primary motivational force of an individual is to find a meaning in life, his analytical ideas in developing a positive attitude to personal experiences associated with trauma is an encouragement to share such as multiple cases off gender-based violence in sub haram African.

Women are known to play vital roles as mothers, producers, managers, community organizers etc. and they constitute about half of the population of the Nigerian State. Their contribution to the social and economic development of societies cannot be over emphasized because of their dual roles in the

productive and reproductive spheres. Yet their participation in formal and informal structures and processes, where decisions making are made as regarding the use of societal resources generated by both men and women are made, remains insignificant. The Nigerian society has been patriarchal in nature which is a major feature of a traditional society (Aina, 1998). According to (Stacey 1993; Kramarae 1992; Lerner 1986). It is a structure of set of social relations with material base which enables men to dominate women and also a system of social stratification and differentiation on the basis of sex, which provides material advantages to males while simultaneously placing severe constraints on the roles and activities of females. The patriarchal society is a men's world, where men set the parameters for women's structurally unequal position in families and markets by condoning gender-differential terms in inheritance rights and legal adulthood, by tacitly condoning domestic and sexual violence and sanctioning differential wages for equal or comparable work. Tradition, culture and religion for centuries has entrenched male domination into the structure of social organization and institution at all levels of leadership in the Africa community. Patriarchy justifies the marginalization of women in education, economy, labor market, politics, business, family, domestic matters and inheritance (Salaam, 2003). Also, this culture of patriarchy is a very strong

determinant of male dominance over female and as a result, man will not only sit back in the family to keep the family name and lineage growing while women will be married out, they are also favored in various aspect of the societal structure. Women are often regarded as a second Fidel and their voice must not be heard.

Nigerian society still held bounds with outdated beliefs, which portrays women as insignificant and a weaker group who are relegated to inferior background, without regards to their mental capacity and educational competencies, they are often subjugated to various forms of abuse. Evidently, Nigerian women are not only increasingly being marginalized from advancing in their career life. The rights of women have remained downplayed, with no direct positive impact on the living conditions of the average Nigerian woman. This paper addresses and examines an under-researched aspect of patriarchy and gender-based marginalization and violence, the Nigerian women experience. Broadly, the Nigerian woman is continually at a lesser par and treated unequally when compared to her foreign counterparts in some other nations where the rights of women are enforced. More often than not culture is usually the justification wielded for the denial of women's right and the perpetuation of gender marginalization in Nigeria. Some of these harmful cultural practices pervasively promotes the crimes against the Nigerian women and they include the female genital mutilation (FGM), domestic violence, child brides or forced

marriages, rape, denial of inheritance and many other cases of abuse against women (Mukumu, 2015)

Thus, men are being trained for leadership activities while women are confined to domestic activities; roles are ascribed to them by culture which affect them later in life, thereby making them to lose self-confident/worth and have low self- esteem in their career in adult life and politics inclusive. Despite the pronounced commitment of the international community to gender equality and to the bridging the gender gap in the formal political arena, reinforced by the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW). CEDAW articles (1979), therefore, acknowledge that whatever socio-cultural norms that deny women equal rights with men will also render women more vulnerable to physical, sexual and mental abuse and the Beijing Platform of Action, women are highly marginalized and are poorly represented in social, political and economic activities. (UNDP Report, 2005). The paper examines persistent patriarchy practices and its effect on violence against women and psychosocial well being

### **Patriarchy**

The word "patriarchy" in the past two decades has been used to analyze the origins and conditions of men's oppression of women (Kamarae, 1992). It was originally used to describe the power the head of household wield as a father. The term 'patriarchy' has been used by feminism to refer to the

systematic organization of male supremacy and female subordination (Kamarae, 1992; Stacey, 1993; Aina, 1998; etc.). The term has been defined as a system of male authority which oppresses women through its social, political and economic institutions. Feminist theorists have argued that in any of the historical forms that patriarchal society system takes, whether it is feudal, capitalist or socialist, a sex. The feminist characterize patriarchy as an unjust social system that is oppressive to women. As feminist and political theorist Carole Pateman writes, "The patriarchal construction of the difference between masculinity and femininity is the political difference between freedom and subjection." (Carole 1988). In feminist theory, the concept of patriarchy often includes all the social mechanisms that reproduce and exert male dominance over women. Feminist theory typically characterizes patriarchy as a social construction, which can be overcome by revealing and critically analyzing its manifestations (Ann, 2001). Okpe, (2005) submits that patriarchy is a broad network or system of hierarchical organization that cuts across political, economic, social, religion, cultural, industrial and financial spheres, under which the overwhelming number of upper positions in society are either occupied, controlled and dominated by men. Thus, any system that operationalizes an order that accords men undue advantage over women is considered patriarchal. It is observed in the literature that the establishment and practice of male dominance over women and children, is a historic process formed

by men and women, with the patriarchal family serving as a basic unit of organization. A patriarchy is considered the head of the household and within the family he controls productive resources, labor force, and reproductive capacities based on the notions of superiority and inferiority and legitimized by differences in gender and generation.

Thinking of the masculine as superior to the feminine is one of the foundations of gender inequality, or patriarchy. Patriarchal masculinities are a term that can be used to describe those ideas about and practices of masculinity that emphasize the superiority of masculinity over femininity and the authority of men over women. Ideas about and practices of patriarchal masculinities maintain gender inequalities. Violence against girls and women is maintained by ideas about practices of patriarchal masculinities. Violence is used, mostly by men but sometimes by other women, to keep girls and women in their position of having less economic, political and social power than men. When women try to assert their claims to such power, or get involved in protests over economic and political rights, they are often attacked verbally and physically, and because to be female in most societies, is treated as being weaker and lesser than the masculine, and are seen as being 'naturally' vulnerable to male violence, and thus in need of male protection. These ideas about feminine weakness/vulnerability and masculine strength/protection expose girls and women to more violence and reinforce the belief in masculine superiority which

is central to patriarchal masculinities. The amount of violence that follows from this is truly staggering. Globally, the World Health Organization, (2016) reports that 35 percent of women have experienced either intimate partner violence or non-partner sexual violence in their lifetime. Statistics for emotional and psychological interpersonal violence are equally as shocking.

### **Patriarchy and Domestic Violence**

In spite of significant attention given to the topic of domestic violence in Nigeria and some part of the western world in recent years, evidenced particularly by the Violence Against Women's Act enacted in 1994, says that domestic violence continues to be a massive problem with enormous individual and societal consequences. Clearly, it is pertinent that male violence against women creates more destructive consequences than female violence. First of all, male violence creates great fear, and as abuse researchers (Jacobson, N, & Gottman, J., 1998) note, "fear is the force that provides battering with its power" and injuries in turn help sustain the fear. Secondly, due to males' physical (and often social) superiority, male violence against women creates enormous long-term physical and psychological consequences, far more so than female violence. In terms of prevalence, various studies show that most women in Nigeria will be assaulted by not only their intimate partner in their lifetime, but all male member within the community. Patriarchy is the ultimate cause of all abuse against women. It has only been in the past few decades that

domestic violence has been studied in detail. During this period of early modern feminism, the perspective developed that patriarchy, in any and all forms, is the ultimate cause of all abuse against women, for patriarchy is seen as the overarching social construct which ultimately engenders abuse. Typically, violence against women is explained in terms of a power struggle, for the argument that in a patriarchal society those with all the power—males—must resort to violence when their position of dominance is threatened. Also, Cynthia Ezell maintains: Patriarchy is not responsible for an individual husband's violent action toward his wife. It does, however, create an environment ripe for abuse. A weakened immune system does not create the virus that leads to deadly infection, but it provides the environment in which the virus can thrive and do its killing. Patriarchal beliefs weaken the marital system so that the deadly virus of violence can gain a stronghold. While the feminist model has been critical in explaining violence against women, particularly in cultures in which women truly have no power and experience global inequity, women in the western world have far more power than they did a few decades ago, suggesting that there are other factors at play. (Karel K., & Jacqueline L. P., 2003). More recent research on domestic violence also militates against the simplistic feminist assertion that patriarchy is the ultimate cause of all violence against women. There is a growing consensus that no single factor explains men's violence against women; it is multifactorial with many different

and often overlapping causes. [Michele H., & James M., 1999] While some of these factors are undoubtedly influenced and aggravated by various forms of patriarchy, several of these factors transcend them. For example, researchers note that there is biological (differences in brain structure, brain functioning, and hormones), intrapsychic (personality disorders, attachment disorders), (Donald G. D., *et al.* 1999) and social construct (childhood experiences of violence) factors in men's violence against women. Some feminist scholars are quick to dismiss other explanations for domestic violence in favor of their global indictment of men and patriarchy. Michele Bograd, for instance, argues: "the widespread prevalence of wife abuse suggests that it may be more a function of the normal psychological and behavioral patterns of most men than the aberrant actions of very few husbands.[ Joe H., & Grant T. H., 2005] Perhaps the most powerful refutation of the feminist thesis that patriarchy is the underlying cause of all abuse of women is the consensus of several studies in the past decade which assess religion, gender views, and domestic violence. While relatively few studies have been conducted which specifically assess the relationship between religion, patriarchal beliefs, and abuse, most of the studies that have been conducted do not support the global feminist hypothesis.

Patriarchy as a significant contributing factor in most domestic violence. Having noted the weakness of the feminist assertion that patriarchy is the root cause of all violence against

women, it is essential that we recognize legitimate feminist findings. While patriarchy may not be the overarching cause of all abuse, it is an enormously significant factor, because in traditional patriarchy males have a disproportionate share of power and women are left as subordinate. Although some of the view that, domestic violence is the abuse of male physical and often social/religious power and that Abusive males are characteristically insecure and have a low sense of self-esteem. Most feminist has repeatedly demonstrated that patriarchy (male authority and power over females) has provided the foundation for male domination and often abuse. This is clearly evident in our cultures, and in spite of the feminist revolution of the late twentieth century, patriarchy-inspired abuse against women continues on to the present. It's obvious all around us how the women are enduring because of what the society will say when a woman boldly leaves her marriage because she can no longer cope. Most times they decide to stay and endure the abuse because of the stigma of being called "Tokubon" i.e., second hand". A final line of evidence that patriarchy contributes to much physical abuse of women is found in the characteristics of male batterers. The culture has a way of covering up for the male weakness, literature on abusive men repeatedly notes that a primary characteristic of abusive men is a sense of entitlement and superiority over their wives and children, quite possibly because of their own insecurities and need for power and control. (Lundy B, 2002). A husband's sense of superiority

over his wife will often lend itself to the development of rigid patriarchal views. Mary Nomme Russell states: The belief in the superior self, with the man being dominant in an inherently hierarchical relationship, was one of the fundamental aspects of abusive men's belief systems. Competitiveness, an intrinsic part of male socialization, is reflected in abusive relationships in the assumption that positions in the relationship are defined by who is greater and lesser. For abusive men, retaining dominance and superiority were essential in their relationships with their intimate partners. Challenges to dominance by partners were viewed as insurrections requiring coercive action. (Mary N.R., 1995)

### **Psychotherapy as a Useful Tool in Influencing the Development of Mental Wellness among Women in Patriarchal Environment**

Psychotherapy refers to a range of treatments that will help facilitate the resolution of mental health problems, emotional challenges, and some psychiatric disorders among many others (Grohol, 2019). Hence, it is an interactive mutual alliance between the therapist and client aimed at helping the client change some behavioral patterns. Some of the major objectives of psychotherapy will be to help the women reflect and improve his/her wellbeing and mental health, and to help them to resolve troublesome behaviors as a result of years of repression of their right, erroneous beliefs, compulsions, thoughts, or emotions, and to improve relationships of significant order and to

have good social skills (Campbell, Norcross, Vasquez & Kaslow, 2013). According to Madu (2016), psychotherapy helps an individual to regain emotional resilience and to deal effectively with trauma. In this regard, Okpalaenwe (2017) reporting the findings of a research study conducted to explore African psychotherapeutic methods stated that the mere act of storytelling in the folktales is a viable therapeutic process that have enabled African resolve some psychological problem. Hence, cultural resources are viable means of psychotherapeutic processes leading to everyday care and healing practices, therefore, should be integrated into daily life experiences. However, there are over a thousand different psychotherapy techniques, some being minor variations, while others are based on more complex conceptions of psychology including ethics (codes of conduct) and techniques. Be that as may, psychotherapy involves one-to-one sessions, between client and therapist, though some are conducted with groups, including families, thus, it is admirable that everyone accesses psychotherapy as means of living well. Correspondingly, this paper emphasizes that meaningful engagement with psychotherapy provides individual with the necessary skills needed to resolves small and big problems of life. The argument is that there is no borderline of problem/concern that psychotherapy would not be able to address. Psychotherapy focuses on helping people to attain wellness, which cannot happen in isolation since the human

person is a social being. Hence, there is need to reach out to family members and friends of people who undergo psychotherapeutic sessions so as to help them through their interactions to attain total wellness. That is to say, women who need psychotherapy for one reason or the other need their families and friends' assistance in order to live a fulfilled life.

### **Gender-Based Violence and Psychological Oppression:**

#### ***Relevance of psychotherapy in Sub-Saharan Africa***

Our emphasis using the Relevance of Psychotherapy here is to appreciate the role Psychotherapy play with the victims of oppression / abuse in the case of helplessness and hopelessness condition. The optimal knowledge of therapeutic process with reference to PhD publication "All Alone", The Psychosocial condition of widows and childless women (Ezeakor, 2013) relating to Gender-based oppression and trauma life experiences in Africa. The book revealed that victims of abuse and oppressive life experiences speaks volume about their emotional problems, traumatic experiences and psychoanalytical symptoms of life threat. (Victor Frankel, 1946) in "Logotherapy" was able to raise the issue of meaning in his oppression where he came up with the experiences of some people crushed by oppression, that they lose meaning or they are unable to find meaning in life and so are not able to fully develop as a whole person, as a result of insecurity (fear of the unknown).

(Freud 1949., & Pert 1969), thought that unresolved life trauma prevents the person from developing to their full potential. This shows that psychological oppression associated with Gender-based violence, which is a form of trauma, can prevent people from finding or searching for a meaning to life. (Frankel.,1959) thought change would occur when counsellors, Psychologists or Therapists help victims (clients) awaken and connect with their human spirit bringing healing that enables the inner wound find solace, hope and meaning in life. (Freud's 1949) Psychodynamic speaks of freeing the mind of suppressed memories in order to free people of their trauma. This freeing of the mind or self-peace can now lead to Clients finding meaning in their experiences and in their lives. Psychotherapy's emphasis on part of overcoming undesirable life experience is to the collective experiences and any feelings of inferiority arising from the traumatic experiences as a springboard to self-determination as well as self-fulfillment. This fulfillment would help clients (Victims) of oppression and trauma re-establish or create meaning in their lives despite their oppressive experiences. People can also be motivated by hope and courage. Without hope and courage would people try to overcome their negative life experiences, search for meshing, or even be interested in life?

### **The Reference of Therapeutic Process**

The outward expression of thoughts and feeling can help the victims of oppression make sense of their

experience and find meaning in their experiences and meaning in their life. The Counsellor as well as Therapist would help victims explore oppressive or traumatic life experiences and the feelings around those experiences. Working through the experiences will help victims find meaning. Catharsis and Self-exploration are the ventilation of thoughts, feelings and experiences through narrative/storyline and regression which allows the Victim to relive the experience to help victims work through their trauma.

### **Group Process**

The Counsellor or Therapist would also use group therapy as part of the therapeutic process for victims that experienced Gender-based oppression or trauma. The Group can find meaning in their experiences together so two levels of meaning can be utilized, the meaning the individual realizes and a group meaning.

### **Conclusively**

Psychotherapy makes available a space for reflection, healing, growth, strengthens coping mechanisms and creates awareness that Human development generally takes time, sometimes quite long. The end result of a good Therapeutic process is the positive outlook of and on the individual's life. The Therapeutic Process liberates individuals and the indigenous community from trauma and oppression. Therapeutic Process facilitates decision making, enables establishing and maintaining relationships with the society,

developing coping mechanisms, self-actualization and self-development in the individual.

The Group process makes room for not only companionship, warming atmosphere and empathy in terms of experiences but also is insightful to partaking individuals (victims), helping them express themselves and exposing to them new perspectives and new options. The Group process is an empowerment methodology (Carroll, Bates or Johnson, 1997). Group process often times than not, help individuals gain insight to their strengths, develop better understanding of themselves, others (members of the group) and in some cases, their oppressors or abusers (Gazda, 1989; kottler, 1997). The Group process is beneficial to The Oppressors as well as the oppressed who may at advanced levels, find themselves in A group; as they find a new meaning and new perspectives in their journey through and to life changing, stronger and positively developing personalities as well as healthier cognition.

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# Problems Of Expression And Control Of Sexual Activities Of Adolescents In Our Contemporary Society

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## **Abstract**

*Adolescent sexual activities have long motivated a long standing interest for its study. This interest was intensified by the psycho-social variables as well as moral problems associated with it. This paper, therefore, aimed at exploring those problems that emanates from the expression and control of adolescent sexual activities. It also examined theories of adolescent sexual activities in order to explain the causes and appropriate intervention technique for its' amelioration. The problems of adolescents sexual activities include contamination of sexual trees diseases especially the dreaded HIV/AIDS as well as other health related problems such as pregnancy complications, tear of the rectum, death of the feotus or the mother. It also involves cultural, legal, as well as religious implications.*

**Key words:** *Expression, control, sexual activities, and contemporary society.*

## **Introduction**

One of the problems confronting Nigeria today is the increasing involvement of adolescents in many varieties of sexual activities that deviates from the accepted norm and/or has health-related complications especially on the physical and mental health of the adolescents. The increasing nature of this problem behavior has become a matter of public concern and effort to control it poses a great challenge to the government, parents, teachers and researchers

Despite Centuries of formal sexual regulation and cultural taboos, love making and sexual relationship has continued to be part of human

development and perpetuation of human species (Van de Perre 1985). Two major determinants of human sexuality are the inherited sexual response patterns that are means of reproduction of the individual genetic inheritance and the degree of restraints or other types of influences exerted on the individual in the expression of his or her sexuality. This expression of sexuality is more experienced at adolescence due to onset of puberty and its dramatic physical and physiological changes. (Bambra 1999). Throughout Africa and Nigeria in particular, data is accumulating suggesting a declining age of first sexual debut, increasing number of sexually

active adolescents, and high risky sexual behaviours (use of multiple sexual partners, commercial sex and poor use of contraceptives among adolescents) (Imrie *et al.* 2001). Furthermore, the dramatic spread of Human Immune Deficiency Syndromes and Acquired Immune Deficiency Syndromes (HIV/AIDS) in the 1980s especially among the adolescent population has revolutionized the interest in the problem of adolescents sexual activities. Sexual behavior is an important part of our lives. However, so many taboos and myths surround it and this makes it difficult to be dealt with in public, in a direct manner. In the past our culture condemns sex education as dirty and disgusting.

Freud however, broke this attitude in his psychoanalytic theory, which dealt with sex (libido) especially the infantile sexuality. According to him sexual disorders result from excessive suppression of sexual urge. Suppressed sexual impulses too insistent to be contained, force itself into devious channel and sometimes breakthrough in an overt aberrant behaviour. Nevertheless such knowledge was confined to clinical use until the contribution of Alfred Kinsey and his colleague (1953). He discovered that sexual disorders especially homosexuals is developmental disorder and fairly common in early childhood and adolescence. The findings were shocking, exciting, provocative, and controversial. His report, however, was criticized by sex researchers as being potentially biased, since it is based on self report questionnaires and interviews.

His research however provided the baseline data concerning the prevalence of certain sexual practices. Sex research took another form with the publication of William Masters and Virginia Johnson's 1966 Publication of human sexual response. These researchers observed the sexual behavior of volunteer subjects in the laboratory while their physiological response was monitored. According to their report, human sexual response could be described as a cycle with four phases; namely, excitement phase, plateau, orgasm and resolution phase. Though, the United State objected to this on the ground of morality, Masters and Johnson legitimized the scientific study of sexual behavior and dispelled the traditional myths and taboos that surrounded it.

Adolescence, generally referred to as a period between puberty and adulthood, is usually characterized by profound body changes due to hormonal influence, causing biological, physiological and morphological alterations. These body changes lead to progressive sexual impulses as well as initiation of early sexual activities among some adolescents. The early sexual intercourse is usually associated with higher number of sexual partners and consequently a higher risk of contracting many sexually transmitted diseases especially the Human Immune deficiency virus (HIV) and Acquired Immune Deficiency Syndromes (AIDS) (Cleland 1992). Most of the adolescents' sexual excesses and preferences sometimes deviates from the accepted pattern of a given society as well as mars the health of the individual and are

therefore labeled sexual-risk behaviours by the society. Every Society has values and norms that are peculiar to them and guide the conduct of its members. These norms and values, according to Deaclux (1997), are necessary for healthy growth and development of the society. Any lifestyle that deviates from the accepted norm is labeled abnormal behaviour.

### **Problems Adolescents Sexual Activities**

Though sexual activities are necessary for human growth, development and perpetuation of species, (Dormitzer & Gonzalez, 2004), when it deviates from the accepted pattern, it becomes detrimental to the individual and society. There is no doubt that with the apparent lower standard of morality in our contemporary society, sexual activities especially among the adolescent has been in the increase. The World health Organization, (WHO 1993) has said that Nigeria and six other countries account for half of the World's adolescent births. Again the Nigeria Demographic and Health Survey (NDHS 2008), reported that out of the 906 unmarried males and females interviewed, aged 15-19years, 36.2% has had sex before the interview. Although the Adolescents' sexual attitudes and practices vary from culture to culture, some commonalities stand out. Younger ones usually experiment with varieties of sexual preferences which can lead to many unwanted pregnancies. Furthermore, their bodies are not fully developed to go through the process of pregnancy and child birth without adverse health and social implications. Adolescent mothers face a

high risk of obstructed labour than Women in their twenties. According to the Centre for Disease Control and Prevention (CDC, 2003), without adequate obstetric care, adolescent pregnancy can lead to Uterine rupture and a high risk of death of the mother and infant or obstetric fistula, which is the tear between the virgina and the bladder or the rectum. This can cause urine or faeces to leak. Hence many adolescents in our modern society suffer from various complicated health-related problems resulting from early sexual activities. More than 15million new cases of people with sexually transmitted diseases are diagnosed every year and approximately 65% of these cases are diagnosed in people under the age of 24years (CDC, 2003) According to the Center for Diseases Control and Prevention (CDC, 2003), approximately 870,000 pregnancies occur each year among women of 15-19years old. Globally, 50 to 60% of sexually transmitted diseases are found among the 15 to 24-years age group, (Omotosho, 2003). No wonder, in Nigeria the first diagnosed case of HIV was specifically found in a 13-year old girl, (FMOHHS, 1992).

