



Knowledge, Attitudes and Perceptions about Mental Illness in Ekom Iman Community in Akwa Ibom State, South-South Nigeria

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Authors' contributions

This work was carried out in collaboration among all authors. Author JHE designed the study, performed the statistical analysis, wrote the protocol and wrote the first draft of the manuscript. Authors AUI and VEI managed the analyses of the study. Author VEI managed the literature searches. All authors read and approved the final manuscript.

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ABSTRACT

Knowledge and beliefs a community holds about mental illness, has remarkable impact on help seeking path to care and stigmatizing attitudes expressed towards the mentally ill.

Aims: This study examines causal attributions, the perceptions and attitudes towards mental illness and the help seeking behaviour of a community in the south-south region of Nigeria.

Materials and Methods: This is cross sectional descriptive study which was conducted among residents of Ekom Iman community in Akwa Ibom State in the South-South region of Nigeria between March, 2019 and July, 2019. Multistage sampling technique was employed to select the study participants. Causal belief, attitude toward mental illness and help seeking behaviour were assessed using a structured questionnaire.

Results: A total of 130 respondents participated in the study. The average age of respondents was 31.62±8.2 years, consisting of 64.4% males and 35.6% females. Majority, 74.6% had secondary education. Poor knowledge of mental illness and stigmatizing attitudes are common. Most of the respondents prefer to keep a high social distance from the mentally ill and are unwilling to maintain

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close social contacts with them expressed as refusal to share a room (74.7%), marry (92.5%), keeping friendship with them (66.4%). Many believe psychoactive substance abuse (86.2%), brain illnesses/trauma (55.4%) and supernatural factors (72.6%) are etiologic to mental illness. Most respondents considered faith healers (64.3%) and orthodox medical professionals (30.8%) as first choices of treatment and the options best able to treat them.

Conclusion: Causal beliefs of mental illness affects help seeking behavior. Poor knowledge and exposure to mental illness was common. Attitudes towards mental illness were generally negative and stigmatizing. Multidisciplinary community interventions are required to ensure high social acceptance and preference for orthodox professional treatment of mental illness.

Keywords: Mental illness; community; knowledge; attitude; perception; Nigeria.

1. INTRODUCTION

Mental disorders are highly prevalent medical conditions affecting people in all cultures worldwide [1]. It affects mental functions and behavior of an individual and is usually accompanied by varying degrees of impairments in family, social and occupational functioning [2]. It is estimated that 450 million people worldwide suffer from some kind of mental or brain disorder, including behavioral and substance related disorders [3]. Mental health conditions constitute a major global public health disease burden because of the number of persons affected, the disabilities and increased risk of suicide associated with it [4]. According to the Global Burden of Disease study by the World Health Organization (WHO, 2001), neuropsychiatric conditions contribute 4% of the disease burden in Africa, and this projected to rise to 18% by 2020 [5].

Public perceptions of mental illness vary widely across different cultures worldwide, and there exist widespread negative beliefs, attitudes, stereotypes and myths concerning mental illness and the mentally ill in different communities [6]. In many cultures worldwide including Nigeria, mental illness is viewed as frightening, shameful, and incurable, while the mentally ill persons are regarded as dangerous, unpredictable, unstable, untrustworthy, incompetent and helpless in the community [7-8,9]. A World Health Organization report states that the beliefs and attitudes held by members of a community may influence many facets of mental health care. It was also noted that a favorable social environment contributes to improvement in community reintegration of the mentally ill while an unfavorable one may encourage stigma against persons with mental illness [10].

The causal beliefs held by people in different cultures about mental illnesses varies widely and

these beliefs have influences on help-seeking path to mental health services, preferred treatment options, stigma and negative attitudes towards the mentally ill [11]. Studies have reported that in many western industrialized societies, biological and psychosocial causes are more commonly endorsed than spiritual and supernatural causes while in non-western developing countries with predominantly traditional cultures, people tend to endorse supernatural causes more than biological or psychosocial [8,12-14]. However, recent studies seem to suggest an increasing paradigm shift in causal beliefs and attributions about mental illness. These studies reports that earlier predominance of beliefs in supernatural causations seems to be giving way to the biopsychosocial model in many urban environments where more enlightened and increasingly informed populace resides [15,16].

