YOUNG PERSONS' PERCEPTION AND ATTITUDINAL DISPOSITION TO PERSONS WITH MENTAL ILLNESS IN IBADAN SOUTH-WEST LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA

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DEDICATION

This work is dedicated to God who has been my help in ages past and my hope for years to come. In the course of this programme, He raised wonderful people to help me carry on.

CERTIFICATION

I hereby certify that this study was carried out by Oluwatosin Modupe AINA in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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ABSTRACT

The stigma associated with mental illness poses a serious public health concern in Nigeria. The phenomenon adversely affects sufferers' social relationships as well as their physical, psychological and emotional well-being. Young persons' perceptions and attitudinal disposition to people with mental illness in Nigeria have not been fully investigated. This study was therefore carried out to assess young persons' level of knowledge, perceptions and attitude to people with mental illness in Ibadan South-West Local Government Area.

A four-stage random sampling technique was used to select 500 young persons aged 10-24 years that consented to participate in the study. Data were collected using a validated semi-structured questionnaire which consisted of a 20-point knowledge scale, as well as questions on perception and attitudes to mental illness. Twelve Focus Group Discussions (FGDs) were conducted. The quantitative data were analyzed using descriptive and Chi-square statistics while the FGD data were transcribed and analyzed using the thematic approach.

Respondents' mean age was 16.6 ± 3.5 years. 52.4% were males, 85.7% Yoruba and 62.0% Christians. More respondents (66.4%) had secondary education. Majority of the respondents (87.6%) attributed the cause of mental illness to evil spirit. Many respondents (40.2%) stated that medical intervention is the most effective treatment for mental illness while 19.2% were of the view that a combination of medical and traditional treatment is more effective. Respondents' mean knowledge score was 12.3 ± 3.3. The perception of 51.0% of the respondents was that mental illness is curable, while 73.6% were of the view that mental illness is preventable. Twenty seven percent in-school compared with 3.8% out-of-school respondents stated that mental illness is contagious ($p<0.05$). More respondents in the inner-core area of the LGA (25.8%) had a negative attitude to persons with mental disorders compared with those in transitory (21.8%) and peripheral (4.4%) areas ($p<0.05$). Slightly more males (35.8%) than females (35.2%) would be willing to make friends with a person who has mental illness. Seventy

one percent of the respondents stated that they would not make friends with persons with a history of mental illness while 70.4% would be upset to be in the same class or workplace with such a person. Forty five percent reported that persons with mental illness should be locked up. The FGD participants unanimously disclosed that persons with mental illness are stigmatized because of their unacceptable abnormal behaviour such as violence, verbal assault and fear of being attacked by them. It was suggested by most participants that improved medical treatment and the provision of rehabilitation homes should be used to ameliorate the social burden associated with mental illness.

There were negative attitudinal disposition and wrong perceptions which can heighten the stigmatization of mentally ill persons. Community-based mental health promotion programmes implemented through peer education and behavioural change communications are needed to address the identified misconceptions.

Key words: Mental illness, Mental health knowledge, Social stigma, young persons, perception

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INTRODUCTION

Background to the study

Mental disorders are diseases that affect cognition, emotion, and behavioral control and substantially interfere with both the ability of children to learn and the ability of adults to function in their families, at work, and in the broader society. They are common in all countries where their prevalence has been examined. Because of the combination of high prevalence, early onset, persistence, and impairment, mental disorders make a major contribution to total disease burden (Hyman, Chisholm, Kessler, Patel, Vikram & Whiteford, 2006).

The burdens of mental illnesses, such as depression, alcohol dependence and schizophrenia, have been seriously underestimated by traditional approaches that take account only of deaths and not disability. Among women in developed countries aged 15-44, the leading causes of disease burden are: unipolar major depression, schizophrenia, road traffic accidents, bipolar disorder, and obsessive-compulsive disorder (National Alliance on Mental Illness, 2009). In Nigeria 28.5% of those attending primary care setting in an urban area were found to have psychiatric morbidity (Ohaeri, Odejide, Gureje and Olatawura, 1994).

Numerous factors have been linked to the development of mental disorders. In many cases there is no single accepted or consistent cause currently established. A common view held is that disorders often result from genetic vulnerabilities combining with environmental stressors. Genetic studies have indicated that genes often play an important role in the development of mental disorders, via developmental pathways interacting with environmental factors (Kas, Fernandes, Schalkwyk and Collier, 2007). Environmental events surrounding pregnancy and birth and traumatic brain injury may also increase the risk of developing certain mental disorders (Tsuang, Multeni, Rocagni and Riva, 2007). There have been some tentative inconsistent links found to

certain viral infections, to substance misuse, and to general physical health (Phelan, Stradins and Morrison). Abnormal functioning of neurotransmitter systems has been implicated, including serotonin, norepinephrine, dopamine and glutamate systems. Differences have also been found in the size or activity of certain brains regions in some cases (Iversen and Iversen, 2007). Psychological mechanisms have also been implicated, such as cognitive and emotional processes, personality, temperament and coping style. Social influences have been found to be important, including abuse, bullying and other negative or stressful life experiences. The specific risks and pathways to particular disorders are less clear, however. Aspects of the wider community have also been implicated, including employment problems, socioeconomic inequality, lack of social cohesion, problems linked to migration, and features of particular societies and cultures (Pilgrim, David; Rogers & Anne, 2005; Rutter, 2000).

The history of the stigmatization of mental illness is long, but it is probable that intolerance to mental abnormality (and the rejection of people who had it) has become stronger in the past two centuries because of urbanization and the growing demands for skills and qualifications in almost all sectors of employment. Mental illness is also linked to stigmatization, discrimination, and intolerance in rural settings and in all countries, regardless of their level of industrialization and sophistication of labour. Recent studies carried out in developing countries confirm that this stigma is universal (Pickenhagen & Sartorius, 2002).

As Gulleksen (in Fink and Tasman, 1992) wrote about her brother's schizophrenia: "*For me stigma means fear, resulting in a lack of confidence. Stigma is loss, resulting in unresolved mourning issues. Stigma is not having access to resources and being invisible or being reviled, resulting in conflict. Stigma is lowered family esteem and intense shame, resulting in decreased self-worth. Stigma is secrets and silence, resulting in distance. Most importantly, stigma is hopelessness, resulting in helplessness*" (Byrne, 2000).

The stigma attached to mental illness often leads to underestimation, under diagnosis and under treatment of mental disorders (Baumann, 2007).

Around the world there are programmes in place to reduce psychiatric stigma, and a knowledge base to support these initiatives is slowly emerging (Pinfold, Toulmin, Thornicroft, Huxley, Farmer & Gmhani, 2003)

Young people's perspectives on mental ill-health are, however important on a number of grounds To some extent, their importance lies in the foundations which may be laid in childhood and particularly in early adolescence, for future beliefs and attitudes, since these are likely to have a significant influence on the success of community care policies (Wahl and Kaye, 1992; Scottish Mental Health Forum, 1992)

Problem Statement

There is no health without mental health as mental health is the foundation for well-being and effective functioning for an individual and for a community. Mental health promotion covers a variety of strategies, all aimed at having a positive impact on mental health, it involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles (WHO, 2008).

The result of the community study carried out by Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola (2005) on the knowledge of and attitude to mental illness in Nigeria, suggests that knowledge about mental illness is very low in the Nigerian communities. The views about mental illness were generally negative as people with mental illness were believed to be mentally retarded and dangerous. Less than half of the participants believed that such people could be treated outside hospital and only a few thought they could work in regular jobs.

Negative views such as those implying that people with mental illness are irresponsible and therefore incapable of making their own decisions are widespread and also the belief that they are dangerous and are to be feared. Negative beliefs often lead to discrimination, this makes people with mental health problems living in the community prone to rampant harassment (Gureje *et al*., 2005).

Attitude to mental illness is consequently characterized by intolerance of even basic social contact with people known to have such illness. In a society in which poor health

facilities and poverty make the care of people with mental illness a major burden for both patients and their families, the degree of stigma experienced by individuals with mental illness suggest an unusual level of illness-related burden. Most of the study participants were unwilling to have social interactions with someone with mental illness. Only a few would want to have a conversation, be willing to maintain a friendship and would not be disturbed to work with a person with mental illness and very few of the participants would consider marrying someone with mental illness (Gureje *et al*., 2005). As a result of the stereotypes and prejudice that result from misconceptions about mental illness, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people (Corrigan & Watson, 2002).

The stigma and deprivation of the basic human rights faced by those with mental disorders has attracted attention all over the world and is becoming a serious issue for debate and concern (International Union for Health Promotion & Education, 2005).

Several studies have been done among the adult population in Nigeria on the stigmatization of people with mental illness by Gureje *et al* (2005), Adewuya and Makanjuola (2005), Adewuya and Ogunlade (2007), but few studies have been carried out among young persons.

Justification of the Study

Even though a lot of studies have been done on community perception, knowledge and attitude towards mental illness among older people, there is a paucity of literature on the perception of young persons in the Nigerian communities about mental illness and their attitudinal dispositions to people with mental illness.

Information on the perception of young persons in the community about mental illness is very important, because young persons are affected by mental illness as a result of their direct contacts with friends, relatives, family members or persons in their neighbourhoods who are experiencing mental illness. Their views about mental illness are however important, as these would determine their attitudinal dispositions and their desire to help persons with mental illness in their homes and communities.

Information obtained from this study would be used to develop community based mental health interventions which would help in reducing stigma in the community. Young persons who have been enlightened can act as sources of information for friends and neighbours and also create positive changes in the attitude of the community members towards mental disorders.

Research Questions

1. What do the young persons know about mental illness?
2. What are their perceptions about mental illness and people experiencing mental illness?
3. What are their attitudinal dispositions towards persons with mental illness?
4. What sorts of words or phrases do they use to describe someone who experiences mental health problems?

Objectives of the Study

The broad objective of this study was to document the perceptions and attitudinal dispositions of young persons towards people with mental illness in Ibadan South West Local Government Area (L.G.A) of Oyo State.

The specific objectives of this study were:

1. To assess the knowledge of the young persons about mental illness.
2. To determine the perceptions of young persons in Ibadan South-West L.G.A of Oyo State about mental illness.
3. To determine the attitude of the young persons towards people with mental illness.
4. To document the sort of words or phrases the young persons would use to describe someone who experiences mental illness.

Hypotheses

The following hypotheses were tested:

1. There is no association between the sex of the respondents and their knowledge of mental illness.
2. There is no association between the school group of the respondents and their perception about people with mental illness.
3. There is no association between the sex of the respondents and their attitude towards people with mental illness.
4. There is no association between the respondents' place of residence and their attitude towards people with mental illness.

CHAPTER TWO

LITERATURE REVIEW

World Health Organization (WHO) definition of health stresses the importance of mental, physical and social well-being and not the mere absence of disease. The essential dimension of mental health is clear from this definition of health in the WHO constitution which states that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health is more than the absence of mental disorders, it can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community (WHO, 2008).

The terms mental illness and mental disorders would be used interchangeably in this section.

Mental disorders

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. They often result in a diminished capacity for coping with the ordinary demands of life. Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing. The good news about mental illness is that recovery is possible because they treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan (NAMI, 2008).

Types of mental disorders

The most widely applied classification of mental disorders are:

(i) The Diagnostics and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV).

(ii) International Statistical Classification of Disease, Injuries and cause of death (ICD-10).

a. Mental Sub normality/Mental retardation

b. Anxiety disorder

c. Affective disorder

d. Schizophrenia

e. Personality disorder

f. Mental disorders presenting with physical symptoms

g. Organic brain syndrome

For the purpose of this study only a few of the common types of mental disorders would be reviewed.

Socio economic burden of mental disorders

The economic impact of mental disorders is wide-ranging, long-lasting and enormous. These disorders impose a range of costs on individuals, families and communities. In the United States of America, the annual total costs related to mental disorders have been reported as reaching 147 billion US dollars, more than the costs attributed to cancer, respiratory disease or AIDS. Due to low availability and coverage of mental health care services, indirect costs arising from productivity loss account for a larger proportion of overall costs, estimates of direct costs in low income countries are low. There are hard-to-measure costs such as loss of employment, reduced productivity, the impact on families and caregiver, the negative impact of premature mortality, negative impact of stigma and discrimination or lost opportunity costs to individuals and families that have not been taken into account (WHO, 2004). It is calculated that the cost to the Nigerian economy of untreated mental illness runs into billions of naira every year. The majority of the expense of care is paid by patients and families. This is usually difficult as mental illness can last for many years.

Global burden of mental disorders

Mental, neurological and behavioural disorders are common to all countries and cause immense suffering (WHO, 2008). One fifth of teenagers under the age of 18 years suffer from developmental, emotional or behavioural problems; one in eight has a mental disorder; among disadvantaged children the rate is one in five. Mental and neurological account for 13% of the total Disability Adjusted Life Years (DALY's) lost due to all diseases and injuries in the world (WHO, 2004). The burdens of mental illnesses, such as depression, alcohol dependence and schizophrenia, have been seriously underestimated by traditional approaches that take account only of deaths and not disability. While psychiatric conditions are responsible for little more than one percent of deaths, they account for almost 11 percent of disease burden worldwide (National Alliance on Mental Illness, 2009). People with mental illnesses die at least 25 years earlier than the rest of the population. The share of the total burden due to mental illness varies between developed countries; in African countries, primarily due to the disproportionate burden due to communicable, maternal, perinatal and nutritional conditions (70-75% compared with 5% in developed countries) (WHO, 2000).

In Nigeria, evidence from general health care settings shows that about 10% of adult attendees meet ICD-10 criteria for definite psychiatric disorders commonly, major depression, anxiety disorders, somatoform disorders, dysthymia and alcohol abuse (Gureje, Odejide, Olatawura *et al*., 1995). A recent large scale community study suggests that about 45 of every 1000 persons in the community have experienced at least one depressive episode in their lifetime, while about 12 have done so in the previous 12 months (WHO, 2004). Also, 65 out of every 1000 men reported a substance use disorder in their lifetime. The findings of the lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health shows that 12.1% of the sample had had at least one lifetime DSM-IV disorder and that 5.6% had experienced at least one of the disorders in the prior 12 months. Specific phobia was the most common disorder, occurring in 5.4% ever in lifetime and in 3.5% in the prior 12 months (Gureje, Lasebikan, Kola and Makanjuola, 2006). The overall prevalence of psychiatric morbidity found at the community level in Oyo State, in a study carried out by Amoran, Lawoyin and Oni

(2005) was found to be 21.9%, (18.4% in the urban areas and 28.4% in the rural areas). The adolescent age group was found to have higher psychiatric morbidity when compared to the adults in that study (Amoran, Lawoyin and Oni, 2005).

Young People and Mental Illness

About one in five teen suffers from diagnosable mental health disorders, although it is unknown exactly how many of those problems persist into adulthood. Nevertheless, it is safe to say that for many, the problems identified in adolescence follow them into adulthood. One study, for example, found that about three-fourths of those with a diagnosable mental disorder at age 26 had first been diagnosed in their teens (Kim-Cohen et al., 2002). Although research shows that 50 percent of mental disorders begin by age 14, it can take several years for the illness to be detected and appropriately treated. Early detection and treatment of mental disorders can result in a substantially shorter and less disabling course of mental illness (United State Government Accountability Office (GAO), 2008).

Depression, anxiety and substance use disorders are the most common mental disorders. They account for three-quarters of the burden, measured in disability-adjusted life-years lost, generated by all the mental disorders (Andrews and Wilkinson, 2002).

Oshikoya and Alli (2006) in their studies on perception of Drug Abuse amongst Nigerian undergraduates identified dependence and addiction as one of the major consequence of drug abuse, characterized by compulsive drug craving seeking behaviours are use that persist even in the face of negative consequences. These changes are maladaptive and inappropriate to the social or environmental setting, therefore may place the individual at risk of harm (Abudu, 2008). Experiment with drugs during adolescence (11 – 25 years) is common. At this age, they try so many new things. They use drugs for many reasons, including curiosity, because it feels good, to reduce stress, or to feel grown up. Using alcohol and tobacco at a young age increase the risk of using other drugs later. In one of the WHO's and the World Heart Foundation's data, posit that in Nigeria, 22.1% of school youth age between 12 to 17 years use tobacco, in South Africa, it is 19.1%, 15.1% in Ghana and 16.2% in Kenya (Abudu, 2008).

Schizophrenia

Schizophrenia is a severe mental disorder which usually starts in adolescence or early adult life and often has a chronic disabling course. It is characterized in general by fundamental and characteristics distortions in form and content of thinking and perception (loosening of associations, delusions, and hallucinations), mood and behaviour (Ayuso-Mateus, 2006). It affects more than one percent of the population (American Psychiatry Association, 2007). Incidence studies show that onset of schizophrenia and other Non-Affective Psychosis (NAP's) is typically in middle to late adolescence for males and late adolescence to early adulthood for females, although later onsets are observed. Childhood-onset cases are quite rare but particularly severe (Nicolson and Rapoport 1999).

People with schizophrenia are not especially prone to violence and often prefer to be left alone. Studies show that if people have no record of criminal violence before they develop schizophrenia and are not substance abusers, they are unlikely to commit crimes after they become ill (National Institute of Mental Health, 2007). Scientists have long known that schizophrenia runs in families. It is seen in 10 percent of people with a first-degree relative (a parent, brother, or sister) with the disorder. People who have second-degree relatives (aunts, uncles, grandparents, or cousins) with the disease also develop schizophrenia more often than the general population. The identical twin of a person with schizophrenia is most at risk, with a 40 to 65 percent chance of developing the disorder (Cardno and Gottesman, 2000).

It is likely that an imbalance in the complex, interrelated chemical reactions of the brain involving the neurotransmitters dopamine and glutamate (and possibly others) plays a role in schizophrenia (NIMH, 2007).

Signs and symptoms

No single symptom signals schizophrenia. Any one of its symptoms also can be found in other mental illnesses, such as bipolar disorder or Alzheimer's disease. The symptoms of schizophrenia fall into three broad categories:

Positive symptoms are unusual thoughts or perceptions, including hallucinations, delusions, thought disorder, and disorders of movement.

Negative symptoms represent a loss or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life. These symptoms are harder to recognize as part of the disorder and can be mistaken for laziness or depression.

Cognitive symptoms (or cognitive deficits) are problems with attention, certain types of memory, and the executive functions that allow us to plan and organize. Cognitive deficits can also be difficult to recognize as part of the disorder but are the most disabling in terms of leading a normal life (NIMH, 2008).

Diagnosis

Diagnosis takes time. In clinical practice, symptoms generally need to be followed for at least six months. But neither time nor the illness, wait for a diagnosis. The survey found the following: People living with schizophrenia and in treatment, report an average delay of 8.5 years between the onset of symptoms and the beginning of treatment. Almost five years elapse between symptom onset and diagnosis of any kind of mental health condition. The average age of onset was 20.5 years old, with males generally experiencing symptoms two years earlier than females, and the average age of any mental health diagnosis is 24.5 (NAMI, 2008).

According to the ICD-10 criteria, the patient must have one very clear symptom (and usually two or more) belonging to first four basic symptoms, or symptoms from at least two of the next four symptoms, should have been clearly present for a period of one month or more (See Appendix 6).

Global burden/Prevalence of schizophrenia

Schizophrenia occurs in approximately 1% of the population, affecting three million people in the United States. In the systematic review provided by Saha *et al.* (2005) on the prevalence data on schizophrenia across cultures, distilling the findings from just under 200 studies from 46 nations, the median prevalence of schizophrenia was 4.6 per 1,000 for point prevalence, 3.3 per 1,000 for period prevalence, 4.0 for lifetime prevalence, and 7.2 for lifetime morbid risk (Bhugra, 2005). The age-standardized prevalence for schizophrenia estimated by WHO epidemiological sub regions in the year 2000 was 3.43 per 100,000 for males and 3.78 per 100,000 (Ayuso-Mateos, 2006).

The prevalence rates of schizophrenia depend upon a whole range of factors, such as the availability of and response to treatment. Findings have revealed that there were no significant differences between males and females, or between urban, rural, and mixed sites, although migrants and homeless people had higher rates of schizophrenia and, not surprisingly, developing countries had lower prevalence rates (the lower prevalence of schizophrenia in developing countries has been previously documented) (Bhugra, 2005). The factors underlying the better outcome of schizophrenia in developing countries remain essentially unknown but are likely to involve interactions between genetic variation and specific aspects of the environment (Jablensky, 2000).

People with schizophrenia are at significantly higher risk for a number of physical health problems when compared to the general population (Ryan and Thakore, 2002). They die from heart disease, diabetes, and other medical causes at a rate two or three times greater than the rest of the population. Ten percent die from suicide, yet schizophrenia is a manageable disease (NAMI, 2008).

Socio-economic burden

Schizophrenia affects more than 2 million Americans, or 1% of the nation's population age 18 or older. It is one of the most severe mental illnesses, one of the most feared, and yet also one of the most misunderstood compounding the cruelty of the disease, which can wear down a person's daily life and hopes for the future (NAMI, 2008). Schizophrenia has life-changing consequences, which can include lost or damaged relationships, disability, academic failure, unemployment, dependency, isolation, physical illnesses, jail or prison, and homelessness. Not surprisingly, 63% of people living with schizophrenia have accepted money or financial support from family members or friends; 56% have depended on them for transportation; and 50% for housing. 59% of individuals living with schizophrenia under the age of 35 report decreased engagement in job searches (NAMI, 2008).