The term adolescence varies among scholars because of the varying levels of bio-social and economic development which influences puberty among individuals and societies. However, most scholars agree that adolescence is a transitional stage, between childhood and adulthood, precisely, between 13 and 20 years (Baruth, 1995). During this period, needs, desires, and activities change with

sexual maturation and intensification of heterosexual interest and concern. Adolescents' sexual motivation emerges from pubertal development and experiences resulting from environmental vicissitudes, somatic needs, and sensory drives. Sexuality, therefore, is the focus of many teenagers (Ibeagha, 1999) and constitute an adolescents' way of coping with the psychological, and environmental stresses of life. (VanDyk, 2001). Adolescents who yield to irresistible sexual impulses and acting on the spur of the moment are usually sexually at risk. They are controlled by a compulsion and may be victim of unconscious processes. According to theories of sexual behaviour, adolescents' sexual activities also co-occur with delinquency, alcohol and other drug use. Problem sexual behaviour theory also assert that it co-vary with parent's income, poor school performance, occupational status and socio-psychological variables like motivation, belief, and peer influence.

The conceptual development of human sexuality and love making dates back to the second Century B.C, however the scientific study of human sexuality began around 19<sup>th</sup> Century, during the Victoria Age (Bryant, 1967). According to Bryant, sex is conceived as holy, being the creation and gift of God, which is only fulfilled as regulated by the law of God in marriage. According to this assertion, sex is an exclusive privilege of married adults. Any deviation from that is referred to as sexual-risk behaviour. Many scholars, however, oppose this point of view. For

example, many intellectuals, philosophers, religious leaders, and law maker have long debated the exact conception or parameters to evaluate sexual practices that can be labeled sexual-risk behaviour, (Nagel, 1990). According to Nagel, many Catholic and protestant scholars conceive sexual-risk behaviour as a cause and symptoms of the decaying society's moral standard. Yet, other scholars argued that sexual-risk behaviour is an intrinsic evolution of social groups. According to this school of thought, the co-evolution of genes and knowledge lead to a proportion of the population being sexually deviant, (Faucauty, 2000).

Nevertheless, most scholars agree that sexual-risk behaviour is a difficult concept to define or conceive accurately. They therefore, opined that it will be conceived and defined from an individual's own perception, experience, moral and cultural orientation. What constitutes unacceptable sexual behavior varies between societies and within society, over time. Issues relating to gender, age, relationship, aggression, the definition of consent and location, all influence whether a particular sexual act is considered legal or illegal (Agafanova, 1999). Sexual abstinence by adolescents and sexual intercourse between two mutually monogamous and uninfected partners are usually the only normal sexual relationship in many cultures (CDC, 2002). Other practices such as voyeurism, self masturbation, touching, massaging, hugging and use of sexual toys by adolescents are also labeled sexual risk-behaviour by some scholars. There is also a long debate on

the preponderance of sexual activities among male and female adolescence.

Gender differences in sexual risk-behaviour have been widely researched in the field of psychology. Adolescents have been found to differ in their sexual attitude, beliefs and practices (Oliver 1993) and premarital sexual permissiveness. Studies have shown that male and female adolescents engage in pre-marital sexual intercourse with preponderance occurrence in female (Cleland 1992). However Clement and Kruse (1994) asserted that the traditional male - female differences in early sexual experiences had disappeared and females were at least as likely as male to engage in sexual relationships. Among secondary adolescents both sexes practice love making though male - female differences are evident in other respect (Hope, 1985). However analysts have commented on differences in expectations and values regarding male and female sexual behaviour. For example, in many societies, it is excusable for male to become sexually active at a significantly earlier age than female (Meeker, 1994).

### **Psychotherapeutic Approach to the Problems**

Despite the social and legal consequences of these sexual excesses, as well as the human and material resources employed by the government, to curtail it, there has been an alarming increase in sexual activities especially among the adolescents. Nevertheless, the identification of the psychological

undertone of the sexual-risk behavior and the discovery that behavior change is possible through behavior intervention has become imperative for Prevention and reduction of the problem adolescent sexual behavior (Trull & Phares, 2001). Although Intervention programmes targeting at adolescent sexual-risk behaviours have been developed, empirically validated intervention programmes in settings specific to the youth have not received adequate attention. For most adolescents attend schools and the venue offers opportunity for understanding and modifying sexual-risk behavior among adolescence. Again many intervention programmes provide general information on health rather than specific sexual-risk reduction approaches like refusal skills, abstinence and correct condom use. Those programmes also lack evaluation designs to assess the impact of their programmes. Again the study outcomes have not shown enough clearly successful impart of those programmes. Most of them lack theoretical basis, operational model, scientific design and evaluations. Sex education, as at present, increases knowledge of human sexuality, with little or no proof of the extent to which the programmes have reduced sexual-risk behavior. The school based guidance and counseling, provide comprehensive information about career choice for adolescents, but not necessarily adolescent sexual behaviour.

Furthermore, in responding to the above flaws in the strategies for preventing sexual-risk behaviour, the American Psychological Association (APA) recently passed a resolution

promoting empirically behaviour intervention programmes. In consonance with the APA (2000) resolution, the behaviour intervention programme, that will be used in controlling adolescents' sexual activities, should be in corporate a more focused behavioural-skills acquisition technique. This has been proved effective in treating sexual deviants, postponing sexual involvement and reducing sexual-risk behaviour. For example, Durlak and Wells (1997) discovered meaningful positive effects in increasing competencies across a number of affective/emotional, cognitive, academic, and behaviour domain, with adolescents.

There is, therefore, the need for a study that incorporates Behaviour intervention programme that will specifically address these issues as well as social skills acquisition as prevention strategies. Such preventive Psychological intervention will focus not only in curbing the sexual-risk behaviour and its resultant health hazards but prevent its occurrence. Although medications that can lengthen the life span of victims of such sexual transmitted diseases like the HIV/AIDS infections are available, a more lasting solution is possible through Behaviour intervention (Frenado & Feras, 2000). According to Farrington (1991), two Types of behavior intervention techniques that have been found to be effective in prevention and control of sexual-risk behaviour are assertive training and self-control procedures. These two behaviour technique, enable clients to communicates their feelings and rights to others so as to derive

maximum reinforcement, (Walker1988). These intervention techniques help adolescents to manage their feelings and emotions and remain focused under distressing conditions (Jaarsveld, 2004).

These two behaviour intervention techniques (Assertive training and Self-control procedures) are also skill-acquisition-oriented programme that incorporate the traditional information approach of sex education with social skills building activities (Idahosa, 1999). These are active rather than passive strategies that help adolescents to personalize sexual issues and develop specific negotiation, sexual impulse control and assertive refusal skills in relation to sexual relationship. It also emphasizes the dual message of first, adolescents should abstain from sex but if and when sexually active they should use effective contraception. Research evidence has shown that the dual message of encouraging adolescents to delay intercourse, but to use contraceptive if and when they have sex, is more effective than the approaches that focus solely on abstinence or solely on contraception (Olley, 2003).

### **Conclusion and Recommendations**

The discovery that adolescents sexual activities has some psychological undertone makes psychological intervention imperative. This is because the increasing nature of adolescents sexual activities has become worrisome and demands pragmatic psychological intervention. Strategies. The intervention strategies include teaching the adolescents how to resist peer and media pressures, behaviour analysis and

rehearsal, modeling, role-playing and self-monitoring as well as sexual communicative skills. The government should therefore engage well trained psychologists and other helping professionals for controlling the expression of deviant sexual activities. She will also ensure that the films and Internet gadgets imported into this country are censored. The Non-governmental organisations should organize seminars as well as awareness, with the youth as the target audience. The church should intensify her teaching on moral instructions. The parents should be encouraged to pay more attention to the upbringing of their children and wards. The teaching of sex education should be made compulsory in all levels of education in Nigeria. When these measures are religiously followed, the expression of sexual activities among adolescents will definitely be controlled.

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# Role Of Religious Devotion And Marriage Duration On Sexual Dysfunction Among Married Women Within Jos Metropolis: Implications For Couple/Marital Therapy In Nigeria

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## **Abstract**

*The total of 137 married women participated in this cross-sectional study aimed at understanding the role of religious devotion and marriage duration on sexual dysfunction among married women, as well as its implications for couple/marital therapy in Nigeria. Participants were purposively selected. Findings of the study did not show significant association between religious devotion and sexual desire disorder, ( $\chi^2 = 2.184$ ,  $df = 1$ ,  $p = 0.109$ ). Also, significant association between marriage duration and sexual desire disorder was not found, ( $\chi^2 = 0.563$ ,  $df = 1$ ,  $p = 0.362$ ). However, significant association between religious devotion and female orgasmic disorder was found ( $\chi^2 = 12.714$ ,  $df = 1$ ,  $p = 0.0001$ ), with 24 participants that have high religious devotion and 8 that have low religious devotion having female orgasmic disorder. Finally, significant association between duration of marriage and female orgasmic disorder was found, ( $\chi^2 = 5.578$ ,  $df = 1$ ,  $p = 0.032$ ),*

*with 27 of those married 15 years and below and 5 of those married 16 years and above having female orgasmic disorder. The authors conclude that the role of religious devotion and marriage duration on female sexual desire disorder is unclear. However, religious devotion and duration of marriage predispose married women to having female orgasmic disorder. Therefore, it is recommended, that women's sexual functioning is an important area to consider during premarital counseling. Couple/marital therapist should diversify in addressing sexual issues with emphasis on issues relating to religion such as religious devotion, attitudes and beliefs and challenges associated with early years of marriage such as inexperienced sexual relationship.*

**Key words:** *Religious Devotion, Marriage Duration, Sexual Dysfunction, Married Women, Jos Metropolis, Couple/Marital Therapy.*

### **Introduction**

Generally, the prevalence of sexual dysfunction is on the increase, many factors are identified as the causative factors of sexual dysfunction. In this present study, the authors are only interested in understanding the association between religious devotion (which has to do with an individual's commitment in religious activities) and marriage duration on female sexual desire and orgasmic disorder. Sexual dysfunction is silently destroying many marriages and leaving partners of sexual dysfunctional husbands and or wives in pains. According to Lauman, Paik, and Rosen (1999) the prevalence of sexual dysfunction in women is higher than that of males. Among expectant mothers in Jos South local government are of Plateau state Nigeria, Karuri, Balle and Saleh (2020) found the prevalence of 70% for sexual dysfunction. The overall prevalence of desire disorder was 20.0%, arousal disorder 25.0%, lubrication disorder, satisfaction disorder and orgasmic disorder has the prevalence of 32.5%, 22.4% and 27.5% respectively.

According to Lazarus (1978) most women attending treatment for orgasmic dysfunction with religious orthodoxy reported that during their early years of life, they came to regard sex as evil. Similarly, Heiman, Piccolo and Piccolo (1976) found a clinical relationship between religious orthodox and female orgasmic dysfunction. Many women do not have (or rarely experience) orgasms due to the fact that their attitudes about sex have been strongly influenced by the rigid religious environment in which they were brought up in. Analyzing the role of religious upbringing in relation to sexual arousal, satisfaction and orgasm, Maters and Johnson (1970); Daniluk and Browne (2008) discovered that sexual restriction and religious upbringing in western religion such as Christianity, Islam, Judaism, Catholicism and Protestantism suppress women's sexual pleasure and were related to sexual dysfunction. Furthermore, Maters, Johnson and Kolodny, (1986) discovered that a rigid religious background in childhood correlates with adults sexual dysfunction. Likewise, Simpson and

Ramberg, (1992) discovered a significant link between sexual dysfunction and highly religious upbringing.

In most cultures, the cultural influence of religion play a significant role in sexual attitudes (Blum, 2015). Leftkowitz, Gillen, Shearer and Boone, (2004) discovered that religious devotion and religion significantly predict sexual behaviour. No wonder, Cowden and Bradshaw (2007) reported that individual's attitude towards sex is impacted by their religious practices. Similarly, Higgins, Trussell, Moore and Davidson, (2010) discovered that low religious belief has been associated with greater sexual satisfaction. While, McFarland, Regnerus, and Uecker, (2011) did not find any significant difference in sexual satisfaction between religious and nonreligious couples. Individual's sexual thought, feeling, urges, fantasies and behaviours can be judge based on religious guidelines and standards (Burris, Smith & Carlson, 2009). Religious commitment among women is associated with decrease sexual activity, sexual guilt and inadequate sexual activity (Abbott, Harris, & Mollen, 2016). Abadi, Abera, Gebru, Brhane, and Medhin, (2013) discovered that religious belief is a significant predictor of sexual dysfunction. Furthermore, McCool-Myers, Theurich, Zuelke, Knuettel, and Apfelbacher, (2018), reported that consistently being religious is a significant risk factor of female sexual dysfunction. Among religious women, orgasm difficulty was experienced more compared to non-religious women

(Kontula, & Miettinen, 2016).Likewise, Muslim women like other women experience arousal, desire and orgasmic disorders (Rahman, 2018).In a cross-sectional study among women in Jos-North, Saleh, Oyakose, Talko, Balle, Job and Dabit (2021) discovered that religious devotion had significant effect on female orgasmic disorder, women that had low religious devotion had higher orgasmic disorder mean score compared to their counterparts with high religious devotion.

Among Nigerian ambulatory primary care setting patients high sexual dysfunction was found among married female adults (Adebusoye, Ogunbode, Owonokoko, Ogunbode, & Aimakhu, 2020). While, among women in North-East of Iran it was documented that females with longer duration of marriage had female sexual dysfunction (Jafarzadeh,Fazel, Dashti, Moshkani, Haghghi, Foji, & Kamalim, 2016). Similarly, Zainah, Nasir, Hashim, and Yusof, (2012) reported that sexual satisfaction reduced with increase in marriage duration. While among married couples, wives married between 13-18 years poses about 10 times significant risk of developing sexual dysfunction compared to those married 1-6 years (Amidu, Owiredu, Gyasi-Sarpong, Woode, & Quaye, 2011). In a systematic review of sexual dysfunction among reproductive age women, Alidost, Pakzad, Dolatian and Abdi (2021) reported that age, depression, increase duration of marriage, low education level and presence of disease were identified as high risk factors for sexual dysfunction. Maasoumi, Elsous,

Hussein, Taghizadeh, & Baloushah (2019) reported prevalence of 61% for female sexual dysfunction among married women in Gaza Strip, out of which 26.4% had desire disorder, 20.2% had arousal disorder, 18.4% had orgasm disorder. Furthermore, 6.7% had lubrication disorder while, 79% and 21.2% had pain and satisfaction disorder respectively. Polygamy, wife's age and job, intercourse frequency, husband's age and job, education, number of children, marital duration, abortion history and family planning methods did not have significant statistical association with female sexual dysfunction.

This present study is guided by "New View of women's sexual problem" theory, the theory rejects assertion that universally sexual experience has the following stages; desire, arousal and orgasm, the theory views sexual problem as medical and non-medical, disease as socially created labels and provides a person-centred conceptualization of sexual problems (Tiefer, 1996). According to The working Group on new view of women's sexual problem (2000) and Mitchell (2008) women's sexual problem can be caused by the following factors sociocultural, political or economic factors, partner and relationship factors, psychological factors and medical factors

### **Statement of the problem**

Women with female sexual interest/arousal disorder hardly desire sex and they find it difficult to be aroused, while those with female

orgasmic disorder partly enjoy sexual relation but they hardly attain orgasm. Sexual dysfunction is a silent killer of marital bliss among couples. Many couples are not satisfied with their marriage due to inadequate sexual satisfaction. However, most individuals suffering from sexual dysfunction are not aware that they have sexual dysfunction most especially among women. In this present study the sexual dysfunctions of interest are female sexual desire and orgasmic disorders respectively. Thus, this study aims at understanding the association of religious devotion and marriage duration on female sexual desire and female orgasmic disorders. Therefore it is hypothesized that;

1. There would be significant association between religious devotion and sexual desire disorder
2. Marriage duration would likely have significant association with sexual desire disorder
3. There would be significant association between religious devotion and female orgasmic disorder
4. Marriage duration would likely have significant association with female orgasmic disorder

### **Method**

#### **Design**

This study utilized cross-sectional design; participants of interest were purposively selected within Jos metropolis of Plateau state Nigeria.

## **Instruments of Data Collection**

### **Religious Affiliation Scale (RAS)**

Religious affiliation scale was design to measure religious devotion among Nigerians. The instrument has 21-items designed to assess the extent to which people indulge in religious activities (Omoluabi, 1995). Okunola (1995) reported the mean score of 26.7 and 35.04 for males and females respectively. Omoluabi (1995) reported test-retest reliability of .97, the scale has divergent validity coefficient of -.26 (Erinoso, 1996).

### **Female Sexual Function Index (FSFI)**

Female Sexual Function Index is a brief, self-report measure of female sexual function. Expert panel conducted the initial face validity testing of items of the questionnaire. Among 131 normal controls and 128 age-matched women suffering from female sexual arousal disorder, the authors Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, Ferguson, and D'aguson, (2000) identified 6-domain structure, desire, subjective arousal, lubrication, orgasm, satisfaction, and pain for the instrument based on a principal components analysis. In this present study only sexual desire and orgasm subscales were used for the purpose of the study. Rosen et al (2000) reported overall test-retest reliability coefficients of the individual scale ranged between  $r = 0.79$  to  $0.86$ . High internal consistency Cronbach's alpha of  $0.82$  and higher was reported.

## **Participants**

The total of 137 married women participated in this study. Mean age of participants is 30.07 with standard

deviation of 6.517. The minimum age of participants was 19 with maximum age of 49. Majority 113(82.5%) of the participants were Christians, only 24(17.5%) were Muslims. Fifteen (10.9%) of the participants indicate that they were sexually abused in the past compared to 122 (89.1) that were not abused sexually.

## **Procedure**

Data was collected within Jos metropolis of Plateau state Nigeria, only married women participated in this study. Participants were drawn from five (5) communities within Jos metropolis (Jos-Bukuru area). Only participants that consent to participate where included in the study, instrument of data collection was administered to participants of interest individually by five (5) of the researchers. Ethical guidelines for human participants in research were adhered to. Participants were purposively selected, only those that indicated that they were married at the time of data collection were included in the study, those that did not met the inclusion criteria were excluded.

## **Result**

### **Hypotheses testing**

#### **Hypothesis1:**

There would be significant association between religious devotion and sexual desire disorder.

**Table 1: Chi-square analysis for sexual desire disorder and religious devotion**

sexual desire disorder	Religious devotion			Chi-square ( $\chi^2$ )	Df	p-value
	Low religious devotion	High religious devotion	Total			
sexual desire disorder	65	53	118	2.184	1	0.109
Normal sexual desire	7	12	19			
Total	72	65	137			

Result of table 1 showed that there was no significant association between religious devotion and sexual desire disorder, ( $\chi^2 = 2.184$ ,  $df = 1$ ,  $p = 0.109$ ).

**Hypothesis2:**

Marriage duration would likely have significant association with sexual desire disorder

**Table 2: Chi-square analysis for sexual desire disorder and marriage duration**

Sexual desire disorder	Marriage duration			Chi-square ( $\chi^2$ )	Df	p-value
	Less than 15 years	More than 16 years	Total			
Sexual desire disorder	111	7	118	0.563	1	0.362
Normal sexual desire	17	2	19			
Total	128	9	137			

Result as shown on table 2 showed that there was no significant association between marriage duration and sexual desire disorder, ( $\chi^2 = 0.563$ ,  $df = 1$ ,  $p = 0.362$ ).

**Hypothesis 3:**

There would be significant association between religious devotion and female orgasmic disorder

**Table 3: Chi-square analysis for female orgasmic disorder and religious devotion**

Female orgasmic disorder	Religious devotion			Chi-square ( $\chi^2$ )	Df	p-value
	Low religious devotion	High religious devotion	Total			
Orgasmic disorder	8	24	32	12.714	1	0.0001
Normal orgasm	64	41	105			
Total	72	65	137			

Result as shown on table 3 revealed a significant association between religious devotion and female orgasmic disorder, with 24 participants that have high religious devotion and 8 that have low religious devotion having female orgasmic disorder, ( $\chi^2 = 12.714$ ,  $df = 1$ ,  $p = 0.0001$ ).

**Hypothesis 4:**

Marriage duration would likely have significant association with female orgasmic disorder

**Table 4: Chi-square analysis for marriage duration and female orgasmic disorder**

Female orgasmic disorder	Marriage duration			Chi-square ( $\chi^2$ )	df	p-value
	Less Than 15 Years	More than 16 Years	Total			
Orgasmic disorder	27	5	32	5.578	1	0.032
Normal orgasm	101	4	105			
Total	128	9	137			

Result of table 4 showed a significant association between marriage duration and female orgasmic disorder, with 27 of those married 15 years and below and 5 of those married 16 years and above having female orgasmic disorder, ( $\chi^2 = 5.578$ ,  $df = 1$ ,  $p = 0.032$ ).

**Discussion**

Findings of this study titled role of religious devotion and marriage duration on female sexual dysfunction among married women within Jos metropolis did not show significant association between religious devotion and sexual desire disorder. Similarly, McFarland *et al* (2011) reported that significant difference between religious and non-religious women was not found in relation to sexual satisfaction. Also, result of hypothesis two showed that marriage duration did not have significant association with sexual desire disorder. Similarly, among women in Gaza Strip, Maasoumi, (2019) reported

that marriage duration did not have significant statistical association with female sexual dysfunction. Findings of this study implies that being religious (religious devotion) and duration of marriage has no significant influence of married women’s sexual functioning in the area of sexual desire and orgasmic disorders respectively.