The impact of the stigmatizing attitudes and poor knowledge of mental illness in many developing countries have shown to be a major hurdle to improving mental health services. An increase in the basic knowledge about mental illness, its causes and characteristics in the community can lead to significant positive change in the perception of people towards mental illness. This has the potential to cause a more tolerant and receptive attitudes in a community, which are necessary for a successful community mental health care services delivery. A good knowledge about mental illness in the society can result in early help seeking and thereby provide a framework for early treatment interventions leading to improved long-term treatment outcomes for mental disorders [17,8,18].

Considering the magnitude of mental health needs in many developing countries, and the limited resources available for treatment, there is a need to develop services that can reach the maximum number of individuals at the lowest

cost through the development of an integrated community based treatments and support programs for mental disorders [19]. Rössler (2006) noted, that the role of the community is important in the prevention, treatment and rehabilitation of the mentally ill persons [20]. According to the WHO (2001) one way of achieving integration of mentally ill people into the society is through the concept of Community-based Mental Health Practice (CMHP) [21]. Studies have shown that stigmatising attitudes towards mental illness may in part be related to the various socio-demographic characteristics of the people [7,22]. This study aims to determine the causal beliefs, stigmatizing attitudes toward mental illness and help seeking behavior of a community in a resource poor environment.

2. MATERIALS AND METHODS

2.1 Location of the Study

This study was conducted in Ekom Iman, a semi-urban community in Etinan Local Government Area of Akwa Ibom State, located in the South-South (Niger Delta) region of Nigeria. Etinan had a projected population of 169,284 in 2015 [23].

2.2 Subjects

A multistage (Random and opportunity) sampling was employed in recruiting a convenience sample of 135 study participants. Four wards were randomly selected out of the identified eight wards in the community. The houses in the wards were numbered in the selected settlements and the first household was selected randomly thereafter, using a table of random numbers, 135 Households were selected. From each of the selected household, one individual, 18 years of age and above was randomly selected for inclusion into the study.

2.3 Procedure

The study was conducted among adults 18 years and above in Ekom Iman Community in Etinan Local Government Area of Akwa Ibom State. Questionnaires were administered to adults above 18 years of age people who consented to the study. Previously trained medical undergraduates (research assistants), fluent in Ibibio language assisted in administering the questionnaires to participants in a face to face interview format in each of the selected houses, giving a total of 130 respondents. Visitors and

mentally sick persons were excluded from the study.

2.4 Measures

2.4.1 Semi-structured socio-demographic questionnaire

A socio-demographic questionnaire designed by the authors was used to obtain information Measures evaluated includes socio-demographic details (age of the patient and family member, gender, educational status, marital status, religion, occupation), History of contact with someone with mental illness or having provided care for someone with mental illness was also obtained.

To determine the knowledge level of the community concerning the manifestations of mental disorders, we adopted and modified a pre-existing semi-structured questionnaire [24,25]. From a check list of seven items representing some symptoms of mental illness, respondents were asked to either agree or disagree with each of the items. This was a considered a proxy measure of mental health knowledge of disease presentations in a lay population.

To determine whether the persons with mental illness were perceived by respondents to be dangerous, we asked, "In your opinion, how likely is it that a mentally ill would do something violent toward other people" Responses were either yes or no.

Participants were asked to indicate their preferred treatment options ranging from western orthodox medicine (Hospitals), trado-medical practitioners (herbalists and other traditional healers), and spiritual healing (prayers in churches, mosques, and other places of worship).

Participants were also interviewed using the questionnaire developed for the World Psychiatric Association Pro-gram to Reduce Stigma and Discrimination Because of Schizophrenia [26]. This questionnaire which was developed to measure stigma internationally was adapted for this study by replacing 'schizophrenia' with 'mental illness'. It consist of 18 dichotomous questions regarding the causes of mental illness, views about mental illness and social distance practices related to mental illness.

