Stigmatising attitudes towards the mentally ill: A survey in a Nigerian university teaching hospital

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Background. The burden of mental illness is particularly severe for people living in low-income countries. Negative attitudes towards the mentally ill, stigma experiences and discrimination constitute part of this disease burden.

Objective. The aim of this study was to investigate knowledge of possible causes of mental illness and attitudes towards the mentally ill in a Nigerian university teaching hospital population.

Method. A cross-sectional descriptive study of a convenience sample of 208 participants from the University of Uyo Teaching Hospital, Uyo, Nigeria, using the Community Attitudes towards the Mentally Ill (CAMI) scale. Information was also obtained on beliefs about possible causes of mental illness.

Results. The respondents held strongly negative views about the mentally ill, mostly being authoritarian and restrictive in their attitudes and placing emphasis on custodial care. Even though the respondents appeared to be knowledgeable about the possible role of psychosocial and genetic factors in the causation of mental illness, 52.0% of them believed that witches could be responsible, 44.2% thought mental illness could be due to possession by demons, and close to one-third (30%) felt that it could be a consequence of divine punishment.

Conclusions. Stigma and discrimination against the mentally ill are widespread even in a population that is expected to be enlightened. The widespread belief in supernatural causation is likely to add to the difficulties of designing an effective anti-stigma psycho-educational programme. There is a need in Nigeria to develop strategies to change stigma attached to mental illness at both institutional and community levels.

Research findings from several countries have confirmed the global nature of negative attitudes towards the mentally ill.[1] Poor community knowledge of causes and the presentation of mental disorders have sometimes been advanced as reasons for stigmatising attitudes. 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) in more than 20 countries.[2] The results of the WPA school workshop programme in UK and Canadian secondary schools are quite encouraging.[2] Although it is postulated that educational interventions may lead to a reduction in stigmatising behaviours towards the mentally ill,[3-5] it appears that there is no direct relationship between stigmatising opinions and lack of knowledge of mental illness, even among mental health service providers.[6-8] The burden of mental illness with its attendant disability is particularly severe for people living in low-income countries.[9,10] Negative attitudes, discrimination, and stigma experiences of the mentally ill, coupled with poor knowledge of causes of mental illness, are likely to contribute to this disease burden.

A few studies have shown that negative feelings against the mentally ill are prevalent in Nigerian communities.[11] There is a need for more research on community knowledge of likely causes of mental disorders and attitudes towards the mentally ill, using standard instruments. To this end we examined attitudes towards the mentally ill in a Nigerian university teaching hospital population using the Community Attitudes towards the Mentally Ill (CAMI) scale.[12] Data were also obtained on knowledge of possible causes of mental illness.

Methods

The study was conducted at the University of Uyo Teaching Hospital, Uyo, Nigeria. Permission was obtained from the local Hospital Ethics Committee and the Medical Advisory Panel on Research. The study was carried out among teaching hospital senior staff members, excluding nurses, as nurses' attitudes towards the mentally ill compared with those of journalists had been investigated in a previous study.[14] Medical students in their final years were also asked to participate. Informed consent was obtained from all participants recruited into the study.

We obtained two sets of data. The first set comprised demographic variables, and the second set responses to 40 items derived from the CAMI scale,[12] a self-report inventory for measuring public attitudes towards the mentally ill. The CAMI includes four subscales (authoritarianism (AUTH), benevolence (BNVL), social restrictiveness (SRST) and community mental health ideology (CMHI)). Alpha coefficients were 0.63, 0.67, 0.64 and 0.60 for the AUTH, BNVL, SRST and CMHI subscales, respectively. Alpha coefficients for all 4 scales were above 0.60, indicating satisfactory though modest levels of reliability. The subjects were asked to rate each statement on a 5-point scale (strongly agree, agree, neither, strongly disagree, disagree). Subjects were also asked to complete a 10-item self-report inventory of questions about knowledge of mental illness derived from a previous Nigerian study.[14]

Statistical methods

The results of the study were analysed using the Statistical Package for Social Sciences (SPSS 11.0). Sample means and frequencies were calculated as appropriate.

Within-group differences were analysed by the independent samples *t*-test and one-way ANOVA. Coefficient alphas were computed to obtain internal consistency estimates of reliability for the CAMI subscales. The level of significance was set at $p<0.05$.

Results

We interviewed 208 respondents, comprising 38 medical doctors, 100 undergraduate medical students (4th and 5th years), and 70 other hospital personnel, made up of 10 pharmacists, 5 physiotherapists, 12 laboratory technologists, 9 medical records officers, and 34 administrative staff (accounts staff, senior clerical officers, unit administrators, etc., without medical training). There were 140 male (67%) and 68 female (33%) respondents. Their mean age was 32.1 (standard deviation (SD) 9.8) years (range 18 - 55 years).One hundred and thirty-four respondents (64%) were single and 74 (36%) were married.

Perceptions of causes of mental illness

Participants' responses to questions on 10 possible causes of mental illness are shown in Table I.

