

**A STUDY OF SOCIAL STIGMA AND DISCRIMINATION AGAINST PEOPLE  
LIVING WITH MENTAL ILLNESS IN BENUE STATE, NIGERIA**

**BY**

**Terungwa, MPEM  
B.Sc. (BSU, 2005), M.Sc. (BSU, 2012)  
P16SSSG9077**

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**MAY, 2021**

## DECLARATION

I declare that the work in this thesis entitled “**A Study of Social Stigma and Discrimination against People Living with Mental Illness in Benue State, Nigeria**” has been carried out by me, in the Department of Sociology, Faculty of Social Sciences, Ahmadu Bello University, Zaria. The information derived from the literature has been duly acknowledged in the text and list of references provided. No part of this thesis was previously presented for another degree or diploma at this or any other institution.

Terungwa, MPEM

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**Signature**

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**Date**

## CERTIFICATION

This thesis entitled “A STUDY OF SOCIAL STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH MENTAL ILLNESS IN BENUE STATE, NIGERIA” by Terungwa MPEM meets the regulations governing the award of the degree of Doctor of Philosophy (PhD) Degree in Sociology of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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Dr. J. M. Hellandendu  
Chairman, Supervisory Committee

---

Date

---

Prof. B. Tanimu  
Member, Supervisory Committee

---

Date

---

Dr. V. O. Olisah  
Member, Supervisory Committee

---

Date

---

Dr. E. C. Akpa  
Head of Department

---

Date

---

Prof. Sani Abdullahi  
Dean, School of Postgraduate Studies

---

Date

## **DEDICATION**

This work is dedicated to my beloved parents: my late father, Mpem Amaigbe, and my mother, Mfaze Mpem, for the support and sound foundation they laid for me during my days in school. The work is also dedicated to my beloved wife, Mrs. Esther Mgunengen Mpem, and my loving children: Blessing Iveren Mpem, Christopher Kpamor Mpem, Jacob Mpem and Anita Doomater Mpem. Thanks for your prayers and support.

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## ABSTRACT

*Mental healthcare is not given the desired attention like other illnesses in Nigeria. The existing psychiatric hospitals are only concentrated in the urban areas and laws to protect the rights of people with mental illness against stigma and discrimination are ineffective. There is lack of coordinating mechanism to take care of public education on mental illness. Consequently, people with mental illness and their family members are therefore left to suffer alone. Furthermore, they also have to contend with the symptoms of the disease on one hand and the stereotype and prejudice due to misconception about mental illness on the other. As a result, they internalize public stigma and become devalued members of the society. This study examined public attitude towards mental illness. The study examined the prevalence of internalized stigma against people with mental illness. The study examined the level of discrimination of people living with mental illness by mental healthcare professionals. The study also examined the stigma experienced by family members of people with mental illness and the strategies they use to cope with stigma. The labeling theory of mental illness was adopted as a theoretical frame work for the study. Data were collected in six selected local government areas in the State, Benue State University Teaching Hospital, Federal Medical Center Makurdi and six traditional psychiatric hospitals. A survey questionnaire was administered to 400 members of the public, 468 people living with mental illness, 468 caregivers and 69 mental health care professionals. In-depth Interviews were held with people living with mental illness, their family members and mental health care professionals. Data collected were analyzed using SPSS version 23. The findings revealed that members of the public have negative attitude towards mental illness. This was demonstrated through the unwillingness of members of the public (54.3%) to associate with the mentally ill, to entrust sensitive tasks like babysitting to them (64.6%) and to marry persons who had once suffered from mental illness (58.3%). The study also revealed that 67.9% of the people suffering from mental illness had elevated internalized stigma. People living with mental illness who received traditional health care had elevated stigma scores more than those who attended orthodox ( $t = 4.404$ ,  $df = 466$ , sig. 2 tailed ( $p) = 000$ ). Nurses and social workers with mean rating of 2.94 and standard deviation of 0.87, 2.94 and standard deviation of 0.97 respectively exhibited more negative attitude. It was also revealed through in-depth interviews with people having mental illness that they took overdose of the drugs from the hospitals to forget about the public stigma they experienced. It was recommended that government and non-governmental organizations should embark on public awareness to educate members of the public about mental illness. It was also recommended that government and non-governmental organizations should undertake psycho educational programs and counseling targeted at people with mental illness receiving traditional psychiatric care. Anti-stigma courses should form an integral part of the training curricular of medical schools. Stigma of mental illness remains a major challenge to the individual with mental illness, their family members and the society at large because it affects productivity. Consequently, concerted effort should be made to end stigmatization and discrimination of mental illness.*