Findings of hypothesis three revealed a significant association between religious devotion and female orgasmic disorder, with majority of those that had high religious devotion having female orgasmic disorder compared to those with low religious devotion. This finding implies that high

religious devotion significantly associates with female orgasmic disorder. Similarly, Saleh *et al* (2021) found a significant effect of religious devotion on female orgasmic disorder. Also, Leftkowitz *et al* (2004) reported that religious devotion significantly predicts sexual behaviour. Furthermore, religious commitment and religious belief has been identified with decrease in sexual activity and sexual dysfunction (Abadi *et al* 2013; Abbott *et al*, 2016; McCool-Myers *et al* 2018). Finally, result of hypothesis four revealed a significant association between duration of marriage and female orgasmic disorder, with 27 of those married 15 years and below and 5 of those married 16 years and above having female orgasmic disorder. Findings of this study imply that early years of marriage predisposes married women to having female orgasmic disorder, possibly due to inexperience. Contrary to earlier literatures, Jafarzadeh *et al* (2016); Alidost (2021) reported that increase in marriage duration had significant effect on female sexual dysfunction. No wonder, Zainah, *et al* (2012) reported that sexual satisfaction reduced with increase in marriage duration. Amidu *et al* (2011) reported that women married between 13-18 years poses about 10 times risk of developing sexual dysfunction compared to those married 1-6 years. Thus, finding of this present study is an implication for clinical practice, there is need for psychotherapists, and clinicians to pay more attention to sexual dysfunction among women generally.

### **Implications for Couple/Marital Therapy**

Adequate sexual satisfaction can be heaven on earth while dysfunctional sexual relationship can be hell on earth for couples. Results of this study indicated that religious devotion and duration of marriage has significant effect on female orgasmic disorder. This implies that high religious devotion (commitment to religious activities or being religious) and duration of marriage (early years of marriage) predisposes women to being diagnosed with female orgasmic disorder. Thus, couple/marital therapist should diversify in addressing sexual issues with emphasis on issues relating to religion such as religious devotion, religious attitudes and beliefs and challenges associated with early years of marriage such as inexperienced sexual relationship. Furthermore, sexual related issues during pre and post marital counselling for intending couples and newly wedded couples should be an area of emphasis, considering that sex related issues is silent in most cases. There is need for couple/marital therapist to create more awareness to couples on sexual dysfunction and psychotherapy for those diagnosed with female orgasmic disorder should focus on sensate focus, sexual skill training and self-direct masturbation

This study has the following limitations, only women were included in this study, thus, the researchers recommend that men should be included in future study in order to understand how religious devotion and duration of marriage affects men's sexual

functioning. Also, only religious devotion and marriage duration were the independent variables in this study, therefore, future study should consider the role of more variables such as age, educational level, health status, parity, and polygamy among other possible factors that affects individuals sexual functioning.

### Conclusion

Role of religious devotion and marriage duration on female sexual desire is unclear. However, result of the study showed significant association between religious devotion, marriage duration and female orgasmic disorder. Thus, the authors conclude that religious devotion (being religious) and duration of marriage are predisposing factors for sexual dysfunction among married women. Therefore, it is recommended, that women's sexual functioning is an important area to consider during premarital counseling, and routine hospital visit, also, there is need for more awareness for sexual dysfunctions, considering that most women are dying in silence due to inadequate sexual satisfaction. Couple/marital therapist should diversify in addressing sexual issues with emphasis on issues relating to religion such as religious devotion, religious attitudes and beliefs and challenges associated with early years of marriage such as inexperienced sexual relationship. Couple/marital therapist should create more awareness to couples on sexual dysfunction and psychotherapy for those diagnosed with female orgasmic disorder should focus

on sensate focus, sexual skill training and self-direct masturbation.

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# The Relevance Of Rational Emotive Behavioural Therapy On The Reduction Of Crystal Methamphetamine (*Mkpuru Mmiri*) Use Among The Youth In Nigeria

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## **Abstract**

*It is clear that mkpuru mmiri (crystal methamphetamine) is a dangerously addictive substance and illegal. Misuse of mkpuru mmiri (crystal methamphetamine) among the youths in Nigeria has been observed to be hazardous and even deadly. This is because a large amount of dopamine remains in the brain cells synapses for long periods of time after use. The dopamine keeps the cells activated, allowing the user to experience the powerful feelings of euphoria. After a while, the user is unable to produce dopamine naturally and requires the drug to feel normal, needing larger doses to experience feelings of pleasure. Stopping suddenly does not cause a physical withdrawal, as with heroin. Instead, the person may feel extreme fatigue, mental depression, irritability, apathy, and disorientation which will warrant need for psychotherapeutic help. Consequently, Rational Emotive Behaviour Therapy (REBT) treatment becomes imperative for help, since it is known to be an action-oriented approach to treating a variety of cognitive, emotional and behavioral concerns. According to REBT it is an individual's thinking about events that leads to emotional and behavioral problems. By focusing on the present, REBT treatment seeks to help individuals examine and change these unhealthy patterns of behavior, including self-defeating and self-sabotaging behaviors.*

**Key words:** *Mkpuru Mmiri (Crystal Methamphetamine) Use, Rational Emotive Behavioural Therapy, Nigeria.*

## **Introduction**

Mkpuru Mmiri (Crystal Methamphetamine) has spread across most towns and even remote villages in Nigeria. It was even suspected that the hard drug contributed in no small measure to the problem of the so called 'unknown gunmen' in parts of the South

East, Nigeria in recent time. Some people actually believe that only people who take such drugs could be killing people and destroying property without any provocation and without showing remorse. Currently, some communities have started identifying those who sell the drug in their areas and are banishing

them, while their youths who were known to be taking it are publicly punished by flogging them in village squares (Ujumadu, 2021). Several questions concerning this scourge are in the public domain. One of the questions is what is Mkpuru Mmiri? Considering that the drug's "high" comes on and fades very quickly, users frequently take many doses in a "run and crash" cycle, causing them to give up food and sleep, while continuing to take the drug every few hours for up to several days.

Mkpuru Mmiri (Crystal Methamphetamine) as is called in Igboland (Nigeria), is an extremely potent and addictive stimulant that affects the central nervous system and several other systems of the body. This substance has a molecular structure that is chemically comparable to Amphetamine, a medicine used to treat Attention Deficit and Hyperactivity Disorder, and Narcolepsy, a sleep disorder. It resembles glass fragments or shiny, gleaming glass shards with bluish-white boulders. Methamphetamine or Mkpuru Mmiri is taken by smoking, swallowing the pill form, snorting or sniffing, or by injecting the powder that has been dissolved in water or alcohol. Globally, this substance has been referred to as Meth, Trash, Crank, Biker's Coffee, Tweak, Speed, Ice, Shards, Stove Top, Yaba, Chalk, Crystal, Crank or Shabu.

Just like other stimulants such as cocaine or amphetamines, using even small amounts of methamphetamine can cause similar debilitating health effects. Some of these include faster breathing

and an increased irregular heart rate, increased wakefulness or difficulty in sleeping, increased blood pressure and temperature, stroke, restlessness, decreased appetite, and in many cases, central nervous system disturbances such as convulsion or seizures.

There is also an increased risk for contracting infectious diseases such as hepatitis B and C, and HIV for people who inject methamphetamine. These diseases are transmitted through sharing sharp objects such as needles or drug equipment containing blood or body fluids. Due to its ability to alter judgement, Methamphetamine use can lead to risky behaviours, such as sexual violence and unprotected sex, which also increases risk for infection. Studies have shown that HIV causes more damage to nerve cells, and potentially interferes with an individual's ability to think, understand, learn and remember more cognitive problems. The use of mkpuru Mmiri/methamphetamine may hasten the advancement of HIV/AIDS and its effects.

Some other long-term effects of methamphetamine may include serious dental problems, anxiety, permanent changes in brain structure and cognitive function, addiction, extreme weight loss, memory loss, hallucinations (seeing things and hearing voices that are not real), and death. While some of these changes to the brain are reversible, others are not. Recent studies have linked the use of methamphetamine to Parkinson's disease- a disorder of the nervous system that affects movement and balance. As a result of the effect of

this drug on the heart, brain and other vital organs, an overdose is treated with an intent to prevent a stroke by restoring blood flow to the brain, prevent a heart attack by restoring blood flow to the heart, and by treating affected organs. Timely intervention is key to preventing further damage to the body, caused by this substance.

There is currently no approved treatment for methamphetamine addiction. Medicines and other innovative treatments for methamphetamine use, including vaccinations and noninvasive brain stimulation utilising magnetic fields, are still being researched and developed. As with other drugs, the key to preventing methamphetamine addiction is avoiding usage. Other approaches such as cognitive-behavioural treatment, which helps individuals identify, avoid, and manage events that are likely to trigger drug use, and motivational incentives, which employ vouchers or modest monetary rewards to urge patients to stay drug-free, can help manage methamphetamine addiction. People can, and do recover from methamphetamine addiction if they have ready access to effective treatments that address the multitude of medical and personal problems resulting from short or long-term use.

Psychotherapy for methamphetamine use continues to be the first line treatment option and is effective in reducing methamphetamine (Mkpuru Mmiri) use (Wisdom, Manuel, & Drake, 2011). Although a number of reviews of psychological treatment for

methamphetamine use have been conducted (Ciketic *et al.*, 2011; Cohen, Huguet, Cohen, Vera, & Dardennes, 2017). None have examined the effects of rational emotive behavioural interventions for methamphetamine (Mkpuru Mmiri) use and its symptoms. One current treatment manual believes that it “involves a clear, mutually acceptable treatment plan that is designed to meet the needs of the individual” (Jenner & Lee, 2008, p. 2). While MA (MM) is addictive, the treatment outcomes associated with it are similar to other drugs of abuse, such as cocaine (Otero, Boles, Young, & Dennis, 2006, p. 12). This being said, MA (MM) dependence treatment is still challenging. Youths who abuse MA (MM) have high rates of treatment incompleteness, severe cravings, and the presence of depressive symptoms during withdrawal (Buxton & Dove, 2008; Kay-Lambkin, 2008). Some current treatment approaches are designed to change the way a client thinks while subsequently attempting to alter their behaviour through this thinking. Other approaches take a more classical conditioning approach to changing behaviour (Lee & Rawson, 2008).

However, before considering if REBT treatment option is feasible and pertinent to Mkpuru Mmiri (methamphetamine) use there are some essential points to consider. A non-judgmental approach to the client is essential; “there is strong evidence to suggest that one of the most important ingredients of a successful intervention is in building rapport and therapeutic

alliance” (Kay-Lambkin, 2008, p. 320). Time will need to be spent engaging the client; reminding of appointments through phone calls or even text messages can improve engagement. With MA dependency, it is thought that the longer a treatment program lasts, the better the outcomes (Kay-Lambkin, 2008, p. 319). The treatment model should be holistic, considering biological, psychological, and social processes (Halkitis, 2009).

### **Mkpuru Mmiri (Methamphetamine)**

Mkpuru mmiri is the Igbo slang for Methamphetamine or Crystal Meth, a very dangerous illicit drug. It looks like Ice or white chalk crystal and sometimes can be blue. That is why the users sometimes refer to it as “ice.” It can be dissolved in water. It was developed in Japan in 1919 and grossly abused during World War II when it was issued to pilots on a suicidal mission called “kamikaze.” After the world war, it was briefly used as a medication for depression and for controlling obesity, but it was quickly abandoned and banned thereafter, especially from the 1970s. Meth is categorised as Schedule II (i.e. “drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence”) by the International Drug Control Conventions.

Since the 1990s, the production of crystal meth has been hijacked by Mexican drug cartels and they came into Nigeria to set up laboratories in 2016. It is a very addictive stimulant that renders the user hyperactive and prone to

destructive tendencies which at the extreme do not exclude suicide or homicide at the slightest provocation and without a feeling of remorse. As a stimulant, it has powerful euphoric effects, similar to those of cocaine. Meth typically keeps users awake, depriving them of sleep. Its use and abuse also carry acute health risks including high blood pressure and cardiovascular-related illness.

Aside from being unable to sleep and being violent, users exhibit anti-social behaviours arising from paranoia and hallucination. The drug takes a toll on the physical look of its users. It typically makes them look older and their faces prone to acne. Sometimes, excessive use leads to damaged gum and teeth, commonly called “meth mouth.” What is most frightening is that meth addiction is one of the most difficult to treat, because no drug can cure it, except by behavioural therapy, which at the moment is not readily available in the country.

### **Consequences of Mkpuru Mmiri (Methamphetamine) Use**

**Withdrawal symptoms:** Withdrawal symptoms have been linked to a propensity for a relapse of drug abuse. Dysphoric mood is the main symptom for methamphetamine withdrawal, which requires at least two of the following additional symptoms to establish a diagnostic: psychomotor agitation or retardation, vivid, unpleasant dreams, fatigue, insomnia or hypersomnia, and increased appetite

(Lago & Kosten 1994). The severity of Methamphetamine withdrawal symptomatology, which varies among individuals, is likely to influence the ability of MA-dependent patients to maintain abstinence (Chen, Lin, Sham, Ball, & Loh, 2003). An understanding of methamphetamine withdrawal may inform on the development of strategies for relapse prevention.

**Psychosis:** Psychosis induced by methamphetamine is a typically transient phenomenon that involves symptoms of delusions, and hallucinations (Karila, Petit, Cottencin, & Reynaud, 2010). Methamphetamine-induced hallucinations are predominantly auditory (experienced in 85% of cases of methamphetamine psychosis), visual (46%) and tactile (21%). Delusion of persecution (71%), of reference (63%) and of “mind reading” (40%) are also common (Harris, Boxenbaum, Everhart, Sequeira, & Mendelson, 2003). There is considerable variability in both the dose required and the onset of psychotic symptoms (7 minutes-34 minutes). The duration of psychotic symptoms is variable, dissipating within a week of abstinence, or persisting indefinitely. Psychosis can also be accompanied by an emotionally labile state, agitation and hostile behaviour, and can require hospitalisation sedation and antipsychotic medication in severe cases. Psychosis induced by methamphetamine is a transient phenomenon remitting rapidly following the stop of consumption (McGregor, Srisurapanont, Jittiwutikarn, Laobhripatr, & Wongtan,

2005). Methamphetamine use can precipitate and exacerbate psychotic symptoms among people suffering from schizophrenia. Therefore, Methamphetamine users who have a pre-existing proneness to psychosis are at particularly high risk of experiencing symptoms of psychosis (Darke, Kaye, McKetin & Duflou, 2008).

**Depression:** Depressive symptoms are common. A recent study reported that a third of methamphetamine users had been diagnosed with depression at some point in their lives (McKetin, McLaren & Kelly 2005). A recent prospective cohort study of young Thai methamphetamine-users found that depressive symptoms decreased significantly among those who stopped using methamphetamine over the 12-month study period (Sutcliffe, German, Sirirojn, Latkin, & Aramrattana, 2009). Methamphetamine initiation during adolescence is associated with adulthood depression, whereas early depression was not predictive of future Meth use (Degenhardt, Coffey, Moran, Carlin, Patton, 2007).

**Anxiety:** High levels of anxiety disorders are reported (Zweben, Cohen, Christian, Galloway, & Salinardi, 2004). Half of methamphetamine users reported symptoms of anxiety prior to initiation, and 75% had experienced severe anxiety symptoms since methamphetamine use (Darke, Kaye, McKetin & Duflou, 2008). 11% of methamphetamine users have received a diagnosis of an anxiety disorder in their lives (McKetin,

McLaren & Kelly, 2005). Higher levels of depression, suicide and anxiety have been associated with longer methamphetamine use, early onset, high degree of dependence, frequent use and injecting (Sommers, Baskin, & Baskin-Sommers, 2006).

**Violent behaviours:** Violent behaviours appear common among methamphetamine users, particularly among people who inject these drugs reported and after methamphetamine use (Zweben, Cohen, Christian, Galloway, & Salinardi, 2004). In the McKetin et al. (2005) study, 12% of methamphetamine users had committed a violent crime in the preceding year. Sommers and al. found that more than a third of methamphetamine users had assaulted someone while intoxicated with the drug (Sommers, Baskin, & Baskin-Sommers, 2006).

**Addictive comorbidities:** Methamphetamine users consume a variety of drugs. Cannabis use is common, and the majority drinks alcohol. Some have a history of heroin use, and the use of other psychostimulants is common (Degenhardt, Coffey, Moran, Carlin & Patton, 2007). The importance of concomitant use of other substances with methamphetamine is that, when combined with alcohol, cocaine or opiates, methamphetamine toxicity is increased (Marshall & Werb, 2010).

**Overdose:** Overdose appears to be significant sources of morbidity and

mortality among young methamphetamine users, and includes agitation, dilated pupils, hypertension, tachycardia, and rapid respiration (Marshall & Werb, 2010). Other features include hyperthermia, shivering, dyspnea, chest pain, renal failure, and coma. Elevated risks of overdose among non-injecting methamphetamine users are reported (Werb, Kerr, lai, Montaner, & Wood, 2008). Those who inject methamphetamine either on its own or in combination with other illicit drugs such as heroin are also at risk of suicide (Ochoa, Davidson, EvansL, Hahn, & Page-Shafer, 2005).

**Cardiovascular pathologies:** Methamphetamine users are at an elevated risk of cardiac pathology. Emergency department data has shown consistent chest pain, cardiac arrhythmias (tachycardia), palpitations and hypertension to be among the most common physical symptoms after methamphetamine intoxication (Guharoy, Medicis, Choi, Stadler, & Kusiowski, 1999). A prolongation of the QTc beyond 440 ms is reported among 27.2% of the methamphetamine users (Haning, & Goebert, 2007). Cardiovascular consequences of methamphetamine use include acute coronary syndrome, acute myocardial infarction, acute aortic dissection, and sudden cardiac death (Kaye, McKetin, Duflo & Darke, 2007). Cardiovascular complications associated with methamphetamine use can occur with all of the major routes of administration (Kaye, McKetin, Duflo & Darke,

2007). When methamphetamine is combined with alcohol, cocaine or opioids, toxicity and stress on the cardiovascular system is increased (McGregor C, Srisurapanont, Mitchell, Wickes, & White, 2008).

#### **Cerebrovascular complications:**

Methamphetamine use is associated with ischemic stroke, intracerebral haemorrhage and subarachnoid haemorrhage, especially among young patients (Ho, Josephson, Lee & Smith, 2009). A study showed no evidence that the ischemic stroke associated with methamphetamine use is due to an inflammatory etiology but may be due to a process of accelerated atherosclerosis (Ho *et al.*, 2009). Methamphetamine leads to increased catecholamine levels, leading to coronary vasoconstriction, production of oxygen-free radicals, myocardial fibrosis, and cardiomyopathie because of the direct toxicity to extra and intracerebral vessels, leading to changes in luminal calibre (Ho *et al.*, 2009).

**Neurotoxicity:** Repeated use of methamphetamine involves the degeneration of dopamine and serotonin axons and termini, located in the frontostriatal region, leading to depletion of these monoamines (Cadet, Jayanthi & Deng, 2005). The mechanisms of neurotoxicity are not understood completely, but involve oxidative stress and apoptosis. Primate experiments demonstrate that methamphetamine use can lead to neurotoxicity human positron emission tomography and magnetic

resonance imaging showed brain abnormalities including inflammation, reduced neuronal density and reduced density of dopaminergic markers (Sekine, Minabe, Kawai, Suzuki & Iyo, 2002). These abnormalities mediate cognitive deficits among methamphetamine users, caused by damages in the cingulate, frontal, and striatal regions (Clemens, McGregor, Hunt & Cornish, 2007).

**Parkinson's disease:** Neurocognitive impairment caused by methamphetamine is caused by frontostriatal and limbic abnormalities. The main functions altered are learning, episodic memory, executive functions, speed of information treatment, working memory and perceptual narrowing (Scott, Woods, Matt, Meyer & Heaton, 2007). The cognitive deficits persist over six months after withdrawal (Clark, Robbins, Ersche & Sahakian, 2006; Kim, Lyoo, Hwang, Chung, & Hoon-Sung, 2006).

**Sexual behaviours:** Methamphetamine use is reported to enhance sexual pleasure, to facilitate prolonged sexual activity, and to delay and increase orgasm (Semple, Grant & Patterson, 2004). Methamphetamine is used in combination with drugs such as sildenafil to enhance sexual performance (Shoptaw & Reback, 2007). The association with others drugs (cocaine, rohypnol) promotes compulsive sexual activity and high-risk activities such as unprotected, anonymous and receptive anal sex among homosexual methamphetamine dependent users

(Bang-Ping, 2009; Semple, Zians, Grant & Patterson, 2006).

**Infectious diseases and blood borne virus transmission:** Sexual risk behaviour and sharing used needles increase the risk of blood-borne virus transmission (HIV, hepatitis B, hepatitis C).

Methamphetamine-using homosexual men are a high-risk group for HIV seroconversion, because of the high use of methamphetamine among homosexual men who engage in risky sexual practices and those with HIV (Buchacz, McFarland, Kellog, Loeb, & Holmberg, 2005; Burcham, Tindall, Marmor, Cooper, & Berry, 1989). A study has shown a significantly increased risk of Chlamydia trachomatis infection among methamphetamine-using women (Paz-Bailey, Kilmarx, Supawitkul, Chaowanachan & Jeeyapant, 2003).

### **Rational Emotive Behavioural Therapy**

The Rational Emotive Behavioral Therapy is also known as the “ABCDE” model of psychological disturbance and change. This theory is a behavioral therapy. It is one of the cognitively oriented approaches to counselling and psychotherapy. It is also directive in nature. His theory is based on learning theories. It is the pioneering form of cognitive behaviour therapy developed by Ellis in 1955. REBT is an action oriented approach to managing cognitive, emotional and behavioural

disturbances. According to Ellis (2010) working to change your personal philosophy is a valid therapeutic technique which can lead to a genuine growth. Behaviour, emotion and cognition are all interrelated. He tells us how to recognize irrational belief patterns based on “must” and “should”. He then presents methods for self-analysis and therapy.

