

A Descriptive Study of Stigmatization of Mental Illness: Findings from Yobe State, Nigeria

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I. INTRODUCTION

Mental illness is a clinically significant behavioural or psychological syndrome associated with distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning), or with a significantly increased risk of suffering, death or an important loss of freedom. In addition, the syndrome must not be merely a predictable and culturally sanctioned response to a particular event, such as the death of a loved one. Whatever its original source, it must be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual (American Psychiatric Association, 2013). Mental illness can affect anyone. But some people are more at risk than others due to factors such as age, gender, economic status, disability or substance abuse. When it arises, mental illness reduces the sufferer to a level of helplessness, thereby leading to suffering. It affects the individual's process of thinking and ability to function, consequently reducing his/her social roles and overall productivity in the community. Mental health problems place a huge burden on the family and the community at large. They are the leading cause of all non-fatal disease worldwide (Whiteford et al., 2013). Mental illness can develop at different stages of an individual's life. Attention deficit hyperactivity disorder (ADHD) is evident from very early childhood, when children start school, as their behaviour can be compared to others of the same age, whereas conditions such as schizophrenia can develop in the late teens to early twenties for men and early to late twenties in women. There are no set conditions as to whom mental illness can affect; it often depends on the individuals' life circumstances and events, just as is the case with physical illness (American Psychiatric Association, 2013).

Causes of mental illness

The causes of mental illness are multifaceted and vary according to the disorder. While the roots of some mental illnesses are unidentified, research have shown that biological, psychological and environmental influences all play significant roles in the aetiology, development or progression of most mental illnesses. Genetics is a major causal factor for many mental disorders (Shi, Gershon, & Liu, 2008; VanDeMark et al., 2005). Mental illnesses sometimes run in families, suggesting that people who have a family member with mental illness may be more likely to develop it themselves. Susceptibility is passed on in families through

genes. Studies have shown that several mental illnesses are linked to abnormalities in several genes rather than just one or a few, and that how these genes interact with the environment is unique for every person (even identical twins). This is why a person can inherit a susceptibility to a mental illness without necessarily developing the illness. According to Nutt (2008), some mental illnesses are caused by abnormal functioning of nerve circuits or pathways that connect particular regions of the brain. Nerve cells within the brain communicate through chemical substances called neurotransmitters. Excess or otherwise of these neurotransmitters in some regions of the brain is responsible for some mental illnesses. Nutt (2008) reported that a strong relationship exists amongst the three main monoamine neurotransmitters in the brain (i.e., dopamine, norepinephrine and serotonin) and specific symptoms of major depressive disorder. In depressive patients, some specific symptoms are related to the increase or decrease of specific neurotransmitters, meaning that specific symptoms of depression could be attributed to some neurochemical mechanisms (Werner & Covenas, 2010). In addition, defects or injury to certain structures or areas of the brain have been reported to cause mental health problems (Fleminger, 2008). Psychosocial factors such as stress and poverty have also been implicated in the development of mental illness ((Kobau et al., 2012). Severe psychological trauma suffered in childhood, such as emotional, physical or sexual abuse; important early loss, such as the loss of a parent; neglect; and poor ability to relate to others are examples of psychosocial predictors of mental illness (Álvarez et al., 2011; Everett & Gallop, 2000; Mulder, Beautrais, Joyce, & Fergusson, 1998).

