SOCIAL DISTANCE TOWARDS THE MENTALLY ILL PERSONS AMONG MEDICAL UNDERGRADUATES IN UYO, NIGERIA. THE IMPACT OF MENTAL HEALTH EDUCATION AND TRAINING ON ITS MAGNITUDE.

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ABSTRACT

Background: *A high level of stigmatizing attitudes and social distance towards persons with mental illness has been reported in the medical community.*

Objective: *This study was conducted to assess the social distance of medical undergraduates towards persons with mental illness and the impact of medical education and training on its magnitude.*

Methods: *This was a two stage cross-sectional descriptive study conducted on a sample of medical undergraduates. Participants were interviewed using an adapted version of the questionnaire developed for the "World Psychiatric Association Program to Reduce Stigma and Discrimination Because of Schizophrenia", and Bogardus social distance scale.*

Results: *A total of 86 respondents participated in the study in both pre-clerkship and post-clerkship phase. The average age of respondent was 23.86 ± 4.2 years, consisting of 52.3% males and 47.7% females. The mean social distance score decreased significantly from 2.68±1.02 at the pre-clerkship period to 2.03±1.05 at the post clerkship period (p=0.006). The social distance was significantly associated with perception of dangerousness.*

Conclusion: *The social distance towards the mentally ill was significantly reduced by mental health education and training. Health educational approaches will be helpful in reducing stigma and social distance towards the mentally ill persons.*

Key words: *Mental illness, medical undergraduates, social distance, Nigeria.*

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INTRODUCTION

For people with mental illness, stigma is the largest single obstacle to improving their quality of life.[1] The history of this stigmatization is as old as this illness has existed.[2] Negative views such as those implying that people with mental illness are dangerous to others, that it reflects weakness of character, that these disorders are self inflicted and that it is feigned or imaginary, or that it is incurable are unfortunately deeply rooted in the society.[3] Many studies have shown that these negative opinions, beliefs and attitudes are widespread globally.[4-6] Studies from Nigeria has demonstrated widespread negative views towards mental illness and poor knowledge regarding causation, and an overwhelming majority believe that those with mental illness are dangerous and un-suitable for normal social contact.[7] Supernatural reasons were found to be the most popular explanations for mental illness amongst both caregivers and patients. The prejudices and beliefs which people hold in different cultures tend to be based on the prevailing local system of belief.[8]

This discrimination and stigmatizing attitude against mentally challenged people have negative consequences on help seeking behaviours, housing, education and employment prospects, leading to significant increases in the burden of mental illness and a marked negative impact on the quality of life of the mentally challenged.[9-12]

Social distance towards the mentally ill is a concept which expresses the proximity one desires between oneself and another person in a social situation and assesses expected discriminatory behavior towards adults with mental illness. Low social distance is characterized by a feeling of commonality, or belonging to a group, based on the idea of shared experiences. In contrast, high social

distance implies that the person is separate, a stranger, or an outsider. Social distance research can provide valuable insight into factors that influence mental illness stigma[13-15]. It has been postulated that educational interventions will lead to a reduction in stigmatizing attitudes towards the mentally ill.[16-18] Psycho-educational interventions have been used as a tool in the fight against stigma and discrimination related to mental illness by the World Psychiatric Association (WPA).[19] Studies on the impact of education or information on attitudes of individuals towards mental illness have shown that education may have positive impact on these prejudices.[20,21] Health educational approaches have been cited as important in reducing stigma towards the mentally ill. According to Corrigan et al (1999), those with more knowledge about mental illness were less likely to endorse negative or stigmatizing attitudes.[19,20]

Stigma associated with mental illness is more frequently reported in the general community than in the medical community although studies have reported high levels of ignorance, prejudice and discrimination towards mentally among health professionals including medical students.[10,22-24] Research has demonstrated the positive effects of completing undergraduate psychiatric training and of specific education program on attitudes of medical students.[25,26]

MATERIALS AND METHODS

Study centre

This study was conducted in the Department of Mental Health, University of Uyo Teaching Hospital. The hospital is a 500 bedded tertiary referral centre in Uyo, a capital city in the oil rich south–southern region of Nigeria. Approval was obtained from the local Hospital Ethics Committee and the Medical Advisory Panel on Research.