Ellis discusses and demonstrates the modeling approach, use of humour, cognitive homework, unconditional acceptance of client, the use of strong language and dealing with low frustration tolerance. He also describes the application of these principles in his own life experience. In the “ABCDEF” system, “A”- refers to the activating or external event which can be an activity, action or event. “B”- refers to irrational beliefs about “A”, that belief then leads to “C”. C- refers to the feeling/emotional and behaviors that result from “B” (e.g. “A does not cause C” but B causes “C”). “D”- stands for disputes or arguments against irrational beliefs. “E”- stands for new effect, the result of holding healthier beliefs (Jorn, 2016). Then “F”- refers to the developed feelings of oneself either at point and after point C or at point after point “E”. The philosophy behind this theory is that man is basically rational and irrational. When he is rational, he is effective, happy and competent.

However, illogical or irrational thinking the client manifest sometimes is as a result of emotional disturbance or neurotic behaviors such as anger, hatred,

depression, fear, love, joy, happiness, etc.

According to Akinade (2016), the central theme of this theory is that therapists can help clients to live the most self-fulfilling, creative and emotionally satisfying lives by teaching them how to recognize and discipline their thinking. The theory follows the medical treatment of analysis, synthesis, diagnosis, prognosis, counselling or treatment and follow-up. Rational Emotion Behavioral Therapy (REBT) is a prescriptive model which presents the therapist as essentially a teacher or elder who applies a rational problem solving process in an individual teaching relationship. Ellis believes that man acquires rational and irrational thinking and behavior through child rearing process and the type of reinforcement given by the significant person especially the parents. "If adaptive and maladaptive behaviors are learned, they can be unlearned and desirable behaviors replaced by obsolete ones" (Olayinka 2000).

The ABCDE technique is key to helping clients understand how they are convincing themselves to engage (again) in an addictive behavior or to derail themselves (Ellis, McInerney, DiGiuseppe, & Yeager, 1988; Ellis & Velten, 1992; Tate, 1993). It may also be the key tool your clients use once they begin to try to better manage life. Even pre-contemplation clients may find a counseling session worthwhile if you do an ABCDE on someone who aggravates them. Young people, for example, rarely see themselves as having problems with

methamphetamine (Mkpuru mmiri); it is the problems resulting from their alcohol or drug use that aggravate them. They may, for example, be interested in figuring out how to get their parents off their back, and you can do an ABC first on what their parents might be telling themselves to get themselves so unreasonably upset.

Hence, rational Emotive Behavior Therapy (REBT) counseling technique is suitable for turning irrational thinking into rational thinking. When counseling is taking place, the counselor will invite clients to interact in changing irrational thoughts and feelings into rational. Rational Emotive Behavior Therapy (REBT) counseling technique invites clients to identify problems together, so that clients can provide the feedback needed to overcome the client's own problems.

REBT also encourages clients to be more tolerant of themselves and others, and invites them to achieve personal goals. This goal is achieved by getting people to learn to think rationally to change self-destructive behavior and by helping them learn new ways of acting. So in this case as a counselor has a role as a person who helps clients/drug addicts to change the behavior of drug addiction and prevent acts of drug abuse by using the REBT approach in the counseling process.

### **Relevance of Rational Emotive Behaviour Therapy**

Rational Emotive Behaviour Therapy (REBT) view on addiction is that people engage in such unhealthy behaviors

because of their irrational beliefs. The initial reason for why the individual turns to substance abuse may be guilt, shame or depression, which effect person's evaluative emotional and behavioral belief system and contributed immensely to unrealistic, arbitrary and crooked inferences and distortions thinking, and when person in an insensible and devout way overuse absolutist, dogmatic and rigid "should", "must" and "ought", they tend to disturb and upset themselves (Alao 1990).

According to Sarah (2005) in most cases, parent cause their children emotional difficulties, which in turn leads to irrational thinking". This happens when they become upset with the behavior of their children, and ceased all the support given to the child. This affected seriously the child's emotion leading to guilt, anger, anxiety and having low frustration tolerance. And which could be dealt effectively by using disputation techniques (Sarah, 2005).

Larberg (1990) opined that since avoidance of aversive consequences is one key aspect to continue substance use, one strategy is to block avoidance of these consequences via response prevention. This means a client should be confronted to face the aversive consequences that she/he fears and typically avoids or escapes. REBT is then applied as an educational process in which the therapist often active-directive teaches the client how to identify irrational and self-defeating beliefs and philosophies, which in nature are rigid, extreme, unrealistic, illogical and

absolutist, and then to forcefully and actively question and dispute them and replace them with more rational and self-helping ones.

### **Rational Emotive Behavioural Therapy and Mkpuru Mmiri (Methamphetamine)**

Rational Emotive Behavioural Therapy (REBT) views mkpuru mmiri (methamphetamine) use as an adapted behaviour that coexists with distorted beliefs about the need to use (Halkitis, 2009, p. 110). This approach was first adapted to treat addiction by Marlatt and Gordon (1985). Practitioners who use REBT believe that as addiction progresses, the client experiences diminished ability to control their behaviour. In this context, REBT is based in a school of thought that underlying learning is associated with irrational behavior processes that is a factor to mkpuru mmiri (methamphetamine) use (DeVito, Worhunsky, Carroll, Rounsaville, Kober, & Potenza, 2012, p. 228). The therapist asks the client to understand the role that mkpuru mmiri (methamphetamine) abuse plays in the individual's life, and teaches them relapse coping skills (Buxton & Dove, 2008, p. 1538). Since, craving control is also central to REBT. Clients are taught to recognize the thoughts that are likely directed by mkpuru mmiri (methamphetamine) abuse. It teaches that small decisions, like the decision to avoid certain social networks or environments, could have big implications. Clients are provided with

tools to develop problem solving skills, and are taught ways to assertively say no to mkpuru mmiri (methamphetamine) use (Carroll, 2014, p. 100).

This approach has been found effective in increasing abstinence rates, as well as the self-efficacy of the client to discontinue use (Lee & Rawson, 2008, p. 315). One report assessing the neurological changes in clients of REBT found decreases in fMRI brain activity after treatment, in regions that are associated with response impulsivity and other “processes widely proposed to contribute to addiction” (DeVito, Worhunsky, Carroll, Rounsaville, Kober, & Potenza, 2012, p. 233). Despite research on REBT finding that it can be effective, it is not always adopted into clinical practice. This is thought to be the case for three reasons. First, there are not many high-quality training programs available. Second, the cost of training clinicians and the relative complexity of the treatment program is quite high when properly implemented. Lastly, high rates of turnover in the field make the training-cost implications more severe, leading to a lack of a REBT-trained workforce (Olmstead, Ostrow, & Carroll, 2010, p. 200).

### **Implications of Rational Emotive Behaviour Therapy in Nigeria**

Rational Emotive Behavioural Therapy is highly directive. It can be readily applied into the Nigeria culture in which people are very directive in modifying other people’s attitude, perceptions, thinking and behaviours.

1. According to Nweke, Essuman, Anagbogu, Emekekwe, *et al.*, (1999) it offers a very quick way of making the client have insight into the causes of his Mkpuru mmiri (methamphetamine) use problem.
2. It can be used by therapists to modify sound attitudes and perceptions among Mkpuru mmiri (methamphetamine) users in Nigeria.
3. Individuals can also use it to identify the irrational thinking and behavior that prompted Mkpuru mmiri (methamphetamine) usage.
4. Essentially R.E.B.T follows the medical approach to treatment-analysis, synthesis, diagnosis, prognosis, and counseling and follows up. It is logical approach to Mkpuru mmiri (methamphetamine) users, since REBT is suitable in treating neurotic problems and it is quite suitable in Nigerian psychotherapy.
5. The goal of therapy is to eliminate client’s self-defeating behavior and assist him acquire a tolerant and rational view of life. Therefore, REBT will help Mkpuru mmiri (methamphetamine) users to conquer self-defeating behaviors that have kept some of them stunted in life.
6. R.E.B.T is very relevant in Nigerian context because therapist uses diverse procedures as, teaching, reading, assignment etc. in solving problems like Mkpuru mmiri (methamphetamine) use.

The model is deductive and directive and has been found effective for treatment of substance use disorder.

7. The technique is shorter than others and permits an effective use of therapist's limited time. The therapist can persuade, teach, confront or use any of the techniques to dispute client's illogical and irrational beliefs, teaching him a more logical way of thinking or viewing his problem.

### **Conclusion**

Mkpuru mmiri (methamphetamine) abuse affects the ability of the youths to function well. One of the challenges is how to manage the addiction reasonably. Consequently, REBT tends to be appropriate therapy that will help these youths overcome their Mkpuru mmiri (methamphetamine) abuse and consequences associated with it. Since, REBT approaches is useful to help challenge the abuser's negative thinking and alleviate Mkpuru mmiri (methamphetamine) use among the youths. That is why, Ellis stated that a primary reason why youths turn to Mkpuru mmiri (methamphetamine) abuse is because they harbor feelings of guilt, shame, or depression. These beliefs are emotional drivers for Mkpuru mmiri (methamphetamine) abuse, and as long as the youths continues to hold these beliefs, Mkpuru mmiri (methamphetamine) abuse will persist. Hence, the aim of REBT therapy is to address Mkpuru mmiri (methamphetamine) abuse by

eliminating the beliefs that trigger these irrational behaviors in the first place. With REBT treatment, the aim is to not only stop irrational behaviors, but also to eliminate the beliefs that led to these behaviors in the first place. This proactive approach supports youths in their journey to eliminate the self-destructive that are driving Mkpuru mmiri (methamphetamine) abuse through the development of insights and acceptance that will empower the youths develop healthy, and fulfilling lives.

### **Recommendations**

1. Programs that is REBT therapeutically oriented is needed in various institutions (churches, schools, homes, community) that will educate the youths on the dangers of mkpuru mmiri (methamphetamine) abuse.
2. Clubs that is similar to alcohol anonymous should be created; this will help mkpuru mmiri (methamphetamine) abusers to take responsibility of their recovery process.
3. Campaign that will enlightened the masses on the efficacy of REBT on treatment of mkpuru mmiri (methamphetamine) abuse. The campaign could be through public drama, exhibition, organized lectures inviting physicians, psychologist, NDLEA officials, and Drug repentance etc.
4. With REBT awareness campaign parents and community members will understand that in most cases they cause their children emotional

difficulties which in turn lead to irrational thinking, and hence leading to mkpuru mmiri (methamphetamine) use. For instance, strictness, aggressive, and over expectations that often leads to guilt, anxiety, low frustration tolerance and depression. Therefore, using REBT techniques to make parents and community members to develop a good rapport with their children, could enhance self confidence in the youth, and allows him to communicate his problems without result to mkpuru mmiri (methamphetamine) use as a solace.

5. Significant other in the youths' lives should have an interactive forum with the REBT therapist in order to know the primary symptoms of mkpuru mmiri (methamphetamine) use. So that they could easily report to the therapist immediately the recovery is witnessed.

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# Trauma Resilience, Hope And Quality Of Life Among Victims Of Herders/Farmers Crisis In Logo Local Government Area, Benue State, Nigeria: Their Relevance To Psychotherapy Practice

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## **Abstract**

*This study investigated trauma resilience, hope and quality of life among victims of herders /farmers crisis in Logo Local Government Area, Benue State. A cross-sectional survey design was employed. Using purposive sampling technique, 275 victims including 35(12.7%) males and 240(87.3%) females were drawn from Logo local government area. Their age ranged from 7- 61 years with the mean age of 9.46 (SD=10.75). Data collection was done using Connor-Davidson Resilience Scale (CD-RISC) with Cronbach's alpha of .93, Adult Hope Scale (AHS) with Cronbach's alpha of .95 and World Health Organization Quality of Life (WHOQOL) Brief Scale with a Cronbach's alpha of .83. Two hypotheses were generated and tested using Multiple Linear Regression. Findings indicated that, there was a significant influence of trauma resilience on quality of life among victims of herders/farmers crisis in Logo local government area. The study also revealed significant influence of hope on quality of life of the victims of herders/farmers crisis in Logo local government area of Benue State, Nigeria. The implication of findings of this study is that Therapists working with trauma survivors such as victims of herdsman victims can harness what is known about natural recovery to foster resilience in their patients. Therapists can achieve this by encouraging victims to seek out close social ties to cope with*

*symptoms and find meaning in life through quality of life and positive experience in general.*

**Key words:** *Crisis, Resilience, Trauma, Hope, Quality of Life, Herdsmen, Farmers, Psychotherapy.*

### **Introduction**

Nigeria has experienced a considerable increase in natural resource conflicts since the early 1990s. The increasing clashed between farmers and pastoralists have recently become worrisome, especially in the wetland areas of the middle belt, North central Nigeria and have also escalated and spread southward, threatening the country's security and stability. As expected most media outlets both local and international have cashed in on the stories around the unfortunate conflict with highly exaggerated accounts motivated by ethnic and religious undertones. This has led to increased misunderstanding and level of distrust among Nigerians (Basil 2015).

As these conflicts increase in frequency, intensity and geographical scope, so does their humanitarian and economic toll. Over the past seven years thousands have been killed; precise tallies are unavailable but survey of open source reports that that fatalities may have reached an annual average of more than 2,000 from 2013 till date, for some years exceeding the toll. Tens of thousands, have been forcibly displaced, with properties, crops, and livestock worth billions of naira destroyed, at great cost to both local and state economics (Fao, 2017). The victims of these attacks have suffered unprecedented hardship and this had

affected their quality of life and well-being. It has increased the feeling of uncertainty, fear and risk aversion (Becker & Rubinstein, 2017) which are widely known to affect behaviour.

Violent conflict and crises in Nigerian, like other parts of the world, have created a rift in human relations caused serious threats to security among many others effects (Basil, 2015). Crisis is inevitable as long as one lives together especially in a multi-ethnic, cultural and religious community like Nigeria. However, violence leaves us with various forms of retardation and under development. Studies by Basil (2015) and Ekpeyrin (2016) have shown that, serious conflict erupt between herdsmen and farmers leading to loss of lives, valuable properties and destruction of vast expanse arable agricultural farm lands thereby raising serious threats to food security and health to mention a few. Since then farmers have developed fear for attack and could no longer go to farm or harvest their farm produce. This has dire consequences for sustainable food production and development in the agriculture subsector in the regions of attack in particular and Nigeria in general, people have fled their home to avoid further attacks and are now living in IDP camps. A lot of them have been through adverse situations in one way or the other, the magnitude of which is beyond words which have left them with

little or no feeling of hope as they are traumatized.

Trauma has a lot of adverse effects on victims, it has been linked to chronic health problem. Such as health disease, and early death, as well as mental, emotional and behavioural disorders (Miltroy, 2013). Everyone is likely to experience trauma in their life, it is unavoidable. Trauma affect individuals of all ages and cultures with lasting consequences that can be damaging and detrimental to one's health and well-being. How people are affected by these events, how they cope and recover varies greatly and is dependent on the level of one's resilience to some extent (Unger, 2013). Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress (Margilia &Kulis, 2008). Hope has been shown to be an important part of the recovery process. Hope has the ability to help people heal faster and easier. Individuals, who main rain hope especially when battling illness significantly enhance their chances of recovery. This is important because numerous people with chronic physical or mental illness believe that their condition is stable (Snydey 2004) hope is a very important construct in helping individuals overcome fear and bounce back to their normal life from traumatic events such as terrorist attacks, life from communal conflicts or a fight for national resources which has been the order of the day in Nigeria.

### **Trauma resilience and Quality of Life**

There are a growing number of researches in the area of trauma

resilience and quality of life of several categories of people who have experienced trauma in one way or the other. For example, Le Lin and Ying Wang (2009) conducted a study to examine the extent social support mediates resilience and quality of life in survivors of the 2008 Wenchuan Earthquake in China. Self-report psychological questionnaires, the standard Chinese 12-item. Short Form (SF 12v2), the Resilience Scale for Adults (RSA), and the Social Support Rating Scale (SSRS) were used to interview a total of 2080 survivors from 19 countries in the 2008 Wenchuan Earthquake area. A regression analysis was sued to evaluate the mediating effect of social support on quality of life. The result of the study indicated that males and individuals with a higher level of education were found to have a better quality of life. The association between resilience and quality of life improved after social support was included, suggesting that at least a part of this association was mediated by the level of social support provided. This analysis shows that the level of resilience and quality of life after an earthquake (traumatic event) was associated with the level of social support.

Elsewhere, Bastaminia, Rezaei and Tazesh (2015) carried out a research to study the relationship between resiliency and quality of life in the State of Yasouj University of Yasouj with random cluster sampling was conducted over a period of 8 months. Data collection tool in this study included Czech list of demographic data, the World Health

Organization Quality of Life Questionnaire (WHOQOL-BRIEF) and Iranian species and resilience questionnaire Conner and Davidson (CD-RIS). Analysis of the results using the STATA 12 software by using descriptive and analytical statistics such as multivariate linear regression was conducted. Results: the mean age of participants was  $8.3 \pm 2.4$  years boys ( $6.4 \pm 9.24$ ), girls ( $8.2 \pm 3.23$ ). Among the four domains of quality of life, environmental health and physical health respectively lowest ( $3.22 \pm 5.51$ ) and highest ( $8.16 \pm 2.69$ ) to be allocated. The mean score of resilience total  $17 \pm 8.66$  was estimated. Linear regression models showed that the resiliency of the significant role in determining the quality of life in general and its four dimensions ( $p > 0.001$ ). Conclusion: In order to improve the quality of life of students we need to provide greater knowledge and skills in the field of resilience, and this except by turning on of the students of these skills in his presence is not possible.

Also, Fauci, Bonciani and Guerra (2012) investigated the impact of the 2004 tsunami on the quality of Life of the Sri Lankan population. It focused on the factors that have contributed to an increase in the people's susceptibility to the impact of hazards-their vulnerability – as well as of the natural ability to cope of the populations affected – their resilience. The study was based on the conduction of 10 Focus Group discussion and 18 in-depth interview, then analysed through qualitative analysis software. The analysis shows

that each factor involved in the interplay among the different processes that produced the changes in the affected people's quality of life is at the same time a damaged asset, a vulnerability factor and a resource to draw upon for coping.

Holbrook and Hoyt (2004) carried out a study to measure the importance of gender differences in quality of life and psychologic morbidity after major trauma. 1,048 eligible trauma patients triaged to four participating trauma center-hospitals in the San Diego Regionalized Trauma System were enrolled in the study. The enrollment criteria for the study included age 18 years and older. Quality of life outcome after trauma was measured after injury using the quality of well-being scale, a sensitive index to the well end of the functioning continuum (range, 0=death to 1.000 optimum functioning).

Depression was assessed using the Center for Epidemiologic studies scale. Symptoms of Acute Stress Reaction (SASR) was assessed using the impact of events scale. Patient outcomes were assessed at discharge and at 6, 12, and 18 months after discharge. Results of the study indicated that women (n 313) were significantly more likely to have poor quality of life outcomes at follow-up than men (n=735) (women vs. men: 12-month follow-up odds ratio [OR] = 2.2,  $P < 0.001$ ; 18-month follow-up OR = 2.0,  $p < 0.00$ ). Quality of well-being scores at each of the 6-, 12-, and 18-month follow-up time points were markedly and significantly lower in women compared with men, independent of

injury severity, serious and moderate injury status, lower extremity injury, intentional or unintentional injury type, and blunt or penetrating injury. Women were also significantly more likely to develop early combined depression throughout the 18-month follow-up period (OR 2.3  $p < 0.001$ ).

### **Hope and Quality of Life**

Esbensen and Thomsen (2011) studied the characteristics in Quality of life (QoL) and hope in elderly people newly diagnosed with cancer, and to compare the results for those who survived six months after diagnosis with those who did not. The design of the study was a quantitative study including drop-out analysis. Data were collected prospectively from a group of 101 older people with cancer. The core questionnaires EORTC QLQ-C30 was used to measure QoL and Nowotny's Hope Scale (NHS) was employed to measure hope. Participants who died within six months of diagnosis had significantly lower QoL and had more complaints about symptoms compared to those who survived. However, hope did not differ significantly between those who died and those who survived.

Also, Meng-Yao, Yang, Li-Liu and Wang (2014) assessed quality of life as well as the integrative effects of social support, hope and resilience on quality of life among Chinese bladder cancer patients. A cross-sectional study was conducted at the First Hospital of China Medical University in Liaoning province, China. A total of 365 bladder cancer patients eligible for this study and

completed questionnaires on demographic variables, FACT-BL, Perceived Social Support Scale, Adult Hope Scale, and Resilience Scale-14 during July 2013 to July 2014. The average score of FACT-BL was  $87.60 \pm 16.27$  (Mean  $\pm$  SD). Hierarchical regression analyses indicated that social support, hope and resilience as a whole accounted for 30.3% variance of quality of life. Under standardized estimate (13) sequence, social support, hope and resilience significantly and positively are associated with quality of life, respectively.

Tavakol and Heidarei (2015) in a study, examined the relationship between the quality of life and hope with depression, among divorced women and divorce applicant. The population of this study includes all of the women who referred to the family divorce court Ahvaz City in 2014. The population of the number of divorce cases was 125 people and 191 available widows were selected in available sampling method and the total numbers of them were 316 person. The tools which were applied in this study consist of Miller Hope Scale (1988), the World Health Organization (1978). The results based on correlation and regression analysis shows it was equals  $a=0.001$  and there is a positive relationship between hope and quality of life with depression among divorced women and divorce applicant in Ahvaz City.