Prevalence of mental illness

Epidemiological studies in different parts of the world have provided data on the prevalence of mental disorders (Kessler et al., 2010; Kessler & Üstün, 2008; Merikangas, Nakamura, & Kessler, 2009). These studies have shown that mental disorders are common, with more than one third of the population in most countries studied reporting sufficient criteria for diagnosis of mental disorders at some point in their lives (Andrade et al., 2013). Yet, there is very limited data on the subject of the prevalence of mental illness on a global scale. The data on the global prevalence of mental disorders available reflects specific mental illnesses. Within this, the prevalence estimates vary widely across countries (Andrade et

al., 2013). Lack of this information is the result of poor mental health services and facilities, particularly in the developing countries (Saxena, Thornicroft, Knapp, & Whiteford, 2007). According to some research, one out of every four persons who turn to the health services for help is troubled by mental or behavioural disorders that have not been correctly diagnosed and/or treated (Hwu, Yeh, & Chang, 1989; Sherer, 2002). The World Health Organization estimated that in general, more than 450 million people around the world suffer some form of mental or psychological disorder, including behavioural and substance abuse disorders (World Health Organisation, 2018). This figure is prodigious, especially considering that mental health is necessary not only for the overall well-being of the individual, but also for improving human development in terms of economic growth and poverty reduction.

The majority of mentally ill people live in developing countries (van der Ham et al. 2011), where mental health services and facilities are somewhat non-existent. Where such facilities and services are available, they are far below international standards, and patients often do not utilize them for treatment. Instead, they prefer to consult traditional healers or religious therapists (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). In Nigeria, as in most developing countries, research on mental illness and mental health services is inadequate. The few published studies are mainly carried out to provide data on a regional scale. For example, (Gureje et al., 2005; Ukpong & Abasiubong, 2010) studied the knowledge and attitudes of Yoruba-speaking people in three south-western states of the country. Also, (Audu, Idris, Olisah, & Sheikh, 2011; Kabir, Iliyasu, Abubakar, & Aliyu, 2004) studied people's beliefs and attitudes towards the mentally ill in north-western states of the country. There is limited research on perceptions of mental illness and people's attitudes towards the mentally ill in the north-eastern states of Nigeria. This paper investigates how the people in Yobe state in north-eastern Nigeria perceive and behave towards people living with mental illness.

Over the past decade, national surveys of psychiatric disorders have been carried out in three European countries, the USA and Australia, in probability samples of the general population (1–5). They have shown that mental disorders are frequent and associated with a wide range of Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project Introduction Over the past decade, national surveys of psychiatric disorders have been carried out in three.

II. METHOD

Participants

In this research, 160 participants were used. They were drawn from the three zones that form the political divisions of Yobe state. The age of the participants ranged from 17 years to 65. The participants were selected by research assistants recruited and trained on how to administer the questionnaire, interview

skills and the techniques of breaking barriers to interview resistance. This was to prepare the research assistants to be able to adequately administer the questionnaire, at least to respondents who could not read and understand it in English and would therefore find self-administration difficult.

Instrument

The community awareness of mental illness (CAMI) scale (Taylor & Dear, 1981) was used to assess the respondents' attitudes towards people living with mental illness. CAMI can be self-administered or administered to respondents by trained research assistants. The instrument consists of 40 items placed on a 5-point Likert scale, ranging from 1 = strongly agree to 5 = strongly disagree. It consists of four major subscales, with 10 items each: authoritarianism (AU), benevolence (BE), social restrictiveness (SR) and community mental health ideology (CMHI).

The authoritarianism (AU) subscale describes a mentally ill person as someone who is inferior and therefore requires supervision and coercion. Items in the authoritarianism subscale are designed to assess the respondents' attitudes towards the need to hospitalize the mentally ill patient. It also assesses the difference between mentally ill people and others; the importance of shielded, institutional or isolated care of the mentally ill; and the causes of mental illness.

The benevolence (BE) subscale deals with public attitudes that involve a humane and compassionate view of mentally ill persons. The statements on this subscale therefore address attitudes around societal responsibilities towards individuals with mental illness; the need for caring, empathetic and kind attitudes towards people with mental illness; people's preparedness to become personally involved; and anti-custodial attitudes and feelings (Evans-Lacko, Henderson, & Thornicroft, 2013).

Items on the social restrictiveness (SR) subscale measures the tendency to see the mentally ill individual as dangerous; the tendency to distance oneself from the mentally ill person; lack of responsibility; and perceptions of the normality of the mentally ill.