Participants

This 2-stage cross-sectional study was conducted among two consecutive classes of fifth year medical students who had 4 weeks psychiatric clerkship at the department of psychiatry.

Questionnaires were administered to all consenting students before the onset of clinical posting on the first day and on the last day of the posting in psychiatry. Written informed consent was obtained before entry to the study. Participants self-completed the questionnaires which included socio-demographic proforma to obtained information about age, sex, marital status and place of residence of participants. To determine whether the persons with mental illness were perceived by participants 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 scored on a likert scale as (1) very unlikely, (2) somewhat unlikely, (3) somewhat likely, (4) very likely?"

Participants were also interviewed using the questionnaire developed for the World Psychiatric Association Pro-gram to Reduce Stigma and Discrimination Because of Schizophrenia.[7] This tool was developed to measure stigma internationally. It was adapted for this study by replacing 'schizophrenia' with 'mental illness'. It consist of 17 dichotomous questions regarding the causes of mental illness, views about mental illness and social distance practices related to mental illness.

The Bogardus social distance scale[27] is a psychological testing scale created by Emory S. Bogardus to empirically measure people's willingness to participate in social contacts of varying degrees of closeness with members of diverse social groups such as racial and ethnic groups. Social distance questions asked how willing respondents would be to 1. Move in next door to the mentally ill person, 2. Spend an evening socializing with the person, 3. Make friends with the person, 4. Start working closely with the person, and 5. Have the person marry into the family. Responses on a likert scale (1 = definitely, 4 = definitely not) were summed and divided by 5 so that scores could range from 1 to 4.

Statistical analysis

The results of the study were analysed using the Statistical Package for Social Sciences (SPSS 11.0). Descriptive statistics were used for general description of study participants. Sample means and frequencies were calculated. Inferential statistics such as chi square, student test were used as appropriate. The level of significance was set at $p<0.05$.

RESULT

A total of eighty six fifth year medical undergraduates were included in the study. The mean age of participants was 23.86 ± 4.2 years. The age distribution of the students indicated that 78 (90.7%) were in the range of 20 to 29 years, and 8(9.3%) were 30 to 39 years old. More than half were males (52.3%). The majority of the participants (89.5%) were never married. Two students representing 2.3% of participants had utilized mental health service and ten students representing (11.6%) had a positive family history of mental illness. See Table 1

DISCUSSION

Stigma associated with mental illness is more frequently reported in the general community than in the medical community. This study assessed stigmatizing beliefs and opinion in a subset of the medical community against the backdrop of reports in the stigma literature suggesting a high level of stigmatizing attitudes towards the mentally ill persons among medical personnel.[28,29] For effective health care delivery, it is important that health professionals are not hampered by prejudiced attitudes and unnecessary psychological distance to any group of patients.

We found a high social distance which participants desired to maintain towards the mentally ill. Our findings however contradicts previous studies[30,31] which have

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Variables	Participants N(%)
Mean Age	23.86±4.20
Age in years	
20-30	78(90.7)
31-40	8(9.3)
Sex	
Male	45(52.3)
Female	41(47.7)
Marital Status	
Single	77(89.5)
Married	9(10.5)
Place of Residence	
Urban	78(90.7)
Rural	8(9.3)
Use of Mental Health Services	
Yes	2(2.3)
No	84(97.7)
Family History of Mental Illness	
Yes	10(11.6)
No	76(88.4)

Perceived causes of mental illness

Most participants believed there were multiple causes of mental illness with psychoactive substances abuse being cited most. The least mentioned is God's punishment as etiologic to mental illness.