The most commonly cited cause of mental illness was misuse of drugs (89.4%). Others included traumatic life events (82.7%), misuse of alcohol (75.0%), stress (72.1%) and genetic inheritance (68.3%). Most respondents gave more than one possible cause of mental illness. It is noteworthy that witchcraft, possession by evil spirits and punishment from God were endorsed as possible causes by 52.0%, 44.2% and 30.0% of respondents, respectively.

Table I. Respondents' reported causes of mental illness

Perceived cause	No.*	%
Misuse of drugs (cannabis, cocaine, heroin, etc.)	186	89.4
Traumatic events	172	82.7
Misuse of alcohol	156	75.0
Stress	150	72.1
Genetic inheritance	142	68.3
Physical abuse	128	61.5
Witches	108	52.0
Possession by evil spirit	92	44.2
Poverty	88	42.3
God's punishment	62	30.0

*Participants gave multiple responses.

Attitudes towards the mentally ill

The distributions of responses for the 4 CAMI scales items were varied (Tables II - V), and were stigmatising for measures of authoritarianism, which elicited the most negative attitudes, with 78% of respondents disagreeing that large mental hospitals were an outdated means of treating the mentally ill, reflecting the view that mentally ill persons could be a threat to public safety (Table II). Seventy-five per cent of respondents felt that there was something about the mentally ill that made it easy to tell them from normal people, and 69.2% disagreed that less emphasis should be placed on protecting the public from the mentally ill. Following this, the statements 'Mental patients need the same kind of control and discipline as young children' and 'As soon as a person shows mental disturbance he should be hospitalised' were ranked equally (62.0%). Except for the mentally ill being perceived as a burden on society (40.4%), the respondents could be seen as having strongly benevolent attitudes towards the mentally ill (Table III).

The distribution of responses on the social restrictiveness scale (Table IV) shows that 82.7% of respondents were of the opinion that the mentally ill should be denied their individual rights, and that women who were once patients should not be trusted as babysitters (50.0%). The Community Mental Health Ideology

Table II. Respondents' attitudes to mental illness statements for the CAMI authoritarianism scale

	N	%
Large mental hospitals are an outdated means of treating the mentally ill (strongly disagree/ disagree)	162	78.0
There is something about the mentally ill that makes it easy to tell them from normal people (strongly agree/agree)	156	75.0
Less emphasis should be placed on protecting the public from the mentally ill (strongly disagree/ disagree)	144	69.2
Mental patients need the same kind of control as young children (strongly agree/agree)	126	62.0
A person should be hospitalised once he shows signs of mental illness (strongly agree/agree)	126	62.0
Mental illness is an illness like any other (strongly disagree/disagree)	84	40.0
Lack of self-discipline and willpower is one of the main causes of mental illness (strongly agree/ agree)	76	36.5
Keeping them behind locked doors is one of the best ways to handle the mentally ill (strongly agree/ agree)	34	16.3
Virtually any one can become mentally ill (strongly disagree/disagree)	32	15.4
The mentally ill should not be treated as outcasts from society (strongly disagree/disagree)	8	4.0

Table III. Respondents' attitudes to mental illness statements for the CAMI benevolence scale

	N	%
The mentally ill are a burden on society (strongly agree/agree)	84	40.4
It is best to avoid anyone who has mental problems (strongly agree/agree)	34	16.3
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for (strongly disagree/disagree)	32	15.4
More tax money should be spent on the care and treatment of the mentally ill (strongly disagree/ disagree)	26	12.5
The mentally ill do not deserve our sympathy (strongly agree/agree)	20	9.6
The mentally ill have for too long been the subject of ridicule (strongly disagree/disagree)	18	8.6
We have a responsibility to provide the best care for the mentally ill (strongly disagree/disagree)	14	6.7
We need to adopt a more tolerant attitude towards the mentally ill in our society (strongly disagree/ disagree)	10	4.8
Increased spending on mental health services is a waste of tax money (strongly agree/agree)	10	4.8
There are sufficient existing mental health services in Nigeria (strongly agree/agree)	6	2.9

Table IV. Respondents' attitudes to mental illness statements for the CAMI social restrictiveness scale

	N	%
The mentally ill should be denied their individual rights (strongly agree/agree)	172	82.7
Women who were once patients in a mental hospital can be trusted as babysitters (strongly disagree/disagree)	104	50.0
The mentally ill should not be given any responsibility (strongly agree/agree)	68	32.7
Anyone with a history of mental illness should be excluded from taking public office (strongly agree/agree)	56	27.0
The mentally ill are far less of a danger than most people suppose (strongly disagree/disagree)	54	26.0
I would not want to live next door to someone who has been mentally ill (strongly agree/agree)	46	22.1
The mentally ill should be isolated from the rest of the community (strongly agree/agree)	38	18.3
No one has the right to exclude the mentally ill from their neighborhood (strongly disagree/ disagree)	30	14.4
Mentally ill patients should be encouraged to assume the responsibility of normal life (strongly dis-agree/disagree)	20	9.6
A woman would be foolish to marry a man who has suffered from mental illness, though he seems fully recovered (strongly agree/agree)	14	6.7