The second part consisted of 18 items detailing possible causes to which mental illness could be attributed. These came under three models: psychosocial (life stresses, alcohol/substance misuse and personal deficit); supernatural (divine sanctions, evil forces and fate); and biological (heredity, brain injury, and infection/childbirth).

The questionnaires used in this study were translated into the local dialect (Ibibio language) separately by two bilingual translators. The two versions were combined and revised and then back translated into English by another bilingual translator. The translation was refined after back translation until agreement was obtained among the four people involved in the translations.

2.5 Data Analysis

Descriptive statistics such as frequencies, mean and standard deviation were computed for socio-demographic and clinical characteristics of the participants and other variables as appropriate. Inferential statistic such as chi-square was used to determine the relationship between independent variables and outcome variables. Significance was computed at $p < 0.05$.

The Statistical package for the social sciences 16 (SPSS Inc., Chicago, IL, USA) program was used for statistical analysis.

3. RESULTS

A total of one hundred and thirty persons with completed questionnaires participated in the study. The mean age of participants was 31.62 ± 8.7 years. More than half were males (64.4%). About 45.2% participants were married; Christian constituted 98% of studied population and 32% were skilled laborers. A large percentage (74.6%) had secondary education. 3.2% of participants had utilized mental health service and 30.5% had a positive family history of mental illness.

1.2% had provided care for someone with mental illness. This implies that only a small proportion of our respondents have had a history of significant contact or familiarity with the mentally illness (Table 1).

3.1 General Knowledge of Mental Illness

The common symptoms of mental illness identified by respondents, from a list of seven items include public nakedness (72.8%) destructive behavior (50.3%) aggression (verbal/physical) 12.6% 3. Talking off context (36.1%) and aimless wandering tendencies (32.5%), neglect of self care (55.2%), Withdrawal/ keeping to self (6.4%), declining

Table 1. Socio-demographic characteristics of respondents

Variables	Participants N (%)
Mean Age	
Age in years	31.6±8.7
≤45 years	76(58.5)
>45 years	54(41.5)
Sex	
Male	84(64.4)
Female	46(35.6)
Marital Status	
Single	71(54.8)
Married	59(45.2)
Years of education	
≤12 years	97(74.6)
>12 years	33(25.4)
Religion	
Christianity	128(98.5)
Islam	2(1.5)
Use of Mental Health Services	
Yes	4(3.2)
No	126(96.8)
Family History of Mental Illness	
Yes	40(30.5)
No	90(69.5)

abilities to carry out assigned duties or function socially (5.5%). The response pattern shows that gross/overt behavioral deviations like public naked, neglect of self care, destructive behaviours were more easily recognisable by majority of participants as symptoms of mental illness while only a small proportion of our sample could recognize the less overt symptoms like withdrawal to self and declining functional abilities as indicating mental illness. This suggest a mental health knowledge gap.

3.2 Etiological Beliefs

Most respondents endorsed multiple causes of mental illness. Commonly endorsed causes for mental illness were psychoactive drug abuse (86.2%), followed by magic or spirit possession (72.6%), brain disease/trauma (55.4%) and psychological distress (52.5%). Effect of divine wrath or God's will, heredity, fate and childbirth/infection were not common responses. The response pattern of respondents on organic causation of mental illness showed that majority (86.2%) endorsed psychoactive drugs abuse and (55.4%) and brain illness/trauma as important causes of mental illness. The respondents with lower level of formal education were as likely as those with higher level of education to endorse organic contributions to etiology of mental illness ($P=.08$). Belief in supernatural causes of mental illness was significantly different among participants in terms of the level of education. The respondents with higher level of education were less likely to endorse spiritual causation of mental illness compared to those with lower level of education ($P=.02$). Other demographic characteristics of gender, marital status and occupation were not factors that significantly affected the respondents' views on etiologies of mental illness (Table 2).