TABLE 2: RESPONDENTS' REPORTED VIEWS ABOUT CAUSATION OF MENTAL ILLNESS

Perceived Causes of Mental illness	Pre-posting Agree	no(%) Disagree	Post-posting Agree	no(%) Disagree	p-value
1. Drug or alcohol/cannabis use causes mental illness	81(94.2)	5(5.8)	80(93.0)	6(7.0)	0.53
2. Possession by evil spirit	38(44.2)	48(55.8)	32(37.2)	54(62.8)	0.95
3. Traumatic event or shock causes mental illness	74(86.0)	12(14.0)	72(83.7)	14(16.3)	0.10
4. Genetic or familial factor causes mental illness	78(90.7)	8(9.3)	74(86.0)	12(14.0)	0.34
5. God's punishment causes mental illness	12(14.0)	74(86.0)	4(4.7)	82(95.3)	0.41
6. Brain disease causes mental illness	79(91.9)	7(8.1)	78(90.7)	8(9.3)	0.64
7. Biological factors other than Brain causes mental illness	56(65.1)	30(34.9)	74(86.0)	12(14.0)	0.15
8. Stress causes mental illness	60(69.8)	26(30.2)	79 (91.9)	7(8.1)	0.34
9. Physical abuse causes mental mental illness	64(74.4)	22(25.6)	75(87.2)	11(12.8)	0.18
10. Poverty	57(66.3)	29(33.7)	64(74.4)	22(25.6)	0.41

The survey results show that most of the participants believed that mental illness is caused by alcohol or drug misuse (94.2%), brain disease (91.9%), genetic inheritance (90.7%), possession by evil spirits (44.2%), traumatic events (86%) and physical event or shock (60%). The participants were as likely to hold these opinions before and after psychiatric clerkship as none of these views showed statistically significant differences. See table 2.

Social distance and stigma

About 2.3% of participants had utilized mental health services while only 11.6% of them admitted to have relatives or friends with mental illness. The proportion of participants who scored above 2, the midpoint of the scale, was 64 (74.4%) representing a high social distance towards the mentally ill persons. The mean social distance score decreased significantly from 2.68±1.02 at the pre-clerkship period to 2.03±1.05 at the post clerkship period (p=0.006). The gender of the participants did not seem to be the factor affecting the social distance, as there was no statistically significant difference between gender-based mean scores before and after the posting. The mean scores is as shown in table 3

TABLE 3. MEAN SCORES OF SOCIAL DISTANCE; PERCEIVE DANGEROUSNESS AMONG PARTICIPANTS BEFORE AND AFTER CLINICAL POSTING.

Variables	Pre-posting	Post-posting	test statistics	p-value
Social distance				
Total (Mean, SD)	2.68±1.02	2.03±1.05	t=2.81	**0.006**
Perceived Dangerousness				
Total (Mean, SD)	66.00 (31.19)	46.36 (24.21)	t=2.29	**0.027**

Social distance and Perception of dangerousness

Table 3 shows that the proportion scoring above the median score (31.19%) was higher at the beginning of the posting than the end. There was significant association between perception of dangerousness and the amount of social distance desired between study participants and mentally ill persons both before and after clinical posting (p=0.002, p=0.05 respectively).

Attitudinal social distance practices.

With regards to social distance practices and mental illness, more than half (58%) of our respondents would be afraid to hold a conversation with the mentally ill, while 44% declared that they were prepared to maintain a friendship with someone who had been mentally ill. Less than half (23.3%) were prepared to share a room with someone who had experienced mental illness. These views did not significantly change after the clinical posting.

Participants were less likely to be ashamed if someone in their family experienced mental illness (p=0.04) and they were also less prepared to consent to increasing social intimacy with someone who had experienced mental illness in terms of consenting to marital union (p<0.01). See table 4.