The community mental health ideology (CMHI) subscale deals with the acceptance of mental health services and the integration of mentally ill patients into the community. The scale therefore assesses readiness of the community to accept mentally ill patients; acceptance of mental health facilities in residential neighbourhoods; and acceptance of the principle of deinstitutionalized care (Evans-Lacko et al., 2013).

The study area

The study was conducted in the three political zones that make up the political divisions of Yobe State, north-eastern Nigeria. Yobe state shares local boundaries with Bauchi, Borno, Gombe and Jigawa states. It borders the states of Diffa and Zinder to the north in the Republic of Niger. Yobe state lies mainly in the dry savanna belt; therefore, climatic

conditions are hot and dry almost throughout the year, except in the southern part, which has a milder climate. Yobe state has a population of 2,321,591 spread across the 17 local government areas, politically divided into zones A, B & C. Agriculture is the major economic activity for most people in the state. Yobe state is one of the states with the worst health indices in Nigeria. This is in addition to being backward educationally and economically. The state has 528 health facilities in total: 508 public and 20 private health facilities. Of these 528, there are 12 general hospitals and 8 comprehensive health centres providing secondary health care across the state (Yobe state Ministry of Health 2009). The remaining 508 health facilities are primary health care clinics spread across the 178 electoral wards. The hospitals and primary health clinics are characterized by inadequate supplies of drugs and medical equipment and an inadequate number of professionally trained staff (Yobe state Ministry of Health 2009). None of the state-owned health facilities has a ward dedicated to providing psychiatric or mental health care.

Study Design/Procedure

The study is designed to be conducted in the state's three political zones. Research assistants administered the questionnaire to 60 participants selected from three local government areas in each zone. Data was collected using the community attitude towards the mentally ill (CAMI) scale (Taylor & Dear, 1981). The research assistants were trained in questionnaire administration techniques; interview skills; assurance on confidentiality; techniques for obtaining informed consent; and breaking barriers for interview resistance. The questionnaire was administered via interview only to participants who could not read and understand the items in English. Participants who could read and understand the items of the questionnaire were allowed fill it in by themselves.

III. RESULTS

This research consists of 160 participants; their ages range from 17 to 65 years. There are 68 (43%) female and 92 (57%) male. Of this number, 64 (40%) are married ($f=24$, $m=40$), 70 (44%) participants are single ($f=22$, $m=48$). The remaining 26 (16%) are either divorced, separated or widowed ($f=15$, $m=11$). Only 20 (13%) of the participants have studied up to tertiary education level. A significant number 104 (64%) had secondary education, while 21 (13%) have attained primary education and the remaining 15 (9%) are either illiterate or have had informal education (Quranic or adult education).

On the community attitudes towards the mentally ill (CAMI) scale, 141 (88.13%) participants in this study strongly disagreed or disagreed that mental illness is an illness like any other illness. A significant number of participants 129 (80%) strongly agreed or agreed with hospitalization of anyone who exhibits sign of mental illness, and 122 (70%) that mentally ill people should be controlled like young children. Others believed that the best way to handle the mentally ill is to keep them behind locked doors (110, 69.38%). Regarding the

causes of mental illness, more than half of the participants (84, 52.50%) attributed it to lack of self-discipline and willpower. On the other hand, only 40 (27.50%) of the participants believed that mental illness can afflict anyone.

On the benevolence subscale, 118 (73.75%) of the participants strongly agreed or agreed that people with mental illness do not deserve any sympathy. Another 85 (53.13%) participants do not believe it is worth spending tax money on mental health services. This corresponds to the endorsements by 64 (40.00%) of the participants with strong disagreement on spending more money on care and treatment of mentally ill patients. Negative attitudes towards people with mental illness was further expressed by 84 (52.50%) of the participants who described the mentally ill patients as burden on the society while 85 (53.13%) of the study participants suggested avoiding people with mental illness.