Treatment

Antipsychotic medications have been available since the mid-1950s (NIMH, 2007), although lifestyle plays an important role in this increased risk, as do effects of the illness itself, the stigma associated with mental illness, and side effects of antipsychotic

medication. Therefore advances in medicine, including antipsychotic medications, psychosocial therapy, and rehabilitation, now enable many people who live with schizophrenia to recover and live productive, fulfilling lives (NAMI, 2008). Like diabetes or high blood pressure, schizophrenia is a chronic disorder that needs constant management. At the moment, it cannot be cured, but the rate of recurrence of psychotic episodes can be decreased significantly by staying on medication (NIMH, 2007).

Depression

Major depressive disorder is also known as major depression, unipolar depression, unipolar disorder, or clinical depression. There is no single known cause of depression. Rather, it likely results from a combination of genetic, biochemical, environmental, and psychological factors (NIMH, 2008). Some types of depression tend to run in families, suggesting a genetic link. However, depression can occur in people without family histories of depression as well (Tsuang & Faraone, 1990). Genetics research indicates that risk for depression results from the influence of multiple genes acting together with environmental or other factors (Tsuang, Bar, Stone & Faraone, 2004). In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode. Subsequent depressive episodes may occur with or without an obvious trigger (NIMH, 2008).

Signs and symptoms

The core symptom of major depression is a disturbance of mood; sadness is most typical, but anger, irritability, and loss of interest in usual pursuits may predominate. Often the affected person is unable to experience pleasure (anhedonia) and may feel hopeless. In many countries of the developing world, patients will not complain of such emotional symptoms, but rather of physical symptoms, such as fatigue or multiple aches and pains.

Typical physiological symptoms that occur across cultures include sleep disturbance (most often insomnia with early morning awakening, but occasionally excessive sleeping), appetite disturbance (usually loss of appetite and weight loss, but occasionally excessive eating), and decreased energy. Behaviorally, some individuals with depression exhibit slowed motor movements (psychomotor retardation), whereas others may be

agitated. Cognitive symptoms may include thoughts of worthlessness and guilt, suicidal thoughts, difficulty in concentrating, slow thinking, and poor memory. Psychotic symptoms occur in a minority of cases (Hyman *et al*, 2006). The person may report persistent physical symptoms such as fatigue, headaches, digestive problems, or chronic pain; this is a typical presentation of depression, according to the World Health Organization's criteria of depression, in developing countries (Patel, Abas, Broadhead *et al* 2001).

Diagnosis

According to the DSM-IV, a person who suffers from major depressive disorder must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a two week period. This mood must represent a change from the person's normal mood; social, occupational, educational or other important functioning must also be negatively impaired by the change in mood (See Appendix 7).

Global burden of depression

Depression is a major cause of morbidity worldwide (WHO, 2001). Lifetime prevalence varies widely, from 3% in Japan to 17% in the US. In most countries the number of people who would suffer from depression during their lives falls within an 8–12% range (Andrade, Caraveo-Anduaga & Berglund, 2003; Kessler, Berglung, Demler *et al*., 2003). In a pilot study on depression among secondary school students Malaysia by Adlina *et al* (2007) findings revealed that Females were more depressed than males. The Chinese students were more depressed compared to Indian students. Students whose parents had no formal education or had only primary education were more depressed than students whose parents had secondary, college or university education depression increased with increasing number of siblings. Depression contributed to the habit of drug abuse, gum sniffing and stealing but not to smoking and alcohol abuse. Suicidal tendencies were more likely among the depressed students (Adlina, Suthahar, Ramli, Edariah, Aye Soe, Ariff, Narimah, Nurafiza & Kurulia, 2007).

In a study carried out by Ademuya *et al* (2007) among a sample of 1095 Nigerian adolescents using the Beck Depression Inventory to screen in depressive symptoms, the

prevalence of major depressive disorders was 6.9% (Adewuya, Ola & Aloba, 2007). Among a total of 1105 participants recruited for a study carried out in Oyo State by Amoran *et al.* (2007), the overall prevalence of depression was found to be 5.2%. The findings revealed that depression was more prevalent among women (5.7%) than men (4.8%). Depression was found to be common in rural areas (7.3%) than the urban areas (4.2%) (Amoran, Lawoyin & Lasebikan, 2007).

Treatment

Depression, even the most severe cases, is a highly treatable disorder. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that recurrence can be prevented. Once diagnosed, a person with depression can be treated with a number of methods. The most common treatments are medication and psychotherapy (NIMH, 2008).

Bipolar Disorder

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks (NIMH, 2010). It is called bipolar disorder because there are 2 phases to the illness: an "up," or manic phase, and a "down," or depressive phase. Bipolar disorder is distinguished from unipolar depression, which is a recurrent episodes of depression without any episodes of elevated mood. Persons who have bipolar disorder may have either more episodes of mania or more episodes of depression in the course of their illness (Torpy, 2009). Symptoms of bipolar disorder are severe. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives (NIMH, 2010).

Signs and Symptoms

People with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes." An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode.

Sometimes, a mood episode includes symptoms of both mania and depression. This is called a mixed state. People with bipolar disorder also may be explosive and irritable during a mood episode (NIMH, 2010)

Symptoms of mania or a manic episode include:

Mood Changes

- A long period of feeling "high," or an overly happy or outgoing mood
- Extremely irritable mood, agitation, feeling "jumpy" or "wired."

Behavioral Changes

- Talking very fast, jumping from one idea to another, having racing thoughts
- Being easily distracted
- Increasing goal-directed activities, such as taking on new projects
- Being restless
- Sleeping little
- Having an unrealistic belief in one's abilities
- Behaving impulsively and taking part in a lot of pleasurable, high-risk behaviors, such as spending sprees, impulsive sex, and impulsive business investments

Symptoms of depression or a depressive episode include:

Mood Changes

A long period of feeling worried or empty and loss of interest in activities once enjoyed, including sex

Behavioral Changes

- Feeling tired or "slowed down"
- Having problems concentrating, remembering, and making decisions
- Being restless or irritable
- Changing eating, sleeping, or other habits
- Thinking of death or suicide, or attempting suicide (NIMH, 2010).

Diagnosis

Bipolar disorder usually is first diagnosed in young adults or persons in their late teens, though it can occur in children and older adults as well. As a result of the fact that the

symptoms of bipolar disorder are variable, it may be difficult to diagnose bipolar disorder right away. A medical history and physical examination is usually performed to look for other causes of symptoms and other psychiatric diagnoses (Torpy, 2009).

Treatment

Because bipolar disorder is a lifelong and recurrent illness, people with the disorder need long-term treatment to maintain control of bipolar symptoms. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity (Miklowitz, 2006).

Global burden of Bipolar Depression

In a U.S. study, the lifetime prevalence rate of bipolar disorder was 4.5% (1.0% for bipolar I disorder, 1.1% for bipolar II disorder, and 2.4% for manic and depressive symptoms that did not meet all the diagnostic criteria for bipolar I or bipolar II disorder). Bipolar disorder is associated with premature death and is among the leading causes of disability in the developed world in people 15 to 44 years of age (Murray and Lopez, 1997). The rate of completed suicide is approximately 5% among patients who have never been hospitalized, but it is as high as 25% early in the course of the illness (Tondo, Isacsson and Baldessarini, 2003; Inskip, Harris and Barraclough, 1998). Bipolar disorder is associated with a high rate of suicide. It is important for persons with bipolar disorder to receive proper diagnosis and treatment with a psychiatrist as early as possible to minimize their risk of self-harm (Torpy, 2009).

Knowledge and perception of mental illness

'Were' mental illness in the Yoruba notion is classified into three categories – '*were aniloruwa*' (mental illness that one is born with), '*were ran*' (hereditary mental illness), and '*were alive*' (mental illness due to affliction) (Jegede, 2005). A lack of knowledge of causes, symptoms and treatment options of mental disorders in the public and a lack of personal contact with affected individuals can result in prejudices and negative attitudes towards them and subsequently in stigmatization and discrimination (Baumann, 2007). In a study carried out by Rose *et al.* (2007) among 14 year old school children about mental illness, the level of factual knowledge among the participants about mental illness was

remarkably low, and this may partially explain why their rates of recognition of mental illness were poor (Rose *et al*. 2007)

Prior research has indicated that between 1950 and 1996 fear of the mentally ill, specifically those with psychosis, has increased (Phelan, Link, Stueve, and Pescosolido, 2000). Also, since the 1950s the publics' definition of mental illness has broadened to include non-psychotic disorders. Although people perceiving psychosis as a definition of mental illness has decreased, among those who are perceived to have psychotic symptoms, perceptions of dangerousness have actually increased since 1950 (Phelan *et al*., 2000). This suggests that stigmatization remains as an influential force in our society and in the personal experiences of those with mental health problems. The conclusion of the literature review on stigmatization of mental illness by Hayward and Bright (1997) was that there were enduring themes of people with mental illness being perceived as: being dangerous, being unpredictable, difficult to talk with, having only themselves to blame, being able to pull themselves together, having a poor outcome and responding poorly to treatment (Crisp *et al*., 2000). Apart from these negative stereotypes, there also exists a positive stereotype about the mentally ill. Among the general public, the belief prevails that there is a close association between "genius" and "madness". Previous studies indicate that there is a relationship between stereotypes about people with mental illness and a preference for greater social distance (Angermeyer and Matschinger, 2004).

The findings of a study carried out by the BasicNeeds UK & Students' Campaign Against Drugs in Kenya among school-going youths in Nairobi revealed that most of the students defined people with mental disorders as individuals who are crazy or mad while mental disorders are largely associated with supernatural powers of either witches or the church (BNKE & SCAD, 2008). In the study carried out among some adults in Northern Nigeria, drug misuse in form of alcohol ingestion, cannabis and other psychoactive street drugs were perceived as major causes of mental illness, followed by effect of divine wrath or God's will, magic or spirit possession, and accidents or trauma (Kabir *et al*. 2004). The Yorubas believe that mental illness can result from four perspectives, natural source, such as those resulting from accidents or drug use, supernatural or mystical source, such as those resulting from the anger of the gods, preternatural source, which is

usually caused by witchcrafts (*Were Ifise*), the inheritable ones (*Were Iran*), and mental illness that one is born with (*Were Amuturimwa*) (Jegede, 2005).

In a study carried out among traditional healers in Ibadan by Jegede (2005) findings revealed that the treatment of mental illness is determined by the perceived cause or causes among the Yorubas. Certain types of mental illnesses such as those considered to be hereditary were reported to be incurable. However, the participants revealed that mental illnesses caused by natural, mystical or supernatural, and preternatural forces can be healed (Yorubas do not believe that mental illness can be permanently cured. It is seen as a continuous process because a mentally ill person is being controlled by spirits, either due to a natural factor or other factors. Informants indicated that patients must be under permanent observation so that their condition does not get deteriorated. Hence, the concept of '*alawoku*' (meaning semi-healed person) is a stigmatized perception of former mentally ill persons (Jegede, 2005).

Sources of information

One group of people consistently found to be misrepresented and stigmatized by television is persons with mental illness (Wahl, 1992). The media are a useful location to begin the search for negative representations and adverse attitudes to mental illness, and ultimately the media will be the means of any campaign that aims to challenge and replace the stereotypes attached to mental illness (Byrne, 2000). The National Alliance for the Mentally Ill (NAMI) suggests that the media is a powerful force in shaping the image of mental illness and what persons with mental illness are "like." Studies highlight how, through films, newspaper reports and television programmes, people with mental health problems are represented in stereotypical roles and a pejorative language against difference is normalised through 'crazy', 'out of control', 'loony' characters (Pinfold *et al*., 2003).

Attitude towards mental illness

Negative attitudes to people with mental illness start at playschool and endure into early adulthood (Weiss, 1994). Erroneous beliefs about causation and lack of adequate knowledge have been found to sustain deep-seated negative attitudes about mental illness (James, 1998). Conversely, better knowledge is often reported to result in improved attitudes towards people with mental illness (Stuart and Arboleda-Florez, 2001). In a study carried out by Adewuya and Oguntade (2007) on Doctors, attitude towards people with mental illness in Nigeria, beliefs in supernatural causes of mental illness were prevalent. The mentally ill were perceived as dangerous and their prognosis perceived as poor. High social distance was found amongst 64.1% of the participants (Adewuya and Oguntade, 2007).

People have strong negative expectations of those with conditions such as schizophrenia. Watch people's reactions to someone shuffling along the street like a stereotypical 'chronic psychiatry patient', even though the crowd do not know the specific label, the patient is avoided and socially rejected (Gray, 2002). Commonly young people feel that mental illness is embarrassing (Barney, Griffiths, Jorm, Christensen, 2006). Young people who believe that mental illnesses are the responsibility of the person affected are more likely to react to people who are mentally ill with anger, pitilessness or avoidance (Corrigan *et al*., 2005). The majority of the students who participated in the study carried out in Kenya among school-going youths said that they would run away from persons with mental disorders (BNKL & SCAD, 2008). Results of the study carried out by Kabir *et al* (2004) showed that majority of the respondent harbored negative feelings towards the mentally ill, mainly in the form of fear and avoidance (Kabir *et al*., 2004).

In a study carried out in India among women with schizophrenia and broken marriages, by Thara *et al* (2003) in India, findings revealed that there were instances wherein a mother of a married woman who is mentally ill, had to take her away from her husband's house on account of the severe physical and mental abuse that the patient was suffering at the hands of her in-laws and husband (Thara *et al*., 2003).

Stigmatization of mental illness

Many people with serious mental illness are challenged douhly. On one hand. they struggle with the symptoms and disabilities that result from the disease. On the other. they are challenged by the stereotypes and prejudice that result frnm misconceptions about mental illness. As a result of both. people with mental illness are robbed of the opportunities that define a quality life: good jobs. safe housing. satisfactory health care. and affiliation with a diverse group of people (Corrigan & Watson. 2002).

We are all likely to have to deal with mental illness at sometime. whether in family members. work colleagues or ourselves. The difficulties of living with psychiatric distress are magnified by the experience of rejection which is the consequence of stigma (Gray. 2002). Webster's New Twentieth Century Dictionary (1983) defines stigma as "something that detracts from the character or reputation of a person. group. etc.: a mark of disgrace or reproach: a mark. sign. etc. indicating that something is not considered normal or standard" (Phelan. Bromet and Link. 1998) It can be considered as an amalgamation of three related problems: a lack of knowledge (ignorance), negative attitudes (prejudice), and excluding or avoiding behaviours (discrimination) (Rose *et al*., 2007). Research on the stigma of mental health disorders has differentiated between public stigma and self-stigma. Pubic stigma refers to the reactions of lay persons towards a stigmatized group with a mental disorder, whereas self-stigma refers to the internalization of ideas and the reaction of those affected by a stigma (Rush *et al*. 2005).

The stigma attached to mental health has two major component beliefs. neither of which has any substantial basis in reality. The belief that the mentally ill are violent and a threat to Society (they are crazed killers who hear voices to kill other people and then do so). Also the belief that mentally ill persons are weak, and that they are moral failures (Mentally ill persons could have prevented their illnesses or could pull out of them if only they were not such weaklings) (Domberk. 2008). Although stigmatizing attitudes are not limited to mental illness, the public seems to disapprove persons with psychiatric disabilities significantly more than persons with related conditions such as physical illness. Severe mental illness has been linked to drug addiction, prostitution, and criminality. Unlike physical disabilities, persons with mental illness are perceived by the

public to be in control of their disabilities and responsible for causing them (Corrigan and Watson, 2002).

Sartorious believes that medical professionals, especially psychiatrists, contribute to stigma through both the careless use of diagnostic labels and through treatments that produce significant side effects (such as extrapyramidal signs), which mark the person as having a mental illness more so than the original symptoms (Hocking, 2003).

About fifty percent of those in self-help and outpatient programs report discriminatory experiences (Markowitz 1998), and over seventy percent of those with both a major mental disorder and a history of substance abuse report four or more types of social rejection (Link, Struening, Rahav, Phelan, and Nuttbrock, 1997).

The stigma and deprivation of the basic human rights faced by those with mental disorders has attracted attention all over the world and is becoming a serious issue for debate and concern (International Union for Health Promotion & Education, 2005).

The impact of stigmatization of mental illness

Psychiatric treatment seems to have a negative effect on individuals due to the cultural definitions of the "mentally ill." When an individual is diagnosed with a mental illness, cultural ideas about the mentally ill (e.g., incompetent, dangerous) become personally relevant. Because these cultural views are so negative, those who receive the label expect to be devalued and discriminated against (Link *et al.*, 1987). The stigmatization of people with mental illness affects the quality of medical care they are given (Adewuya & Ogunlade, 2007). In a recent Australian survey, people with mental illness and their families said "less stigma" was the number one thing that would make their lives better. They wanted healthcare workers who "treated them with more respect", who "would appreciate just how far a little kindness goes", and a community that "would understand that we are not lazy or weak" and that recovery is not simply a matter of "pulling yourself together" (Hocking, 2003).

Embarrassment and stigma may prevent people experiencing mental illness from seeking help. Because of anticipated stigma, the patients withdraw from social relations and develop low self-esteem. They also harbour feelings of not being like other patients

Denial and fear from exclusion have a strong effect on perceptions of self and serve to heighten their fears about mental illness. Stigma also entails a low public esteem that leads to the perception of hopelessness and to a shift in identity towards second-class category of psychiatric case. Many patients with severe mental illness try to conceal the illness. The ones who decide to reveal it, risk major obstacles to their lives and performance (Thensen, 2001; Wahl, 1999). In a study carried out by Phelan *et al* (1998) on the Psychiatry illnesses and Family stigma, half of the participants reported making some effort at concealment while almost 40 percent either told no one or limited communication about the hospitalization to their circle of close friends, neighbors, and family.

Secrecy acts as an obstacle to the prevention and treatment of mental illness at all stages and poorer outcomes in chronic mental disorders are likely when patients' social networks are reduced (Brugha *et al*., 1993). Prior research indicates that the effects of stigma on well- being are not short lived; they do not simply dissipate overtime. For instance, a longitudinal study of men diagnosed with both substance abuse and mental health problems over a one year period demonstrated that even when their conditions had improved, the participants still reported adverse outcomes such as self-reports of depression, discrimination, and fear of rejection by others (Link *et al*., 1997).

The family member's relationship to the patient may affect the extent to which the patient's stigma is transferred to the family member. For example, family members who live with the ill relative can expect to be exposed to more stigma than those who do not, because their [redacted] are more likely to know about their relative's illness and because interaction heightens the acquaintance's probability of contact with the patient (Phelan *et al*., 1998). Findings showed that that greater perceptions of stigma towards caregivers were associated with significantly higher levels of depressive symptoms suggests that in addition to posing a barrier to the recovery of people with mental illness, stigma erodes the morale of the family members who help care for them. Caregivers may retreat from social support and adopt avoidance coping in order to fend off anticipated rejection and/or embarrassment (Perlick, Miklowitz, Link *et al*., 2007).

In a Swedish study, 18% of relatives of patients with severe mental illness reported that the patient would be better off dead. This figure increased to 40% in relatives who felt that the patient's mental illness caused mental health problems in themselves (Osman & Kjellin, 2002). Findings from a study in India by Thara *et al* (2003) among women with schizophrenia and broken marriages revealed that the women were being overwhelmed by the whole sequence of events and have ultimately resigned to fate. In deep depression, some of them have contemplated ending it all by committing suicide. Hostile criticism from relatives further reinforced their sense of being a burden to their families and hurtful to them (Thara, Kumath and Kumar, 2003). Among the Yorubas, mental illness has some social significance for interpersonal relationships. It forms part of the regulatory aspects of life. It determines one's acceptance in the society and causes social instability, especially in marriage (Jegede, 2005).

Words used to describe people experiencing Mental Illness

A study carried out by Wilson *et al* (2000) on how mental illness is portrayed in children's television, showed that the most common terms used to describe mental illness in the children's television were 'crazy', 'mad' and 'losing your mind'. Other commonly employed terms included 'nuts', 'driven bananas', 'twisted, deranged' or 'disturbed', 'wacko' or 'cuckoo', 'loony, lunatic' or 'loon', 'insane', and 'freak'. These behavioural examples may contribute to children learning how to separate, alienate, or put others down by bullying, intimidation or verbal harassment (Wilson *et al*., 2000). In an intervention study intended to reduce stigma among 14 year old school students by Rose *et al* (2007), 85% participating students provided 250 words and terms to describe a person with mental illness and three-quarters of these terms are strongly negative in referring to people with mental health problems (Rose *et al*., 2007).

Programmes aimed at reducing stigma of mental illness

Over the last decade, public health interest in both the burden of mental illness and the hidden burden of mental health related stigma has grown. Organizations such as the World Health Organization the WPA and the World Association for Social Psychiatry to name a few, have all recognized stigma as a major public health challenge.

In 1996, the WPA initiated a global program to fight stigma and discrimination because of schizophrenia. In the ten years since its inception, more than 20 countries have joined the WPA's Open-the-Doors global network, making this the largest and longest running anti-stigma program to date. Participating countries (in order of enrolment) include Canada, Spain, Austria, Germany, Italy, Greece, the United States, Poland, Japan, Slovakia, Turkey, Brazil, Egypt, Morocco, the United Kingdom, Chile, India, Romania, with several more in the planning phases (Stuart, 2008).