Rode (2015) carried out a study to understanding how family members of survivors of man-made trauma sometimes experience trauma severely

themselves and may suffer from post-traumatic stress disorder, depression and poor quality of life. Most studies focus on the victims and ignore the effect of the incidents on the victim's family members. This study investigated the possible predictive and mediating determinates of quality of life in this often forgotten population, focusing specifically on the role of socio-demographics, mental impairments, coping mechanisms, resilience and hope on subjective quality of life. Data were collected between October 2007 March 2008, a self-report questionnaire incorporating seven scales was administrated to 175 family members of victims of man-made trauma. One-way ANOVA was performed to compare the variance in the reported quality of life. The structural equation models of path analysis were used to evaluate the main effects and interactions and interrelations among variables. Of the psychosocial factors, having a personal previous traumatic experience was found to significantly affect post-traumatic stress disorder, depression and physical health. Post-traumatic stress disorder and depression were found to directly and indirectly affect quality of life. Coping mechanism, resilience and a hope state mediated the effect of post-traumatic stress disorder and depression making the three significant predictors of subjective quality of life.

### **Hypotheses**

- i. There will be a significant influence of resilience (personal competency and acceptance of self and life) on quality of life among victims of herders/farmers crisis in Logo local government area.
- ii. There will be a significant influence of hope (pathways and agency) on quality of life among victims of herdsmen attack in Logo Local Government Area.

### **Method**

#### **Design**

The study employed a cross-sectional survey design. This is the design that involves the collection of data from a relatively large number of participants to make inferences about a population of interest at one point in time. The researcher adopted the use of questionnaire to carry out the study.

#### **Participants**

The researcher used 275 participants for the study. The study comprised of 35 (12.7%) males and 240(87.3%) females. The ages of the participants ranged from 7 to 61 with the mean age of 9.46, median 16.00(SD=10.75). Furthermore, 120 (43.6%) of the participants were of single status, 88 (32.0%) were divorced. The participants also comprised of 3(1.1%) who attained tertiary education, 131(47.6%) who attained primary/post primary education, while 141(51.3%) had no formal education. All the participants in the study 275 (100%) were from Tiv ethnic group. Also in the study, 266(96.7%) were from the Christian religion while 9 (3.3%) were from other religions.

## **Instruments**

Three instruments were used for data collection. They include resilience scale, hope scale, and quality of life scale. The instruments were combined in a single questionnaire which comprised of four sections: A, B, C and D. Section "A" comprised of bio-data of the participants which include sex, age, marital status, religion, tribe and education.

Connor-Davidson Resilience Scale (CD-RISC) in section "B" was developed by Connor and Davidson (2003) as a means of assessing resilience. The CD-RISC is based on Connor and Davidson's operational definition of resilience, which is the ability to "thrive in the face of adversity. The CD-RISC consists of 25 items, which are evaluated on a five point Likert scale ranging from 1-5: 1= not true at all, 2 rarely true, 3 sometimes true, 4 often true, 5=true nearly all of the time. The reliability coefficient of this instrument was .93 Cronbach's Alpha.

Section "C" comprised of the Adult Hope Scale (AHS) developed by Snyder, Irving and Anderson (1991). The adult hope scale has 12 items which are evaluated on an eight point likert scale (1=Definitely False, 2=Mostly False, 3 Somewhat False, 4 Slightly False, 5=Slightly True, 6= Somewhat True, 7 Mostly True, 8=Definitely True). The reliability coefficient was .95 Cronbach's Alpha.

Section "D" World Health Organization Quality of Life

(WHOQOL) Brief was developed by the World Health Organization (1991). The aim was to develop an international cross-culturally comparable quality of life assessment instrument. The WHOQOL-BRIEF instrument comprises of 26 items with a five point likert scale (1 very poor, 2 poor, 3 neither poor nor good, 4=good, 5=very good). The reliability of the instrument was 83. Cronbach Alpha.

## **Procedure**

Data for this study were collected through direct contact with participants. Permission was sought from the head, IDPs Camp officials where the study was carried out. The questionnaires were administered to the victims of herdsman attack in Logo Local Government and the responses of the participants which were based on their willingness, constituted the data for this study.

## **Data Analysis**

The statistical tools that were used for this study were Multiple linear regression and Hierarchical multiple regression. This statistics was arrived at because the researcher wanted to establish the independent and joint influence of the variables in the study. Other descriptive statistics such as mean, median, standard deviation and percentages were equally used in the study.

**RESULTS**

**Table 1: Multiple linear regressions showing the influence of resilience (personal competency and acceptance of self and life) on quality of life among victims of herdsmen attack in Logo local Government area.**

DV	Predictors	R	R <sup>2</sup>	df	F	t	P
Quality of Life (overall)	Constant	.122	.015	2,206	1.545	33.320	.000
	Personal competent				1.010	-.081	.012
	Acceptance of Life				-.113	-.913	.362

The result presented in Table 1 revealed that resilience (personal competency and acceptance of self and life) predicted overall quality of life among victims of herdsmen attack in Logo Local Government Area [R=.394, R<sup>2</sup>=.155, F(2,380)=34.957, P<.0.1]. Resilience (personal competency and acceptance of self and life) jointly contributed 1.5% of the total variance observed in overall quality of life of the victims. On the various dimensions, the results indicate that personal competence ( $\beta$ =-.010, t=-.081, p<.01) predicted quality negatively and acceptance of life did ( $\beta$ =-.113, t=-.913, p. >05) did not predicted quality of life among victims of herdsmen attack in Logo Local Government Area. Based on this result, hypothesis one was confirmed.

**Table 2: Multiple linear regressions showing the influence of hope (pathways and agency) on quality of life among victims of herdsmen attack in Logo Local Government**

DV	Predictors	R	R <sup>2</sup>	df	F	$\beta$	t	p
Quality of Life (overall)	Constant	.200	.040	2,206	4.298		33.713	.000
	Pathways					.335	2.932	.004
	Agency					-.268	-2351	.020

The result presented in Table 2 revealed that hope (pathways and agency) predicted overall quality of life among victims of herdsmen attack in Logo local Government area [R=.200, R<sup>2</sup>=.040,]F(2,206)=4.298, p<.01]. Hope (pathways and agency) jointly contributed 4.0% of the total variance observed in quality of life among victims of herdsmen attack in Logo Local Government Area. On the various dimensions, the results indicate that pathways ( $\beta$ =.335, t=2.932, p<.01) and agency ( $\beta$ =-268, t=2.351, p<.01) all made significant independent contributions to the model both in the positive and negative direction respectively. Based on the above results, hypothesis two was confirmed.

## **Discussion**

Hypothesis one which states that there will be a significant influence of trauma resilience on quality of life among victims of herdsmen attack in Logo local government area was tested using multiple regression. The result indicated that, there was a significant influence of trauma resilience on quality of life among victims of herdsmen attack in logo local government area. This finding is in line with the work done by Carlson, Wailer and Mitchell (2012) who examined the relationship between resilience and quality of life in breast cancer patients. The results showed quality of positively correlated with the levels of resilience. The finding is also consistent with the finding of Bastamina, Rezaei and Tazesh (2015) who carried out a study to find out the relationship between resilience and quality of life in the state of Yasouj University Students. Their linear regression analysis showed that resiliency played a significant role in determining the quality of life in general and its four dimensions. Work of by Jarnil and Azra (2012) who investigated the relationship between resilience and quality of life of diabetes patients is equally in consonant with the current study. Their result demonstrated that trait resilience had unconditional positive effect on all aspects of quality of life.

The second hypothesis states that there will be a significant influence of hope on quality among victims of herdsmen attack in Logo local government. This hypothesis was tested

using multiple linear regression. Finding from the analysis indicated that, that hope significantly influenced quality of life of the victims of herdsmen attack in Logo local government area. This findings is in line with Tavakol and Heidearei (2015) which examined the relationship between the quality of life and hope with depression among divorced women and divorce applicants where 316 persons participate in the study. The result showed that there was a significant relationship between hope and quality of life.

## **Relevance for Psychotherapy Practice in Nigeria**

Therapists working with trauma survivors such as victims of herdsmen victims can harness what is known about natural recovery to foster resilience in their patients. In this study, three factors that facilitate natural and therapeutic recovery following trauma: resilience, quality of life and hope. Therapists can easily target these factors using well established trauma focused treatments. It is established that encouraging victims of trauma to seek out close social ties to cope with symptoms and positive experience in general. If psychotherapy could adopts this procedure it could results to better outcomes in terms of hope and quality of life.

## **Conclusion**

Based on the findings of this study it can be concluded that trauma resilience is a significant factor in determining quality of life among victims of herdsmen attack in Logo local government. Similarly

hope was found to be a significant determinant of quality of life among victims of herdsmen attack in Logo local government area.

### Recommendations

Based on the findings of the study the following recommendations were made:

- i. Resilience training programmes through therapy session can help improve the psychological adjustment of the victims in the course of their experience in the IDPs camps
- ii. It was also recommended that the government, nongovernmental organizations and private spirited individuals should instill hope to victims of herdsmen attack in Logo local government area in order to improve their quality of life.
- iii. Psychological wellbeing and self-enhancement through resilience training are needful to the internally displaced persons.

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# **Domestic Violence And Substance Use As Correlates Of Suicidal Ideation Among Persons With Substance Use Disorder: Implications For Psychotherapy Practice**

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## **Abstract**

*The objective of this study was to ascertain the relationship between domestic violence, substance use and suicidal ideation among persons with substance use disorder and its implications for Psychotherapy practice in Anambra State, Nigeria. A correlation research design was employed and the statistics used for this study was pearson moment correlation. The participants comprised of 41 persons with substance use disorder; participants ranged in age from 14 to 78years ( $M = 28.3$ ,  $SD = 5.47$ ). The researcher employed census and purposive sampling methods in selecting these participants. The major instruments used in this particular study were the domestic violence scale, drug attitude scale and suicidal ideation scale. The results showed that domestic violence was positively correlated with suicidal ideation among persons with substance use disorder in Anambra State, Nigeria. Also, substance use was found to positively correlate with suicidal ideation among persons with substance use disorder in Anambra State, Nigeria. In the context of the outcome of this study, it is important that increased suicide risk screening through psychotherapy and prevention efforts for individuals with substance use disorders are needed. Thus, several studies tend to suggest that psychological interventions, particularly psychotherapy, are usually more effective than medications in the treatment of substance use disorder.*

**Keywords:** *Domestic violence, Substance use, Suicidal ideation, Substance use disorder, Psychotherapy.*

## **Introduction**

Suicide appears to be a national tragedy and a key public health problem. According to the World Health

Organization, suicide is a worldwide public health problem causing approximately one million deaths every

year (World Health Organization, 2018). It is the third most common cause of death in domestic violence and persons with substance use disorder (Anderson, 2002). Although studies have shown that substance abuse is a risk factor for completed suicide (Brent, 2015; Shaffer, 2008), as well as for suicide attempt and ideation (Goldman & Beardslee, 2009; Gould et al., 2003; Levy & Deykin, 2009), hardly ever have the independent contributions of explicit substances been the focal point of inquiry (Garrison, McKeown, Valois, & Vincent, 2013; Kandel, Raveis, & Davies, 2011). Studies on completed suicide have not had enough statistical power to identify differences between types of drugs used, due to small sample sizes (Gould *et al.*, 2003). In some epidemiological studies of suicidal ideation and substance use (Garrison *et al.*, 2013; Kandel *et al.*, 2011), psychiatric disorders, highly associated with both suicidal ideation, domestic violence and substance use/abuse, were not assessed or taken into account. To date, little is known about the independent contribution of each substance to suicidal ideation and domestic violence (e.g., cigarettes, alcohol, cannabis, methamphetamine), controlling for the use of other substances and other psychiatric disorders. Such knowledge would help us to understand the etiology of suicide, domestic violence and consequently, to facilitate its prevention. It is hoped that by using large-scale epidemiological survey data with detailed measures of suicidal ideation, domestic violence, substance use/abuse, and psychiatric

disorders, this study will make a contribution toward filling this knowledge gap.

There are numerous theories regarding the relationship between suicidal ideation and substance abuse, including: (1) The effects of acute intoxication lead to high-risk behavior; (2) substance use disorders in youthful suicide completers may be secondary to affective illnesses, such as depression (Schwartz, 2010; Deykin, Levy, & Wells, 2007); and (3) as self-destructive behaviors, suicidal ideation and substance abuse share common biological, behavioral, and environmental origins or result from common vulnerabilities (Forman & Kalafat, 2008). Risk factors that are related with suicidal ideation include psychopathology, stressful life events, physical/sexual abuse, domestic violence, poverty, family history of suicidal ideation and psychiatric disorders, as well as biological factors such as serotonergic abnormalities (Gould *et al.*, 2013; Shaffer, 2008). Many of these are also risk factors for adolescent substance use and abuse (Giovino, Henningfield, Tomar, Escobedo, & Slade, 2015; Hawkins, Catalano, & Miller, 2012; Virkkunen & Linnoila, 2013).

Domestic violence (also named domestic abuse or family violence) is violence or other abuse by one person against another in a domestic setting, such as in marriage or cohabitation (Rodriguez, 2006). It may be termed intimate partner violence when committed by a spouse or partner in an

intimate relationship against the other spouse or partner, and can take place in heterosexual or same-sex relationships, or between former spouses or partners (Goudbout *et al.*, 2009). Domestic violence can also involve violence against children, parents, or the elderly. It takes a number of forms, including physical, emotional, economic, religious, reproductive, and sexual abuse, which can range from subtle, coercive forms to marital rape and to violent physical abuse such as choking, beating, female genital mutilation, and acid throwing that results to death (Jackson, 2009).

Globally, the victims of domestic violence are significantly women, and women tend to experience more severe forms of violence (Rodriguez, 2006). They are also likelier than men to use intimate partner violence in self-defense. In some countries, domestic violence is often seen as justified, particularly in cases of actual or suspected infidelity on the part of the woman, and is legally permitted. Research has established that there exists a direct and significant correlation between a country's level of gender equality and rates of domestic violence, where countries with less gender equality experience higher rates of domestic violence (Whiting *et al.*, 2009). Domestic violence is among the most underreported crimes worldwide for both men and women (Winters *et al.*, 2004), due to social stigmas regarding male victimization, men who are victims of domestic violence tends to face an increased likelihood of being overlooked by healthcare providers.

### **Statement of the Problem**

Suicide is a major public health concern in Nigeria. Alcohol, tobacco, and other drug use disorders have all been implicated in suicidal behavior in multiple studies (Brent, 2015; Shaffer, 2008; Gould *et al.*, 2003), but most prior research has examined non-fatal suicidal behavior such as suicide ideation or suicide attempt. Only a handful of studies have examined the relationship between substance use disorders (SUDs), domestic violence and suicide mortality. Of these, the majority have focused solely on the relationship between alcohol use disorders (AUD) and suicide, with few studies exploring the potential role of other Substance use disorders and domestic violence on suicidal ideation. Most of these studies do not consider whether multiple Substance Use Disorder (SUDs) together with domestic violence contribute greater risk than single SUD. The purpose of this study is stated thus; to determine the relationship between domestic violence, substance use and suicidal ideation among persons with substance use disorder. Hence the following hypotheses were tested at .05 level of significance

- H1. Domestic violence will not significantly predict suicidal ideation among persons with substance use disorder.
- H2. Substance use will not significantly predict suicidal ideation among persons with substance use disorder.

## Method

### Participants

Forty-one (41) persons with substance use disorder took part in this study as the participants, 34 were males, while 7 were females. Their age ranges were between 14-78 years. Their mean age was 28.3 and the standard deviation was 5.47. Also, 13 (15%) were married, 24 (75%) were single while 4 (10%) were divorced/separated. For selection of participants, census and purposive sampling technique were used. Census was adopted because of the small number of sample size while the purposive sampling technique was used because only persons with substance use disorder in the NDLEA centre were used, as the participants were selected based on this particular criterion of substance use and instruments were administered by the researcher with the selected participants from the area of the study.

### Instruments

#### *Domestic violence scale*

It is a 30 item inventory designed by Marshal (2002) to assess the possible causes of domestic violence couples experience that can lead to separation and divorce. The scale followed a 5-point likert format ranging from frequently "5" to never "1". With reliability alpha score of 0.72. Physical abuse items include 6, 7, 14, 18, 20, 24, 25, 26, 27, 28, 29, and 30 (item 21 are not included in subscale computation). The mean score of these items is computed by summing the values of the items and dividing by the applicable number of items. Higher scores are indicative of greater physical abuse.

#### *Drug attitude scale*

The scale was developed by Goodstadt, Cook, Magid & Gruson, (1978). Drug attitude scale has two sections. The first section sought personal information and demographic characteristics of the participants. Section B contains 6-item subscales dealing with opiates, alcohol, cannabis, tobacco, hallucinogens and general drug use which seek to elicit responses relating to the present study. The instrument was developed and validated by Goodstadt, Gaynoll cook, Simmiemagid, Valerie & Gruson (2013). Five studies were conducted, employing three independent samples of high school students, leading to the development and assessment of the reliability and validity of this drug attitudes scale. The results of these studies support the conclusion that this scale shows substantial reliability and validity with the alpha score of 0.73 which shows the reliability of this instrument for this present study. The respondents were asked to state the extent to which they agree or disagree with each statement in the appropriate part by marking (\*) in the 5-point likert type interval scale starting from, 1.strongly agree 2. Agree 3.undecided 4.Disagree 5. Strongly disagree.

#### *Suicidal Ideation Scale*

The 10-item SIS was developed by Rudd (1989) specifically for the purpose of assessing the severity or intensity of suicidal ideation via self-report. It is a Likert-type scale. Each item, which describes suicidal thoughts or behaviors, is scored from 1 ("never or none of the time") to 5 ("always or a great many times"), depending on "how often the subject has felt or behaved that way during

the past year.” The SIS was subjected to pretesting prior to this study. A pilot study with 30 university students resulted in a high level of internal consistency reliability for the SIS (coefficient alpha = .90). Item-total correlations ranged from .49 to .78. As evidence of construct validity, the SIS correlated highly with measures of depression (the Center for Epidemiologic Studies Depression Scale [CES-D]; Radloff, 1977) ( $r = .55$ ,  $p < .001$ ) and hopelessness (the Beck Hopelessness Scale; Beck, Weissman, Lester, & Trexler, 1974) ( $r = .49$ ,  $p < .001$ ).

### Procedure

The data for the research was collected at the National Drug Law Enforcement Agency Anambra State, Nigeria. This is because the persons with substance use disorder examined in the study were actually under rehabilitation in the centre. Also, the centre was chosen because of accessibility and willingness of the participants to take part in the study. Copies of the study questionnaire were administered to about 45 drug dependent persons who were purposively selected. At

the end of the exercise, only 41 were correctly filled and returned for analysis. Administration of the study instrument was done after discussion with the persons with substance use disorder and the participants were encouraged to fill and return them immediately under some minutes (30-45 minutes). Following confidentiality, informed consent, and willingness to take part in the research, copies of the questionnaire were administered to the 40 carefully and purposively selected participants in the centre. While administering the copies of the questionnaire, participants were neither forced nor intimidated to take part. Those who were not eager and those that were reluctant to take part were excluded. The participants did not receive any remuneration for participating in the study.

### Results

**Table 1: Pearson Product Moment Correlation**

		M	SD	1	2	3	4	5	6
1.	Age	28.3	5.47	1					
2.	Gender	1.23	0.43	.02	1				
3.	Marital Status	1.53	0.68	.37**	.07	1			
4.	Domestic violence	66.6	23.8	.11	.17	.34**	1		
5.	Substance Use	47.4	9.15	.05	.09	.13	.39**	1	
6.	Suicidal Ideation	18.2	7.57	-.14*	.03-	.12*	.34**	.25*	1

### **Descriptive statistics and correlations are presented in Table 1**

The bivariate correlation matrix revealed several significant associations between the variables measured in this study. Age was significantly and negatively correlated with suicidal ideation ( $r = -.14$ ), and positively correlated with marital status ( $r = .37$ ). Marital status was positively correlated with domestic violence ( $r = .34$ ), and negatively correlated with suicidal ideation ( $r = -.12$ ). Domestic violence was significantly correlated with substance use ( $r = .39$ ), and Suicidal ideation ( $r = .37$ ). Substance use was significantly correlated with Suicidal ideation.

### **Discussion**

The objective of this study was to determine the relationship between domestic violence, substance use and suicidal ideation among persons with substance use disorder and its implications for Psychotherapy practice.

Hypothesis one which stated that domestic violence will not significantly correlate with suicidal ideation among persons with substance use disorder was tested, the result showed that suicidal ideation and domestic violence were positively correlated. This finding is consistent and in support with the findings of Whiting *et al.*, (2009) who reported the prevalence and correlates of suicidal ideation among low-income pregnant women receiving prenatal care at a university obstetrical clinic from February 2009 to March 2010. The prevalence of antenatal suicidal ideation in their finding was higher than other

population-based samples though their sample was predominantly single, low-income, and 19% experienced domestic violence during pregnancy. Also this finding supports the findings from Rodriguez (2006) who studied the link between domestic violence, mental health and suicidal ideation. Using data from a group of 650 Pakistani women, they found domestic violence to significantly predict suicidal ideation. The effect of verbal aggression on suicidal ideation appeared to be mostly mediated via its impact on mental health. In addition, the present study findings is in line with Rahmani, Salmasi, Rahmani, Bird, ASghari, Robai, Asghari, Jafarabadi and Gholizade (2019) who investigated the impact of domestic violence-related factors on suicide attempt in married women and found that Suicide attempt was significantly lower in women who reported a sense of peace in life or lived with their mother or father-in-law.

Hypothesis two which stated that substance use will not significantly correlate with suicidal ideation among persons with substance use disorder was also tested, the result showed that suicidal ideation and substance use were positively correlated. This result is in consonance with the findings of Hesse and Skogen (2020) who assessed suicide among people treated for drug use disorders in Denmark 2010–2020, and found that risk of suicide is increased among people with drug use disorders. Increased risk was associated with younger age at enrolment (hazard ratio [HR]=0.97, 95% confidence interval

(CI): 0.95, 0.98), history of psychiatric care (HR = 1.96, CI 95%: 1.39, 2.77), opioid use (HR = 1.81, 95% CI: 1.23, 2.68), and alcohol use (HR = 1.56, 95% CI: 1.09, 2.23). Lower risk was associated with cannabis use (HR = 0.69, 95% CI: 0.50, 0.96). Also the finding of this study supports the findings of Lynch and Ahmedani (2020) who reported that substance use disorders were associated with increased relative risk of suicide for both women and men across all categories, but the relative risk was more pronounced in women. Substance use disorders are associated with significant risk of suicide mortality, especially for women, even after controlling for other important risk factors.