TABLE 4: SOCIAL DISTANCE PRACTICES

Social Distance Practices		Pre-posting Agree	no(%) Disagree	Post-posting Agree	no(%) Disagree	p-value
1.	Are you afraid to have a conversation with the mentally ill	50(58.1)	36(41.9)	24(27.9)	62(72.1)	0.34
2.	Would you be upset or disturbed about working with the mentally ill	42(48.8)	44(51.2)	52(60.5)	34(39.5)	0.25
3.	Would you be able to maintain a friendship with the mentally ill	60(69.8)	26(30.2)	38(44.2)	48(55.8)	0.09
4.	Would you be unwilling to share a room with the mentally ill	20(23.3)	66(76.7)	14(16.3)	72(83.7)	0.06
5.	Would you be ashamed if you were Related to the mentally ill person and people knew	62(72.1)	24(27.9)	42(48.8)	44(51.2)	0.04
6.	Would you be prepared to marry a mentally ill person	6(7.0)	80(93.7)	7(8.1)	7(8.1)	<0.001

reported that stigma might be less common in Africa. It has been suggested that these early reports of low stigma in Africa may have been due to paucity of research in this environment rather than a more culturally receptive attitude to mental illness.[30] In the medical community, previous studies have similarly reported a high level of stigmatizing attitude among medical students.[32,33] In our study, there was a significant reduction in attitudinal social distance towards the mentally ill persons in the pre and post clerkship period. This seems to suggest positive impact of health education and training in reducing stigma and social distance. Promotion of mental health education strategies may therefore be pivotal in reducing stigma in the medical and in the general community. It is suggested that for the medical community, education and an examination of attitudes towards mental illness should be included in medical training.[34] The high social distance found in our sample before psychiatry clerkship, may be a reflection of the widespread negative attitudes and prejudices to mental illness common in their community[7,35] which may have 'rubbed off' on the medical undergraduate community.

In support of previous research findings, there was significant association between the perception of the risk of violence and the desire to maintain social distance from that person. A previous study had reported that perceptions of dangerousness are important determinants of social distance.[36] Also, previous research on violence shows a modest elevation in violence among people with mental illnesses[37], although only a minority of persons with mental illnesses has been reported violent.[37,38] Our findings on perceptions of dangerousness are consistent with those of Phelan and colleagues in their study[39] which reported a correlation between risk of violence and high social distance. This widely held erroneous opinion on the violent tendencies of the mentally ill observed in this study may be a focus of educational intervention strategies to reduce the stigmatizing behaviors and attitudes towards the mentally ill.

Responses to the different questions on attitudes and social distance practices show that across many areas of social interactions, we found a strong desire for social distance. One plausible reason for this is that the symptoms of mental illness may themselves represent undesirable personal attributes that people want to avoid. Lack of direct contact with persons with mental illness may also explain this finding in our sample. The role of previous contact in reducing the social distance towards the mentally ill has been highlighted in previous Nigerian studies.[10,11] In our sample, only a small proportion have had any reasonable form of contact with the mentally ill as 93% of respondents reported no family history of mental illness. Research findings in Nigeria and other developing countries have demonstrated poor knowledge regarding causation of mental illness. In many third world cultures an overwhelming majority believes in spiritual causation of mental illness. A high proportion of our sample endorsed belief about spiritual causation of mental illness and this opinion did not significantly change after the period of mental health clerkship. Beliefs such as this may promote high stigmatizing attitude in the medical community and may engender prejudices that may impair effective health care delivery services.

Also, a high proportion of our study participants expressed opinions that suggest that a very high level of intimacy such as marital relationship or sharing a room with someone who had experienced mental illness would remain unacceptable in spite of more enlightenment. Most of our respondents seemed to be less prepared to consent to a high level of increasing social intimacy with someone who had experienced mental illness such as sharing a room. Only a few would consent to a marital union. This attitude may not be unconnected to the fact that majority believe in genetic factor as cause of mental illness, genetic factors were believed by half of our participants to be a cause of mental illness, there are fears about mental illness being passed on to future offspring.[40]

CONCLUSION

This study has shown that stigma towards the mentally ill reported in the medical community is driven in part, by unfounded fears of dangerousness and subsisting erroneous beliefs that suggest spiritual dimension to causation of mental illness. The high degree of stigma and social distance in this study is also a reflection of the sigma and negative attitudes in the society towards the mentally ill and this is in spite of the high level of enlightenment of our sample compared to the general population. There is the need for multilevel educational strategies to address this challenge.

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