The programme has five important characteristics that distinguish it from other previously developed programmes. First, it is an international and collaborative programme. Second, it is conceived as a long-term programme rather than as a campaign. Third, it involves family and patient organisations as well as governments, community agents, and health services at all stages of the programme, from its planning to its evaluation. Fourth, it emphasises the need for sharing experience and information obtained in the course of the programmes among all concerned, within and between countries. Finally, and perhaps most importantly, the programme's targets are selected on the basis of a process of consultation with people who have schizophrenia and their families rather than on the basis of theoretical constructs. This means that the targets of the programmes in different countries (and even in different regions of the same country) vary. It also means that the forces uniting the programme are shared convictions about the principal and overall goals of the programme rather than an imposed and artificial uniformity of specific short-term objectives (Kalra & Sartorius, 2005).

Changing minds

Changing Minds is an anti-stigma campaign trying to encourage everyone to stop and think about their own attitudes and behaviour in relation to mental disorders. The Royal College of Psychiatrists, the professional body for all psychiatrists working in the UK and the Republic of Ireland, has public education as one of its main objectives. Following its highly successful "Defeat Depression" Campaign (1992 - 1996), the College felt that its next campaign should be to tackle the problem of stigmatization of people with mental health problems. In 1997 a working party was convened and a Strategy Document produced. It proposed goals, content and structure for a five-year long Campaign which

was carried out from 7th October, 1998 to 7th October, 2003. The working party recommended that the Campaign should focus on six of the most common mental health problems: anxiety, depression, schizophrenia, dementia, alcohol and drug addiction, eating disorders.

Target populations included doctors, children and young people, employers, the media and the general public. The aims of the Campaign were to increase public and professional understanding of mental health problems and to reduce stigma and discrimination. During the five years of the campaign, a substantial Tool Kit of materials was developed, to help change minds and reduce stigma (Royal College of Psychiatrists, 2006).

Some Theories and Models on stigma of mental illness

Path analysis of stigma

Path A

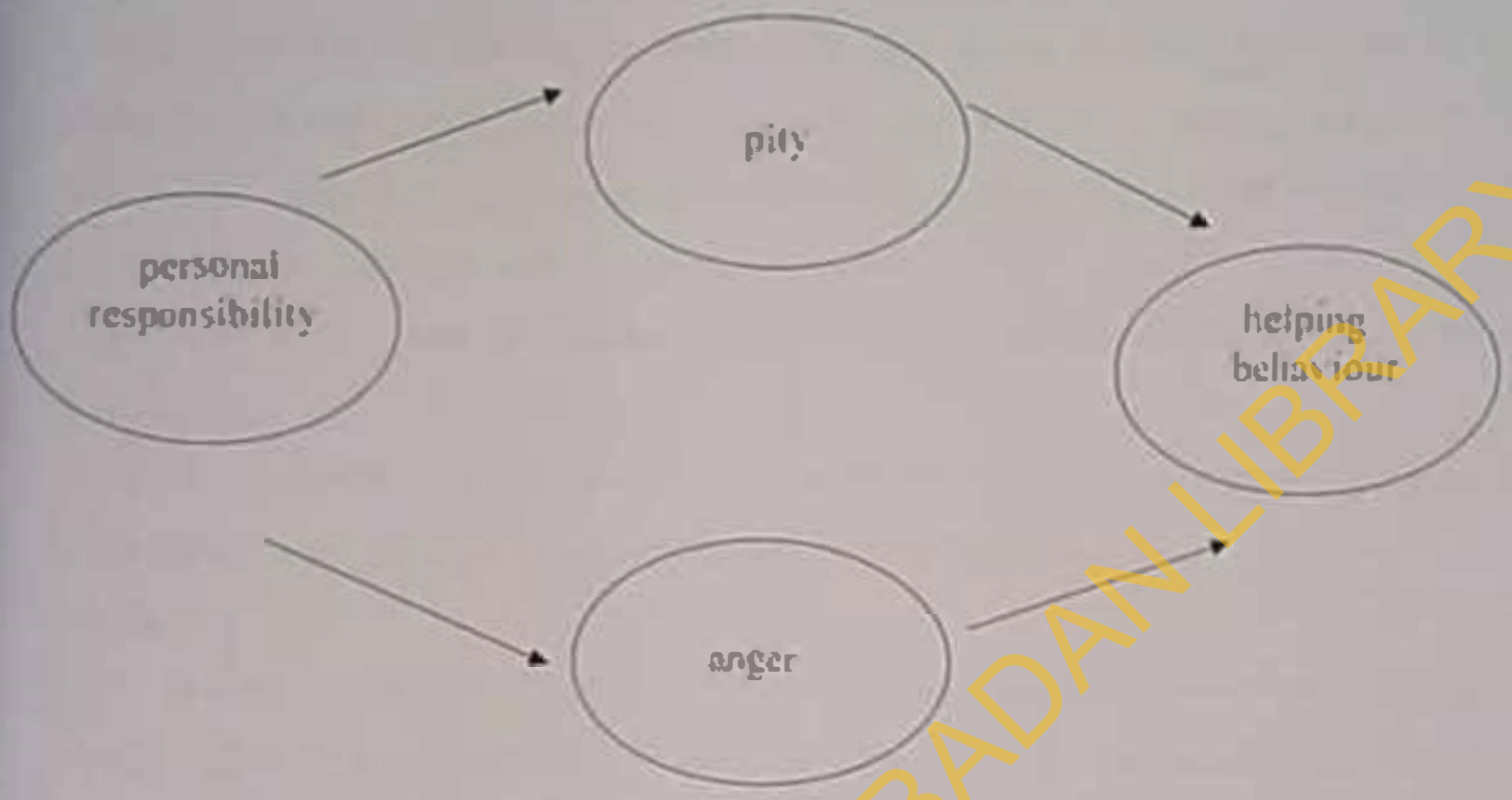


Figure 2.1a. Hypothetical paths accounting for stigmatizing reactions. Path A represents relationships between attributions of personal responsibility for mental illness, subsequent pity or anger, and the effects of this pity or anger on helping behaviour (Bernard Weiner, 1995).

Path B

Figure 2.1b Path B represents attributions of dangerousness, subsequent fear, and avoidant behavior (Corrigan, 2004).

Source: Challenging two mental illness stigmas: Personal responsibility and dangerousness (Corrigan *et al.*, 2002).

Path A explains how attributing personal responsibility for a negative event, for instance, an individual assuming that the mentally ill person is responsible for his or her behaviour leads to anger ("I'm sick and tired of that kind of irresponsibility"), and diminished helping behaviour e.g refusing to render assistance to the mentally ill person ("Am not going to give him a ride"). On the other hand, attributing no blame to the mentally ill person leads to pity ("That poor man is ravaged by mental illness") and the desire to help ("I will rent him a room until he's back on his feet").

The model depicts that withholding opportunities is parallel to the refusal of helping behaviour.

Attitude correlates with behaviour, when attitudes are based on direct experience and when behaviours requires a preceding deliberative process to initiate.

Path B

This model by Corrigan, explains how attributing a person's behaviour as dangerous leads to fear. Fear about a person's dangerousness in turn results in avoidant behaviours. Hence employers failed to hire persons with serious mental illness and landlords did not permit people with psychiatric disabilities to stay in their homes.

A unitary theory

Like all attitudes, stigmatization has three components: cognitive (e.g. "schizophrenics are violent"), affective (e.g. anxiety), discriminatory (e.g. refusing to give someone accommodation). Stigmatization involves self-sheltering and self-seeking behaviour. It is a protective device for the stigmatizer and in a good number of cases, unfair on the stigmatized, as he or she may be the victim of a rumour or may not be harmful as some other stigmatized individuals. The stigmatiser on each occasion of avoiding the stigmatised, draws primary gain from reducing his or her anxiety and is thus powerfully reinforced. The stigmatiser also draws secondary benefits from stigmatization by avoiding possible loss, danger and victimization and by increasing his or her chances of economic survival (Haghighat, 2001).

Combating stigma

Educational Intervention

The starting point for all target groups and at every level is education (Byrne, 2000). Public education has been found by some authors to be ineffective while some reported short term effect. Campaigns of public education are likely to enhance the effect of social desirability on people's responses in campaign surveys compared with the same effect in pre-campaign surveys, by the fact that during the campaign people are given implicit messages about the objection ability of stigmatization in so many ways. The development of a cure for mental illness is likely to reduce stigmatization when it is shown to be effective (Haghighat, 2001).

It will take more than two short educational workshops to address young people's deep-rooted beliefs and fears about interacting with people with severe mental illness. However, introducing the subject of mental illness alongside a personal, social, health and education teaching programme that focused upon other important social and health issues, such as friendship and bullying, healthy eating and contraception, should ensure that mental health problems are recognized as a central health concern for young people to understand and self-manage (Pinfold *et al*, 2003).

Focusing on feelings

Contacts with psychiatric patients are usually burdened with dilemmas, therefore there is need to deal with the affective level. There is possibility that during some these 'unstructured discussions', the fear and anxiety of participants are more likely to be ventilated. It would not be adequate to tell people that patients are not dangerous what they need is to feel free to discuss how fearful they were when they heard about a patient attacking someone in the street. Destigmatisation, if it is ever to be successful, needs to provide forums for the expression of fears, in which people can speak up as questions and express their worries. If taken seriously and relieved of their anxiety people are likely to consider the feelings of the patients as well.

An aspect of work on the on the affective component of stigmatizing attitude would be to involve the work of arts such as writing novels or making films with the help of

interested psychiatrists and patients in collaboration with artists. Theses works are likely to affect the feelings of the people at the affective level (Haghighat, 2001).

Discrimination level

Legislation reflects and moulds public attitudes. It is possible that new laws contrasting with personal attitudes would challenge people into debate and self-questioning and people would have to bring their behaviour in line with the law to avoid legal sanctions. The final outcome in some cases is likely to be a change of attitudes. Thus anti-discriminating laws acting as symbols 'parental authority and judgement can act as institutional support (Haghighat, 2001).

Political intervention

The attitude of the state to the extent and implications of inter-individual competition is likely to influence the citizens' attitude. and vice versa.

Conceptual Framework

The planning of activities aimed at behavioural change requires a thorough behavioural diagnosis of the factors that influence existing behaviour and attitude of youths towards people with mental illness and this will help in the adoption of healthier. positive and desired behaviour. This diagnostics process can be explained using theoretical frameworks that can explain the various concepts related to youths behaviour. Thus research is a behavioural and attitudinal diagnostic effort and has been guided by two health behaviour models.

Ecological Model

The use of this Ecological framework is to move health educator practitioners beyond a more traditional focus of individual behaviour change and its inherent tendency toward blaming the victim of a health problem, not the wider environmental influences and constraints that led to the problem. The Ecological model encourages analysis that can result in strategies that change social groups, organizations. communities and policies. not just individuals (McLeroy, Bibeau, Steckler and Gane, 1988).

The ecological model specifies five different levels or factors that influence human behaviour

Intrapersonal factors: characteristics of the individual such as knowledge, attitude, behaviour, self-concept, skills, perception, and knowledge of young persons about mental illness influence their attitude towards people with mental disorders.

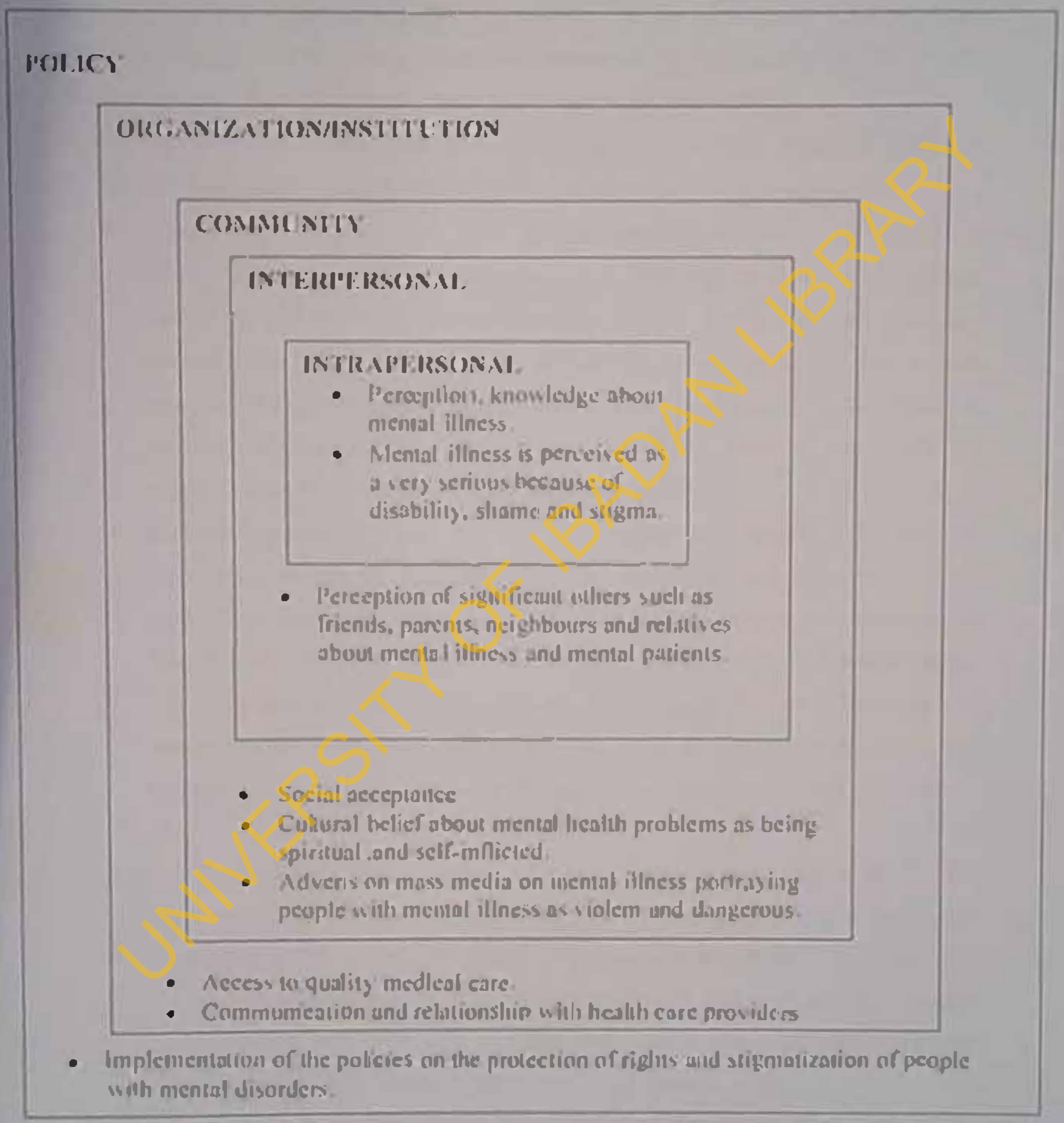
Interpersonal factors: Interpersonal relationships with family members, friends, neighbours, contact at work and acquaintances are important sources of influence in the health related behavior of individuals. Perceptinn of these significant others about mental illness nnd its severity is a very mlluential factor on the behaviour and attitude of young persons towards people with mental illness.

Institutinnal factors: these include social institutions with organizational characteristics, formal and informal rules and regulations. Cultural beliefs, acceptance of the mentally ill in the society, advertisements and programs on the mass media about mental illness and people with the disorder have a great influence on the attitude of the young persons towards the mentally ill. Rules and regulations in organizations concerning employment and among social groups on provision of social support also affect the behaviour towards the people with mental illness. Organizational change is therefore an essential componen that can be used to create an organizational culture that is supportive of health issues and improve the adoption of health promotion programs.

Community factors: These include the relationships among organizations, institutions and informal networks. Access to quality medical services and good communication with health care providers, implementation of programs tackling stigma which involves individuals and groups in the community can influence the social values and self-confidence of the mentally ill persons in the society. Existing groups in the community can be used to help deliver health services and initiate intervention programmes.

Public policy: this involves the implementation of policy and laws at local, regional and national levels. Policy impacts health directly and can be seen in regulations governing housing standards, employment opportunities, other social amenities and also in the control of inter personal behaviour as people will want to bring their behaviour. At this level there is need to strengthen the ability of mediating structures in the community to influence policy to meet community health goals.

Figure 2.2 Ecological Model for the perception and stigmatizing tendencies of young persons towards people with mental illness.



PRECEDE Model

The PRECEDE model offers a framework for problem solving and planning (Green, Kreuter, Deeds and Patridge, 1980). The model is a true model meant for pragmatic efforts to change behaviour. It specifies five different diagnoses: social (quality of life), Epidemiological, Behavioural, Educational, and Administrative Policy.

Consistent with the behavioural perspective, the educational diagnosis phase of PRECEDE emphasizes three factors: predisposing enabling and reinforcing factors.

- **Predisposing Factors:** these refer to antecedents to behaviour that provide the rational or motivation for the behaviour. It includes knowledge, beliefs, attitude, perception and perceived seriousness of the illness. The knowledge, perception and belief of young persons about mental illness will influence their attitude towards people with mental illness. Poor knowledge of the causes and treatment of mental disorders brings about a negative perception which in turn results in a negative attitude towards the mentally ill and vice versa.
- **Reinforcing factors:** These are factors subsequent to a behaviour that provides continuing reward, or incentives for the behaviour, and contributes to its persistence and perpetuation. It includes knowledge, attitude and behaviour of friends, peers, family members, association or group members, opinion leaders (e.g. religious, political, social) towards the mentally ill. The effectiveness of mental health policies regarding the address of the stigmatization of people with mental illness, which should brings about a positive attitude towards the mentally ill.
- **Enabling factors:** These are antecedents that enable a motivation to be realized e.g access policies. These include educational or literacy programmes that should be put in place to educate the youths on issues concerning mental illness and also the provision of adequate medical support for people with mental illness. Access to basic social amenities such as employment and housing can also reduce the prevalence of mental disorders and stigma in the society.

The behavioural diagnosis explains the acceptability of the mental ill persons in the society.

Epidemiological diagnosis: provision of good health services and social amenities for the people with mental disorders results in the reduction in the prevalence of mental disorders.

Quality of life: Higher acceptability by other people such as family members, relatives, friends, co-workers, landlords and employers leads to reduction of stigma and faster recovery for the mentally ill.

Figure 2.3 PRECEDE Framework for the perception and stigmatizing tendencies of young persons towards people with mental illness.

Administrative Quality of life and policy Diagnosis

Educational Diagnosis

Behavioural Diagnosis

Epidemiological Diagnosis

Communication strategy
Youths and other members of the community must be informed about mental illness and the consequences of stigmatization of the mentally ill.

→

Predisposing factors
- Knowledge and perception of youths about mental illness.
- Attitude towards people with mental disorders.
- Belief about the causes of mental illness.
- Perceived seriousness of illness.

Reinforcing factors
- Previous experience with a person who is mentally ill.
- Positive influence of members of the community.
- Effectiveness of the mental health policies.
- Cooperation of family members of the mentally-ill.

Enabling factors
- Access to information on mental disorders.
- Availability of adequate treatment for people with mental illness.

→

Acceptability of the mentally ill people by youths and other members of the society

→

Reduction in the prevalence of mental illness

→

Less suffering, reduced stigma, higher acceptability in the community and faster recovery.

CHAPTER THREE
METHODOLOGY

This chapter begins with the design, description of the study area, study population and study variables. It also describes the methods and instruments of data collection and data analysis, the validity and reliability instruments and ethical considerations.

Study Design

A cross-sectional study was used to document the perception and attitudinal disposition of young persons towards people with mental illness in Ibadan South-West Local Government Area of Oyo State.

Study Area

The study area is Ibadan South-West Local Government Area of Ibadan, which is one of the 33 Local Government Areas in Oyo State. It was carved out of the defunct Ibadan Municipal Government on 27th August, 1991 by the former Military President, General Ibrahim Babangida. Ibadan South-West Local Government is approximately 150 kilometer from Lagos. It has a land mass of about 244.55 square kilometres which makes it one of the largest Local Government Area in Oyo State. The L.G.A is made up of 12 administrative wards and has a population figure of 283,098 according to the 2006 population census (NPC, 2006). Ibadan South-west Local Government Area shares its boundaries with Ibadan North-West Local and Ido Local Government by the North, Oluyole Local Government by the South, Ido Local Government by the West and Ibadan North and South East by the East. The LGA is made up of people from different social, religious and cultural background, professionals, artisans, both unemployed and employed. Majority of the inhabitants are Yoruba while there are also Hausa, Igbo, Edo, Fulani, Ebik, and other ethnic group. The LGA, although totally urban, is made up of communities with varied socio-economic classes with some high brow areas and also some poor communities.

There are 82 primary schools and 26 secondary schools in the Local Government. The Press Centre of the Nigeria Union of Journalism (NUJ), Oyo State Council at Iyaganku also falls within the Local Government Area. The bulk of the Oyo State Industrial Estate lies within the Local Government. About 50 percent of the companies in the Local Government are located in Oluyole Industrial Estate while the remaining 50 percent are spread across the L.G.A. As a result of the high concentration of industries, the inhabitants are highly enterprising. The L.G.A is directly connected to many L.G.As within the metropolis by a good road network. The railway to the Northern States passes through the North-West of Ibadan South-West Local Government Area. Important markets within the L.G.A include Aleshinloye, Agbeni, Gege, Oja-Oba, Oke Ado, Owode (Apata) and Old Gbagi market. Also notable hotels in the L.G.A are D-Rovans, Kankanlo Inn, Lalia Hotel among others.

Study Population

The study population consists of young persons (10-24 years) residing in Ibadan South-West Local Government Area of Oyo State. According to the National Population Commission, the projected population of youths ages (10-24 years) calculated from the population figure of 101,071 provided in 1991 to 2009 would be 170,888 using the projection formula.

Inclusion Criteria

The participants in the study were those individuals within the age range 10-24 years residing in the study area.