Suicide is a national tragedy and a major public health problem. It is the third most common cause of death in domestic violence and persons with substance use disorder. The findings from this study points to the nature and consequences of suicide and suicidal ideation which may form the basis for a policy response to the problem associated with it. In addition, some intervention and prevention programs on suicidal ideation amongst persons with substance use disorder will be suggested in this work. Without doubt, this study is also of practical relevance to the non-governmental organizations, clinical and social researchers who may be interested in this field of study. Finally, the study findings will go a long way in positively reforming the persons with substance use disorder on the dangers of domestic violence and substance use which could

result to suicidal ideation, suicidal attempt or suicide commission.

### **Implications for Psychotherapy**

Clinical decision-making regarding patients with suicidal risk is largely based on the experience of health care providers, rather than international guidelines. Suicidal patients are heterogeneous, and frequently non-adherent to treatment or follow-up. It is of utmost importance that psychotherapists in Nigeria take into consideration the above findings when treating patients with substance use disorder. The predominance of available scientific evidence has established that psychological interventions, particularly psychotherapy, are usually more effective than medications in the treatment of substance use disorder (Antonuccio, 1995).

According to American addiction centre resource (2015), the term "psychotherapy" encompasses a broad spectrum of interventions led by therapists, for the benefit of patients. A partial list of the things that psychotherapy may attempt to accomplish would include but not be limited to:

- Providing a safe and trustworthy forum in which hurting people can discuss their present-day issues and problems
- Providing a safe and trustworthy forum in which hurting people can talk about how they came to be the way they are (exploration of past experience)

- Promoting the sharing and releasing of shameful and emotionally toxic experiences in a way that promotes personal empowerment and feelings of self-worth and belonging.
- Teaching specific coping skills for managing specific problems and symptoms
- Providing a place where people can make friends and give and get interpersonal support
- Providing a parental-style figure who gives authoritative guidance to those people who are in need of external guidance
- Providing a model and personal experience of what trust-worthy relationships look like (so that such relationships can be pursued outside of therapy)

From among this list, at least four specific therapy agendas may be discriminated:

**Supportive psychotherapy** aims to offer patients a safe and trustworthy forum in which they may discuss the troubling aspects of their lives. The therapist strives to listen to the patient, who is encouraged to share emotionally. When needed, the therapist may act as a strong guide/authority figure, outlining things that the patient should do and not do. This type of therapy is not exploratory and doesn't delve into the past histories of patients. It is most helpful for interpersonally and emotionally fragile patients, and/or patients who become disorganized when

confronted with stressful situations and memories.

**Coping-focused psychotherapy** aims to teach patients specific and practical ways to cope with specific problems such as Depression, Anxiety, Panic and Substance Abuse relapse prevention. The best and most effective forms of coping-focused psychotherapy are those that are based on scientific research. Most any form of Cognitive-Behavioral Therapy is recommended. Relapse Prevention programs are highly recommended.

**Social skills/interpersonal/growth psychotherapy** aims to teach patients to become more emotionally and socially mature in their dealings with others. For a variety of reasons, many addicts tend to have poor interpersonal skills and to deal with their emotions in self-destructive ways. Social skills/interpersonal/growth psychotherapy (usually performed in a group therapy context) helps patients to learn about and practice (within the session amongst each other) healthy ways of communicating with others.

**Exploratory psychotherapy** aims at helping people to uncover the links between past experiences (trauma, violence, abuse, etc.) and present behavior. Because exploratory forms of psychotherapy often involve recalling painful past events, this sort of therapy can be disorganizing and itself traumatic to fragile recovering persons, and to dually diagnosed patients with psychotic

or other severe symptoms, it is not recommended. There is much evidence in fact that healing from many forms of mental illness can proceed just fine without any need to bring up past traumas (the most effective forms of psychotherapy for improving functioning being the coping focused varieties). However, exploratory psychotherapy (and particularly a behavioral form known as exposure therapy) is useful in treating many anxieties and trauma based disorders, and should not be ruled out as an option for recovering persons with stable sobriety under their belts. (AACR, 2015).

### **Limitations of the Study**

The main limitation of this study is generalization. However, this is the inherent nature of a quantitative study design since the study participants are selected by the investigators from a particular area. Hence the views expressed are those of the participants in that area and may not necessarily reflect the views held by every substance use disorder person in the nation at large.

### **Conclusion**

The study examined the relationship between domestic violence, substance use and suicidal ideation among persons with substance use disorder and its implications for Psychotherapy practice in Anambra State, Nigeria. Employing a correlation design and selecting a total number of 30 participants with substance use disorder. In the study two hypotheses were tested, and the findings

showed that domestic violence and suicidal ideation were positively correlated. Also, the findings showed that substance use and suicidal ideation were positively correlated.

### **Recommendations**

Based on the findings of the study, the following recommendations were proffered;

1. Reforming the persons with substance use disorder through Psychotherapy on the dangers of domestic violence and substance use in the course of the rehabilitative Psychotherapy is highly recommended.
2. In psychotherapeutic assessment of domestic violence, the different identified dimensions contributing to poor mental health should be incorporated.
3. To reduce the risk of suicide in women, violence against women should be condemned and appropriate prevention measures be taken by health professionals, including the utilization of efficacious psychotherapeutic tools.
4. Access to psychotherapeutic treatment for co-morbid mental health problems for people with drug use disorders could potentially reduce risk of suicide.
5. Increased suicide risk screening and psychotherapeutic prevention efforts for individuals with substance use disorders are needed.

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# Small Group Versus Large Group Psychotherapy In Africa

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## **Abstract**

*Group psychotherapy started with large numbers of people participating in a single psychotherapeutic session at once. More traditionally group psychotherapy began to be practiced with no more than twelve persons. When group therapy involves a therapist/therapists working with more than 10-12 people/ clients at a time it becomes a large group therapy. However, research evidence does not show that large groups are less effective than small groups. For the fact that Africans are collectivistic and communalistic, large groups may sometimes be more suitable for persons of African descent.*

**Key words:** *Small Group, Large Group, Psychotherapy, Africa.*

## **Introduction**

Tracing the origin of group psychotherapy is an interesting historical pierce. Meiers (1945) posits that group psychotherapy is said to have a long past and a short history, which seems paradoxical. The argument is that psychotherapy and group psychotherapy have long traceable roots in antiquity. It is said that the Cults, religion of folklore, folklore and poetry of Egyptian, Greek, Oriental, East Indian, Chinese, and Polynesian and American Indian medicine provides many fields of the past of the roots of psychotherapy and group psychotherapy. Early poets,

literary authors and scientists had written much about the effects of groups and large gathering of individuals. Meiers (1945) appears to make a distinction between the past and the history of group psychotherapy. Whereas the past of group psychotherapy lies in the ancient world, the history represents the course of the healing arts in the form of well recorded and systematized disciplines growing with civilization. In Meiers' s account indicates that it was Johannes Christian Reil was who lived between 1859 and 1813 that in 1803 predicted that the Psychic

treatment of mental disturbances would in future add a doctorate degree in Psychotherapy; this is thought to be the first coinage of the term psychotherapy (Meiers (1945)).

The short history of group therapy lies in the works of Pratt (1908) a Boston internist, who had interactions with patients who had tuberculosis at the Boston Dispensary and observed that the patients' emotional reactions, their feelings of shame and discouragement because of their illness, often interfered with their capacity to adhere to self-care regimens. Rather than his original idea of visiting the patients in their homes. Pratt began to gather large numbers of the patients, meet to discuss their attitudes, report on their efforts at self-help in dealing with their ailments, and receive instruction from him. The groups started meeting on 1<sup>st</sup> 1905, helping the patients to understand the nature of their illness, teach them how they could contribute to their own recovery, and to inspire them to sustain their courage in living with a chronic ailment. These groups were quite large, consisting of over a hundred patients who sat in rows in classroom fashion facing the speaker on the platform. One of the early pioneers in large group psychotherapy had the motto: "By the crowd they have been broken; by the crowd they shall be healed (Ettin, 1988). As developments in the field continued, group psychotherapy often involved more than one client attended to by a therapist at a time. It has become more or less like a tradition for group therapy to have between 8 and ten clients being attended to together by one

or more therapists at the same time in the same therapy sessions.

When group therapy involves a therapist/therapists working with more than 10-12 people/ clients at a time it becomes a large group therapy. Obviously in such a scenario the group dynamics will be more difficult to manage compared to the regular group therapy. Some authors have reported large group psychotherapies where sessions have upwards of over sixty persons (Brown, Cochrane, Hancox, 2000; White, Keenan, Brooks, 1999).

Main, Elliot and Brown (2005) argue that there is a large unmet need for psychological services for anxiety and depressive disorders such that there is a need to develop larger-scale psychological interventions. The authors contend that Group interventions could help meet the need but the kind of Cognitive Behavioural Therapy (CBT) approach used merits investigation. They are opinion that current patterns of service delivery are problematic, individual therapy is expensive, and thus usually restricted to those with severe and disabling problems. Comparing large group therapy with small, weekly anxiety management groups, Brown, Cochrane, Mack, Leung and Hancox (1998) reported that the two formats were equally effective, with both groups showing significant changes compared to the wait-list control group. In fact, the authors conclude that a full-day workshop format can be seen as a realistic alternative to traditional weekly groups for clients with a similar degree of distress, and in situations where large

groups of people have to be reached. White, Keenan and Brooks (1992) developed "Stress Control" therapy for use in large groups, usually twenty or more participants with generalized anxiety disorder, that were referred to an already over-stretched clinical psychology primary care service. The authors used a mixture of didactic teaching combining elements of traditional group therapy and a self-help package. They ran five different types of groups: cognitive therapy; behaviour therapy; cognitive behaviour therapy; placebo (subconscious retraining); and a wait-list control. Post-therapy results showed that the three active treatments, and to a lesser extent the placebo group, showed highly significant change on the majority of the outcome measures. Brown, Cochrane and Cardone (1999) are of the view that large group therapy may be a time and cost effective method of delivering psychological interventions to a relatively large number of people, and is often well received.

Cunningham, Bremner, and Boyle (1995) have shown that very large groups can be used in helping parents whose children have some health challenges. The design is a form of group psychotherapy rather than mere social meetings or self-help groups such as in the case of persons with substance use disorders. Getting a large number of parents together in one session has many financial and learning advantages including the reduction of stigma of mental disorders.

Hawker (2007) strongly argues that large group therapy, with more

participants than are traditionally included in therapeutic groups, may be effective and more efficient than individual or small group therapy. The author opines that faced with long waiting lists and a never ending demand for services, clinicians and managers often advocate group therapy as a way of treating clients more efficiently. Large-scale anxiety management groups, it has been observed, were pioneered by Jim White, running with up to 60 participants at a time (White, 2001).

Barlow, Burlingame and Fuhhriman. (2000) argue that Group psychotherapy draws on research and applications from diverse fields, covers an array of topics from psychoeducation to analysis (often blurring the boundary between group psychology and group psychotherapy). According to these authors group psychotherapy can take virtually any shape and its efficacy of group psychotherapy has been established in the empirical literature and does not depend on the number of clients bit on the interactions within the groups.

It is reported that controlled trial of 6-session large-group anxiety management for adults showed reduced anxiety following large group cognitive therapy, behaviour therapy, or CBT in comparison to large group placebo anxiety management and a waiting-list control group (White, Keenan, & Brookes, 1992). Brown *et al* (2000) reported that large-scale stress group as a workshop format for the general public (with 20-25 participants at a time) were as effective as small groups, with

anxiety reductions maintained at 3-month follow-up.

Munro and MacPherson (2001) reported that two -session large group anger management for adults in a forensic service resulted subsequently in lower dropout rates for individual treatment than would normally be expected, even though it may perhaps be thought that the group was not too large.

Sometimes large group therapy may involve didactic elements. Hawker (2007) is of the view that didactic large groups have a long cultural history from pulpit sermons, to school teaching, to public lectures by parenting gurus. The author observes that seminars in universities and training conferences break large groups of 20-30 participants into subgroups for experiential learning. According to the author, in that type of scenario large groups could be seen as psychoeducational classes but still maintains elements of therapeutic encounters. However, even if such large groups were to be regarded as psychoeducational classes, they still offer equivalent benefits and experiences to therapy.

Hawker (2007) sees large group therapy as having great potential to help people with mental disorders and their carers to deal with problems such as anxiety disorders, depressive disorders, major neurocognitive disorders, ADHD, autistic spectrum disorders, perhaps even psychotic and eating disorders. As in every therapeutic approach, there is no doubt that some problems may be helped by large group treatment, and some may not (Hawker, 2007).

### **Large Group Psychotherapy in Africa**

The building blocks of psychotherapy lie ultimately in understanding of human nature and systems of meaning of human functioning, such that whenever mental or psychological disorders arises, there will be a systematic method to restore normalcy and natural order—that would permit continuous healthy human growth. Virtually all the traditional psychotherapeutic approaches were developed in West cultures and psychotherapists often view these psychological interventions from the prism of the West. While there may be similarities between cultures and groups, the hall mark of understanding human nature is in the culture. Approaches to psychotherapy in Africa must be seen in the context of African philosophy and psychology. In this regard African philosophy and psychology (Africology) may be summarized in the Ubuntu Philosophy. The word Ubuntu is derived from a Nguni (isiZulu) aphorism: *Umuntu Ngumuntu Ngabantu*, translated as “a person is a person because of or through others”. It is embedded in African collectivism, implying: “I am because we are”. Ubuntu can be described as the capacity in an African culture to express compassion, reciprocity, dignity, humanity and mutuality in the interests of building and maintaining communities with justice and mutual caring. In south eastern Nigeria as indeed other parts of Africa, there are many groups within which things are done together for the well-being of individuals and large groups. Some

examples of these large groups include extended kinship (ikwu na ibe), descent (umu nna), clans (ndi obodo), women of the society (umu ada), age groups (ito ogbo), ancestral system (ndi icihie). These groupings are reflected in African traditional governmental system including *nze na ozo* all of which have their spiritual meanings. Africans are religious in every way and in everything. Therefore, psychotherapy in and for Africans must take these issues into account rather than wholly being undiluted copy of western interpretation of psychotherapy. The implication is that group psychotherapy, especially large group therapy perfectly fits African way of life.

Throughout the ages, Africans have always had some ways of dealing with mental distress however, it would appear that the word 'Psychotherapy in Africa' first appeared in the literature in 1996 as part of an edited book by Madu, Baguma and Pritz (1996) entitled: *Psychotherapy in Africa*.

Very large group therapeutic sessions are acceptable in African culture permitting clients not only to solve their personal psychological distresses but also maintain the communalistic philosophy of the continent. Without any doubt, the field of psychotherapy has evolved over the years to acknowledge the reality and potential clinical benefits of recognizing the prime importance of African culture. Community building is a very important African lifestyle; what affects one person affects the other members of the society and these issues can be discussed

in very large groups. In white cultures it is common for individual families to handle their issues alone and easily involve Government agencies to intervene but this can be handled in Africa via small or large group setting maintaining the harmony of the society. Before the whites colonized Africa, community used to be the uniting factor and here very large groups play important roles in resolving psychological distress. The vestiges remain to date. Columbus (2009) opines that value system in Igbo culture, Nigeria is seen in terms of having desirable or esteemed characteristics or quality. Large group therapy may be more realistic and beneficial in this setting.

Training in and practicing of psychotherapy as a special discipline in Africa in general, and Nigeria in particular is still in its infancy (Madu, 2005, 2009, 20015, 2016, 2020; Madu & Govender, 2005; Madu & Ucheagwu, 2020; Onwukwe & Madu, 2019). The first ever and only dedicated school of psychotherapy in the entire African continent is the *School of Psychotherapy and Health Sciences Okija*, Anambra State, Nigeria. The foundation was laid by an Austrian trained Clinical Psychologist who later also specialized in psychotherapy. In the school, there is often this seeming overlap in some areas between psychotherapy and psychology, and between Africa and Europe.

For sure international psychology influences indigenous psychology and it is known that many African psychologists with Western training

have incorporated their instruction to include aspects of African culture that may not be necessarily relevant to Western psychology. These colourations have great value viewed from the prism of African philosophy. African psychotherapists recognize the importance of the extended family and community which is more suited to the societal norms of African culture than Western culture. Psychotherapists must be sensitive to the African worldview when dealing with African clients. The African worldview informs the way in which Africans relate to phenomena, including challenges that life presents to African clients. The British Association for Counselling and Psychotherapy (BACP) (2009) defines counselling as “a private and confidential setting which explores the difficulty, distress or loss of direction and purpose that the client is facing, as the role of a counsellor should be able to encourage to look at different aspects of their life”. This privacy may be broken in group therapy and more importantly in very large group settings which are in consonance with African culture.

Asante (1987) is associated with the development of the term “Afrocentricity”. He introduced the concept in 1980 in a book: “Afrocentricity: the theory of social change” (Gray, 2001:19). According to Asante (1987) Afrocentricity is literally placing African culture at the centre of any analysis that involves studying African people. Afrocentricity is said to be a perspective that allows Africans to be subjects of historical experiences

rather than objects on the fringes of Europe. The idea is that African people can and should see, study, interpret and interact with people, life, and reality from the vantage point of African people rather than from the vantage point of European, Asian, or other non-African people, or from the vantage point of African people who are alienated from Africanness.

According to Asante (1987) Afrocentricity is based on African cultural beliefs, practices and values and it will be inappropriate to apply the Eurocentric theories of human behaviour to explain the behaviour of Africans. European theories of human behaviour reflect notions of human behaviour developed in European and Anglo-American cultures which unfortunately claim to provide universal explanations of human behaviour- a universalism that many Africans will not accept. Group psychotherapy for Africans cannot neglect the collectivistic and communalistic disposition of people of African descent and this is the beauty of large group settings in the continent. Ettin (1988) asserts that over its first quarter century, pioneers in the group approach wrote about the purposes and possibilities of collective therapy, with special attention toward: (1) theoretical variables such as curative factors and therapy goals; (2) the basic logistics of practice including optimum group size, composition, membership criteria and the length, frequency, and structure of meetings; and (3) technical considerations such as the role of the therapist and the process of the group.

These issues must be as well be seen from African world view.

There is no doubt that what works for one person may not work for another even when they have apparently the same psychological problems. There is no research evidence that what is done in small group psychotherapy of 8-10 clients cannot be done in large groups. Zarbo, Tasca, Cattafi, and Compare (2016) have shown that group psychotherapy works, and this is irrespective of the number of clients in a single session. Rather than the number of clients in therapy, the main pillar of psychotherapy integration is the important research findings that despite the varying theoretical rationales and approaches of different schools of psychotherapy, they all produce similar outcomes (Barth et al., 2013). What this means is that psychotherapists need to integrate psychotherapy models having the evidence that common factors across psychotherapy approaches (e.g., therapeutic alliance, client expectations, therapist empathy, etc.) likely account for more outcome variance than the specific effects attributed to each psychotherapeutic approach.

### Conclusion

Group dynamics may differ according to the number of clients but such dynamics cannot be taken out of relevant sociocultural context. Group psychotherapy appears to have gone through a circle; Pratt (1908) started with very large groups, a tradition of small groups (8-12 clients) later developed and current evidence and

practice does not show that large groups detract from the efficacy of group psychotherapy, instead the efficacy in terms of natural real world practice support the application of large group therapy.

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# **The Effectiveness Of Traditional Healing In The Treatment Of Mental Illness In Africa: A Critical Review**

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## **Abstract**

*The traditional healers play a key role in healing the health problems of communities by using the Herbs and other methods in Africa. The natives are in favour of traditional medicine in curing their health problems. Mental illnesses in some cultures are believed to be as a result of spiritual and family misfortune and only traditional healers have a solution to them. The study reviewed literatures on the effectiveness of traditional healing in curing mental illnesses. Search on peer review articles that reported the activities and the effectiveness of traditional healing in the treatment of mental illness was done to provide insight into the effectiveness of traditional healing in the treatment of mental illness. The present study revealed that the traditional healing methods were effective in the treatment of mental illness and are well accepted by the communities. However, the lack of standard of dosage and wide spread of fake healers are often reported as weak point in the traditional healing system. It is recommended that the integration of traditional healers in the conventional health care system in Africa is useful to make society healthier.*

**Key words:** *Traditional Healing, Mental Illness, Africa*

## **Introduction**

A mental illness is a health problem that significantly affects how a person feels, thinks and behaves, thus diminishing one's capacity for coping with ordinary demands of life. The most common mental disorders encompass depression, generalized anxiety disorder, panic

disorder, phobias, social anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (Linyua & Njagi 2013). Globally, approximately 450 million people suffer from one or more of these disorders, and almost 1 million people commit suicide

every year due to these disorders (WHO, 2011).

Mental disorders are also highly prevalent in Africa. For instance, Jenkins, Njenga and Okonji (2012) reported the prevalence of 10.8% amongst the population of Kenya, largely comprising mixed anxiety depression, panic disorder, generalized anxiety disorder and depressive episodes. In Uganda, mental illness such as depression, anxiety and bipolar disorder is 9.3%, 8.5%, and 4.9% respectively (Orley & Wing, 1979). Out of 80% of Congolese patients diagnosed with mental illness, the majority have schizophrenia, anxiety and mood disorders<sup>9</sup>. A national survey conducted by Herma *et al* (2009). Across the nine provinces of South Africa found that at least one in five South Africans is adversely affected by mental disorders, with common ones being major depression (9,8%), and agoraphobia (9,8%). Other epidemiological studies restricted to certain provinces of South Africa also indicated that mental disorders are rampant (Burns, 2014, & Jacob, 2015).

Generally, mental health problems are associated with multi-faceted factors including social changes, work stress, discriminations, social exclusions, poor lifestyles, risk of violence and physical illnesses (WHO, 2014). Therefore, elimination of some of these factors will contribute significantly towards the management of mental disorders. Mental illnesses can be effectively treated and managed using pharmacological and psychosocial treatments.