3.3 Perception of Dangerousness

Majority of study participants (63.8%) hold the belief that the mentally ill persons are dangerous and should be avoided. This belief was more strongly held by respondents with no history of previous close contact with mentally ill persons ($P=.04$). Years of formal education and other demographic variables like age, gender did not significantly alter the likelihood of holding this belief.

3.4 Attitudes towards Mental Illness

Responses to questions on attitudes towards mentally ill persons show that majority of

respondents prefer to maintain a high social distance from the mentally ill persons. Various stigmatizing attitudes and practices of the respondents towards persons with mental illness include shame to be identified with them, 72.3%, unwillingness to share rooms, 74.7%, unwillingness for marital union (92.5%) and avoiding most social contacts and friendship with them (66.4%) unwillingness to co-operation at work, 51.2%.

Table 2. Respondents perceived causes of mental illness

Variables	Yes (%)
Psychosocial factors	
Life stresses (marriage, work, finance)	68(52.5)
Misuse of substances (psychoactive agents, alcohol)	112(86.2)
Personal deficit (failure, lack of willpower)	15(11.5)
Supernatural factors	
Divine sanction (God's will/divine punishment)	21(16.2)
Evil forces (witchcraft/sorcery/evil spirits)	94(72.6)
Fate (destiny/bad luck)	21(16.2)
Biological factors	
Heredity	40(30.8)
Brain injury	72(55.4)
Childbirth/infection	33(25.4)

Table 3. Social distance practices and attitudes towards mental ill persons

Stigmatizing practices	Yes (%)
1. Are you afraid to have a conversation with the mentally ill	76(58.1)
2. Would you be upset or disturbed about working with the mentally ill	66(51.2)
3. Would you be able to maintain a friendship with the mentally ill	86(66.4)
4. Would you be unwilling to share a room with the mentally ill	97(74.7)
5. Would you be ashamed if you were related to the mentally ill person and people knew	94(72.3)
6. Would you be prepared to marry a mentally ill person	120(92.5)

3.5 Help Seeking Behavior

In this study, 30.8% of respondents believed orthodox mental health professional care is the best place to receive care as the first choice of treatment. Majority of the respondents (64.3%) prefer prayer houses/faith healers as the first treatment choice in the pathway of care. Trado-medical attention was cited as a first treatment option of care by 1.2% of respondents. Years of education, gender and age were not significant factors affecting these choices.

4. DISCUSSION

This study surveyed a typical semi-urban community in a predominantly traditional culture of a developing country to determine public beliefs about mental illness in view of increasing cultural, economic and social changes as a result of developments in science and technology, communication, urbanization etc. Previous studies in these countries, especially in sub-Saharan Africa, revealed that people's knowledge of mental illness, including the causal attributions, help seeking path to care and stigma towards the mentally ill persons had been largely erroneous and influenced by cultural factors and the prevailing local beliefs system [7,8,24,27]. This study is important because the impact of the stigmatizing attitudes and poor knowledge of mental illness among Nigerians have been shown to be a major hurdle to improving mental health care services in Nigeria [28]. The role of the community in the care and management of mental illness is important and is now regarded as the basis for the development of mental health programmes. This is because the public attitudes to these illnesses have negative impact on treatment and recovery outcomes. It has direct implication on the prevention, treatment and rehabilitation and quality of life of those affected by the disease [29,30].

In the present study, knowledge about symptoms and manifestations of mental illness was found to be poor. Response pattern to questions on presentations of mental illness indicates that majority of respondents mostly endorsed gross behavioral deviations like public nudity, violent and destructive behaviour as indicative of mental illness. The more insidious and less dramatic symptoms of mental illness are usually not often well recognised by the general populace. This is consistent with previous studies which reported similar findings [31,32].

Early recognition of the sign of mental illness appears to play an important role in treatment delay. Florid behavioural deviations are more likely to trigger public responses and early help seeking. Previous studies have reported that when the initial symptoms of mental illness were mainly 'negative symptoms' the sufferers tended to stay longer in the community without treatment. These negative symptoms such as deviation from a daily routine or impairment in functioning tended to be regarded as less problematic by the public. The presence of gross behavioural deviations and 'positive' psychotic symptoms tends to promote early help seeking [33-35]. This offers promising target for information programmes to improve illness recognition and early treatment seeking of the community.