**Key words: Stigma, Mental Illness, Internalized Stigma, Public, Family Members, Benue State**

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## **CHAPTER ONE**

### **1.0 Introduction**

#### **1.1 Background to the Study**

Mental illness is a term used as a general description for persons who exhibit persistent abnormal behavior (Corrigan, *et al.*, 2005). The illness affects adversely the normal condition of the mental, psychological and emotional make up of the affected person, which makes capacity of insight, orientation, judgment, thought, mood and perception very blurred and disoriented (World Health Organization, 2001). It is a health condition that affects how a person feels, thinks, behaves and interacts with other people (Ihaji, *et al.*, 2013).

Mental illness is generally responsible for 14 percent of the world's disease burden (WHO, 2013), and this is expected to increase by 15 percent by the year 2020 (Hugo, *et al.*, 2003). According to WHO (2012), an estimated 25 percent of the world population suffer from one form of mental disorder in their lifetime. Mental illness conditions are linked with about one quarter of the disabilities in the world (Andrews, *et al.*, 1998), and 75% of those affected are found in low income countries. It has also been reported by Kessler, *et al.*, (2001) that in spite the high prevalence of mental health illness in the world, only about 30 to 40 percent of people living with mental illness seek treatment due to the stigma and discrimination. The prevalence of mental illness in Nigeria is approximately 20%, and this shows that with a population of about 174 million in 2013 (World Bank, 2013), about 35.4 million Nigerians might have been suffering from mental illness (Oyewunmi, *et al.*, 2015).

Mental illnesses are of different types and they affect victims in varying degrees of severity. They differ in terms of the etiology, symptoms, prognosis and their therapy (Olubumi, 2009). Some of the major types of mental illnesses include mood disorders, anxiety disorders, personality disorders, psychotic disorders, traumatic related disorders, substance abuse disorders and eating disorders etc. The basic manifestations of mental illness include unremitted deviations in virtually all aspects of social behavior like inappropriate affect, bizarre behavior, language irregularity, poor social skills, mood swings, and alteration in thinking and acting etc. (WHO, 2012). People with psychotic disorders, mood disorders and substance abuse disorders are more likely to be perceived as violent and unpredictable by members of the public and are highly stigmatized compared to people with other mental health disorders (Thornicroft, *et al.*, 2009).

Members of the public believe that people who have suffered from mental illness are incompetent and dangerous, especially those with psychosis, mood disorders, and drug dependence. Because of this, people show negative attitude towards them. People also believe that mental health conditions like substance abuse and eating disorders are self inflicted by the affected person; therefore, members of the public show less sympathy and negative attitude to people that exhibit such abnormalities (Michaels, *et al.*, 2012).

Most people in Nigeria attribute mental illness to supernatural powers, wrath from ancestral spirits and gods (Hailemariam, 2015). Lack of knowledge, belief system, superstition, the fear and exclusion of people who are perceived as being different, misconception, lower educational levels, less professional experience by health care professionals, low familiarity with the experience of mental illness have also been identified as factors related to stigmatizing behavior towards people with mental illness (Mainas and Diatri, 2008; Adewuya, *et al.*, 2010; Kluit and Goossens, 2011; Baffoe,

2013; Ahmed, *et al.*, 2014). Nyamongo (2013) added that wars, poverty and natural disasters have influence on mental health and psychosocial well being of the people.

Members of the society may accept stereotypes about mental illness and act on the basis of these stereotypes by blocking mentally sick people's access to life chances that define a desirable life; such chances include employment, educational opportunities, satisfactory health care, and safe housing. Members of the public may also discriminate against people living with mental illness by avoiding even basic social contact with them, and by refusing to marry from families who have a mentally sick member (Cifti, *et al.*, 2013). When one comes from a family with a mentally ill person, any deviant behavior one exhibits is attributed to the mental illness found in the family. Consequently, people living with mental illness gradually internalize the public stereotype and experience diminished self esteem, self efficacy and disempowerment. This may affect people with mental illness in seeking for treatment (Khan, *et al.*, 2011), recovery from the illness, integrating with other members of the society, and seeking for employment (Stuart, 2008).