Pharmacological treatments include Amitriptyline, Carbamazepine, Chlorpromazine, Clomipramine, Diazepam, Fluoxetine, Fluphenazine, Haloperidol and Lithium carbonate (WHO, 2009). Psychosocial treatment of mental illness entails crisis management, psychotherapy such as cognitive-behavioral, supportive, and family therapy, and usually outpatient treatment where appropriate (Burns, 2014).

In African traditional setting, there was always an explanation as to why someone was suffering from a certain mental illness at a particular time. According to Ayodele (2002), mental illness and other diseases mostly revolve around witchcraft/sorcery, gods or ancestors, natural, as well as inherited. According to Madu and Govender (2005), biology alone does not explain disease causation to an African, because, it is seen as a social phenomenon and as such has significance for the whole ethnic group and immediate community members. Illness in the African society is different from the Western medicine point of view. Illness is believed to be of natural, cultural, or social origin (White, 2015). Mental illness is widely thought to be related to supernatural causes such as angered spirits, witchcraft, or alien/evil spirits. African traditional beliefs consider the human being as being made up of physical, spiritual, moral, and social aspects. The functioning of these three aspects in harmony signified good health, while if any aspect should be out of balance, it signified sickness. Thus, the treatment of an ill person involves not only aiding

his/her physical being but may also involve the spiritual, moral, and social components of being as well. Madu (2003), said that when assessing the mental health of indigeneous peoples, it is necessary to remember that the distinctness of their cultures and how they express distress and conceptualise well-being challenge many universalist notions in psychiatry. The knowledge base about the mental health of indigeneous people must include information about traditional medical practices and their relatives effectiveness (Madu, 2003).

A traditional healer is one who provides medical care in the community that he lives, using herbs, minerals, animal parts, incantations, and other methods, based on the cultures and beliefs of his people. He must be seen to be competent, versatile, experienced, and trusted (Sofowora, 1982). In specific cultures, these people go by their local names, depending on their tribe, such as *babalawo*, *dibia*, or *boka*, etc. in Nigeria, *Sangoma* or *inyanga* in South Africa, *akomfo*, *bokomowo* in Ghana, *niam-niam*, *shaman*, or *mugwenu* in Tanzania, *nga:nga* in Zambia, and *shaman* or *laibon* in Kenya (Abdullahi, 2011). It is common to see traditional healers dressed in certain peculiar attires, with head bands, feathers, and eyes painted with native chalk.

In Africa, traditional healers (THs) play a vital role in the health care of the majority of the people (Sorsdahl *et al*, 2009). Therefore, it is not surprising that approximately half of African population seeking formal health care

for mental disorders consult traditional healers as their first line of care (Burns & Tomita 2015; Gureje *et al*, 2015; Whiteford *et al*, 2013; Sorsdahl, Stein & Flisher, 2013; Seedat *et al*, 2009). Traditional healing for the treatment of mental illness is preferred for a number of reasons including its accessibility, affordability and its philosophy of seeing the person holistically (Chan, 2014). According to Chipfakacha, (1994), all cultures have disease theory systems which include attributional concepts to explain illness causality. Although the ailments are common to all human societies, their types, the ways they are diagnosed and treated depend on how people regard them, and normally varies from one society to another.

The use of traditional healing remedies for mental illness has always been part of human culture. Among the Igbo culture in Nigeria, disease is generally referred to as '*oria*' (sickness). They attribute the causes to several agents such as sorcery, breaking of taboos, mystical disease and witchcraft (Okwor, 1997). In the quest to dominate and conquer the environment in which they live, they devised a way to cure these diseases. According to Okonkwo, (2012), In spite of the rapid growth in the development and spread of modern medicine, traditional knowledge on the use of herbs continues to be the most popular alternative to health problems in Nigeria.

Traditional healers make use of traditional medicine in the treatment of mental illness. Traditional medicine is viewed as a combination of knowledge

and practice used in diagnosing, preventing, and eliminating symptoms of mental illness. This may rely on past experience and observations handed down from generation to generation either verbally, frequently in the form of stories, or spiritually by ancestors or, in modern times, in writing (Mokgobi, 2014). It is a wide belief among Africans that before attaining knowledge in traditional African medicine, one is often required to be initiated into a secret society, as many characteristics of this form of medicine can only be passed down to initiates.

### **Statement of the problem**

Mental health in Africa have not received considerable attention. Observing that culture is an important factor in mental health care, and that each culture has its own unique conceptualization about Mental illness and treatment approaches. Western psychotherapies have been questioned among some indigenous psychological health professionals, since it was developed on the western concept of illness and culture.

In recent times there have been debates among psychological health professionals on the desirability of developing more indigenous psychotherapy that is based on the cultural values of Africans towards their perception of mental illness. This has raised the question of how effective traditional healing are in the treatment of mental illness. Traditional healers have received much criticism over the effectiveness of their mode of treatment

since the advent of the western psychotherapeutic methods.

In Nigeria for instance, the ambience of psychiatric victims or madmen at every corner and under bridges has raised some concerns on the actual role of psychiatric hospitals and their efficiency and effectiveness in use of western psychotherapeutic treatment models. Contrary to western influences in medical treatment, it appears that communities continue to comprehend mental illness through their own cultural parameters.

### **Objectives of the Research**

The objectives of this research can thus be summarized as follows:

- 1) To review empirical studies on the effectiveness of traditional healing in the treatment of mental illness in Africa.
- 2) To point out the treatment approaches for mental illness offered by the traditional healers in Africa.
- 3) To point out the weak points identified in the traditional healing system in Africa.

### **Research Questions**

- 1) Could traditional healing be effective in the treatment of mental illness in Africa?
- 2) What are the treatment approaches offered by traditional healers in the treatment of mental illness in Africa?
- 3) Are there weak points to be found out in the traditional healing system in Africa?

### **Significance of the Research**

This Review is significant because of the following reasons:

1. The review will bring into focus the importance of traditional healers in the treatment of mental illness in Africa.
2. The review will highlight studies that have shown that traditional healing has been effective in the treatment of mental illness in Nigeria and other parts of Africa
3. Finally, the review will highlight the importance of culturally based approach in the treatment of mental illness in African communities.

### **Operational definition of terms**

***Mental Illness:*** Mental illness is a mental health situation that significantly and negatively affects how a person feels, thinks and behaves.

***Traditional Healer:*** This is a healer that make use of any or all traditional healing approaches (i.e., herbs, incantations, animal parts etc.) in the treatment of mental illness

***Traditional Healing:*** Traditional healing is an indigenous or cultural healing methods utilized by traditional healers in the treatment of mental illness in Africa.

### **Literature Review**

A literature search was conducted to gather relevant information on the traditional approach to the treatment mental illness in Africa.

### **Theoretical Review**

#### **Holistic model**

This model combines many health modalities and models of health care with the goal of helping the patient or client achieve optimal physical, mental, emotional, social, and spiritual health (Klinghardt, 2005). The ultimate goal of holistic medicine is to use all the available diagnostic and treatment modalities to optimize the health of the person on all levels of well-being, without doing harm to the person. The premise of holistic medicine is to attempt to treat the patient as opposed to the illness. A holistic approach to mental health puts the patient, not their diagnosis or their symptoms, at the center of their treatment plan. By addressing their emotional, mental, physical, and spiritual needs, a holistic approach to mental health looks at the whole person. Ancient systems of medicine such as Traditional healing have long taken a holistic approach towards obtaining and maintaining good health. It looks at mental illness from a systemic perspective rather than in isolated units.

The concept of a mind-body-spirit approach to mental and physical health is based on the idea that a state of well-being is the result of physical, mental and spiritual elements working together in harmony. Therefore to be mentally healthy, we should pay attention to the mental, physical and spiritual aspects of our lives. The holistic approach is an effective method for treating mental health conditions because it views the

patient not as a generic problem to be solved, but as a unique human being who acts and reacts in response to his body, environment, circumstances, and life experiences.

### **Empirical Review**

Catherine investigated 387, participants in Uganda and found out that over 80% of patients with psychosis used both biomedical and traditional healing systems. Those who combined these two systems seemed to have a better outcome (Catherine, 2011). Motunrayo and Ezeibunwa (2014) examined healthcare utilization among people with mental illness in Abeokuta and Ibadan, Southwest Nigeria as a way of understanding the context in which health seeking and treatment take place. The study Findings revealed that participants have a strong perception that mental illness is caused mainly by supernatural force and Most of the participants preferred the traditional pathway to treatment, irrespective of its perceived limitations.

Baarnhielm and Ekblad (2000, p. 442) reported that an amulet was perceived to be effective in treating mental illness, stating that “her [the patients’] feeling of being worried decreased”. According to study report Zeynep(the patient) had combined health care treatment with the use of an amulet given to her by her family. The family had told her that the amulet had healing power and Zeynep trusted in this. When she had started to use the amulet her feeling of being worried decreased. The traditional Māori treatment of

*whakawetewete* was perceived to be effective and the young patient reported that he “had not heard any more voices and he and his mother could not recall the last time he had had a seizure like episode” (Bush & NiaNia, 2012, p. 350). Similarly, Connor (1982), reported three specific cases in which *Balian* ritualistic treatments were effective in treating mental illness. Additionally, Connor (1982, p. 785), states that “in many cases I encountered ... the patient recovered after only a short course of traditional treatment”.

Audet, Ngobeni, Graves and Wagner (2017), reported that Traditional Healers reported having the ability to successfully treat: seizure disorders (47%), patients who have lost touch with reality (47%), paralysis on one side of the body (59%), and substance abuse (21%). Mbwayo, Ndetei, Mutiso and Khasakhala (2013), investigated the types of mental illnesses treated by traditional healers, and their methods of identifying and treating mental illnesses in their patients with Kenyan population and the study reported that traditional healers are able to recognize some mental disorders, particularly those relating to psychosis. However, they are limited especially for common mental disorders. The study also reported that Only 15 (4.9%) of the patients responded that they were not satisfied with the traditional healers’ services. The rest (95.1) responded that they were satisfied with the traditional healers’ services. Mbwayo, Ndetei, Mutiso and Khasakhala (2013), also reported that Less than 20 (6.55%) patients combine

traditional medicine with modern medicine. Some of the patients who combine treatments claim that they only take pain killers when they have sudden headaches; while others said that they go to hospital for investigations and then tell the traditional healer who then treats them.

Ngobe, Semenya and Sodi (2021) reported that traditional healers treat seven psychological ailments, viz. adjustment disorders, depression, mental illness due to ancestral calling, mental illness due to bewitchment, mental illness due to breaking of taboos, psychotic disturbance and substance induced mental illness, and have demonstrated certain level of efficacy in treating mental illness. Nortje, Oladeji Gureje and Seedat (2016) reported based on the systematic review they conducted on the effectiveness of traditional healer that some evidence suggests that traditional healers can provide an effective psychosocial intervention. Their interventions might help to relieve distress and improve mild symptoms in common mental disorders such as depression and anxiety. However, little evidence exists to suggest that they change the course of severe mental illnesses such as bipolar and psychotic disorders. As earlier as 70's, Harding (1973) study of patients with psychosis admitted to a traditional healer's compound in Nigeria reported significant rates of improvement that were similar to those achieved with the psychiatric treatment of the time (Harding, 1973). Sorketti, Zainal and Habil (2013), reported in a study carried

out in central Sudan on the outcome of psychotic disorders by traditional healers that there was a significant reduction in the severity of psychotic symptoms after a mean period of stay of 4.5 months.

In a survey from Bali, two-thirds of patients reported at least an improvement after seeing religious healers, although non-psychotic patients reported more improvement than those with psychosis (Kurihala, Kato, Reverger, & Tirta, 2006). Notably, recruitment at conventional psychiatric services in these studies probably excludes patients who were helped the most by traditional healers. In a controlled study, Kleinman and Gale (1982) reported that Taiwanese patients attending a tang-ki shrine mostly with somatic complaints owing to psychiatric or psychosocial problems (i.e., somatization) were less satisfied with their treatment and outcome than were patients attending western medical services matched for demographic and illness variables. In Zimbabwe, Patel *et al.*, (1998) compared outcomes between traditional medical practitioners, primary health-care clinics, and private general practitioners, using a validated questionnaire at 1 and 12 months, and reported generally high rates of improvement in symptoms of common mental disorders irrespective of the type of treatment. Koss (1987) asked patients with similar complaints attending either spiritist healers or receiving psychotherapy in primary care to rate their expected degree of problem resolution or symptom alleviation before the session. After the sessions, patients

attending spiritist healers rated outcomes significantly higher than those attending psychotherapists

MacLaren, Asugeni, Asugeni and Kekeubata (2009) recruited patients in remote hamlets in the Solomon Islands who had been treated by traditional healers for buru (possessed). Subjective rates of permanent cure were 50%, with 30% finding temporary relief and 20% reporting no improvement. Salan and Marezki (1983) reported on a sample of patients attending Indonesian traditional healers with a wide variety of complaints reported high rates of improvement (60%) for psychological and psychiatric problems.

### **Method**

The method describes the research methodology for the research. It is very important because it gives the information on how the research was carried out.

### **Instrument**

This review aimed to include publications that address, directly or indirectly, the effectiveness of traditional healing for mental disorders in Africa. The following broad keywords were used in the literature search to maximize the scope of the search: traditional healing, traditional healers, traditional healing and mental health, traditional healing and mental illness, traditional treatment and effectiveness. Eight widely used databases were searched including EBSCOhost, Cochrane Library, PubMed, PsychOnline, PsychLit, Social Science Citation Index,

and African Journals On-line. Reference lists of included articles were consulted for additional papers.

### **Procedure**

Only peer reviewed studies published in English were included in the review. No starting period was specified so as to be as inclusive as possible. The current review included quantitative and qualitative studies that employed focus groups, individual interviews, case studies, and observations which provided insight into the effectiveness of traditional healers in the treatment of mental illness. Effectiveness was defined in the broadest sense of *does it or does it not work*. As such, *effectiveness* in this review refers to the subjective impact of traditional healing and interventions as reported.

### **Design**

The design has analytical design. The analytical design is a non-empirical design in which facts and information already available are used to analyse and make critical evaluation of a phenomenon. Analytical design, especially when considered with another design(s) allows a researcher to achieve creative thinking that gives insight into performance dynamics of event (Coral & Bokelmann 2017).

It involves the in-depth study and evaluation of available information in an attempt to explain complex social issues like the effectiveness of traditional healing in the treatment of mental illness which is the focus of the current study.

## Findings

The following findings are presented according to the research questions

### 1. *Could traditional healing be effective in the treatment of mental illness in Africa?*

Studies Across most African countries reviewed in this study proved that traditional healing is effective in the treatment mental disorder

### 2. *What are the treatment approaches offered by traditional healers in the treatment of mental illness in Africa?*

The treatment approach adopted by traditional healers for the treatment of mental disorders varied according to the severity and the symptom of the sickness; such as

- i. Herbal treatment (herbs in form of liquid or powder),
- ii. Spiritually removing the illness,
- iii. talk therapy and
- iv. rehabilitation.

In every new situation and with every new patient, the traditional healer decides from the pool of treatment options which one is most appropriate, depending on the following factors:

- i. the type of mental illness,
- ii. the cause of the illness,
- iii. the healer's knowledge of mental illnesses and
- iv. corresponding treatments,
- v. the type of healer or his/her specialization, and

- vi. the healer's former experience.

Individual context and personality thus played a vital role in this decision process.

### 3. *Weak Points*

Weak points of traditional healing in Africa:

- i. The lack of standard dosage in the administration of herbal medication. This could result to a great danger in treatment.
- ii. The widespread reported cases of fake healers and healing.

## Discussion

The studies of major mental illness suggest that acute psychotic episodes might improve somewhat over time under the care of traditional healers. Studies that assessed outcome at least 6 months after the healing show that initial modest improvements are often maintained (Halliburton, 2004; Abbo *et al*, 2012; Harding, 1973). However, little evidence exists to suggest that this improvement is different from the natural course of the illness. The only reviewed literature using conventional psychiatric care as a control showed a non-significant trend towards a worse outcome for the traditional healer patients (Halliburton, 2004). Salib and Youakim reported that attending religious healers might increase the risk of relapse in chronic schizophrenia (Salib & Youakim, 2001).

In Zimbabwe, two decades ago, Patel *et al* (1998) compared outcomes between traditional medical practitioners, primary health-care clinics, and private general practitioners, using a validated questionnaire at 1 and 12 months, and reported generally high rates of improvement in symptoms of common mental disorders irrespective of the type of treatment. Although the differences between practitioners did not reach significance, patients attending traditional healers tended to report more improvement than those attending primary health-care clinics. In Puerto Rico and Koss (1987) asked patients with similar complaints attending either spiritist healers or receiving psychotherapy in primary care to rate their expected degree of problem resolution or symptom alleviation before the session. After the sessions, patients attending spiritist healers rated outcomes significantly higher than those attending psychotherapists, with the difference largely being explained by pre-existing expectations. These two controlled studies suggest that traditional healers might be as helpful as conventional primary care services for psychosocial and neurotic complaints, although the results vary by culture and comparison group.

Lemelson (2004) noted that traditional healing is often thought to help individuals to reframe and make sense of their illnesses, but that this highly subjective process might not necessarily improve underlying neuropsychiatric symptoms. He therefore studied the effectiveness of

Balinese traditional healers in treating the symptoms of obsessive-compulsive disorder or Tourette's disorder, which are less responsive to non-specific therapies than common psychosocial problems. Of 22 patients with these disorders who had repeatedly consulted dukuns (Indonesian shamans), only one patient noted a temporary improvement. He suggests that the psychosocial techniques used by traditional healers are ineffective in treating neuropsychiatric symptoms. Although wide variation exists, traditional healers in general could be modestly helpful in the treatment of common mental or neurotic disorders that are most responsive to psychosocial interventions. In particular, patients with mild depression and anxiety tend to respond favorably to repeated, regular, intense contact with a traditional or spiritual healer (Boelens, Reeves, Replogle, Koenig, 2012; Dixon, 1998; Mainguy, Valenti Pickren, Mehl-Madrona, 2013; Mehl-Madrona, 1999; Zacharias, 2006 ).

Ae-Ngibise *et al.* (2010) in their study in Ghana has mentioned that limited research has been conducted to explore the factors that support or obstruct collaboration between traditional healers and public sector mental health services. They indicated many reasons for the appeal of traditional and faith healers, including cultural perceptions of mental disorders, the psychosocial support afforded by such healers, as well as their availability, accessibility and affordability. A number of barriers hindering collaboration, including human rights and safety

concerns, skepticism around the effectiveness of 'conventional' treatments, and traditional healer solidarity, were identified. Mutual respect and bi-directional conversations surfaced as the key ingredients for successful partnerships. Sorketti, Zuraida and Habil (2010) stated that collaboration between mental health professionals and traditional healers could help to end harmful methods of practice by the traditional healers, such as: isolating patients in an unhealthy, non-hygienic environment; depriving patients of nutritional food; beating patients; misdiagnosis; and mismanagement.

Fundamental weak point of traditional healing is the lack of standard dosage in the administration of herbal medication. This could result to a great danger in treatment. Therefore, standardization of dosage in traditional healing system should be considered for the improvement of the traditional health care system.

Another, fundamental weak point of traditional healing system is the widespread reported cases of fake healers and healing, though, this is not limited to traditional healing practice only. Ebomoyi (1982) observes that since the proficient healers could be rendering beneficial services to a large population, it might be a common place to encounter quacks among the practitioners.

These challenges notwithstanding, there is increasing evidence that traditional healing would continue to hold sway in both rural and urban

communities of Africa even when modern health care facilities are available (Bamidele *et al.* 2009) to meet wide range of health care needs.

### **Clinical implications**

This study provides good, clinical, evidence-based data for policy makers to use to improve mental health services policies and plans, and can also be useful for other countries with similar traditional healing methods and a similar cultural background.

- 1) Traditional healing approaches produce some improvement in the signs and symptoms of psychotic disorders, but a lot of issues and concerns about the approaches practised by traditional healers need to be addressed.
- 2) Traditional healer centres may constitute a community resource for mentally ill people in a culture where they are recognized and valued.
- 3) We need to modify community concept, attitudes and practices concerning mental health services and the care of the mentally ill, and raise public awareness to decrease stigma of mental illness and enhance utilization of available services.
- 4) We need to ensure community involvement and participation in the delivery and utilization of mental health services.
- 5) We need to extend mental health services in the community, making use of the primary health care settings, and in collaboration with

the traditional healing centres, integrate the mental health services into the main stream of the general health services and primary health care so as to decrease the duration of untreated mental illness by early community detection and collaboration with traditional healer centres.

- 6) To encourage more mental health research relevant to community needs and demands, especially that related to mental health and traditional healing practices.

### Conclusion

The outcome of this review suggest that traditional healing approaches produce significant improvement in the signs and symptoms of psychotic disorders. We cannot underestimate the role of traditional healers in providing culturally and sociably accepted care to their community. An atmosphere of understanding, trust and respect should be created between modern health workers, traditional healers and the communities they serve. It is very important for professional health care workers to collaborate with traditional healers because most people with mental illness consult traditional healers first, or they alternate between healers and doctors, thereby wasting a lot of resources. Lack of standard dosage and widespread of fake healers are identified as fundamental weak points of traditional healing system.