Exclusion Criteria

Individuals whose ages did not fall within the age range 10-24 years and those who are not residing in the study area were not included in the study.

Sample size Determination

The Projected Population till Date was calculated using the projection formula provided by the National Population Commission (NPC).

$P_t = P_0 e^{(r\,a)}$

Pi = New Population

Po = Initial Population

r = Population growth rate (2.86% for 1991 to 2006 and 3.2% for 2006 - till date)

n = difference in years

e = exponential

The projected population of young persons ages (10-24 years) calculated from the population figure of 101,071 provided in 1991 would be 170,888 using the projection formula.

The sample size was determined using the EPI-INFO Statistical Package.

Size of population	-	170,888
Desired Precision (%)	-	5.0
Expected prevalence (%)	-	50.0
Confidence level (%)	-	95.0
Sample size	-	384

The sample size was rounded up to 500 to take care of incomplete questionnaires.

Sampling method and procedure

A four stage random sampling technique was adopted for the purpose of this study.

Stage 1: Stratified random sampling was used in the stratification of the 12 wards in Ibadan South-West L.G.A into inner core, transitory and peripheral areas based on existing criteria (Adeniyi and Brieger, 1982) and the communities were divided into each stratum.

Stage 2: Simple random sampling was used in the selection of 9 communities from the wards in the ratio 4:4:1 derived from the stratification of the communities into inner core, transitory and peripheral areas.

The number of participants to be selected from each community was done by proportion based on the population of people in each community to make up the sample size.

Stage 3: The convenience sampling was used in the selection of houses where young persons from the communities were met.

Stage 4: Snowballing sampling technique was used in selecting the young persons who were within the age range of 10-24 years from the houses to make up the desired sample size.

According to the National Population Commission, Nigeria Demographic and Health Survey 1999 states that one third (36.5 million) of Nigeria's total population of 123 million are youth between the ages of 10 and 24 (see table 3.1)

Instruments for data collection

A combination of qualitative and quantitative methods was used for data collection.

Qualitative Method

The research team made up of the researcher (who was also the FGD facilitator) and two other colleagues who served as a recorder/note taker and observer respectively. The team paid a visit to the contact persons at Ring Road (which represented a peripheral area), Ago Tailor (a transitory area) and Bode (representing the inner-core area) communities, (Adeniyi and Brieger, 1982). The contact persons were briefed by the researcher about the purpose of the research, the nature of the data collection instrument that the researcher wants to use. They were also briefed on the procedures which involved the use of a tape recorder to record the responses of the discussants and the criteria for the selection of the discussants which includes youths within the ages 10-24 years and the fact that they must be residents within the community. The discussants were recruited using the snowballing sampling method.

Focus Group Discussion (FGD) guide was used to collect data for the qualitative aspect of the study. These were used to explore more information, such as to identify a range of opinions and ideas of the respondents on mental illness and to improve the quality of data collected. The FGD guide comprised of 10 items which focused on youths' knowledge of mental illness, local terminologies used to describe people with mental illness, the young persons' perception about mental illness, their responsibilities towards people experiencing mental disorder, their attitude towards people with mental illness and their opinion on causes of discrimination against people experiencing mental disorder. Four FGDs were conducted among the youths in the three communities (Bode, Ago-Tailor,

Ring Road). Two FGDs were conducted among males between ages 10-19 years and 20-24 years and two FGDs among females between ages 10-19 years and 20-24 years, making a total of 12 FGDs. The snowballing sampling method was used in recruiting the participants for the FGDs. The sessions were conducted in Yoruba language while the FGD session conducted at Ring Road for the male group 20-24 years was the only discussion conducted in English Language. Majority of the discussants were of the Yoruba ethnic group within the age range 10-24 years. The Focus Group Discussions took an average of 30 minutes. Table 3.2 shows the summary of the FGDs conducted in each community.

Table 3.1 Distribution of respondents

Communities	Population in 1991	Projected Population till date	Population of young persons (30% of intal population)	Ratio	%	No
Oja-Oba	1,737	2,936	881	1	2	10
Gege	4,409	7,455	2,236	3	6	31
Eleko	31,384	53,063	15,919	18	37	184
Idi-Arere	2,369	4,005	1,202	2	4	20
Odo-Ona	21,697	36,685	11,006	12	25	122
Jericho	3,981	6,731	2,019	3	6	30
OkeBola	6,967	11,780	3,534	4	8	41
Molete	529	8,949	2,685	3	6	31
Oluyole Estate	5,097	8,621	2,586	3	6	31
Total						500

Table 3.2 Summary of FGDs conducted in each community

Community	10-19 years	20-24 years	Total
Bode	2	2	4
Agu-Tailor	2	2	4
Ring Road	2	2	4
Total	6	6	12

Quantitative Method

An interviewer-administered, semi-structured questionnaire was used for the survey. The questionnaire used in this study was a modified version of the questionnaire developed for World Psychiatric Association to Reduce Stigma and Discrimination Because of Schizophrenia (WPA, 2002). This instrument has been used in some community studies by Gureje et al. (2005) on the knowledge and attitude to mental illness in Nigeria. Data generated with the FGDs were used for the modification of the questionnaire. The questionnaire consists of a total of 45 questions which were grouped under five sections to cover the demographic profile of the respondents and the objectives of the study. The first section generated information on the demographic profile of the respondents, the second section gathered information on the perception of the respondents about mental illness and people experiencing the disorder, section three generated data on the sources of information of the respondents about mental illness, their knowledge of the causes of mental illness, effective treatment, identification of people with mental illness and the relationship of the respondents with people whom they know are experiencing mental illness. The fourth and fifth section assessed information on the attitudes of the respondents towards people who have mental disorders, the words and phrases they would use to describe such persons and their suggestions on ways of reducing the discrimination and stigmatization of people with mental illness respectively. The questionnaire was written in English, translated into Yoruba language and back translated for easy understanding by the respondents.

Validity of instruments

Several steps were taken to ensure the validity of the instruments. Each of the instruments was subjected to proper scrutiny and validation by peers and the project supervisor critically examined the instruments and made necessary corrections which were effected. They were later subjected to experts' opinions by specialists in psychiatry and the instruments were translated into Yoruba language (see Appendix 3). The instruments were then pre-tested among groups with similar characteristics in three communities in Ibadan North Local Government Area to determine how effective the developed instruments would be in collecting appropriate data relevant to the research objectives. The pre-test was also used to determine the level of comprehension of the questions, the amount of time (in minutes) it will take to fill the questionnaires and to carry out the Focus Group Discussions.

Reliability of the Questionnaire

The reliability coefficient of questionnaire was determined from the pre-test using the Alpha-Cronbach test. The Alpha-Cronbach test reported a reliability coefficient of 0.8. This was interpreted as a high reliability since a correlation coefficient that was greater than 0.5 is usually interpreted as high reliability.

Pre- testing of instruments

Focus Group Discussions

The research team made up of the researcher and two other colleagues who served as a recorder/note taker and observer paid a visit to the contact persons at Bashorun (which represented a peripheral area) and Oje (representing the inner-core area) communities. The contact persons were briefed by the researcher about the purpose of the research, the nature of the data collection instrument that the researcher wants to use procedures involved such as the use of a tape recorder to record the responses of the discussants and the criteria for the selection of the discussants, which includes youths within the ages 10-24 years and the fact that they must be residents within the community. Thereafter dates were fixed for the Focus Group Discussions.

two FGDs were conducted in each community. Separate FGDs were held for the male groups within the ages 10-19 years and 20-24 years and females within the same age groups 10-19 years and 20-24 years in each community. The verbal informed consent of the participants was sought before the commencement of the Focus Group Discussions. The sessions were conducted in English language at Bashorun and Yoruba language at Oje. In the first session for males at Oje, nine young persons participated in the discussion. The second session was also at Oje for female group, seven young persons participated in the discussion. Nine youths participated in the third session of the FGDs which took place at Bashorun for the female group, while eight young persons participated in the fourth session of the Focus Group Discussion conducted with the male group. The Focus Group Discussions took an average of 35 minutes while the longest discussion lasted for 45 minutes while the FGD pre-test lasted for four days.

Questionnaire

Data generated with the reviewed version of the FGD guides were used to design the questionnaire for the survey. A total of 50 questionnaires (10% of the sample size) were administered and collected over a three-day period (26th-28th [illegible] 2009). The first session of the questionnaires were conducted at Bas[illegible] peripheral area) among 10 youths consisting of eight females [illegible] set of 20 questionnaires were pre-tested at Yemetu (which repres[illegible] among 20 respondents consisting of 13 males and 7 females. The [illegible] test was conducted at Oje (representing the inner-core area) [illegible] consisting of 14 males and 6 females. A total of 29 males and 21 [illegible] the questionnaire pre-test exercise. The following were the observations [illegible] of the pre-testing exercise:

1. Almost all the respondents were willing to participate except that [illegible] initially thought it was funny to be talking about mental illness.
2. Due to the fact that respondents were interviewed in their homes, there [illegible] distraction from the mothers and neighbours who were also interes[illegible] participating in the study.
3. There was a need for the modification of the topic of the study, which [illegible] perception and stigmatizing tendencies of youths towards people with [illegible]

mental illness in Ibadan South-West Local Government'. The word 'serious' in the phrase 'serious mental illness' made no difference to the respondents as mental illness generally. Therefore the topic was modified to 'Perception and stigmatizing tendencies of youths towards people with mental illness in Ibadan South-West Local Government'.

4. Question 24 in the knowledge segment 'Are there effective treatments for mental illness?' which was close ended was modified to an open ended question for free opinion of the respondents, because it was discovered from the Focus Group Discussions that aside medical treatments, traditional and religious interventions were also mentioned by the respondents as effective treatments for mental illness.
5. Question 25 in the knowledge segment 'Negative attitude towards challenges of life can result into serious mental illness was removed because it was found to be unnecessary as it seems to be a repetition of Question 23o 'Stress (such as academic, emotional or work) can cause mental illness'.
6. Another question 'Have you seen the person get well overtime with treatment?' was added to the knowledge segment.
7. Question 35 in the attitudinal segment ' People with serious mental illness might attack someone', was removed because it was a mere repetition of question 13 in the perception segment 'People with serious mental illness are dangerous'. The two statements meant the same when translated into Yoruba.
8. Question 46 which was the suggestion segment had to be reviewed as it was too long and tiring for the respondents due to the fact that it was the last question.

All these observation were noted and the corrections were made for the modification of the questionnaire before it was used for the real survey.

Data Collection Process

Firstly, all the Focus Group Discussions were conducted in the three selected communities in the L.G.A. The FGDs (12 in all) were conducted by the researcher and 2 other colleagues who served as recorder or note taker and an observer with the use of the Focus Group Discussion guide. All discussions were properly recorded and compiled. Each FGD session took an average of 30 minutes with a maximum of 45 minutes and the exercise lasted for two weeks.

The validated semi-structured questionnaires were administered with the help of three colleagues (a male and two females). Criteria for selection of respondents were based on the age of the young persons. only those who fall within the age range 10 - 24 years were selected. A total of 500 questionnaires were administered to eligible respondents over a 19.day period. At the end of each day. the questionnaires were serially numbered for recall purposes. Data collected were checked for completeness and accuracy and stored in a safe and secure location. There was a hundred percent return rate and it took an average of 15 minutes to fill the questionnaires. Data collection process lasted for a period of six weeks.

Data Analysis

The FGD sessions were transcribed, and themes were developed. Verbatim quotations were cited to support some of the claims made by the respondents. Administered questionnaire was adequately stored and kept away from people. The information gathered with the use of semi-structured questionnaire was entered into and analyzed using SPSS (Statistical Package for the Social Sciences) software. Version 15.0. This was done after accurate editing and coding had been done. Chi-square. T- test. and ANOVA statistics were used to analyze the quantitative data and a p-value less than or equal to 0.05 was considered statistically significant.

The knowledge score on mental illness was calculated for each respondent using a 20-point scale. Each positive knowledge response had a score of 1. while a negative knowledge response had a score of 0. The scores were then summed up to give a composite knowledge score for each respondent. A score between 15-20 points was graded as a high knowledge; a score between 11-14 points was graded as an average score while a score between 0-10 points depicts a low knowledge.

The perception score was calculated for each respondent using a 22-point perception score. Each positive perception response had a score of 2. undecided response had a score of 1 and a negative perception response had a score of 0. The scores were then summed up to give a composite perception score for each respondent. The higher the score (12-22

points), the more positive the perception, while a lower score (0-11 points) depicts a negative perception.

The attitudinal score was calculated for each participant using a 26-point attitudinal scale. Each positive attitude response had a score of 2, undecided response had a score of 1 and a negative attitude response had a score of 0. The scores were then summed up to give a total attitudinal score for each respondent. The higher the score (14 – 26 points), the more positive the attitude of the respondents towards mental illness, while a lower score (0 - 13 points) depicts a negative attitude.

Ethical Considerations

Approval to conduct the study was sought with a letter of introduction from the department of Health Promotion and Education and another letter of approval from the UCH/UI Ethical Review Committee (see Appendices 9 and 10). The heads of the households were also approached for verbal approval. Secondly, the questionnaire was designed to be anonymous to ensure confidentiality. The details of the objectives of the study were clearly explained to the respondent in Yoruba language where necessary. Thirdly, informed consent was obtained from each of the study participant, this was supposed to be verbal or written but participants preferred verbal consent. A written informed consent (which was translated for non-literate participants) was developed (see Appendices 9 & 10), it contained relevant information about the nature of the research, full disclosure on procedures, discomforts (time cost for each participant), benefits, voluntariness and most importantly confidentiality steps the research would adhere to. The aspect on confidentiality was well stressed, to make the participants divulge the necessary information that would answer the research questions.

Limitations of the Study

Some parents did not allow their children to participate in the study as they believed that one could be cursing oneself by discussing issues on mental illness. Some of the youths that were approached to take part in the discussions refused because they felt that mental illness is a ridiculous issue to be discussed, while some of them had the notion that we were merely using them for a funded project. It took quite sometime to convince them

that the research was only for academic purposes. Participants in the lower age group had a poor knowledge of what constitutes mental illness and this resulted in having uncompleted questionnaires for most respondents within the ages 10 and 14 and a shorter time was used in the FGDs conducted among the lower group than the older group. Most of the respondents thought it might be implicating to reveal their relationship with the people whom they know have mental illness. For this reason some of them did not state their relationship with the mentally ill persons they know or even agreed that they know anyone experiencing mental illness, despite a lot of conviction and assurance that their responses would be kept confidential and mainly for the purpose of the research. Despite the fact that the researcher applied a high level of randomization in the sampling procedure, nine communities in an L.G.A were too minimal to represent the entire Oyo State.

CHAPTER FOUR

RESULTS

This chapter presents both the qualitative and quantitative findings of the study. The findings from the Focus Group Discussion are presented in Section One while the survey findings are presented in Section Two.

Section One: Findings from the Focus Group Discussion

This section provides the results of the findings from the Focus Group Discussion.

Socio- demographic characteristics

Majority of the discussants were of the Yoruba ethnic group within the age range 10-24 years. All the discussants in the age group 10-19 years were in-school while majority of the discussants in the age group 20-24 years were out of school.

Knowledge of mental illness

Defining mental illness

Majority of the discussants stated that mental illness is a brain disorder that has to do with the malfunctioning of the brain which makes an individual behave abnormally or in a way that is different and contrary to social norms. A few of them were of the opinion that mental illness is a shameful thing in the society.

Types of mental illness

The discussant had a limited knowledge of the types of mental illness. However, a few of them particularly the discussants in the older male groups were able to classify mental illness based on the causes.

The various types of mental illness mentioned were:

- *Street madness*
- *Violent type*

- *Gentle type*
- *Fluctuating (on on and off) mental illness*
- *Substance use such as heroine, marijuana, cocaine and alcohol drinking*
- *The type caused by spiritual attack or curse as a result of strife over family possessions*
- *The type caused by sleeplessness*
- *The type of mental illness caused by too much thinking or emotional stress when someone is being jilted or disappointed by a lover*

A male discussant also said: "*Some types of mental illness are hard to know, you will only know when the person is drunk*".

A female discussant in the peripheral area also made the same classification in Yoruba language into "*Elegbe*" that is the chronic type of mental illness and "*Omiiran*", the mild type of mental illness. She was of the same opinion with the other discussants that the individuals who have the violent or chronic type of mental illness are usually found on the street with dirty or torn clothes and bushy hair. She stated that sometimes, they may be naked.

Causes of mental illness

A wide range of causes was attributed to mental illness by the discussants.

Several themes emerged from this section. Firstly, most of the discussants attributed the cause of mental illness to the use of hard drugs or substance misuse- alcohol drinking and cigarette smoking.

The second theme was that mental illness can be caused by evil spirit or spiritual attack. Majority of the discussants agreed that mental illness could be a spiritual attack, may be as a consequence of the evil deeds done by the individual to someone else. It was also stated that someone may be inflicted with the illness by some diabolic forces as a result of insulting or offending an elderly person. Envy and strife in the extended family over family inheritance was also mentioned by the young persons as a cause of mental illness.

A few of the discussants had this view that mental illness can be caused sometimes by money rituals which usually backfires on the individuals who are not contented with what they have and would want to make money at all cost.

The third theme was that mental illness is hereditary. Some discussants in all the three areas were of the same opinion that sometimes mental illness is sometimes hereditary and could also be as a result of generational curse.

Fourthly, mental illness can be caused by academic and emotional stress. A few of the discussants said that mental illness can also be caused by reading too much. A male discussant specified the duration to be reading for over five to six hours. Emotional stress resulting from the loss of a loved one, loss of job, lack of employment or being jilted by a lover which could result in sleeplessness was also mentioned as a cause of mental illness.

The fifth theme was, persistent physical illnesses can cause mental illness. A female discussant in the transitory region said this:

"Persistent illnesses such as typhoid, malaria and yellow fever can also cause mental illness".

The sixth theme was that mental illness could be caused by food going through the wrong pathway. A young male discussant in the transitory region said this:

"Some people may develop mental illness when eating and pepper passes through the wrong route to the nasal passage".

The seventh theme is that mental illness could be as a result of head injury. A few of the discussants stated that head injury from a motor accident or a fall can cause mental illness. This was the major cause of mental illness mentioned by the all the discussants in the younger female group in the inner-core area.

A male discussant in the peripheral area said that mental illness could be caused by lack of cross ventilation in the home which could affect someone's brain. Another cause of mental illness that was mentioned was puerperal psychosis referred to as "*Abisinwin*" by a male discussant in the inner-core area. Another younger male discussant in the same area mentioned pregnancy complication as a cause of mental illness. However a male discussant in the same group said this:

"Ti eyan kankan ninu awon obi omo ba ti gba abere soja ri o le fa aisan opolo fun omo won" (if any of the parents had been given 'the soldiers' injection', the child can develop mental illness).

Sources of information

Their sources of information about mental illness include the neighbourhood, schools, market places, radio, television, newspapers and hospitals. Television programmes such as the "*Owuye*" *and* "*Iriri aye*" were mentioned by some participants as a common source of information about mental illness. Some also mentioned that they hear about people with mental illness through the friends, relations and family members of the mentally ill persons, telling other people what they think was the cause of the mental disorder.

Local words and terminologies used to describe people with mental illness

The local words and terminologies used to describe people with mental illness mentioned by the discussants were "*asinwin*", "*alaganna*, "*were*", "*ongunbungunbungunbun*", "*digbolugi*", "*alarun opolo*", "*dindinrin*", and "*amukamukun*". A male discussant in the FGD conducted among the younger groups residing in the peripheral area classified the word "were" (madness) into different categories "*were alomo*" (a mad person with a baby or a child), "*were alakisa*" (a mad person with a bunch of rags), "*were digbolugi*" (a violent mad person), "*were dada*" (a mad person with bushy and tangled hair). "*were to ni policy*" (this name was given to a certain man with mental illness, who always come to buy bread and kunu at a joint close to the area where the discussion was conducted).

Perception about mental illness and people with mental illness

Several themes emerged from the young persons' perception about mental illness and people with mental illness. Firstly, the participants opined that in most cases, mental illness is self-inflicted. This is as a result of indulging in risky behaviour such as alcohol drinking, cigarette smoking and substance misuse which are risk factors for mental illness.

The second theme that emerged was that of mental illness being a consequence of bad deeds. A few of the discussants supported this statement, reporting that some individual indulge in stealing, money rituals, desire for fetish powers, snatching other peoples husbands or wives. Some of them also mentioned that being rude to elders could result in

someone being cursed and invoked with mental illness. This agrees with the young person's perception that people can make other people mad with the aid of fetish powers.

The third theme that emerged was that mental illness could be a destiny. Some of the young persons expressed their feelings that sometimes the individual may be destined by God to have mental illness and in such cases nothing can be done about it except to pray to God for a change in destiny. A male discussant in the peripheral area said.

"I believe that sometimes God will deliberately use the mental illness to put an individual into hiding in order to prevent evil people from tampering with the person's destiny."

The fourth theme that emerged was that mental illness is contagious. A few of the discussants stated that if a person is bitten by someone with mental illness, the illness can be contracted through the bite.

The fifth theme was that mental illness cannot be cured completely with medical treatment. The majority of the discussants believed that mental illness cannot be cured with medical treatment only, but with the combination of medical, traditional and spiritual care. A male discussant in the peripheral area said:

"Those medical doctors only care in their own capacity, but it is only God who can cure completely".