Stigmatizing attitudes against people with mental illness are not limited to lay members of the public. Mental health care professionals too hold negative feelings towards people with mental illness (Hansson, *et al.*, 2013). According to Horsefall, *et al.*, (2010), people living with mental illness who received treatment in traditional and psychiatric hospitals experienced stigma and discrimination due to forced interventions associated with mental health treatment from psychiatric doctors. This involves the use of coercive forms of treatment like chaining, seclusion, physical restraints, intrusion on the private lives of people with mental illness, forced psychotropic medication, rejection, beating and restrictions (Valimaka, *et al.*, 2001).

The stigma and discrimination against people living with mental illness also affect family members of the affected persons. This is what Goffman (1963) called courtesy stigma or stigma by association (Phelan, *et al.*, 1998). They suffer from the mental condition of their sick member through associating with the sick person. Family members complained that they were blamed for the illness of their member, so that they felt ashamed of having a mentally ill person in the family (Larson and Corrigan, 2008).

The experience and expectation of stigma may influence people with mental illness and their family members to adopt measures to cope with the threat of discrimination. Some of the people with mental illness may decide to conceal their treatment to avoid being laid off by their employers. Others may choose to restrict or withdraw from their social interaction with people to avoid being identified as persons living with mental illness, while some may select a small group of people to whom they disclose their problems (Larson and Corrigan, 2008). The cost of disclosure, non disclosure, selective disclosure can expose the stigmatized person to lost opportunities to receive support, risk of rejection from members of the public and others may attempt to provide non-stigmatized members with the necessary awareness on the nature of mental illness (Hamilton, *et al.* 2011).

Statistics on the distribution of population by sex and type of disability showed that there were 6,624 people living with mental illness in Benue state (NPC, 2009). Furthermore, records from the psychiatric unit of the Federal Medical Center Makurdi (FMC Records, 2015) showed that from 2005 to 2015, 112,200 people visited the hospital for treatment of mental illness. At the Benue State University Teaching Hospital Makurdi, 395 in 2013, 44 in 2014 and 643 in 2015 attended the hospital for treatment of mental illnesses (Health Information Management Department BSUTH,

2016). Similarly, a study by Tormusa, (2015), in Benue and Nassarawa states of north central Nigeria revealed that citizens believed that mental illnesses is stigmatized. According to the study, citizens believed that mental illness cannot be completely cured, and that when a person comes from a family with a history of mental illness, any deviant behavior a member exhibits is linked to the mental illness found in the family, and people think the person has been affected by the mental illness as well.

The WHO (2001) highlighted the harm resulting from stigma and discrimination against people with mental illness. The organization argued that people with mental illness experience isolation, loneliness and rejection from friends, relatives, neighbors and employers. At the global level, efforts have been made to combat stigma and discrimination against people with mental illness. The International Convention on the Rights of Persons with Disabilities requires that signatories to the convention adopt all appropriate legislative and administrative measures for the implementation of the rights stated in the convention. They are also to take steps to abolish laws, regulations, customs and practices that discriminate against the interest of persons with disabilities (UN, 2003).

Mental illness is also discussed in the World Health Report (2001) entitled, *New Understanding, New Hope*, which highlights the problem of stigma and discrimination against people with mental illness. The report clearly demonstrated the benefit of working with social net-works in order to accord equal opportunities to all members of the society. The report stressed that the principle of social integration of all persons must be incorporated into all major interventions related to disability issues.

Article 19 of the United Nations Convention on the rights of persons with disabilities indicated that all persons with disabilities have the right to live in the community, and to choose their place of residence. The article further stated that Member State should facilitate the full participation in the community of persons with disabilities (UN, 2003). The European human rights particularly included several components that focus on issues that are critical for people with mental disorders. These components included the convention for the protection of human rights and fundamental freedoms like education, employment, social and legal promotion, free movement and non- social discrimination etc (Caldas, *et al.*, 2011). Nigeria is a signatory to the United Nations Convention on People with Disabilities. The country formulated a mental health policy in 1991, which included the following components: advocacy, promotion, prevention, treatment and rehabilitation of people with mental illness.

Given that mental health is an important precursor of human development, the issues of stigma and discrimination need to be properly addressed.