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# **Effect Of Group Cognitive Behaviour Therapy, Self-Esteem And Quality Of Life On Depressive Symptoms Among People Living With Substance Use Disorder In Nigeria**

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## ***Abstract***

*This study examined the effects of group cognitive behavior therapy, self-esteem and quality of life on depressive symptoms among people living with substance use disorder. A total of 10 diagnosed depressive patients with substance use disorder were recruited from Nnamdi Azikwe Teaching Hospital, Nnewi, Nnewi South L.G.A of Anambra State, Nigeria and were treated with group cognitive behavior therapy. They were administered the Center for Epidemiologic Studies–Depression scale (CES-D), Index of Self-esteem, and WHOQOL-BREF quality of life assessment. The samples were within the age range of 18 to 59 years, mean age of 41.7 and standard deviation of 15.9. The study made use of between group experimental design and matched t-test Statistics. The result indicated a significant difference between cognitive behaviour therapy group and control group at  $t(4) = 6.78, P < 0.01$ . The second hypothesis was accepted indicating a significant difference between depressive patients who are high on self-esteem and depressive patients who are low on self-esteem at  $t(4) = 10.38, P < .01$  respectively. The third hypothesis which stated that people living with substance use disorder who have high quality of life will significantly show less depressive symptoms than those who had low quality of life was also accepted. This shows that people living with substance use disorder who have low quality of life are more depressed than those who have high quality of life at  $t(4) = 7.94, P < .000$ . It is recommended that group cognitive behavior therapy be*

*adopted as an intervention technique in the treatment of patients diagnosed with depressive symptoms with substance use disorder.*

**Key words:** *Group therapy, Cognitive Behaviour Therapy, Self-Esteem, Quality of life, Depressive symptoms, Substance use.*

### **Introduction**

World over, substance abuse forms a major burden to the societies, Nigeria inclusive. It has in the recent time witnessed an annual increasing economic costs, including health, crime related costs, and losses in productivity as a result of indulging in substance by a substantial number of citizens especially the young ones (Cicero, Lynskey, Todorov, Inciardi & Surratt, 2008). Abused substance falls into three categories: depressants (heroin, barbiturates), stimulants (cocaine, crack, amphetamines) and hallucinogens (marijuana, ecstasy). These drugs can be ingested, inhaled, smoked, injected or snorted.

Pivotaly, there continues to be an enormous unmet need for substance use prevention, treatment, care and support, particularly in developing countries, including Nigeria, which made possible the continued increase in the prevalence of substance use disorder (Najt, Fusar-Poli & Brambilla, 2011). Substance use disorder however affects not only individual users, but also their families, friends, co-workers and communities. Children whose parents take substances are themselves at greater risk of substance use and other risky behaviors (Najt, *et al.*, 2011).

Research in this trend has thus linked substance use disorder to crime, street violence and other social problems

that harm communities. Continuous use leads to addiction, interferes with a good nutrient supply to the brain resulting in brain damage, (Shumye, Belayneh, & Mengistu, 2019). It weakens a person's inhibitions, dulls the common sense, brings out sexually aggressive behavior and makes the users more egocentric (Mohasoa, 2010). It also leads to stress and anxiety, which in turn may cause the user to increase the substance dosage to cope with the situation. When this fails, the individual may suffer from uncontrolled depression and may commit suicide (Schiraldi, 2001). These adverse effects of substance use disorder which has been linked to depression justifies the need to examine the factors that affect depression, as well as intervention for depression among people living with substance use disorder.

Depression as it were could best describe as a mood disorder that involves a persistent feeling of sadness and loss of interest. It is different from the mood fluctuations that people regularly experience as a part of life. According to the Mental Health Foundation (2000), the word depression is used to describe a range of moods – from low spirits to a severe problem that interferes with everyday life. WHO (2012) defined depression as a common mental disorder that presents with depressed mood, loss of interest or

pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration, and often presents with symptoms of anxiety. These symptoms can become chronic or recurrent, and can lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities (WHO, 2012).

From this stance, depressive symptoms therefore connote the physical or mental features indicating depressed condition, particularly such a feature that is apparent to the patient

Group cognitive behaviour therapy refers to a group approach that makes use of behavioral, cognitive, relational, and group procedures to enhance the coping skills of the participants, and ameliorate relational and intrapersonal problems that patients may be experiencing (Sheldon, 1999). It is an empirically supported treatment that is both structured and collaborative. It is based on a scientific understanding of the relationship between thoughts, emotions, and behaviours. It is a short-term treatment approach that helps people identify unhelpful patterns of thinking and behaving (Ottawa Institute of Cognitive Behavioural Therapy, 2017).

Self-esteem is thought to provide two basic functions: (1) it is involved in the transfer of information between the individual and the social environment; and (2) it offers a protective function that buffers individuals from negative experiences (Zeigler-Hill, 2013). Self-esteem can therefore be thought of as a

filter through which external information passes through and influences how we interpret our surroundings and react (e.g., mood, behaviour). While high self-esteem may offer protection against negative experiences, it is feasible that low self-esteem may exacerbate slightly negative or even relatively neutral situations. Indeed, self-esteem was found to moderate response to rejection (Ford & Collins, 2010), and those with low self-esteem interpreted ambiguous phrases more negatively (Tafarodi, 1998). Furthermore, individuals with high self-esteem are argued to partake more actively in their surroundings in order to pursue further self-enhancement, while individuals with low self-esteem partake considerably less in order to protect what little self-esteem they have (Baumeister, et.al. 2003). As such, low self-esteem can be a self-fulfilling prophecy, and its persistence poses an influence on many aspects of daily life. Low self-esteem also appears to be persistent, with levels of self-esteem being consistent from childhood, to adolescence, to adulthood, and older age (Orth, Maes, & Schmitt, 2015).

Another factor that may influence depressive symptoms among people living with substance abuse disorder is quality of life. This is a broad ranging concept affected in a complex way by the persons' physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment (WHOQOL Group, 1995). It has been defined by De Walden-Gałuszko (1997) as an

individual's appraisal of his/her own life situation within a specific time span. In other words, it is the appraisal of a fragment of one's life which takes place between the human subject on the one hand, and the factors which have an impact on him/her from the external environment and the internal environment (his/her own body) on the other hand. WHO (2012) defines quality of life (QOL) as an individual purpose-aligned cultural and value system by which a person lives, relative to their aims, hopes, living standards and interests. Recently, WHOQOL (2020) defined quality of life as an individual's perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns.

As a broad, general concept, quality of life has included several domains related to health, but the concept also originally included many other non-health-related issues such as work, family, prosperity, spirituality, and environment. Quality of life in mental health began to gain momentum with increasing concerns about the unsatisfactory life conditions of patients suffering from chronic mental illnesses in the community. Greater emphasis is given on quality of life as an outcome measure for comparison of therapies and programmes as well as for equitable distribution of resources. The recent interest in QOL has been generated due to two main reasons, firstly as a part of the larger drive towards "Health for all" and the promotion of physical, mental

and social well-being, and secondly, a fundamental rethinking of the goal of rehabilitation as an indicator of good QOL, as perceived by the patients and their relatives (WHOQOL, 2020). The relationship of QOL to MDD has not received much attention in the literature.

The dawn of the 21st century presented substance abuse as the most sensible social-mental pathology, which can simply weaken the foundation of cultural-social and personal life of a country, threaten the human dynamics, and spoil its material and spiritual facilities (Singh, Bhattacharjee, Das & Kumar, 2009). It can also have a great effect on behavior and other life layers of people with substance abuse disorder and their family (Najafi *et al.*, 2011).

However, one issue resulting from addiction phenomenon is its influence on the mental health of those living with it. Studies on this subject showed that unstable mental health results in incapability to endure hard situations; and causes damaging physical and mental consequences, including a range of anxiety symptoms, mood disorders, physical symptoms, sleep disorder, social functioning impairment, behavioral and interpersonal problems, personality disorders, obsession (Nooranipoor, 2004), conversion disorders, suicide and hypomania (Grant, Health, Bucholz, Kathleen, Madden, Agrawal, Statham & Martin, 2007). On the other hand, the vulnerability of people living with substance use disorder increases and results in destroying social and interpersonal relationships.

Research along this axis have suggested that some incidence of physical and mental disorders is associated substance use/dependency disorders (Singh et al., 2009; Chang, 2010), however, some of these studies did not look at factors such as self-esteem and quality of life as a focus in a study. On the other hand, review of the literature and psychological researches about the effectiveness of individual and group psychotherapy and counseling methods based on cognitive-behavioral approach shows that there are limited studies that directly investigated the effectiveness of cognitive behavioral group therapy intervention on depressive symptoms among those living with substance use disorder. These reasons warranted a study on effect of group cognitive behaviour therapy, as well as self-esteem and quality of life on depressive symptoms among people living with substance abuse disorder.

### **Purpose of the Study**

This study wishes to investigate whether group cognitive behaviour therapy, as well as self-esteem and quality of life will have effect on depressive symptoms among people living with substance abuse disorder.

Specially, the study would:

1. Determine whether people living with substance abuse disorder who will receive group cognitive behaviour therapy will show less depressive symptoms than the control.

2. Ascertain whether people living with substance abuse disorder who are high on self-esteem will show less depressive symptoms than those who are low on self-esteem.
3. Access whether people living with substance abuse disorder who scored high on quality of life will show less depressive symptoms than those who scored low on quality of life.

### **Research Questions**

1. Will those who will receive CBT differ in depressive symptoms than the control group?
2. Will there be a significant difference in depressive symptoms between those on high and low self esteem?
3. Will there be a significant difference in depressive symptoms between those on high and low quality of life?

According to Onyedibe, Nkechi, and Ifeagwazi (2020), a 12-week group cognitive-behavioural treatment (CBT) reduced anxiety and sadness in Nigerian women with breast cancer. The researchers in this investigation used randomized controlled pre- and post-testing. In this research, three hundred eleven women with metastatic breast cancer were randomly allocated to either CBT (n=16) or Control (n=15). Only one group got a pamphlet about cancer and coping skills during weekly cognitive behavioural therapy sessions lasting 90 minutes. The Hospital Anxiety and Depression Scale (HADS)

was administered to both groups before, during, and after the intervention (HADS). The analysis was carried out with SPSS (HADS). Participants in the CBT group reported significantly lower levels of anxiety and depression than those in the control group at the end of the trial and a two-month follow-up. According to the findings from this study (CBT), cancer care in Nigeria is severely inadequate in the availability and usage of psychological therapies like cognitive behavioural therapy.

Kitinisa's (2019) research focused on adolescent self-esteem, depression, and drug usage. The event was held in Namagoma's St. Marks College. This research included 120 male and female volunteers ranging in age from 11 to 22 years. Questionnaires and SPSS, a statistical software tool for social scientists, were utilized to gather and analyze the data (SPSS version 23.0). The Pearson Correlation Coefficient was used to test hypotheses ( $r$ ). This study demonstrated a statistically significant correlation between self-esteem and depressive symptoms among adolescents, but there was no statistically significant correlation between self-esteem and drug abuse. Two variables have been shown to have statistical significance concerning each other. Research published in 2019 found a correlation between depression and poor self-esteem among adolescents and young adults. There were 113 participants in this study. They were either diagnosed with major depressive disorder (MDD) or moderate depressive symptoms (MDS). Volunteers between

the ages of 19 and 35 comprised the sample pool. The Rosenberg Self-Esteem Scale (RSES), the NEO-PI (NEO-PI), and the Patient Health Questionnaire-9 (PHQ-9) were used to measure the participants' self-esteem, resilience, social support and quality of life.

### **Hypotheses**

1. People living with substance abuse disorder who received group cognitive behaviour therapy will significantly show less depressive symptoms than the control group.
2. People living with substance abuse disorder who are high on self-esteem will significantly show less depressive symptoms than those who are low on self-esteem.
3. People living with substance abuse disorder who have high quality of life will significantly show less depressive symptoms than those who scored low.

### **Method**

#### **Participants**

Participants in the study were 10 diagnosed depressive patients with substance abuse disorder drawn from Nnamdi Azikwe Teaching Hospital, Nnewi, Nnewi South local government area of Anambra State. Convenience sampling was used to select any patient that was willing to participate in the study. This non-probability sampling technique was used because the participants must consent to participate in the study. The participants comprised

of 10 males, aged from 18 to 59 years, with a mean age of 41.7 and standard deviation of 15.9. They met the DSM 5 diagnostic criteria for depression and substance abuse disorder, on drug therapy and on admission in the hospital. Patients with dementia and head injuries were excluded from the study. Patients who were not admitted were also excluded because of the difficulties involved in getting such patients to attend a special programme in the hospital different from their clinic appointment.

### Instrument

Three instruments were used for this study and they are: The Center for Epidemiologic Studies – Depression scale (CES-D) Radloff (1977), Index of Self-esteem (Hudson, 1982); WHOQOL-BREF quality of life assessment (Group, 1998).

### Procedure

The researcher obtained a letter of introduction from the Head of Department of Psychology, Chukwuemeka Odumegwu Ojukwu University, Igbaram, and presented to the medical director of the Nnamdi Azikiwe Teaching Hospital, Nnewi. The proposal was submitted for review by ethical committee. On approval, appointment was made with the nurses in the drug ward to find out the patients that met the inclusion criteria to participate in the study. The nurses of the drug ward introduced the researcher and research assistant to the patients and

asked them to permit the researcher to collect data for research purposes.

### Design and Statistics

The study is a quasi experimental research and the research design is Between- Group Experimental Design. Based on the research design, matched t-test was used to test the hypotheses.

### Result

**Table 1:** Summary table of Matched t-test on the difference between depressed patients scores on pretest and post-test of CBT.

Pair 1	Mean	N	Std. Deviation	Mt	df	Sig. (2-tailed)
Pre-test (treatment group)	52.00	5	1.41	6.78	4	.002
Post-test	39.80	5	3.35			
Pretest(non-treatment group)	56.60	5	7.06	10.38	4	.000
Post test (non treatment group)	46.20	5	3.19			

The above table indicated that the first hypothesis was confirmed at  $t(4) = 6.78$ ,  $P < 0.1$  level of significant. This means that cognitive behavior therapy significantly brought about reduction of the depressive symptoms among people living with substance abuse when compared with the control group.

People living with substance abuse disorder who are high on self-esteem will significantly show less depressive symptoms than those who are low on self-esteem.

**Table 2:** Summary table of Matched t-test on the difference between depressed patients score on high and low self esteem.

Pair 1	Mean	N	Std. Deviation	Mt	df	Sig. (2-tailed)
Low self esteem	56.60	5	7.06	10.38	4	.000
High self esteem	36.20	5	3.19			

The above table also indicated that the second hypothesis was accepted at  $t(4)=10.38$ ,  $P<.01$  level of significant. This means that people with low self esteem were more depressed than those with high self –esteem people living with substance abuse disorder who have high quality of life will significantly show less depressive symptoms than those who scored low.

**Table 3:** Summary table of Matched t-test on the difference between depressed patients score on high and low quality of life.

Pair 1	Mean	N	Std. Deviation	Mt	Df	Sig. (2-tailed)
Low quality of life	51.04	5	1.52	7.94	4	.000
High quality of life	26.06	5	3.03			

The above table also indicated that the third hypothesis was equally accepted at  $t(4)=7.94$ ,  $P<.000$  level of significant. This means that people with low quality

of life were more depressed than those with high quality of life.

## Discussion

The first hypothesis which stated that people living with substance abuse disorder who receive group cognitive behaviour therapy will significantly show less depressive symptoms than the control group was accepted. The result of the Matched t-test statistics showed the mean of the participants in the pre-test group was different from the mean of the participants in the post-test group even when compared with the control group. Due to such effect, it was revealed that group cognitive behaviour therapy significantly brought about symptom reduction on the depressed patients. Thus, the change in scores indicates the effectiveness of group cognitive behavior therapy in reducing depressive symptoms among people living with substance abuse disorder than the control group.

The improvement among the patients in the group cognitive behavior therapy group can be understood in the light of the nature of group cognitive behavior therapy, in which therapist discussed the physical manifestations of depression, substance abuse disorder and general beliefs, also, the increase in score might be attributed from the patients willingness to participate and be in the therapy and also their level of enlightenment and the need to stop substance use because thought stopping was involved in the sessions of group

cognitive behavior therapy while the decrease in symptoms can be attributed to cognitive restructuring in group cognitive behavior therapy group than the control group. Studies by Ede, Igbo, Eseadi and Ali (2020) and Onyedibe, Nkechi and Ifeagwazi (2020) concluded that there are depressive symptom reduction effects for group cognitive behavior therapy intervention on patients when compared to control group. This result is also consistent with other studies examining the effectiveness of group cognitive behavior therapy in the treatment of depressive symptoms among substance use disorder (Adina, Maritim, Sindabi and Disiye, 2017).

A possible explanation of this result could be that patients were encouraged to develop positive or rational thought patterns which essentially requires recognizing self talks, dealing with negative beliefs and enhancing the positive for a balanced psychological health. This helped the patients to make a better assessment of their problems by making rational statements. It was noted that significant reductions in feelings of guilt, helplessness and mood changes have consistently been found as well as decreased substance abuse on the patients. According to behavior theory, it is supported that group cognitive behavior therapy reduces depressive symptoms in patients abusing substances and may have modest effects in recovery in acutely severe ill patients. The theory maintains that depression among substance abuse patients occurs as a result of learning and also can be

managed or treated by unlearning the learned behavior for example through modeling and cognitive restructuring, patients learn appropriate behavior from modeling of important people in their lives.

Active participation and willingness of the patients to be involved in the therapy also played a role. Another reason for the significant difference in the manifestation of depressive symptoms among the patients could be the therapeutic relationship which was achieved by creating a rapport with the patients, being open and accepting them unconditionally and assuring them of their confidentiality during the sessions. Also, the emotive and behavioural component of the therapy which involves cognitive home works, role playing and rational emotive imagery helped in improving their quality of living.

The second hypothesis which stated that people living with substance abuse disorder who are high on self-esteem will significantly show less depressive symptoms than those who are low on self-esteem. The result of the Matched t-test statistics show the mean of the participants who are low on self esteem was different from the mean of the participants who are high on self esteem. Due to such effect, it was revealed that participants who are low on self esteem had increased depressive symptoms compared to participants who are high on self esteem. The reduced score of people with high self esteem may be due to the nature and characteristics of people who are high on

self esteem which includes the ability to believe strongly in oneself, ability to communicate effectively, ability to recover quickly from setbacks and disappointment and high self confidence, while the increased score of people who are low on self esteem may be the characteristics and nature of people who are low on self esteem which includes poor self confidence, negative self talk, and fear of failure.

Studies by Lin, Tang, Yen, Ko, Huang & Liu, (2008) and Lai, et.al (2015) findings revealed that people who are high on self esteem are capable of influencing positively the opinion and behavior of others; they tackle new situations positively and confidently; they have a high level of tolerance towards frustration; they accept early responsibilities, they assess correctly situations; they communicate positive feelings about themselves; they succeed in having a good self-control and the belief that the things they are undergoing are the result of their own behavior and actions unlike participants who are low on self esteem. Also, findings of Choi, Choi, Yun, Lim, Kwon, Lee and Jang (2019); Manna, Falgares, Ingoglia, Como and De Santis (2016) observed that people living with substance abuse disorder who are high on self-esteem show less depressive symptoms than those who are low on self-esteem.

According to behavior theory, it is supported that low and high self esteem are developed through learning. They noted that self esteem is as a result of learning and low self esteem can equally be unlearned. For example, people learn

the act of effective communication skills as well as self confidence. Behavior theory assumes that through cognitive restructuring, modeling and role play, effective communication skills, poor self confidence and low tolerance level when frustrated can all be acquired through learning.

The third hypothesis which stated that people living with substance abuse disorder who have high quality of life will significantly show less depressive symptoms than those who have low quality of life was accepted. The result of the Matched t-test statistics show the mean of the participants who have high quality of life was different from the mean of the participants who have low quality of life. It revealed that participants who have high quality of life had reduced depressive symptom scores compared to participants who had low quality of life. This finding might be because depressed people perceive the world through a negative cognitive triad; that is having a negative view of themselves of the world and the future. They tend to blame themselves for a great many of their failures, whether deservedly so or not. Facing life everyday with these negative attitudes about oneself tends to bring about depression and such cycle leads to low quality of life overtime. For example, an individual who show less depressive symptoms will have high quality of life, whereas an individual who show high depressive symptoms will have low quality of life. Also, among the participants with high quality of life, it is possible to imply that the participants

have good personal relationships, and they feel socially supported by family members, friends, relatives, or acquaintances.

The findings of this study together with the findings of Shumye, Belayneh and Mengistu (2019) and Daly, Trivedi, Nierenberg, Gaynes, Warden, Morris, Luther, Farabaugh, Cook and Rush (2010) reported depressive symptom reduction on patients with high quality of life when compared to participants with low quality of life. This finding of this study is supported by attachment theory which focused on the relationships and bonds between people, particularly long term relationships. It suggested that high quality of life is developed by people with strong relationships including those between a parent and child and between romantic partners. It might be possible that patients who had high quality of life are patients who had their relatives support, strong family ties and support unlike those with poor family support.

### **Implication of the study**

This study investigated whether group cognitive behaviour therapy, as well as self-esteem and quality of life will have effect on depressive symptoms among people living with substance abuse disorder. It was observed in the result that group cognitive behavior therapy was effective in the depressive symptom reduction of people living with substance abuse disorder. It equally revealed that people who are low on self esteem had increased symptoms of depression than people who are high on

self esteem. Lastly, it was observed that people who have high quality of life showed less depressive symptom reduction than those with low quality of life.

The study findings imply that group cognitive behavior therapy is a strong factor in reducing depressive symptom in people living with substance abuse disorder. This is because group cognitive behavior therapy may have modest effects in speeding recovery in acutely depressed patients. The study implies that depression occurs as a result of learning and also can be managed or treated by unlearning the learned behavior for example through modelling, and cognitive restructuring, patients or participants learn appropriate behavior from the modelling of important people in their lives. Also, the instruments used for data collection has implications for clinicians to know and master the self esteem scale, quality of life scale and also substance abuse scale. The instrument identified patients with varying levels of depression and will now be easy for clinicians to identify high and low self esteem together with high and low quality of life.

### **Recommendations**

In view of the foregoing findings, the researcher made the following recommendations:

- Group cognitive behavior therapy should be adopted as an intervention technique in the treatment of depressive symptoms among people living with substance abuse disorder.

More collaborative studies of higher magnitude than this study should be carried out in the 6 geopolitical zones of this country. This would help to bring to forefront the wide spread and magnitude of this disorder.

Mental Health services which are non existence in most, if not all Medical centers should as a matter of urgency be established in all Nigeria medical centers.

It is also recommended that a multi-national approach should be employed by Drug Law Enforcement Agencies, Drug Use related Non-Governmental Organizations, Mental Health Specialist and Mental Health Institutions in fighting the menace of substance abuse disorder in the country.

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