The sixth theme was that most people with mental illness behave abnormally and are also violent and dangerous. The discussants stated that people with mental illness are known to be violent, they could attack and injure people with sharp objects and sticks when provoked and when not. A few of the discussants pointed out that it is very advisable to move away or better still run away when you see someone with mental illness because if such person injure you, he or she can not be arrested or taken to court.

The seventh theme was people with mental illness cannot be successful in life. A female discussant in the peripheral area said:

"I feel that people with mental illness can not succeed in life, because if someone does not have a functioning brain there's nothing good the person can do".

A male discussant in the transitory area also said that he would not dare to have a fight with a mentally ill person because he has a career to pursue while the mentally ill person has no career to pursue in life.

The eighth theme was that people with mental illness are stronger than other people who are seen as normal. In relation to this statement, a male discussant in the transitory area narrated a story of a man with mental illness whose throat was believed to have been cut off so that whenever he eats, some part of the food will leak through the cut. A similar statement was made by a female discussant in the peripheral area, who narrated another story of a lady who developed mental illness in the course of prostitution and eventually got pregnant. In her story, she said the lady had a still-birth when she was to deliver her baby and she had to be operated upon to remove the foetus. She commented that if she was to be normal she probably would have died.

A few of them expressed their sympathy for people with mental illness. Some of them expressed their delight in watching their theatrics on the streets. A male discussant in the transitory area however said this "*Were dan wa ungbon ko se bi lomo*" (it is fun to watch a mad person but you won't want to give birth to such).

Concerns of the discussants about the occurrence of mental illness among young persons

The majority of the discussants pointed out that the easy accessibility to substances such as Cannabis has helped young persons to indulge in substance misuse these days. A male discussant even said that some young persons that indulge in substance misuse do not feed well. As a result, they may develop mental complications. Some other risky behaviour also mentioned by the discussants, were cigarette smoking, alcohol drinking and cultism. In response to this a male discussant in one of the older groups made this conclusion:

"*I think we have different body system. Some people could be affected by doing something for the first time and some others who have been indulging in such acts overtime, may not be affected*".

A female discussant said that sometimes some young persons might be cursed from their childhood. Some other reasons mentioned by the discussants were congenital abnormalities. A male discussant stated that the sickness may be transferred from mother to the child during pregnancy, young persons indulging in extra-marital affairs with married men and women and stealing could result in the individuals being cursed. Another male participant in the same group mentioned that the environment can also cause mental illness. He said:

"Our environment mental illness is usually rampant in the northern part of the country because of the climate and that is common in the area".

Attitudes towards people experiencing mental illness

Causes of discrimination towards people with mental illness

The majority of the discussants attributed the cause of discrimination towards people who are mentally ill to their abnormal behaviour and unpredictable actions. A male discussant said that they can bite or stab someone. Another male discussant said:

"People fear them because their actions are unpredictable, so they avoid them so that they would not be injured".

A female discussant also said that some of them throw stones and tear other people's clothes on the streets. A young male discussant in the transitory area said this about a mentally ill person living in his neighbourhood:

"I hear that a mad man usually attack people whenever he hears the ringing tone of a phone. I was told he almost killed someone on a certain day, but for the people around who restrained him".

Some other reason mentioned by the discussants was that people with mental illness are like ghosts. This was reported by a male discussant who said that people with mental illness are like ghosts and may want to attack other people. Some other reason stated for discrimination against people with mental illness was that mental illness is contagious. A male discussant in the inner core area said this:

"Some people believe that if they move close to a mad person that they could be infected with the mental illness".

There is also the notion that some people who portray themselves as mentally ill, are not truly so. It was reported that some people hide under the pretense of being mentally ill in order to carry out evil deeds such as armed robbery and kidnapping. A female discussant in one of the older groups supported this notion with her comment, she said.

"Nowadays some people pretend to be mad and the ignorant little children who try to mock such persons could be kidnapped in the process".

Most people with mental illness, particularly those who roam the streets were reported to be dirty and smelly. The discussants stated that as a result of this, people see them as disgusting. The discussants also mentioned that some mentally ill persons who roam about in the market places face discrimination because they throw away the wares of the traders.

A female discussant in the peripheral region however gave a different comment. She said:

"People discriminate people with mental illness because they see them as useless and that nothing good can come out of them".

However, a male discussant in the transitory area said that those of them that are treated badly are usually the violent ones while the gentle ones do not usually experience discrimination. Another reason, reported for discrimination towards people with mental illness was the belief that most of the people with mental illness were the cause of their predicament.

Reactions towards close friends, relations or acquaintances that suddenly develop mental illness

The majority of the discussants said they would not be happy. A male discussant said

"I will run away from the person if he or she wants to move closer, but if the person is related to me like my brother or cousin, I will find a way of taking the person for treatment".

Another male discussant said that he will help the person and move closer to him or her. Some said they would help in provision of food, clothing and financial assistance to get the person treated. Two female discussants were of the opinion that the persons can be taken for prayers in the church or mosque depending on their religion and also traditional assistance can also be sought.

A male discussant said his first reaction will be to stay away from the person then later move closer. Another male discussant said he would first take the person to the psychiatric hospital because it is not sensible to keep such person at home. Sympathy was commonly expressed, as most of the discussants stated that if it happens to their friends or classmates, they would advise the parents or relations on where they can get prompt treatment for the individuals who have suddenly develop the illness.

Majority of the discussants expected people to react negatively and mock the friends or relatives of the mentally ill persons. However they concluded with the notion that no one has control over destiny.

The responsibilities of young persons towards people with mental illness

The discussants however portrayed a more positive attitude during this segment of the Focus Group Discussion. The following were mentioned as the responsibilities of young persons towards people with mental illness:

- *They should be seen as human beings irrespective of their illness.*
- *Being patient and gentle with them.*
- *Encouraging them to take their medications.*
- *To stop them from roaming about the streets by restricting them at home.*
- *To mobilize other young persons to take the mentally ill persons to the psychiatric hospitals for treatment.*
- *Provision of basic needs such as money, food, clothing and showing them affection so that they would not feel marginalized.*
- *By fasting and praying for them.*
- *They can be taken to the herbalist, church or mosque for treatment.*
- *To stop discriminating and throwing things at them.*
- *To seek for assistance from government to provide medical support for people with mental illness.*

When discussing about the benefit of rendering assistance, they gave the following responses:

- *It is better for them to get better so that they can be normal again and be successful.*

- *They feel better and would appreciate the assistance rendered to them. A few of them believed that the person will repay such assistance in future to whoever helps them as one good turn deserves another.*

Stigmatization of people with mental illness

Sources of negative images

The discussants reported that the sources of negative images about people with mental illness are newspapers, television and radio programmes, and stories that are told in the neighbourhood. A few of the discussants said that they heard on television programmes that some people pretend to be mentally ill, when they are not in order to perpetrate evil acts such as robbery and kidnapping for money rituals. Some of them said it may be through the close relations and friends of the mentally ill persons who know a lot about them.

When and where people with mental illness experience stigma

The majority of the discussants said that people with mental illness experience stigma everywhere they go such as on the streets, at parties, in the market places, among their friends, relations, in schools and workplaces and even at home. A female discussant said: *"Some mentally ill person may defecate on the ground in public places and people will see them as irritating".*

A male discussant even said that *"There are some mad persons whose presence promotes sales in the market while some could just scatter the wares of the traders and they are beaten up in the process".*

Another discussant said that *"It depends on the mind of the mentally ill person".* He said further, that *"people do not like moving close to the violent ones".* A female discussant also mentioned that they also experience stigma at hospitals, when there is a relapse of the illness. A few of the discussants said that some of them scavenge around water drainages and refuse dumps and this would be irritating to people. Another male discussant in the peripheral area was of the same opinion.

A male discussant in the peripheral area said: "*At home, the people living with them may not want to associate with them. I know a man whose wife left him because he developed mental illness*".

Another discussant in the same area said: "*At home, when there is a visitor coming in, the individuals will be locked up somewhere to avoid embarrassment. Sometimes if the neighbours or relatives see the person outside the home, they will prefer to move far away*".
The discussants also pointed out that sometimes people with mental illness provoke other people with their violent behaviour.

Words used and phrases used to describe someone with mental illness
The common word used by the discussant to describe a person with mental illness was 'were'. Other words and phrases such as *kolomental, abugije, alugannu, digbolugi, radarada, "ori ti tu si lopolo", olopolo kiku, senseless, psycho, "o fesi lopolo", "o ti re", dindinrin, abugije, aloti, asinwin, eulskanskan, "o ti sign l'Aro", "Kowu ako", "Eje ma si lopolo", omiganlamganlungandun, "O ti run mental", "Ori e ti daru", skuring, alodeori, alomoodi, omighana ara* were mentioned by the discussants as words and phrases they use to describe people with mental illness. A female discussant in the transitory region said:
"*Depending on the behaviour of the person, if he likes speaking English, they could call him 'Professor'. If he is dancing, they could call him 'Yabnozi'*".
However a male discussant had a different response: "*Though I call them 'were' sometimes, I also call them 'Idols' or 'prophets', because I know of a mad man who rings a bell and can cite the bible offhand*". Another male discussant said that he does not call them any names because he sees them as human beings.

The impact of discrimination on people with mental illness
Some of the discussants were of the opinion that people with mental illness do not have feelings. A male discussant in the peripheral area was of the opinion that it is true that it is saddening, but people should not be blamed because their behaviour is abnormal. Two male discussants in the same group said that they would not feel it if they are stoned

because they are strong. Another male discussant concluded that – *A mad person will never have the feeling that someone discriminates against him or her because he or she is mentally ill. The day they realize that they are mad is the day they have been totally cured of the illness*"

However most of the discussants admitted that people with mental illness will feel sad, be more depressed, that discrimination usually aggravates their mental illness and that they may even poison or kill themselves when people discriminate against them.

The majority of the discussants emphasized the importance of care for people with mental illness as a way of reducing stigmatization. Most of the discussants suggested that they should be taken for treatment. Some of the discussants said that they should not be allowed to go out until they get better, so that people will not discriminate against them thus, reducing stigma. Some of the discussants also said that a separate place should be provided for mentally ill persons where they can be well cared for. Majority of the discussants suggested that the government should provide assistance by ensuring that the mentally ill persons on the streets are taken to psychiatric hospitals, mental homes or rehabilitation centres.

Some of the discussants also said that government should help in the creation of public awareness using the mass media to educate the people about mental illness. Young persons should be enlightened on the side effects of the use of hard drugs, cigarette smoking and alcohol drinking and restriction should be placed on the importation and sales of hard drugs. Three male discussants said that young persons can also help in stopping discrimination by rebuking those who discriminate against people with mental illness. A discussant suggested that a forum can be organized on the television and radio where the opinion of the masses would be sought on how the discrimination and stigmatization of people with mental illness can be addressed.

Two young male discussants in the transitory area emphasized the need for patience and perseverance when dealing with people with mental illness. A few of the discussants advised that people should not remind them of their illness or ridicule them when they get better.

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Section Two: Findings from survey

This section provides the results of the findings from the survey.

Socio-demographic characteristics

The socio-demographic profile of the respondents is shown in Table 4.1. The ages of respondents ranged from 10 to 24 years with a mean of 16.6±3.5 years. Majority 426 (85.2%) of the respondents were Yorubas and 403 (80.6%) were in-school young persons while 97 (19.4%) were out-of-school young persons.

Table 4.1 Socio-demographic characteristics of respondents. N=500

Variable	Number	(%)
Sex		
Male	262	52.4
Female	238	47.6
Age		
10-14 years	148	29.6
15-19 years	235	47.0
20-24 years	102	20.4
No response	15	3.0
Education Level		
Primary school	29	5.8
Secondary school	332	66.4
Tertiary education	39	7.8
Computer training	3	0.6
Out-of-school	97	19.4
Ethnic Group		
Yoruba	426	85.2
Igbo	45	9.0
Hausa	4	0.8
Edo	5	1.0
*Others	17	3.4
No response	3	0.6
Religion		
Christianity	310	62.0
Islam	186	37.2
Traditional	2	0.4
No response	2	0.4
Occupation	N = 97	
Artisans	40	41.2
Traders	24	24.7
Factory workers	8	8.3
Office assistants	3	3.1
Professionals	2	2.1
Transporter	3	3.1
**Others	17	17.5

*Others include Ebira, Calabar and foreigners

**These consist of admission seekers, graduate, lotto worker, traveling agent and footballer.

Knowledge of mental illness

This section provides result on the knowledge of the respondents about mental illness

Awareness and Sources of information on mental illness

Two hundred and forty five (49.0%) respondents had seen, heard or read any advertisement about mental illness One hundred and seventeen (23.4%) heard about mental illness on the television, 106 (21.2%) heard it on radio, 28 (5.6%) of read about mental illness in newspapers, 28 (7.6%) heard in the neighbourhood, 18 (3.6%) reported to have heard about mental illness in hospitals, 11 (2.2%) were taught in school, while 9 (1.8%) and 2 (0.4%) respectively reported to have heard adverts on mental illness from churches and herbalists.

Knowledge of definition of mental illness

Respondents were asked to define what mental illness is from their own perspectives. Of the respondents, 145 (29.0%) defined mental illness as a brain disorder that makes a person behave abnormally or like a lunatic. Thirty eight (7.6%) respondents defined mental illness as not being in one's right mind or senses. Other definitions are shown on table 4.2

Knowledge of causation

Knowledge of the respondents about the causes of mental illness was assessed by asking them to tick the correct responses to a set of statements. Three hundred and forty four (68.8%) respondents agreed that mental illness can be caused by physical abnormality in the brain while 335 (67.0%) respondents stated that mental illness can be caused by chemical imbalance in the brain. The table 4.3 shows the details of the respondents' knowledge about the causes of mental illness.

Table 4.2 Respondents' definition of mental illness

Responses	Frequency	Percentage (%)
A brain disorder that makes a person behave abnormally or like a lunatic	145	29.0
Abnormality or imbalance of the brain	52	10.4
Not being in one's right mind or senses	38	7.6
Unsettled brain or deviation from the normal brain function	31	6.2
Mental illness is a brain disease caused by alcohol drinking, substance use, too much thinking and accident	30	6.0
Madness or craziness	23	4.6
*An incurable disease	12	2.4
Being unconscious of one's feelings and environment	10	2.0
*Someone of low intelligence	9	1.8
It is self inflicted or a spiritual attack	8	1.6
A disease that disrupts one's life	6	1.2
*Worst state of health and a terrible disease	4	0.8
*A condemned brain	3	0.6
An incoherent speech	3	0.6
*A shameful disease	2	0.4
A malfunctioning medulla oblongata	2	0.4
*Mental problem created by God	2	0.4
Loss of memory	1	0.2
*It is a virus	1	0.2
It occurs in life of children who are not brought up well	1	0.2
*It is similar to malaria	1	0.2
*An invisible spirit controlling someone	1	0.2
*Incorrect responses		

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*An incurable disease	12	2.4
Being unconscious of one's feelings and environment	10	2.0
*Someone of low intelligence	9	1.8
It is self inflicted or a spiritual attack.	8	1.6
A disease that disrupts one's life	6	1.2
*Worst state of health and a terrible disease	4	0.8
*A condemned brain	3	0.6
An incoherent speech	3	0.6
*A shameful disease	2	0.4
A malfunctioning medulla oblongata	2	0.4
*Mental problem created by God	2	0.4
Loss of memory	1	0.2
*It is a virus	1	0.2
It occurs in life of children who are not brought up well	1	0.2
*It is similar to malaria	1	0.2
*An invisible spirit controlling someone	1	0.2
* Incorrect responses		

Table 4.3 Respondents' knowledge about causes of mental illness. N= 500

Causes	Yes (%)	No (%)
Physical abnormality in the brain	344 (68.8)	156 (31.2)
Chemical imbalance in the brain	335 (67.0)	165 (33.0)
Brain disease	392 (78.4)	108 (216)
Heredity	245 (49.0)	255 (51.0)
Physical illnesses	235 (47.0)	265 (53.0)
Possession of evil spirit or spiritual attack	438 (87.6)	62 (12.4)
Poor upbringing by parents	184 (36.8)	316 (63.2)
Head injury	437 (87.4)	63 (12.6)
Convulsion	207 (41.4)	293 (58.6)
Childhood illnesses (e.g. measles, rashes)	215 (43.0)	285 (57.0)
Cigarette smoking	427 (85.4)	73 (14.6)
Substance use (cannabis, heroine, marijuana)	431 (86.2)	69 (13.8)
Alcohol drinking	383 (76.6)	117 (23.4)
Disturbance in relationships (with family, friends, teachers in school)	245 (49.0)	255 (51.0)
Stress (such as academic, emotional or work)	303 (60.6)	197 (39.4)
Physical abuse	212 (42.4)	288 (57.6)
Traumatic events or shock (e.g. assault, death or accident)	426 (85.2)	74 (14.8)
Poverty	217 (43.4)	283 (56.6)
Staying too long under the sun	1 (0.2)	499 (99.8)

More respondents 216 (43.2%) had an average knowledge score, 156 (31.2%) had low knowledge scores while 128 (25.6%) had high knowledge score.

The tables 4.4 and 4.5 show the differences in the mean knowledge scores of the respondents. The mean knowledge score for those in the early adolescence (10-19 years) age group was 12.1±3.2 and for those in the late adolescence (20-24 years) age group was 12.9±3.4. The comparison of mean test for knowledge by age group was statistically significant ($p<0.05$).

The mean knowledge score for males was 12.5±3.5 while that for females was 12.0±3.1. The compared mean test for knowledge by sex was not significant. The mean knowledge score for Christians was 12.3±3.4 while the score for Muslims was 12.2±3.2. The comparison of mean test for knowledge by religion was not significant. The mean knowledge score for the in-school respondents was 12.1±3.3 while that for respondents who were out-of-school was 13.1±3.5. The comparison of mean test for knowledge by school group (in- school or out of school) was statistically significant ($p < 0.05$).

Table 4.4 Comparison of mean knowledge scores of participants by sex and school group.

Variables	Number	Mean	Standard Deviation	t	df	p-value
Sex						
Male	262	12.5	3.5	1.666	498	0.09
Female	238	12.0	3.1			
Total	**500**	**12.3**	**3.3**			
School group						
In-school	403	12.1	3.3	-2.679	498	0.01
Out-of-school	97	13.1	3.5			
Total	**500**	**12.3**	**3.3**			

Table 4.5 Mean knowledge scores of respondents by age, religion, ethnicity and educational status (of in-school respondents)

Variables	Mean	No.	Std Dev.	F	p-value
Age					
10 - 14 years	11.8	11.9	3.1	2.863	0.058
15 - 19 years	23.5	12.2	3.3		
20 - 24 years	10.2	12.9	3.4		
Total	48.5	12.3	3.3		
Religion					
Christianity	12.3	310	12.3	0.230	0.79
Islam	12.2	186	12.2		
Traditional	11.5	2	11.5		
Total	12.3	498	3.3		
Ethnicity					
Yoruba	12.2	426	3.3	1.465	0.19
Igbo	12.8	45	3.8		
Hausa	13.0	4	5.0		
Edo	14.8	5	4.1		
*Others	11.8	16	2.0		
Total	12.3	500	3.3		
Education Status					
Primary education	10.8	29	4.0	3.235	0.01
Secondary education	12.1	332	3.2		
Tertiary education	12.6	39	3.6		
Computer training	13.7	3	1.5		
Total	12.3	407	3.3		

*Others include Ebira, Calabar and foreigners

The effective treatment for mental illness

Two hundred and one (40.2%) respondents stated that the effective treatment for mental illness is medical treatment at psychiatric hospitals. 96 (19.2%) respondents mentioned the combination of medical and traditional as effective for the treatment of mental illness. 36 (7.2%) mentioned that medical and spiritual intervention are the most effective. 12 (2.4%) of the respondents reported that prayer is the most effective treatment, while 21 (4.2%) mentioned that the combination of medical, traditional and spiritual intervention is most appropriate.

Twenty three respondents (4.6%) reported that traditional treatment or intervention is the most effective. 6 (1.2%) respondents mentioned the combination of herbs and spiritual/religious intervention as the most effective. Two respondents (0.4%) stated that beating them and injecting them would be appropriate, while 11 (2.2%) mentioned that showing them love and ensuring they get appropriate treatment would be the most effective treatment for mental illness.

Identification of a person with mental illness

Three hundred and thirty seven (77.3%) respondents reported that they can identify someone with mental illness by their abnormal behaviour and appearance. 52 (11.9%) of them would identify a mentally ill person by their irrational, incoherent speech and lousiness, 37 (8.5%) through their dirty appearance. Six respondents (1.4%) stated that they can identify someone with mental illness if they see the person attacking people, 3 (0.7%) respondents said if they see that the individual is mad while one respondent said that someone who has mental illness would be smoking cigarette or indulging in substance misuse.

Relationship with people experiencing mental illness

Two hundred and twenty seven (45.4%) respondents stated that they knew someone who is experiencing mental illness and only 136 (27.5%) of the respondents reported to have seen the persons get better overtime with treatment.

Of the 213 (42.6%) of the respondents who stated their relationship with the mentally ill persons, 64(30.0%) had neighbours who have mental illness. 103 (48.4%) knew passerby

or people in their neighbourhood who are experiencing mental illness while 13 (6.1%) reported to have friends who are mentally ill.

Some of the respondents, 4 (1.9%), 5 (2.3%), 5 (2.4%) respectively had cousins, family friends and relatives who have mental illness. Table 4.6 shows the detail on the relationship of the respondents with people experiencing mental illness.