As regards causation of mental illness, many respondents believed there were multiple causes of mental illness. A high proportion of respondents endorsed various causes of mental illness which include psychoactive substances abuse, brain disease, possession by evil spirit and psychological trauma and distress. This finding is in agreement with previous studies conducted in Nigeria and in other parts of sub-saharan African countries [8,12,36,37].

In the present study, we found widely held beliefs in the spiritual/supernatural causes for mental illness. This is consistent with findings from previous community based studies in Nigeria that examined beliefs about the causes of mental illness in different regions of the country. These studies have reported that supernatural and spiritual factors were as commonly perceived as causes of mental illness as the abuse of psychoactive substances [8,12,37]. Supernatural and spiritual attributions of causation were held by a high proportion of respondents in this study and this may explain in part, the preference for faith healers and prayer houses as a first choice of treatment in our sample. Similar findings have been reported in previous community based studies conducted in the south-east and south-west of Nigeria where respondents identified prayer house as the first choice for treatment followed by psychiatric hospital [11,38]. The belief in organic influences in etiology, as endorsed by high proportion of respondents may explain why some preferred orthodox professional interventions and treatments as their first choice of treatment. A previous Nigerian by Adewuya and Makanjuola, (2009) had reported that factors that were independently associated

with preference for spiritual or traditional healers included being female, having a lower level of education, having never cared for a person with mental illness, and endorsement of supernatural causal beliefs [39]. In the present study, however, the low level of education and the endorsement of spiritual causation of illness were significant factors promoting the preference for traditional or faith healers. Consultations with traditional and religious healers will often result in significant delays before patients present for professional mental healthcare, with significant negative impact on the treatment outcome of mental illnesses. Reducing delays in initial detection and treatment of mental illness through sustained public enlightenment will improve long-term outcomes [40,41].

Concerning attitude towards mental illness, we found a high level of negative beliefs and stigmatising attitudes. Responses to questions on attitudinal social practices, shows that mentally ill persons are viewed as dangerous and unpredictable in behavior and should be avoided. A high proportion of respondents prefer to keep a high social distance in social situations that require high level of intimacy. This is consistent with findings from previous studies [7,12]. The negative attitudes to mental illness in the community, apart from being a barrier to early presentation for treatment, may also be detrimental to efforts to promote community based treatments, rehabilitation and inclusiveness in the scaling up of mental healthcare services in many low and medium income countries (LAMICS) where there is gross paucity of resources to meet the mental health needs of the populace. A World Health Organization report states that the beliefs and attitudes held by members of community may influence many facets of mental health care. It also noted that a favorable social environment contributes to improvement and reintegration while an unfavorable one may encourage stigma against persons with mental illness [10].

Strategies to enhance positive attitudes, reduce stigma and promote better knowledge of mental illness include education or contact with mentally ill people [42,43] and public enlightenment campaigns. These strategies are important especially against the background of the findings presented here.

This study had some limitations. Firstly being a cross sectional study which cannot establish causality, it is not generalizable and the value

should remain exploratory. Also, this study focuses on mental illnesses in general rather than on a single disease. The study questionnaires were not extensive enough to reflect individual mental disorders and attributes.

5. CONCLUSION

There is widespread belief in supernatural and biological explanations for mental illnesses in a typical community in a developing country. Many believed orthodox professional care and faith healer are best able to treat mental illness. Poor knowledge and negative attitudes towards mental illness is also common. Health education and sustained public enlightenment is needed to reduce stigma and ensure high social acceptance and preference for orthodox professional treatment of mental illness.

CONSENT AND ETHICAL APPROVAL

Ethical Approval for the study was obtained from the Research and Ethical Committee of the Ministry of Health, Akwa Ibom State and patients' consent has been collected by the authors.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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