Table V. Respondents' attitudes to mental illness statements for the CAMI community mental health ideology scale

	N	%
Having mental patients living in a residential area might be good therapy, but the risks are too great (strongly agree/agree)	106	51.0
It is frightening to think of people with mental problems living in residential neighbourhoods (strongly agree/agree)	98	47.1
Mental health centres should be kept out of residential areas (strongly agree/agree)	82	39.4
Locating mental health services in residential neighbourhoods does not endanger local residents (strongly disagree/disagree)	66	31.7
Local residents have good reasons to resist the location of a mental hospital in their area (strongly agree/agree)	44	21.1
Residents have nothing to fear from people coming into their area to receive mental health treatment (strongly disagree/disagree)	32	15.4
The best therapy for many mental health problems is to be part of a normal community (strongly disagree/disagree)	30	14.4
As far as possible, mental health services should be provided through community-based facilities (strongly disagree/disagree)	28	13.5
Locating mental health facilities in residential areas downgrades the neighbourhood (strongly agree/agree)	24	11.5
Residents should accept location of mental health facilities in their neighbourhood to serve the needs of the local community (strongly disagree/disagree)	24	11.5

scale (CMHI) showed that 51.0% of respondents were opposed to having mentally ill patients living in their neighbourhood, and 39.4% would rather not have a mental health facility located in their residential area. There were no significant differences when the CAMI mean subscale scores were compared with respect to age, gender, marital status or occupational groups in our sample.

Discussion

The participants who took part in this study held very negative views about the mentally ill, as shown by the distribution of their responses on 3 out of the 4 CAMI subscales, those of AUTH, SRST and CMHI. A large majority of respondents (78.0%) supported custodial care for the mentally ill. They did not perceive large mental hospitals as outdated in the treatment of the mentally ill, which may be interpreted as seeing the mentally ill as a threat to public safety (Table II). Seventy-five per cent of respondents believed that there was something about the mentally ill that made it easy to tell them from normal people. Most of the respondents (69.2%) did not agree that less emphasis should be placed on protecting the public from the mentally ill.

The findings of this study indicate that stigmatising attitudes to the mentally ill are widely held, even among people working in a tertiary hospital setting. Our findings support earlier observations that stigmatising views about mental illness are not limited to uninformed members of the general public, but include people working in the health sector, and even those who are in contact with patients.[4-6,12]

Misuse of drugs ranked highest as a perceived cause of mental disorder and was endorsed by about 89.4% of study participants. Misuse of alcohol ranked third (75.0%). The finding that there was a strong belief that drugs and alcohol misuse can cause mental illness in this study is consistent with previous reports.[11,13]

Some investigators have advised that such findings needed to be interpreted with caution, as more often than not the public sees the misuse of substances as a moral failing, and such a belief is likely to elicit condemnation rather than understanding or sympathy.[11,13] Although our respondents appeared to be knowledgeable about the possible role of psychosocial and genetic factors in the causation of mental illness, more than half of them (52.0%) believed that mental illness could be caused by witches, almost half (44.0%) thought that it might be due to possession by demons, and close to one-third (30.0%) thought it could be a consequence of divine punishment. Even though supernatural phenomena such as witchcraft and possession by evil spirits are believed to be important causes of mental disorders in non-Western cultures,[17] rates of 52.0% and 44.0% in a tertiary health care setting with an enlightened population are quite worrisome.

Socio-culturally, most Africans regardless of level of education adhere in varying degrees to a belief in supernatural causation

of illness or disease.[18] Cultural misconceptions about mental illness have been known to affect help-seeking behaviour, illness stereotypes and organisational structures put in place for treatment of people with mental illness.[19] Even though our respondents appeared to be relatively enlightened in terms of their endorsement of psychosocial and genetic factors as being important in the causation of mental illness, it is noteworthy that these views coexisted with rather primitive beliefs in supernatural causation as well as negative attitudes towards mentally ill persons, highlighting the need to target health providers in anti-stigma interventions. A strong belief in supernatural causation of mental illness, even among educated health workers, is a pointer to the complexities likely to be encountered in the design of the anti-stigma public education strategies.

Conclusion

This study found that participants did not differ in their CAMI subscale scores when occupational groupings were compared. This unexpected finding (that people with medical training did not differ from those without medical knowledge in stigmatising attitudes against the mentally ill) stresses the urgent need to include stigma on the undergraduate curriculum of our medical schools. Formal lectures on stigma should be mandatory for postgraduate trainees as well. As noted by Stuart, contemporary notions of stigma are grounded in sociological and psychological theoretical traditions, so anti-stigma interventions must target diverse groups of people, and the programme design must allow for culturally relevant content since stigma is pervasive both within and across cultures.[20] There is an urgent need in Nigeria to develop strategies to change stigma caused by mental illness at both institutional and community levels.

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