Perceptions about mental illness and people with mental illness

The perceptions of the respondents about mental illness were determined by asking them to respond with 'agree', 'disagree' or 'undecided' to a set of eleven statements about mental illness and people experiencing mental illness. Two hundred and ninety one (58.2%) respondents agreed that mental illness is self inflicted while 44.6% of the respondents were of the opinion that people experiencing mental illness are dangerous. Sixty five percent of the respondents stated that people with mental illness are often stigmatized or treated unfairly while 223 (44.6%) respondents agreed that mentally ill persons should be kept locked up in a room. Of the respondents, 51.0% were of the opinion that mental illness is completely curable (see table 4.7 for details).

The mean perception score for those in the early adolescence (10-19 years) age group was 12.1±3.3 and that for those in the late adolescence (20-24 years) age group was 11.9±4.0. The comparison of means test for perception score by age was not significant. The mean perception score for Christians was 12.4±3.3 while the mean perception score for Moslems was 11.3±3.5. The comparison of means test for perception by religion was also statistically significant ($p<0.05$).

The mean perception score for the in-school respondents was 12.2±3.4 while that of respondents who were out-of-school was 11.3±3.5. The comparison of means test for perception by school group (in- school or out-of school) was significant ($p<0.05$).

More respondents 306 (61.2%) had an above average perception score (positive perception score) while 194 (38.8%) had between 0 and 11 points (negative perception score).

Table 4.6 Respondents' relationship with the mentally ill persons they know.

Relationship	Frequency	Percentage
Passerby in the neighbourhood	103	48.4
Neighbour	64	30.0
Friend	13	6.1
Family friend	8	3.8
Church member	6	2.8
Relative	5	2.3
Uncle	5	2.3
Cousin	4	1.9
Niece	2	0.9
Brother	1	0.5
School mate or colleague	1	0.5
Boss's younger one	1	0.5
Total	213	100.0

Table 4.7 Perception of respondents about mental illness N = 500

Statements	Agree (%)	Disagree (%)	Undecided (%)	No Response (%)
Mental illness is self inflicted.	291 (58.2)	152 (30.4)	53 (10.6)	4 (0.8)
Mental illness is preventable.	368 (73.6)	101 (20.2)	28 (5.6)	3 (0.6)
People with mental illness are often stigmatized or treated unfairly.	352 (65.0)	147 (29.4)	25 (5.0)	3 (0.6)
A mentally ill person should be kept locked up in a room.	223 (44.6)	254 (50.8)	21 (4.2)	2 (0.4)
People with mental illness are dangerous.	402 (80.4)	74 (14.8)	23 (4.6)	1 (0.2)
People with mental illness cannot work.	332 (66.4)	146 (29.2)	19 (3.8)	3 (0.6)
People with mental illness usually need medication.	470 (94.0)	24 (4.8)	5 (1.0)	1 (0.2)
People with mental illness are often of lower intelligence.	337 (67.4)	123 (24.6)	37 (7.4)	3 (0.6)
People who have mental illness cannot be successful in life	174 (34.8)	282 (56.4)	40 (8.0)	4 (0.8)
Mental illness can be treated in hospitals	409 (81.9)	69 (13.8)	19 (3.8)	3 (0.6)
Mental illness is completely curable	255 (51.0)	194 (38.8)	45 (9.0)	6 (1.2)

The mean perception score for those in primary school was 10.4±3.8, those in secondary school had a mean perception score of 12.2±3.3, and those in tertiary institution had a mean perception score 13.4±4.2 while for those in computer school was 12.3±2.1. The comparison of means test for perception by education status was significant ($p<0.05$). Tables 4.8 and 4.9 show the differences in the mean perception scores of respondents by selected variables.

Table 4.8 Comparison of mean perception scores of respondents by sex and school group

Variables	Number	Mean	Standard Deviation	t	df	P-value
Sex						
Male	262	12.0	3.4	0.179	498	0.86
Female	238	12.0	3.5			
Total	**500**	**12.0**	**3.4**			
School group						
In-school	403	12.2	3.4	2.353	498	0.02
Out-of-school	97	11.3	3.5			
Total	**500**	**12.0**	**3.4**			

Table 4.9 Comparison of mean perception scores of respondents by age, religion, ethnicity and education status (of in-school respondents)

Variables	No.	Mean	Std Dev.	F	p-value
Age					
10-14 years	148	11.9	3.5	0.266	0.767
15 – 19 years	235	12.1	3.3		
20 -24 years	102	11.9	3.9		
Total	**485**	**12.0**	**3.5**		
Religion					
Christianity	310	12.4	3.3	6.868	0.01
Islam	186	11.3	3.5		
Traditional	2	9.0	1.4		
Total	**498**	**12.4**	**3.4**		
Ethnicity					
Yoruba	426	11.9	3.5	0.620	0.71
Igbo	45	12.2	3.3		
Hausa	4	14.5	5.8		
Edo	5	13.2	1.1		
*Others	11	12.0	4.0		
Total	**500**	**12.0**	**3.4**		
Education Status					
Primary education	29	10.4	3.8	5.019	0.01
Secondary education	332	12.2	3.3		
Tertiary education	39	13.4	4.2		
Computer training	3	12.3	2.1		
Total	**403**	**12.0**	**3.4**		

*Others include Ebira, Efik/Ibibio and foreigner

Attitudes towards people experiencing mental illness

Respondents were requested to respond to a group of 13 statements on their reactions to people with mental illness. A positive attitude was identified by disagreement to the negative reactions stated in this section while a negative attitude was detected by a positive response to the negative statements.

Three hundred and thirty eight (67.6%) of the respondents agreed that they would be afraid to talk someone who has mental illness while 71.0% of the respondents agreed that they cannot make friends with somenne who is mentally ill and 70.4% would be upset and disturbed to be in the same class or workplace with someone who has mental illness. Table 4.10 shows the attitude of the respondents towards people experiencing mental illness.

Table 4.10 Attitude of the respondents towards people experiencing mental illness N = 500

Statements	Agree	Disagree	Undecided	No Response
I would be afraid to talk to someone who has mental illness.	338 (67.6)	148 (29.6)	10 (2.0)	4 (0.8)
I would be upset and disturbed to be in the same class with someone who has mental illness.	352 (70.4)	129 (25.8)	11 (2.2)	8 (1.6)
I cannot make friends with someone who has mental illness.	355 (71.0)	119 (23.8)	23 (4.6)	3 (0.6)
I cannot share my things with a classmate who has mental illness.	319 (63.8)	156 (31.2)	21 (4.2)	4 (0.8)
Students with serious mental illness should have their separate classrooms.	392 (78.4)	91 (18.2)	13 (2.6)	4 (0.8)
I cannot render help to someone with mental illness.	79 (15.8)	399 (79.8)	14 (2.8)	8 (1.6)
Mental illness is contagious.	152 (30.4)	298 (59.6)	34 (6.8)	16 (3.2)
I am afraid to live in a neighbourhood with a person who has mental illness.	260 (62.0)	214 (42.8)	18 (3.6)	8 (1.6)
If my boyfriend or girlfriend develops mental illness, I will break the relationship.	238 (47.6)	220 (44.0)	39 (7.8)	3 (0.6)
It is better for the society that people with mental illness do not have children.	168 (33.6)	305 (61.0)	22 (4.4)	5 (1.0)
It is better for the society that people with mental illness do not work with children and adolescents.	348 (69.0)	128 (25.6)	21 (4.2)	6 (1.2)
I will feel ashamed if my friends found out that somebody in my family has mental illness.	329 (65.8)	139 (27.8)	29 (5.8)	3 (0.6)
I would not tell an adult if someone with mental illness is being bullied.	127 (25.4)	316 (63.2)	44 (8.8)	13 (2.6)

More respondents. 334 (66.8%) had below average attitudinal score (1-13 points) which was categorized as negative attitudinal score. while 166 (33.2%) had above average between 14 and 26 points (positive attitudinal score).

The mean attitudinal score for those in the early adolescence (10-19 years) age group was 10.9±5.7 and for those in the late adolescence (20-24 years) age group was 13.7±6.2. The comparison of mean test for attitudinal score by age was statistically significant ($p < 0.05$). The mean attitudinal score for males was 11.7±5.8 while that for females was 11.1±6.00. The comparison of mean test for attitude by sex was not significant.

The mean attitudinal score for the in-school young persons was 11.0±5.8 while that for out- of-school young persons was 13.1±6.1. The comparison of mean test for attitude by school group (in- school or out of school) was also statistically significant ($p < 0.05$).

The mean attitudinal score for those in primary school was 8.2±4.3. those in secondary school had a mean attitudinal score of 10.7±5.6. those in tertiary institution had a mean attitudinal score 14.8±5.9 while for those in computer school 13.3±4.2. The comparison of mean test for attitude by education status was statistically significant ($p<0.05$).

Tables 4.11 and 4.12 show the comparison of mean attitudinal scores of respondents by selected variables.

Table 4.11 Comparison of mean attitudinal scores of respondents by sex and school group.

Variables	Number	Mean	Standard Deviation	t	df	p-value
Sex						
Male	262	11.7	5.8	1.180	498	0.24
Female	238	11.1	6.0			
Total	**500**	**11.4**	5.9			
School group						
In-school	403	11.0	5.8	-3.239	498	0.01
Out-of-school	97	13.1	6.1			
Total	**500**	**11.4**	5.9			

Table 4.12 Comparison of mean attitudinal scores of respondents by age, religion, ethnicity and education status (of in-school respondents)

Variables	Mean	No	Std Dev.	F	p-value
Age					
10-14 years	10.2	148	5.5	11.45	0.00
15-19 years	11.3	235	5.8		
20-24 years	13.7	102	6.2		
Total	**11.4**	**485**	**5.9**		
Religion					
Christianity	11.3	310	5.8	0.07	0.93
Islam	11.5	186	6.1		
Traditional	11.0	2	15.6		
Total	**11.4**	**498**	**5.9**		
Ethnicity					
Yoruba	11.4	426	5.9	0.131	0.99
Igbo	11.2	45	6.0		
Hausa	11.0	4	7.6		
Edo	13.0	5	2.0		
*Others	11.5	16	4.6		
Total	**11.4**	**500**	**5.9**		
Education Status					
Primary education	8.2	29	4.3	0.279	0.00
Secondary education	10.7	332	5.6		
Tertiary education	14.8	39	5.9		
Computer training	13.3	3	4.2		
Total	**11.4**	**403**	**5.9**		

*Others include Ebira, Ebik/Ibibio and foreigners

Stigmatization of people with mental illness

The most common words mentioned by the participants in description of a person with mental illness were 'mad person' (24.8%) and 'were' (22%). The other words and phrases were, *maru* (0.2%), *kariku* (0.4%), *asiwin* (6.2%), *dighelugi* (0.8%), *ayiri* (1.4%), "*ofe si die*" *brain touch* (0.4%), *alayanna* (3.4%), "*ori e ti duru*" (0.2%), *aniskaniskan* (1.2%), *anigangangan* (1.8%), *alarin ajala* (2.6%), *abugife* (0.8%), *drugbo* (0.2%), *dinduria* (3.4%), "*brainlow or alufola kukuru*" (1.0%), "*ko wa riku*" (1.6%), "*o re e*" (0.2%), *alamodi* (1.0%), *sangila* (0.4%), *aladeari* (1.0%), *akinwarapa* (0.6%), *alumegbon* (0.2%), *mental problem* (9.2%), *sick person* (2.2%), *lunatic* (5.2%), *'a person insane'* (3.2%), *crazy* (6.0%), *abnormal person* (12.0%), and *kolomental* (4.2%). However, 4.4% of the respondents do not call them any nickname except their names.

Impact of discrimination and stigma of mental illness

Three hundred and twenty respondents (64.0%) agreed to the statement that mental illness is stigmatizing. 88 (17.6%) of them however disagreed with this statement. Sixty three (21.4%) of the respondents stated that mental illness is stigmatizing because it is a shameful disease while 82 (27.8%) stated that people usually stigmatize the mentally ill persons. The table 4.13 below shows the other responses of the respondents.

Suggestions on ways of reducing discrimination and stigma of mental illness

Respondents were requested to suggest ways in which they think the discrimination and stigmatization of mental illness can be reduced in the society. Individuals should stop stigmatizing people with mental illness (14.2%), individuals should show love, give advice and take the individuals for treatment (22.4%), relatives should stop them from going out and give them treatment at home (2.0%), the government should build mental homes where they can be cared for (9.4%) and organize people to take away mentally ill persons from the streets (5.4%), were their responses among some other suggestions (see tables 4.14 and 4.15).

Table 4.13 Responses of the respondents who agreed that mental illness is stigmatizing. N = 295

Responses	Frequency	(%)
People will stigmatize and discriminate against them	82	27.8
It is a shameful disease.	63	21.4
People will bully and make jest of the person.	41	13.9
The person will be behaving abnormally.	35	11.9
There could be a relapse and it is disgraceful for friends and relatives	31	10.5
People will abuse beat and chase them away.	16	5.4
When the person gets better people will remind him or her about the illness.	11	3.7
The person will locked up in a room.	4	1.4
He or she will not be able to cope with friends and relatives that are normal.	4	1.4
I would not want to go out with such persons	4	1.4
They would feel that people do not love them	2	0.7
The person will not be able to attain the expected level of success	1	0.3

Table 4.14 Suggestions on the roles of individuals and relatives of the mentally ill person in the reduction of stigmatization of people with mental illness.

Suggestions	Frequency	%
The roles of individuals		
Show love and give advice and take the individual for treatment	112	22.4
Help to stop stigmatization of people with mental illness	71	14.2
Individuals should desist from risky behavior.	18	3.6
Take them to herbalist, church or mosque for treatment	15	3.0
Pray for the person	11	2.2
Avoid mentally ill persons.	6	1.2
Call adults to stop people from stigmatizing people with mental illness.	4	0.8
Provide assistance (such as financial)	4	0.8
Lock the person up or stop the person from going out of the home	2	0.4
Pray that God should punish those who stigmatize	2	0.4
People should try to control themselves when they are given bad news.	1	0.2
People should not think too much	1	0.2
The roles of the relatives of mentally ill		
Care for them and take them for treatment in hospitals	63	12.6
Pray for the person and show love	12	2.4
Stop the person from going out and give treatment at home	10	2.0
Take them away from unfriendly environments or areas.	7	1.4
Take them to herbalist for treatment	5	1.0
Take them to church or mosque for prayers	3	0.6
Parents should monitor their children	2	0.4
Relatives should stop discrimination	2	0.4

*multiple responses included

Table 4.15 shows the suggestions on the roles of the community members and the government in the reduction of stigmatization of people with mental illness.

Responses	*Frequency	%
The roles of community members		
Stop stigmatization.	5	1.0
Advise and provide assistance.	3	0.6
Seek for support from the government.	1	0.2
The roles of the government		
Provide free and adequate medical support.	89	17.8
Build mental homes where they can be cared for.	47	9.4
Create mental health and anti-stigma awareness.	29	5.8
Organize people to take away mental ill people from the streets for treatments in hospitals.	27	5.4
Provide assistance for the mentally ill and relatives.	16	3.2
Put restrictions on importation and improve campaign on cigarette smoking, alcohol drinking and use of hard drugs.	10	2.0
Provide more jobs for poverty alleviation.	3	0.6
Arresting and penalize the people who stigmatize	1	0.2

*multiple responses included

Tests of Hypotheses

1. **There is no association between the sex of the respondents and their knowledge of mental illness. This relationship was not statistically significant (p = 0.26). More males (58.6%) than females (41.4%) had high knowledge scores. Therefore the null hypothesis was not rejected (see table 4.16).**

Table 4.16 Hypothesis test for the association between the sex of the respondents and their knowledge of mental illness

Sex of respondents	Knowledge of mental illness				
	Low (%)	Average (%)	High (%)	Total	p-value
Male	79 (58.6)	108 (50.0)	75(58.6)	262	0.26
Female	77 (49.4)	108 (50.0)	53(41.4)	238	
Total	156(100.0)	216 (100.0)	128(100.0)	500(100.0)	

X^2 value = 2.661 df = 2 Column percentages reported

2. There is no association between the school group of the respondents and their perception about people with mental illness. A statistically significant relationship was found between the school group of the respondents and their perception about mental illness ($p = 0.00$). Therefore the null hypothesis was rejected, indicating that the level of exposure to the outside world may likely be a factor influencing the perception of the respondents about mental illness (see table 4.17).

Table 4.17 Hypothesis test for the association between the school group of respondents and their perception about people with mental illness

School group of respondents	Perception about mental illness					
	Negative (%)	Positive (%)	Total	X^2	Df	p-value
In-school	144 (74.2)	259 (84.6)	403(80.6)	8.234	1	0.00
Out-of-school	50(25.8)	47 (15.4)	97(19.4)			
Total	194(100.0)	306(100.0)	500(100.0)			

Column percentages reported

3. There is no association between the sex of the respondents and their attitude towards people with mental illness. This relationship was not statistically, although more males (36.3%) than females (29.8%) had a positive attitude towards people with mental illness (p = 0.08). Thus, the data depicts that gender has no influence on the attitude of the young persons towards people with mental illness. Therefore the null hypothesis was accepted (see table 4.18).

Table 4.18 Hypothesis test for the association between the sex of the respondents and their attitude towards people with mental illness.

Sex of respondents	Attitudes towards people with mental illness					
	Negative (%)	Positive (%)	Total	χ^2 Value	df	p-value
Male	167(63.7)	95(36.3)	262	2.323	1	0.08
Female	167(70.2)	71 (29.8)	238			
Total	334(66.8)	166(33.2)	500(100.0)			

Row percentages reported

4. There is no association between the respondents' place of residence and their attitude towards living in the same neighbourhood with people with mental illness.

The community status of the location of the respondents was cross tabulated with the attitudinal question "I would be afraid to live in the same neighbourhood with someone who has mental illness" using Chi-square statistic. A significant relationship was found between the community status of the location of the respondents and their attitude towards persons experiencing mental illness ($p = 0.02$). More respondents in the inner-core (49.6%), than those in transitory (41.9%) and peripheral (8.5%) areas had a negative attitude towards living in the same neighbourhood with people experiencing mental disorders. The null hypothesis was rejected (see table 4.19).

Table 4.19 Hypothesis test for the association between the community status of the location of the respondents and their attitude towards living in the same neighbourhood with people with mental illness

Location of respondents	Attitude towards persons with mental illness			Total	p-value
	Agree (%)	Disagree (%)	Undecided (%)		
Inner-core	129 (49.6)	105 (49.1)	10 (38.5)	244 (48.8)	0.02
Transitory	109 (41.9)	102 (47.7)	14 (53.8)	225 (45.0)	
Peripheral	22 (8.5)	7 (3.3)	2 (8.7)	31 (6.2)	
Total	260 (100.0)	214 (100.0)	26 (100.0)	500 (100.0)	

X^2 value = 15.126 df = 6 Column percentages reported

CHAPTER FIVE

DISCUSSION

This study explored the perception and stigmatizing tendencies of young persons towards people with mental illness. In this chapter the explanations of the results presented in the previous chapter is given. The socio-demographic characteristics of the respondents, their perception about mental illness, knowledge of mental illness and their attitude towards people with mental illness were explored. The words and phrases used to describe people with mental illness and their suggestions on how discrimination and stigmatization of people with mental disorders can be reduced in the society were also explained. Implications of the findings of the study to health promotion and education and recommendations were also discussed in this chapter.

Socio-demographic characteristics of participants

Five hundred young persons whose ages ranged from 10 to 24 years with mean age of 16.6±3.5 participated in the study. This is consistent with the findings of an earlier study with similar population in Southern California in the United States, which found a mean age of 16.4±2.5 years (Corrigan *et al*., 2005). This study is also consistent with the findings of an earlier study with similar populations in Kenya with participants from public primary and secondary schools in Kangemi area of Kenya (JHNKI & SCAD, 2008), due to the fact that majority of the respondents in this study (81.6%) were in-school young persons, but differ slightly in the sense that this current study is community based. The current study however differs from the studies carried out in Nigeria among adults group from the age group 18 years upward (Gureje *et al*., 2005; Kubir *et al*., 2004), although they are community based studies as well. The number of males in the study population (52.4%) was slightly higher than the female population (47.6%). More than half of the respondents (66.4%) were in secondary school.

The study area is located in South-western Nigeria, this explains why majority of the respondents (85.2%) were of the Yoruba ethnic group.

Knowledge of mental illness

Awareness and Sources of information of mental illness

The media plays a major role as the source of information of mental illness in the society. The television and the radio were the major sources of information followed by the newspapers and stories from the neighbourhood. Television has a powerful influence on shaping culture. It is likely that the media portrayal has a strong influence on how people think about people with mental illness and how they behave when confronted with mental illness and people with mental illness (Angelini *et al*., 2006). In harmony with the PRECEDE and Ecological frameworks for this study, young persons are likely to have a negative perception and attitude towards people with mental illness if they are fed with wrong information by the media about mental illness and people with the disorder. In cinema and television, mental illness is the substrate for comedy, more usually laughing *at* than laughing *with* the characters (Byrne, 1997). Some of the discussants in one of the FGDs also made known their delight in watching the theatrics performance of some mentally ill persons in their neighbourhoods.

Knowledge of definition of mental illness

Access to information and education on mental health and mental disorders is an important factor in the level of knowledge of young persons about mental illness. Respondents in the study generally had an average knowledge about mental illness. It is possible that their knowledge of mental illness was shaped by their cultural setting. Most of the study respondents within the ages 10-14 years had a poor knowledge of types and causes of mental illness. This may be due to their low exposure to mental health education and what constitutes mental illness. Similar findings have been reported in the study carried out by Rose *et al* (2007), in which the level of factual knowledge among the participants who were 14 year old school children, about mental illness was remarkably low. The study participants had a limited knowledge of the types of mental illness. A female discussant made the classification of mental illness in Yoruba language into "*Eleyhe*" that is the chronic type of mental illness and "*Iwisiwa*", the mild type of mental illness. This classification was supported by majority of the discussants, the need for

inculcation of mental health education into the school curriculum and improved health education in the communities.