On social restrictiveness towards people living with mental illness, majority of the participants (131, 81.88%) believed that women with mental illness should not be assigned caregiving responsibility; should not be allowed to hold public office and that people should not be married to someone who has suffered mental illness even after full recovery. Similarly 121 (75.63%) of the participants expressed the view that mentally ill patients should be isolated from the community and denied their individual rights. A total of (94, 58.80%) participants strongly agreed with the statement that they would not live next door to someone with mental illness and they strongly disagreed that people with mental illness are not as dangerous as most people believe.

On the community mental health ideology sub-scale, the participants in this research also held negative views. For example, 104 (65%) participants were not comfortable with mental health centres being sited close to their place of residence; they were afraid of having people with mental illness living in their neighbourhood (84, 52%) and 98 (61%) of the participants would resist a mental health facility located in their area.

IV. DISCUSSION

The most striking result to emerge from the data is that the participants of this study maintain a very negative attitude towards people living with mental illness. The finding is consistent with the results of past studies conducted in Ethiopia, India and Nigeria (Shibre et al., 2001; Ukpong & Abasiubong, 2010; Vijayalakshmi, Ramachandra, Reddemma, & Math, 2013). The majority of the participants disagreed that mental illness is like any other illness. They also expressed a strong belief that anyone with mental illness should be hospitalized or kept behind locked doors and more than half of the participants accepted that mental illness results from a lack of self-discipline and willpower. These findings also concur with the result of the Indian study on attitudes and responses of rural communities towards the mentally ill (Vijayalakshmi et al., 2013), but they are contrary to the views expressed by the participants of American study (Borinstein,

1992), who attributed mental illness to physical disturbances such as chemical imbalances in the brain, and by the participants of another study in south-western Nigeria, who claimed that the causes of mental illness are substance misuse, possession by evil spirits, traumatic life events and stress.

The discriminatory attitude of the participants of this study is further revealed by their disagreement with the statement that people with mental illness should not be treated as outcasts from society. Nor did they believe that mental illness can afflict anyone. This finding contradicts (Borinstein, 1992), in which three quarters of the participants agreed that virtually anyone can become mentally ill. A greater proportion of the participants of this study lacked a compassionate attitude towards the mentally ill. They believed that the mentally ill do not deserve sympathy; that they are a burden on society and that spending on mental health services is a waste of resources. This attitude corresponds with findings from south-west Ethiopia and southern Ghana (Barke, Nyarko, & Klecha, 2011; Girma et al., 2013). Such attitudes of the participants may well be attributed to lack of mental health literacy. Yobe state does not have even a single functional ward in any of its health facilities dedicated to the treatment of mental health conditions, a situation that may reduce awareness about mental illness and reinforce negative beliefs about the cause and availability of treatment approaches for mental health problems.

A high level of social restrictiveness to people with mental illness was expressed by almost all the participants of this study. With 81% of the participants disagreeing that women who were once patients in a mental hospital can be trusted as child minders or babysitters, and strongly agreeing that only a foolish woman would marry someone who suffered from a mental illness. This finding indicates that the participants would not maintain a close social distance with people living with or who have had mental illness at some point in their life. Similar results were reported by (Barke et al., 2011; Smith & Cashwell, 2011), whose participants reported negative attitude related social distance, lack of acceptance and accommodation of mentally the ill. Because society generally has stereotyped opinions about mental illness and its effects on people, many people are of the view that people with mental illness are violent and dangerous, when in the actual sense, as (Kobau et al., 2012) stated, they are more susceptible to being attacked or hurting themselves than injuring other people (Kobau et al., 2012).