## **1.2 Statement of the Research Problem**

The WHO (2013) estimated that the prevalence of mental illness in Nigeria is approximately 20%, this means that with a population of about 174 million in 2013, (World Bank, 2013), about 35.4 million Nigerians are suffering from mental illness (Oyewunmi, *et al.*, 2015). Unfortunately despite this scary statistics, less attention is given to mental health disorders in Nigeria, compared to other diseases like HIV AIDS, Corona, Ebola, tuberculosis. There is also poor awareness of members of the public on mental health issues in Nigeria (WHO-AIMS Report, 2012).

In 2001, Nigeria and 20 other member nations of the African Union signed the Abuja declaration that promised to earmark 15 percent of their federal budgets for healthcare. But WHO-AIMS report (2012) indicated that Nigeria had not made any sufficient progress towards that target. And by 2018, just 3.95% of the Nigeria's budget was allocated to funding Ministry of Health, out of which only 3.3% was allocated to mental health; this is no doubt insignificant considering the enormity of mental health problem in Nigeria.

Apart from the problem of funding, there is also the problem of trained personnel. The WHO- AIMS report (2011), estimated that only 3,195 mental health professionals were working in mental health care facilities in the Nigeria, which means there were just over 11 mental health professionals per 100,000 people. Of this number, there were only 42 psychiatrists (0.15 per 100,000) and 20 psychologists (0.07 per 100,000).

This means there is lack of specialized personnel for mental health care in Nigeria. The report observed further that there is no extant legislation or policy on mental health in Nigeria. The existing Mental Health Policy document in Nigeria was formulated in 1991, and has not been revised. Moreover, Nigeria is still governed by the Lunacy Act, passed in 1958. The law is antiquated and manifestly not in tune with prevailing realities and best practices in mental health treatment. Thus, there is no direct legal framework to protect the rights of people with mental illness against unhealthy practices like involuntary admissions, discrimination which entails denial of employment, housing, etc and the lack of government social safety network to take care of mentally ill persons (Onyemelukwe, 2016). Family and patient associations, non-governmental organizations which focused on counseling, offering social support to people with mental health issues do not exist in Nigeria. There is absence of a coordinating

mechanism to take care of public education and awareness campaigns on mental health and mental disorders in Nigeria (WHO AIMS report, 2012). This means that People with mental illness and their relatives are left to bear the burden of the disease alone. This is the stark reality of the problems people with mental illness face in Nigeria.

Apart from the problems highlighted above, people with mental illness also suffer a double challenge as a result of their mental illness. First they suffer from symptoms of the disability like hallucinations, delusions, anxiety and mood swings; the symptoms of the disease affect him in engaging in a paid jobs and other aspect of social life. Second, people with mental illness are challenged by the stereotype and prejudice from the public misconceptions about mental illness (Michaels, et al., 2012). Members of the public generally have negative attitude towards people living with mental illness, these negative attitudes are fuelled by public misconception and beliefs about mental illness. These misconceptions include the belief that people with mental illness are dangerous, unpredictable, worthless, and that the disease is incurable (Abasiubong, *et al.*, 2007). To compound the problem of people with mental illness, members of the public view them as evil and responsible for their mental disorders. People with mental illness that have been treated in the hospitals and have recovered still face tremendous difficulties accessing jobs from employers, housing from landlords and meaningful social interaction from members of the public, because of stigma and discrimination (Jack-Ide and Middleton, 2012).

A study by Tormusa (2015) among some ethnic groups in Benue and Nassarawa States revealed that stigma and discrimination is prevalent among the Tiv people of Benue State. According to the study, it is believed among the Tiv people that people who have suffered from mental illness cannot get well again, that they have lost the ability to

think and act well and cannot be assigned leadership tasks. Another study by Ihaji *et al.*, (2013) among the Tiv people of Benue State shows that mental illness is hereditary in families. However these studies did not consider the views of the people in other ethnic groups in Benue State. There is therefore the need to obtain a broader knowledge about stigma and discrimination among the people in the ethnic groups in the State. Knowledge about attitude of members of the public will help in developing programs for reducing stigma and discrimination of mental illness.

The major consequence of society's stigma is that people with mental illness gradually begin to internalize the stigmatizing attitudes, which tend to erode previously held opinions about themselves. During this process, the stigmatized persons acquire dominant illness identity, this affects their self concept; they adopt coping strategies as a result of the public stigma by concealing their illness and not seeking treatment. As a result of this concealment, a vicious circle of isolation and abandonment is formed, impacting negatively on the domains of life and affecting chances of recovery and integration into normal life (Link, *et al.*, 1997). However, much attention has been placed by researchers on public attitude towards mental illness while the real experiences of people who suffer from public stigma are not given the desired attention. Knowledge of the experiences of internalized stigma can help to develop intervention to help people with mental illnesses overcome the psychological and social effect of public stigma.