Some demographic characteristics were found to significantly affect their knowledge of mental illness. A statistical difference was found in the knowledge of the young persons. The young persons in the late adolescence group 20-24 years had a higher knowledge than those in the early adolescence group 10-19 years. A significant difference was also found between the knowledge of the young persons at the different level of education. There was also a significant difference in the knowledge of mental illness of the respondents in the two school groups. The out-of-school respondents had a higher knowledge of mental illness than the in-school respondents. This may be due to their higher exposure to the causes mental illness and persons experiencing the disorder in the society.

Knowledge of causation of mental illness

Young persons in this study generally had an average knowledge of causation of mental illness. Possession of evil spirit and spiritual attack was ranked as a major cause of mental illness by the majority of the study respondents and FGD discussants. This may be due to the fact that belief in demons as the cause of mental health problems is a well-known phenomenon in many cultures of the world. This contrasts the findings of a similar study by Kabir *et al* (2004) in Northern Nigeria in which the issue of spiritual attack as the major cause of mental illness was ranked 3rd place by study participants. Some of the young persons who participated in the FGD stated that may be inflicted with the illness by some diabolic forces as a result of insulting or offending an elderly person or someone who is a witch or a wizard.

Academic and emotional stresses were also mentioned by some of the study participants as causes of mental illness. A discussant in one of the FGDs specified the duration to be reading for over five to six hours. This however is a general belief in our society as some mentally ill persons walking about the streets with books and writing materials are usually assumed to have developed mental illness as a result too much reading.

One of the interesting themes derived from the FGDs was that mental illness could be caused by food going through the wrong pathway. This is an evidence of the poor knowledge of mental illness generally found among young persons especially those in group. This can however be addressed through the introduction of mental health education in the school curriculum. Considering these entire wrong views, one may agree with McGuffin & Martin (1999) that public perception of psychiatric disorders will change, as improved understanding of the causes and mechanisms of mental disorders is likely to reduce stigma.

Effective treatment for mental illness

A higher percentage of the respondents (40.2%) agreed on the preference for modern medical care in treating psychiatric illness. Similar changes in attitude towards the modern scientific approach regarding mental disorders was documented by Kabir *et al*. (2004) in their work on the perception and beliefs about mental illnesses among adults in Karfi village, Northern Nigeria. Most of the study participants however opined that the treatment for mental disorders. Due to the general belief that mental illness is most times caused by diabolic forces, it is believed that medical intervention cannot cure such cases. Some of the respondents said that healing can also be a means of treating of mental illness. This may arise due to the perception that mental illness is sometimes caused by the possession of evil spirit.

Identifications of persons with mental illness

Most of the young persons reported that they can identify someone with mental illness by their abnormal behaviour and appearance. Abnormal behaviour in this context is used to describe a deviation from the normal social norms such behaviours include talking to oneself on the street, walking or roaming the street with tattered clothes or naked with dirty and bushy hair e.t.c. This is similar to the findings of the study by Secker *et al*. (1999) where the young people who participated in the study, defined unusual behaviour as a deviation from personal behaviour (the everyday patterns of behaviour of the people they knew) and a deviation from social norms (i.e. a deviation from other people's expectation).

Relationship with persons experiencing Mental Illness

Forty five percent of the respondents reported knowing someone who is experiencing mental illness. This agrees with the findings of the study carried out by Crisp *et al.* (2000) in which about one-half of the respondents reported personal knowledge of someone with mental illness. The relationship ranged from neighbours, persons they see in the neighbourhood, relations, friends and family friends. Knowing someone who has a mental illness is not associated with more enlightened attitudes (Wolff *et al.*, 1996a), but Huxley (1993) identifies that the key factor is direct contact with people who have had "helpful treatment for episodes of mental illness". Just as in Crisp *et al.* (2000), those who reported knowing someone with mental illness were not less likely than others to have negative attitudes towards people with mental illness.

Though it is claimed that the effect of contact with a mentally ill person depends on the nature of the contact and the nature of the illness (James, 1998), in this study there was no significant association between the attitude of those respondents who reported knowing someone with mental disorders and those who reported otherwise ($p=0.78$). Also there was no significant association between the relationship of the respondents with the mentally ill persons they knew and their attitude towards people with mental illness ($p=0.11$). This findings is similar to the study carried out by Corrigan *et al.* (2005) in which the teens who reported being more familiar with mental illness endorsed greater attributions of responsibility and dangerousness to those with mental illness. Rather than diminish stigma, contact seemed to increase it. Only about half of the respondents in this study reported to have seen the mentally ill persons they knew, get better overtime with treatment. This is influenced by various factors mentioned by the respondents such as non-compliance with drugs.

Perceptions about mental illness

More respondents had a positive perception above mental illness and people experiencing mental disorders. Just as expected in the society, majority of the respondents perceived that people with mental illness are dangerous. It corresponds with the Royal College of Psychiatrists' 1998 survey, where 70% believed that people with schizophrenia are violent and unpredictable (Byrne, 2000). This was supported by statements from the FGD

in which a few of the discussant pointed out that it is advisable to run away from people experiencing mental illness because they are not questionable in the court of law if they attack and injure other people. Findings from previous studies (Crisp *et al*., 2000; Gureje *et al*., 2005; BANKE & SCAD, 2008; Corrigan *et al*., 2005) have also revealed that people with mental illness are usually regarded as troublesome and dangerous in the society.

As part of the 'them and us' strategy, mental disorders have also been conferred with highly charged negative connotations of self-infliction, an excuse for laziness and criminality (Byrne, 2000). Some misconceptions about the causes of mental illness were portrayed by the study participants as some of the respondents in this study were of the same opinion that mental illness is self-inflicted. They stated that in most cases, mental illness results from indulging in risky behaviour such as alcohol drinking, cigarette smoking and substance misuse which are risk factors. This also correlates with the findings of Corrigan *et al* (2005) in which peers who abuse alcohol were viewed more negatively than those with mental illness or leukemia, especially in terms of blame, anger, and dangerousness. This finding is also similar to finding by Kabir *et al*., (2004) and Gureje *et al*., (2015).

However most of the respondents opined that mental illness is preventable in most cases if individuals do not indulge in behaviour that would put them at risk of developing the disorder. Some of them however stated that some people have been destined by God to have mental illness – there is nothing one can do to avert the occurrence. Another reason stated was that if it's a curse or spiritual attack, it may not be preventable. Some respondents agreed that people who are mentally ill should be locked up in a room. They felt that this measure would prevent the mentally ill from attacking people in the neighbourhood and also restrict them from roaming the street which could bring about people discriminating and treating them unjustly.

Contrary to the opinion that people with mental illness are often of lower intelligence by most respondents, a few the respondents stated that nowadays some people, who indulge in '*Lotto*' or gambling popular known as "*Baba Ijebu*" in the local language, get numbers from the mentally ill individuals on the streets and some of them testified to the efficacy

of this method. Many of the respondents were of the opinion that people who have mental disorders cannot work for a living. This contrasts the findings of Gureje *et al* (2005) in which only about a quarter of the study participants thought that mentally ill people could work in regular jobs. This difference may be due to the fact that this study population is younger.

Majority of the respondents believed that mental illness can be treated in hospitals, however most discussants in the FGDs expressed the opinion that mental illness is not completely curable with medical treatment only, but with the combination of traditional and spiritual care. Yorubas do not believe that mental illness can be permanently cured. It is seen as a continuous process because it is believed that the mentality of person is being controlled by spirits, either due to a natural factor or other factors (Ayinde, 2005).

Some other misconception expressed by the study respondents was that mental illness is contagious, a few of the young respondents and FGD discussants stated that someone could have mental illness if bitten by a mentally ill person. This may be explained by their low knowledge of mental illness. Mentally ill persons were also believed to be stronger than supposedly normal persons.

There was a statistical relationship between the respondents' educational status and their perception about mental illness. Respondents in tertiary institution though few seemed to have a more positive perception about mental illness than those in secondary and primary schools. A statistically significant difference was also found between the perceptions of the respondents in the two school groups about mental illness. Out-of-school respondents seemed to have a more positive perception about mental illness than the in-school respondents. This may be due to the fact that majority of the in-school respondents were younger and they expressed more comments about the issue.

Attitude towards people with Mental Illness

A general negative attitude towards people who are experiencing mental disorders was perceived by the study participants. Majority of the respondents would want someone with serious mental disorders to have their separate classrooms. Most of them would be afraid to talk to someone who has mental illness talk less of making friends with them. Majority

would be upset to be in the same class and would not want to share their personal possessions with such individuals, and would be afraid to live in the same neighbourhood with mentally ill persons. Less than half of the respondents would break their relationship with girlfriends or boyfriends who suddenly develop mental disorder. This is similar to the study in Kenya where majority of the students who participated in the study said that they would run away from persons with mental disorders (BNKE & SCAD, 2008). In contrast, most of the respondents and discussants in this study said that they will be willing to render help to someone with mental illness and most of them felt that people who are experiencing mental disorders have the right to their own children as other people. However the respondents expressed their disagreement and fear concerning people with mental illness working with children and adolescents. This is similar to the findings of Secker *et al* (1999) in which the young people expressed their sympathy and fear towards the mentally ill.

Family member's relationship to the patient may affect the extent to which the patient's stigma is transferred to the family member. For example, family members who live with the ill relative can expect to be exposed to more stigma than those who do not, because their acquaintances are more likely to know about their relative's illness and because interaction heightens the acquaintance's probability of contact with the patient. Similarly, spouses may be exposed to greater stigma than parents because their social networks and the ill relative's overlap to a greater extent (Phelan *et al*., 1998).

Most of the respondents in this study reported that they would be ashamed to let their friends know if a relative of theirs has mental illness. This is due to the stigma attached to mental illness in the society. Majority of the IDI discussants expected people to react negatively and mock the friends or relatives of the mentally ill persons. The few of the young persons who wouldn't mind telling their friends, said that if they tell, they may be able to get information and assistance on how such persons can be treated. In response to their reactions towards close relations or friends who suddenly develops mental illness, the majority of the IDI discussants expressed their sadness and said that they would help in provision of food, clothing and financial assistance for the person's treatment.

There was no significant association between the sex of the respondents and their attitude towards people with mental illness (p = 0.076), although more males had a positive attitude towards people with mental illness than females. This contrasts the findings of a similar study carried out among secondary school students in Hong Kong by Petrus and Chan (2000) where results showed that boys were found to have more stereotyping, restrictive, pessimistic and stigmatizing attitudes towards mental illness.

A statistical significant difference was found in the in the mean attitude scores of the respondents with respect to their educational status (p=0.000). The young persons in primary school had the highest negative attitude, followed by the young persons in secondary schools. The perception of fear and dangerousness was the main reason that accounted for this. There was also a significant relationship between the residence or location of the respondents and their attitude towards people with mental illness. The environment may likely have an influence on the attitude of the respondents towards people with mental illness. The respondents residing in the less developed areas were more likely to have a higher negative attitude towards people with mental illness than those in the developed areas. This may be due to their level of exposure and the various misconceptions they have about mental illness.

Stigmatization of people with mental illness

People experiencing mental disorders usually experience stigma everywhere they go such as social gatherings in the neighbourhood, in the market places, at school, workplaces, among friends and relations. Discrimination and stigmatization may sometimes arise as a result of lack of tolerance to the unusual and sometimes irritating behaviour of the mentally ill. The nature and extent of the illness are other factors that may bring about stigmatization, most especially the issue of relapse episodes which may occur any where and unexpectedly.

The home is not left out on the list of places where people experiencing mental disorders can be stigmatized. The findings of a study carried out in India among women with schizophrenia and broken marriages revealed that some of the reasons why the women were divorced by their husbands were that the ill woman was not attending normally to

household routines and was behaving in a strange way and sometimes may not be able to meet the husband's sexual needs (Iharo *et al*., 2003).

The kinds of words used to describe the people with mental illness portray the extent of stigma and can sometimes depict a person's likely attitude towards the mentally ill. The most common word in the Nigerian society used to describe people experiencing mental illness was the Yoruba word '*were*' (meaning madness or a mad person). This word was used by this study respondents and discussants to describe the mentally ill persons. In contrast to the general opinion, some of the young persons reported that they do not like calling them names because they regard the people experiencing mental illness as fellow human beings.

Suggested ways of reducing the stigmatization of people with mental illness

The young persons suggested that mental health and anti-stigma awareness should be created in the society as this would increase the knowledge of the public about mental illness and also change the perception and attitude of people towards persons with such illness. The respondents also stated that relatives of persons with mental illness would be encouraged to assist them in getting treated if free and adequate medical services are provided in the psychiatric hospitals. It was also suggested by the respondents that the provision of financial support for medical and basic needs such as food, clothing and housing for the mentally ill can help in improving their health conditions, street wandering and thus reduce stigmatization.

Other suggestions include restrictions on the importation and improved campaign on cigarette smoking, alcohol drinking and substance use. They pointed out that the importation of these harmful substances has a major contribution to the increasing prevalence of mental illness in the society as many youths indulge in the habit of cigarette smoking and substance use these days. Provision of jobs by government for poverty alleviation was also suggested as this will improve the living conditions of the mentally ill. Emotional and spiritual support by relatives, friends and community members also go along way in helping them get better. Curbing stigmatization by confronting or arresting stigmatizers was also suggested. Some of the respondents

suggested that avoiding people with mental disorders is another way of reducing stigma, this is because some individuals experiencing mental illness are violent and can injure other persons.

Implications for mental health promotion and education in schools and communities

The Ottawa Charter for Health Promotion (WHO, 1986) defined five key health promotion strategies or elements. These are building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting health services toward promotion, prevention and early intervention (Centre for Addiction and Mental Health, 2008). Mental Health promotion is consistent with the health promotion process of "enabling people to increase control over, and to improve their own health" (WHO, 1986).

Mental Health Promotion Unit of Health Canada, defined mental health promotion as: The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. This definition is very similar to the general concept of health promotion as defined by the Ottawa Charter (WHO, 1986). Mental health promotion emphasizes two key concepts: power and resilience. Power is defined as a person's, group's or community's sense of control over life and the ability to be resilient (Joubert & Raeburn, 1998). Building on one's existing capacities can increase power and control. Resilience has been defined as "the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity" (Health Canada, 2000). People who have high resilience (i.e., have the capacity to "bounce back" after adversity) are still vulnerable to adverse events and circumstances (Commonwealth Department of Health and Aged Care (CDHAC), 2000).

Development of healthy public policy

National mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health. These would include the socio-economic and environmental factors, as well as behaviour. This requires mainstreaming mental health promotion into policies and programmes in

government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector. Particularly important are the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize.

Anti-stigma interventions or campaigns should be promoted in schools and communities to increase the awareness and knowledge of mental health, the impact of discrimination on people experiencing mental illness and to reduce the stigma of mental illness in the society.

Creation of supportive environments for health

This is aimed to reduce or eliminate risk factors such as anxiety, depression, suicide, violence, stress and distress, discrimination and stigma, which place individuals, families and communities at risk of diminishing mental health. Such interventions include:

- Early childhood interventions. This includes home visiting for pregnant women, pre-school psycho-social interventions, combined nutritional and psycho-social interventions in disadvantaged populations.
- Child and youth development programmes
- Mental health promotion activities in schools
- Mental health interventions at work such as stress prevention programmes.
- Housing policies e.g. housing improvement, provision of housing opportunities for the less privileged and the mentally ill.
- Violence prevention programmes (e.g. community policing initiatives) (WHO, 2007).

Strengthening of community action

Young persons, individuals, groups and communities can adopt various health promoting actions in order to promote their mental health and the reduce stigmatization of mental illness. Actions such as adoption of healthy life styles e.g. stopping tobacco and alcohol consumption and reduction of stress and appropriate use of health services in the early stages of disease can be strengthened with the help of health promotion and education. Individuals in the community can also help in reducing stigma by confronting and correcting stigmatizers to desist from the act.

Development of personal skills

This includes increasing resilience and protective factors such as increasing personal coping skills with discrimination and stigmatization, increasing the self-esteem of the mentally ill and their relations and caregivers, and increasing their sense of well-being. This can be achieved with the help of health education through which information is directed to young persons, individuals, families and communities to influence their knowledge, perception and attitude towards mental illness and the people experiencing the disorders.

Poor knowledge of mental illness and a negative attitude towards people experiencing mental illness have been identified among young persons. Most of the young persons have a negative attitude towards the people experiencing mental illness due to misconceptions about mental disorders. A poor knowledge about mental health and mental disorders and the implications of stigma on people experiencing mental illness are the main causes of these misconceptions. Cultural beliefs and perceptions about mental illness are other main factors that affect the knowledge and attitude of the young persons.

Therefore, confronting stigma of mental illness goes beyond the young persons but should start from the community. In line with the ecological framework, health education can be used to solve this problem. Information, education and communication (IEC) materials can be designed and targeted towards young persons in schools and members of the community in order to increase their knowledge about mental disorders and foster the acceptance of the mentally ill in the schools and in the community.

Reorientation of health services

Mental health promotion in health facilities on drug compliance, adoption of healthy life styles, good parental care, combined nutritional and psycho-social interventions for pregnant women can help in improving the mental health of individuals in the community. Access to quality mental health services, improved health worker and patient relationship, case management, patient education and counseling encourages individuals with mental disorders to adopt the appropriate use of mental health services and also improve their mental health.

Conclusion

The stigma of mental illness remains a powerful negative attribute in the society and certainly requires public health intervention. The damaging impact on the people with the disorder cannot be overemphasized and is also of public health importance. This study has revealed that there was a generally poor knowledge of mental illness and nature of mental illness among young persons and also that a significant relationship exist between the residence or location of the young persons and their attitude towards people with mental illness. The young persons residing in the less developed areas were more likely to have a higher negative attitude towards people with mental illness than those in the developed areas. It appears that there was a general positive perception about mental illness and people experiencing mental disorders but this has not resulted in a positive attitude towards the mentally ill in the society. There is therefore a need for improved health promotion and education programmes and policy in schools and in the community.

Recommendations

The following recommendations are made to address the findings of this research study:

1. Mental health educational sessions with young people are a useful approach for challenging the development of stereotypical attitudes towards people with mental health problems. Thorough evaluation of school mental health awareness programmes is needed to ensure that limited health promotion resources are effectively targeted towards the young persons.
2. Adequate information about mental health, causation of mental illness and the nature of mental illness should be provided to individuals in the community in order to clear the misconceptions and negative cultural beliefs about mental illness.
3. Mental health discrimination should be discouraged wherever it is encountered. This means challenging people who disrespectful and discriminate people who have mental illness. It means being willing to make friends and work with someone who has a history of mental illness.

4. The media should be to address misconceptions and portrayals of negative images about mental illness people experiencing mental illness in the society through entertainment education.
5. Financial, emotional and social support should be rendered to relatives and caregivers of the mentally ill in order to promote both their mental and physical health.
6. Provision should be made for quality and free medical services for the mentally ill at the various health facilities in the nation for improved case management and achievement of higher level of recovery from mental health disorders.

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APPENDIX I

PERCEPTION AND STIGMATIZING TENDENCIES OF YOUTHS TOWARDS PEOPLE WITH MENTAL ILLNESS IN IBADAN SOUTH WEST LOCAL GOVERNMENT AREA OF OYO STATE

FOCUS GROUP DISCUSSION GUIDE

Good evening, my name is Aimi Oluwatosin, a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. My assistants are..... I thank you all for accepting to participate in this discussion. This is a research work that seeks to find out what youths know about serious mental illness, how they feel about it and how they behave towards people with mental illness. The answer you give will strictly be used for research purposes and your names will not be mentioned. There is no right or wrong answers, therefore feel free to say whatever is on your mind in response to all the questions. Kindly permit us to use a tape recorder which will assist us to get all your responses without missing out any.

Thanks for your cooperation.

1. Please can you tell us what you know about mental illness?
   Probe (a) what they have heard, read or are taught.
   (b) their source of information.
   (c) the different types of mental illness they know of and causes.
   (d) what are the concerns of students about the increase in the occurrence of mental disorders among youths especially students in Oyo State.
   (e) meaning and local terminologies used to describe mental illness.
2. Can we discuss what students feel about people who have mental illness?
   Probe for beliefs and perception about mental illness.
3. What do you think are the sources of negative images about people who have mental illness?
4. What do you think are the causes of discrimination towards people with mental illness?
5. What do you think are the impacts of discrimination on people who have mental illness?

6. What in your opinion are the responsibilities of youths towards people with mental illness?

   Probe for (a) responsibilities towards classmates, relatives and friends with mental illness.

   (i) in everyday life

   (ii) in the public sphere

   (b) the benefits of rendering assistance to people with mental illness.

7. How would you feel or react if someone you know develops mental illness?

   Probe for how they would expect other people to react

8. When and where do you think people with mental illness experience stigma?

9. What words or phrase would you use to describe someone who has mental illness?

10. Let us discuss how the issue of stigmatization of people with mental illness can be addressed. Probe for the roles of individuals, families, community members and government in the reduction of stigmatization of people with mental illness

APPENDIX 2

PERCEPTION AND STIGMATIZING TENDENCIES OF YOUTHS TOWARDS PEOPLE WITH MENTAL ILLNESS IN IBADAN SOUTH WEST LOCAL GOVERNMENT AREA OF OYO STATE

QUESTIONNAIRE

Serial No.....