V. SUMMARY

In this study, the aim was to assess discrimination against people with mental illness. Discrimination is against people with mental illness is found everywhere in the world, including the developed countries. Characteristically, it takes the form of stereotyping, suspicion, fear or avoidance of social relationships with people who have mental illness. Mentally ill people are stereotyped as being dangerous and unpredictable. They are stigmatized because of their

appearance, bizarre behaviour and the widespread negative description of mental illness by the media. These attitudes can negatively affect a mentally ill patient's chances of employment or any form of income generation. The major problem attributed to stigmatization of the mentally ill are ignorance about its causes and the limited availability of variety of treatment approaches (Ukpong & Abasiubong, 2010). Research has shown that stigma relating to mental illness comes from a variety of sources, including the immediate families of the mentally ill, communities, religious bodies, co-workers and even mental health practitioners. Other factors responsible for the stigmatization of mental illness are fear of the mentally ill and the view of them as different and inadequate compared to normal individuals. Evidence of the pervasiveness of the stigma relating to mental illness has been well established through research. In the United Kingdom, one survey reveals that 70% of 556 respondents reported that either they or a family member had experienced stigma as a result of their mental illness. Of those, 56% had experienced stigma within their own family, 52% from friends, 44% from their primary care physician, 32% from other health care professionals and 30% within their workplace. Studies from India, South Africa, Ethiopia and Nigeria have all revealed discriminatory negative attitudes towards people suffering from mental illness (Egbe et al., 2014; Girma et al., 2013; Ukpong & Abasiubong, 2010; Vijayalakshmi et al., 2013).

These attitudes towards the mentally ill may cause problems in accessing social services including healthcare services; taking prescribed medications; and adhering to treatment programmes (Everett, 2006). Others include difficulties in coping with the illness, maintaining social relationships, gaining employment and/or the possibility of being fired from work. The problems of stigmatization faced by mentally ill individuals in their daily lives significantly affect their recovery from their illness and their quality of life (Wahl, 1999).

To decrease the burden of mental illness and to expand the availability of treatment options, there is urgent need for a serious community awareness and mass mobilization campaign across the state to enlighten people about the causes of mental illness and the availability of cures. Therefore, much effort is to be devoted to inclusion and to persuading people without mental illness to adopt a non-discriminatory understanding of those who do have mental illness. This could be achieved by engaging suitably skilled health and even non-health workers and volunteers to assist with de-stigmatization campaigns through community-based initiatives. The government, being the major provider of health services, should enact laws leading to the provision of community mental health services, right from the primary healthcare setting. Training programmes should be organized to update healthcare providers about mental illness, particularly those working in primary healthcare settings, and provide them with adequate skills to discern symptoms of mental illness at least

for 'referral to appropriate linkages' for appropriate diagnosis and treatment.

VI. CONCLUSION AND RECOMMENDATIONS

Stigmatization of mental illness is widespread among the people of Yobe state. This is due to their poor knowledge of mental illness owing to negative beliefs about the causes and availability of treatment. Such negative belief about mentally ill people places them at a disadvantage in terms of social relationships and employment and even access to health and social services. Unless something is done to make people in Yobe state aware that mental illness is the same as any form of physical illness and can affect anyone, irrespective of age, gender, education, ethnicity or socioeconomic status, individuals with mental illness will continue to suffer discrimination from other members of society. For this reason, the following recommendations are offered:

- Government, non-governmental organizations and communities should embark on massive awareness campaign to sensitize people across the state to become aware that mental illness is like any other illness and that there are treatments available for mentally ill individuals.
- Community mental health services should be put in place in major primary health centres across the state. There should be a fully equipped wards with facilities and staff dedicated to the treatment of mental health problems in all general hospitals in the state.
- Training opportunities on mental health services should be provided for interested health personnel.
- A school-based mental health programme should be initiated to educate youngsters about the causes and availability of treatments for mental illness.
- Finally, investment in research on mental illness and on how to integrate traditional treatment approaches into modern medical approaches would help reduce problems associated with the belief that mental illness can only be treated by traditional medical practitioners.

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