Dear Respondent,

I am Aina Oluwatosin, a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am carrying out a study on "Perception and Stigmatizing Tendencies of Youths Towards People with Mental Illness in Ibadan South-West Local Government Area of Oyo State". This research is part of the requirement for the award of Master of Public Health (Health Promotion and Education) and the findings will be of immense benefit in the area of healthy behavioural change. Please note that you are not required to write your name on the questionnaire. Kindly feel free to express your opinion and be rest assured that your responses will be kept strictly confidential. Your honest and sincere response to the following questions will be highly appreciated.

Would you want to participate in the study? 1. Yes 2. No

Thank you.

Aina Oluwatosin

INSTRUCTION: Please give appropriate answer and tick (√) where necessary

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

1. Sex 1. Male 2. Female
2. Age (Last Birthday) _____
3. Religion 1. Christianity 2. Islam 3. Traditional 4. Others
4. Ethnicity 1. Yoruba 2. Igbo 3. Hausa
   4. Others (Please specify) _____
5. Name of community _____
6. Are you presently in school? 1. Yes 2. No (If no go to Question 8)

7. If yes, what school 1. Primary 2. Secondary 3. University
4. Polytechnic 5. Others (Specify) _____

8. If no, what work are you doing? Specify _____

SECTION B: PERCEPTION ABOUT MENTAL ILLNESS (Please tick(√) as appropriate)

No.	Statements	Agree	Disagree	Undecided
9.	Mental illness is self inflicted.			
10.	Mental illness is preventable.			
11.	People with mental illness are often stigmatized or unfairly.			
12.	A mentally ill person should be kept locked up in a room.			
13.	People with mental illness are dangerous			
14.	People with mental illness cannot work			
15.	People with mental illness usually need medication			
16.	People with mental illness are often of lower Intelligence			
17.	People who have mental illness cannot be successful in life			
18.	Mental illness can be treated in hospitals			
19.	Mental illness is completely curable.			

SECTION C: KNOWLEDGE ABOUT MENTAL ILLNESS

20. Have you seen, read or heard any advertising or promotions about mental illness before?
1. Yes 2. No (If No go to Question 21)

21. Please define mental illness in your own words.
.....
.....

22. Where did you hear about mental illness?

No	Source of information	Tick as many as apply
a.	Television	
b.	Radio	
c.	Newspaper	
d.	Magazines	
e.	Parents	
f.	Relatives	
g.	Friends	
h.	Others (Specify)	

21. Mental illness can be caused by the following (tick as many as apply)

a.	Physical abnormalities in the brain	
b.	Chemical imbalance in the brain	
c.	Brain disease	
d.	Heredity	
e.	Physical illnesses	
f.	Possession of evil spirits/spiritual attack	
g.	Poor upbringing by parents	
h.	Head injury	
i.	Convulsion	
j.	Childhood illnesses (e.g. measles, rashes)	
k.	Cigarette smoking	
l.	Substance use (e.g. Cannabis, heroine, marijuana)	
m.	Drinking alcohol	
n.	Disturbance in relationship (with family, friends, teachers in school)	
o.	Stress (such as academic, emotional or work)	
p.	Physical abuse	
q.	Traumatic events or shock e.g. assault, death or accident	
r.	Poverty	
s.	Others, specify	

24. What are the effective treatments for mental illness? _____

25. How can you identify someone with mental illness? _____

26. Do you know someone who is experiencing a mental illness? 1. Yes 2. No

27. If yes, how is the person related to you? _____

28. Have you seen the person get well overtime with treatment? 1. Yes 2. No

SECTION D: ATTITUDINAL QUESTIONS ON MENTAL ILLNESS

Note: SA- Strongly Agree, A- Agree, SD- Strongly Disagree, D- Disagree and U- Undecided. Please tick (√) as appropriate

	Statements	SA	A	SD	D	U
29.	I would be afraid to talk to someone who has mental illness.					
30.	I would be upset and disturbed to be in the same class with someone who has mental illness.					
31.	I cannot make friends with someone who has mental illness.					
32.	I cannot share my things with a classmate who has mental illness					
33.	Students with serious mental illness should have their separate classrooms.					
34.	I cannot render help to someone with mental illness.					
35.	Mental illness is contagious					
36.	I am afraid to live in a neighbourhood with a person who has mental illness.					
37.	If my boyfriend or girlfriend develops mental illness, I will break the relationship					
38.	It is better for the society that people with mental illness do not have children.					
39.	It is better for the society that people with mental illness do not work with children and adolescents					
40.	I will feel ashamed if my friends found out that somebody in my family has mental illness.					
41.	I would not tell an adult if someone with mental illness is being bullied					

42. What words would you use to describe a person with mental illness?

43. Is mental illness stigmatizing? 1. Yes 2. No 3. Don't know

44. If yes, in what way?

SECTION E: SUGGESTIONS

45. What can be done to reduce the stigmatization of people with mental illness in Nigeria?

THANK YOU FOR YOUR TIME

APPENDIX 3

IRISI ATI IWA TI O JE MO IDEYESI AWON ODO SI AWON ENIYAN TI O NI AISAN OPOLO NI ILOBA IBILE GUSU IWO-ORUN ILU IBADAN, NI IPINLE OYO

IFOSONA FUN LIRORO

E ku irole, eyin ara mi. Oruko mi ni Aina Oluwatosin, mo je akeko agba ni Department of Health Promotion & Education, Faculty of Public Health, Unifasiti ti Ilu Ibadan. Awon ti o wa pelu mi ni..... Mo dupe lowo yin fun wipe egbe lati kopa ninu ijiroro yi. Ise iwadi yi wa fun lati mo ohun ti eyin odo mo nipa aisan opolo, ero yin nipa aisan opolo ati ihuwasi yin si awon eniyan ti o ni aisan opolo. Awon idahun yin yio wa fun ise iwadi yi nikan, ako si ni daruko yin rara nibikibi. Ko si idahun ti o to tabi eyi ti ko to, nitori na mo fe ki e tureka lati fi ero inu yin han si gbogbo ibere nau. E jowo e gba mi laye lati lo ero gbohungbohun yi. eyi yio ran wa lowo lati gba gbogbo idahun yin lai yo okankan sile rara.

Ese pupo fun ifowosowopo yin.

1. E jowo se e le so ohun ti e mo nipa aisan opolo fun wa?

   Beere nipa (a) ohun ti won ti gbo, ti won ka, tabi ti a ko won

   (b) ibi ti won ti gbo

   (c) orisi arun opolo ti won mo ati ohun ti o n fa aisan opolo.

   (d) kini o je won lokan nipa bi aisan opolo se wopo larin awon odo ni ipinle oyo?

   (e) kini ohun ati awon ede ibile ti a fi n juwe aisan opolo.

2. Nje ale jiroro lori ohun ti awon odo ro nipa awon eniyan ti ni aisan opolo? Beere nipa igbagbo ati irisi won nipa aisan opolo.

3. Nibo ni ero wipe awon ohun ti o to ma lu n fa yo nipa awon ti o ni aisan opolo?

4. Kini ero wipe on fa ihuwasi ni ona ti o to si awon ti o ni aisan opolo?

5. Kini ero wipe o je ipa ihuwasi ni ona ti o to lori awon ti o ni aisan opolo?

6. Kini ero wipe oje ojuse awon odo si awon eniyan ti o ni aisan opolo?

   Beere nipa (a) ojuse won si awon elegbe won ni ile iwe, ebi, ara, ore ti o ban aisan opolo

   (i) ni ojoojumo

(ii) ni awujo

(b) anfani ti o wa ninu riran awon eniyan ti o ni aisan opolo lowo.

7. Bawo lose ma ri lara yin ati kini e ma se bi eni ti emo ba dede ni aisan opolo?

Beere nipa bi won yio ti fe ki awon eniyan miran se pelu.

8. Nigbawo ati nibo ni e lero wipe awon ti o ni aisan opolo ti n dojuko ideyesi?

9. Iru awon ede tabi oro wo ni eyin fi nse apejuwe eni to bani aisan opolo?

10. Eje ki a jiroro lori ohun ti a lese nipa iwa ideyesi si awon eniyan ti o ni aisan opolo.

Beere nipa ipa ti olukuluku, ebi, ara ilu ati ijoba le ko ninu didekun iwa ideyesi si awon eniyan ti o ni aisan opolo.

APPENDIX 4

IRISI AII IWA TI O JE MO IDEYESI AWON ODO SI AWON ENIYAN TI O NI AISAN OPOLO NI ILOBA IBILE GUSU IWO-ORUN TI U IBADAN, NI IPINLE OYO

ATOKA IBEERE

Nomba_____

Oludahun owon.

Oruko mi ni Aina Oluwatosin, mo je akeeko agba ni Department of Health Promotion & Education, Faculty of Public Health, College of Medicine, University of Ibadan. Mo nse iwadi lori "Irisi aii iwa ti o jemo Ideyesi awon Odo si awon Eniyan ti o ni Aisan Opolo ni Iloba Ibile Gusu Iwo-orun Ilu Ibadan, ni Ipinle Oyo". Iwadi yi wa fun ikeko gboye ti Masters of Public Health (Health Promotion & Education). Abajade ise yi yio se anfani fun iyin apada nere ti o ni alafia. E jowo e mo wipe e ko ni lati ko oruko yin sori iwe ibeere yi. E jowo e turaka lati fi ero inu yin han. Ise yi ni idanileju wipe awon idahun yin yio je otun asiri. Inu mi a dun bi e bale fi otito ati ododo dahun si awon ibeere wonyi.

Ese pupo.

Aina Oluwatosin

Oruko Oluheere.....

Ojo.....

INIORAN: E jowo e fi ami yii (√) si iwaju idahun yin.

IPA KINNI

1. Se 1. Okunrin 2. Obinrin

2. Opo eri (Ojo ibi tie se koja)_____

3. E 1. Kristeni 2. Musulumi 3. Abalaye 4. Iyoku (E daruko)____

4. E ya 1. Yoruba 2. Igbo 3. Hausa 4. Iyoku (E daruko)____

5. Oruko adugbo_____

6. Nje e wa ni ile iwe? 1. Beeni 2. Beeko

7. Bi o ba je beeni, ile iwe ewo? 1. Alakobeere 2. Girama 3. Unifasiti

4. Gbogbonise 5. Iyoku (E daruko)_____

8. Bi o baje beeko, iru ise wo ni e nse? _____

IPA KEJI: IRISI AWON OBO NIPA AISAN OPOLO (E jowo e fi ami yi (√) si iwaju idahun yin).

Nu.	Gbolohun	Mo faramo	Mi o faramo	Mi o mo
9.	Aisan opolo je afowofa.			
10.	A le dena aisan opolo.			
11.	Awon eniyan ti o ni aisan opolo ma n saba dojuko ideyesi ati iwa ti o to.			
12.	O ye ki a ma ti eni ti o ni aisan opolo mo inu yara kan.			
13.	Awon ti o ni arun aisan opolo lese eniyan ni ijamba.			
14.	Awon ti o ni aisan opolo o lese ise.			
15.	Awon ti o ni aisan opolo ma n saba nilo ogun.			
16.	Awon ti o ni aisan opolo ma n saba ni iluknye kukuru.			
17.	Awon ti o ni aisan opolo ko le se aseyege ni aye won.			
18.	Awon ti o ni aisan opolo leri iloju ni ile iwosan.			
19.	Aisan opolo se wopan palapala.			

IPA KETA: IMO AWON OBO NIPA AISAN OPOLO

20. Nje e ti ri, ka tabi gbo ipolowo tabi ipolongo nipa aisan teleri?

1. Beeni 2. Beeko

21. Kini aisan opolo ni oroti yin? _____

_____

_____

22. Nibo ni e ti gbo nipa aisan opolo?

No.	Ibi	E li ami yi (√) si iwaju idahun yin.
a.	Amabinmaworan	
b.	Asoromaghesi	
c.	Iwe inuyin	
d.	Mugasini	
e.	Awon obi	
f.	Ebi	
g.	Ore	
h.	Iyoku (E daruko)	

23. Awon n kanwonyi le fa aisan opolo. E li ami yi (√) si iwaju idahun yin.

a.	Aipe opolo	
b.	Aipe eroja inu opolo	
c.	Arun opolo	
d.	Abinibi / ajogunba	
e.	Aisan ara	
f.	Emi buruku /eini ainio	
g.	Erobi o bi to omo daradara	
h.	Iforapa ni ori	
i.	Oibri	
j.	Aisan omode (ita, oru)	
k.	Siga mimu	
l.	Lilo ogun oloro (igbo, ghana)	
m.	Oti mimu	
n.	Ibaseju ti o fini lokan bale (pelu ebi, ore, ooluko ni ile iwe)	
o.	Wahala (eko, iromu tabi ise)	
p.	Ikosi ara (lilu, ija)	
q.	Isele ijaya (iku, ajalu, ijamba)	
r.	Ise	
s.	Iyoku (E daruko)	
t.	Mi o mo	

24. Awon itoju toyekoru wo ni o wa fun aisan opolo _____

25. Bawo ni esele da eni ti o ni aisan opolo mo?

26. Nje e nio enikan ti o ni aisan opolo lowo bayi? 1. Beeni 2. Beeko

27. Bi o baje beeni, bawo ni eni na se je si yin?

28. Nje eti ri wipe ara eni na ti n ya pelu itoju? 1. Beeni 2. Beeko

IPAKERIN: IHUWASI AWON ODO SI AISAN OPOLO

Ti jowo e so boya e fara mo gan, e faramo die, e ko faramo rara, e ko faramo die tabi e ko mo, si awon ibeere wonyi.

No.	Gbolohun	Mo faramo gan	Mo faramo die	Mi o faramo gan	Mi o faramo die	Mi o mo
29.	Eru nla ba mi lati ba eni ti o ni aisan opolo soro.					
30.	Okan mi o ni bale lati wa ni kilaasi kanna pelu eni ti o ni aisan opolo.					
31.	Emi ole ba eni ti o ni aisan opolo sore.					
32.	Emi o le fun eni ti o ni aisan opolo ni ohun emi mi.					
33.	Awon elegbo ti o ni aisan opolo je ki won wa ni kilasi ewe.					
34.	Mi o le se iranlowo fun eni ti o ba ni aisan opolo.					
35.	Aisan opolo je ran eniyan.					
36.	Eru nba mi lati gbe ni adugbo kaana pelu eniti o ni aisan opolo.					
37.	O ye ki nda ore waru bi ore kunrin mi tabi ore binrin mi bani aisan opolo.					
38.	O dara fun awujo bi awon eni ti o ni aisan opolo o ba bimo.					
39.	O dara fun awujo ki awon eni ti o ni aisan opolo ma sise pelu awon omode ati odo.					
40.	Oju ati mi bi awon ore mi ba mo wipe enikan ninu ebi mi ni aisan opolo.					
41.	Mi o ni so fun agbalagba kan bi mo ba ri wipe a huwa ibaje si eni ti o ni aisan opolo.					

42. Awon ero wo ni e le fi se apejuwe ems ti o ni aisan opolo? _____

_____

43. Nje aisan opolo a ma doju ti ni? 1. Beeni 2. Beeko

44. Bi o ba je beeni, ni ona wo? _____

_____

IPA KARUN: ABA

45. Kini a lese lati dekun iwa ideyesi si awon eniyan ti o ni aisan opolo ni Nai[illegible]

_____

_____

_____

_____

APPENDIX 5

DSM-IV - DIAGNOSTIC STATISTICAL MANUAL OF DISEASES: SCHIZOPHRENIA

The following specific diagnostic criteria are reproduced verbatim (except for codings and page references) from the DSM-IV.

Diagnostic Criteria for Schizophrenia

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- delusions
- hallucinations
- disorganized speech (e.g., frequent derailment or incoherence)
- grossly disorganized or catatonic behavior
- negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive Episode, Manic Episode, or Mixed Episode have occurred concurrently with

the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Subtypes

1. Paranoid Type

A type of Schizophrenia in which the following criteria are met:

- Preoccupation with one or more delusions or frequent auditory hallucinations
- None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

2. Catatonic Type

A type of Schizophrenia in which the clinical picture is dominated by at least two of the following:

- motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor
- excessive motor activity (that is apparently purposeless and not influenced by external stimuli)
- extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism
- peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures),
- stereotyped movements, prominent mannerisms, or prominent grimacing
- echolalia or echopraxia

3. Disorganized Type

A type of Schizophrenia in which the following criteria are met:

- All of the following are prominent:
  - disorganized speech
  - disorganized behavior
  - flat or inappropriate affect
- The criteria are not met for Catatonic Type.

4. Undifferentiated Type

A type of Schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type.

5. Residual Type

A type of Schizophrenia in which the following criteria are met:

- Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior
- There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Associated features

- Learning Problem
- Hyperactivity
- Psychosis
- Euphoric Mood
- Depressed Mood
- Somatic or Sexual Dysfunction
- Hyperactivity
- Guilt or Obsession
- Sexually Deviant Behavior
- Odd/Eccentric or Suspicious Personality
- Anxious or Fearful or Dependent Personality
- Dramatic or Erratic or Antisocial Personality

great variation and is by no means inevitably chronic or deteriorating (the course is specified by five-character categories). In a proportion of cases, which may vary in different cultures and populations, the outcome is complete, or nearly complete, recovery. The sexes are approximately equally affected by the onset tends to be later in women. Although no strictly pathognomonic symptoms can be identified, for practical purposes it is useful to divide the above symptoms into groups that have special importance for the diagnosis and often occur together, such as:

a. thought echo, thought insertion or withdrawal, and thought broadcasting;
b. delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;
c. hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;
d. persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);
e. persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;
f. breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;
g. catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;
h. "negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;
i. a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Diagnostic Guidelines

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time during a period of 1 month or more. Conditions meeting such symptomatic requirements but of duration less than 1 month (whether treated or not) should be diagnosed in the first instance as acute schizophrenia-like psychotic disorder and are classified as schizophrenia if the symptoms persist for longer periods.

Viewed retrospectively, it may be clear that a prodromal phase in which symptoms and behaviour, such as loss of interest in work, social activities, and personal appearance and hygiene, together with generalized anxiety and mild degrees of depression and preoccupation, preceded the onset of psychotic symptoms by weeks or even months. Because of the difficulty in timing onset, the 1-month duration criterion applies only to the specific symptoms listed above and not to any prodromal nonpsychotic phase.

The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedated the affective disturbance. If both schizophrenic and affective symptoms develop together and are evenly balanced, the diagnosis of schizoaffective disorder should be made, even if the schizophrenic symptoms by themselves would have justified the diagnosis of schizophrenia. Schizophrenia should not be diagnosed in the presence of overt brain disease or during states of drug intoxication or withdrawal.

APPENDIX 7

DSM- IV CRITERIA - MAJOR DEPRESSIVE DISORDER

According to the *DSM-IV*, a person who suffers from major depressive disorder must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a two week period. This mood must represent a change from the person's normal mood, social, occupational, educational or other important functioning must also be negatively impaired by the change in mood. A depressed mood caused by substances (such as drugs, alcohol, medications) or which is part of a general medical condition is not considered to be major depressive disorder. Major depressive disorder cannot be diagnosed if a person has a history of manic, hypomanic, or mixed episodes (e.g., a bipolar disorder) or if the depressed mood is better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder or psychotic disorder. Further, the symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one) and the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

This disorder is characterized by the presence of the majority of these symptoms:

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 of body weight in a month), or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day

- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Source: American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th edition. Washington, DC: American Psychiatric Association, 1994

APPENDIX 8

ICD -10 CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS
WORLD HEALTH ORGANIZATION, GENEVA, 1992

RECURRENT DEPRESSIVE DISORDER

The disorder is characterized by repeated episodes of depression as specified in depressive episode (mild, moderate, or severe), without any history of independent episodes of mood elevation and overactivity that fulfill the criteria of mania. However, the category should still be used if there is evidence of brief episodes of mild mood elevation and overactivity which fulfill the criteria of hypomania immediately after a depressive episode (sometimes apparently precipitated by treatment of a depression).

The age of onset and the severity, duration, and frequency of the episodes of depression are all highly variable. In general, the first episode occurs later than in bipolar disorder, with a mean age of onset in the fifth decade. Individual episodes also last between 3 and 12 months (median duration about 6 months) but recur less frequently. Recovery is usually complete between episodes, but a minority of patients may develop a persistent depression, mainly in old age (for which this category should still be used). Individual episodes of any severity are often precipitated by stressful life events. In many cultures, both individual episodes and persistent depression are twice as common in women as in men.

The risk that a patient with recurrent depressive disorder will have an episode of mania never disappears completely, however many depressive episodes he or she has experienced. If a manic episode does occur, the diagnosis should change to bipolar affective disorder. Recurrent depressive episode may be subdivided, as below, by specifying first the type of the current episode and then (if sufficient information is available) the type that predominates in all the episodes.

Includes:

- recurrent episodes of depressive reaction, psychogenic depression, reactive depression, seasonal affective disorder
- recurrent episodes of endogenous depression, major depression, manic depressive

psychosis (depressed type), psychogenic or reactive depressive psychosis, psycholic depression, vital depression

Excludes:

- recurrent brief depressive episodes

Source: http://www.mentalhealth.com/p.html ICD-10 Copyright by World Health Organization

psychosis (depressed type), psychogenic or reactive depressive psychosis, psychotic depression, vital depression

Excludes:

- recurrent brief depressive episodes

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