Mental health care professionals, both orthodox and traditional, are in constant contact with people with mental illness, because they provide health care services to them. With the constant contact they have with people having mental illness, it is expected that mental healthcare professionals should exhibit a better attitude towards people with

mental illness seeking healthcare. However, people with mental illness who have visited health care for treatment complained of prejudice and negative treatment against them by mental healthcare professionals. They have also complained that the attitude of mental health care professionals towards them have exacerbated the stigma that they experienced, through practices such as forceful treatment, chaining, restricting them, avoiding contact with them, and adopting a paternalistic stance towards them (Stuart, *et al.*, 2012). A study on the attitudes of doctors towards people with mental illness in Western Nigeria by Adewuya and Oguntade, (2007), shows that Doctors too have negative attitude towards people with mental illness. The study further reveals that the medical Doctors considered people with mental illness to be unpredictable, dangerous, without self-control and aggressive, similar to the perceived public views in very many countries. The attitude of health care professionals towards people with mental illness is vital, remains a barrier to quality care, treatment and recovery and could affect the quality of mental health services and readiness to provide wholesome interventions for individuals with mental illness. While there is evidence in literature that there is stigma of healthcare professionals, the reasons for their negative attitude towards people with mental illness in Nigeria have not adequately been examined by literature.

In Nigeria, specialist mental health care hospitals are few and located in State capitals, isolated from rural areas and therefore inaccessible to the rural people. Apart from the problem of accessibility, cost of treatment of mental health care is also a major constraint for accessing professional mental health care. Because of these constraints, most of the people with mental health challenges in the rural areas patronize traditional and mental health care services that are accessible and affordable to them (Coker, *et al.*, 2015). For example in Benue State, Federal Medical Center Makurdi and Benue State University Teaching Hospital Makurdi are all situated in Makurdi, the State capital, far

away from people in the rural communities. It was observed that most people accessed traditional health care for treatment because of the distance to Makurdi. Even at the traditional psychiatric care, people with mental illness are subjected to the most dehumanizing treatment at these treatment centers. An evidence of the bad treatment meted to people with mental illness was presented by Attoh (2013), based on his observation at a mental health healing center at Ogbunike in Anambra state, Nigeria. Mental patients were chained to the ground, under the trees or in some uncompleted and unroofed structures and were not released from the chains no matter the weather conditions. They were subjected to inhuman treatment like beating with palm-fronds, which are believed to have the power to drive away the demons that cause mental problems. After the beating, “holy” pungent liquids are poured into their eyes and nose, commanding them to sniff it in or else face more beating.

While literature on stigma is available, literature on stigma of traditional mental health care professionals towards people that attend treatment in traditional psychiatric treatment is scanty. In order to effectively provide care for people with mental illness, the attitudes of health professionals towards psychiatric patients are important and needed to be evaluated.

Social stigma does not only affect people with mental illness. It also impact negatively on their family members' social relationships as well, through what Goffman (1963) refers to as courtesy or associative stigma. Family members associate closely with their relatives who suffer mental illness and are involved in help-seeking and treatment decisions concerning their sick relatives. Family members of people with mental illness stay with them in the same compound take them to the hospital and take care of them

when they are sick. Because of their closeness to their sick relative, members of the public direct prejudice against them too.

The prejudice directed against family members of people with mental illness can impose a discrediting negative effect on them, with consequences of social isolation, status loss, discrimination and hiding of their sick relative, which in turn may result to delay in seeking treatment. All of these may result in poor quality of life, depression and increased emotional burden on family members (Ohaeri and Fido, 2001). A study by Catthoor *et al.*, (2015) reveals that family members of people with mental illness reported that they tried to hide the mental illness of their relative always. The family members also reported being excluded from decision making process, being blamed for the affected person's illness, and being avoided by members of the community. While it is known that family members suffer from prejudice as a result of associative stigma, not much is known about the facilitators and barriers to courtesy stigma and coping strategies among family members. Furthermore, much research have been done on stigma of mental illness, but most of the studies have mainly focused on the individuals with mental illness thus, neglecting the family members who are also affected by this stigma. It can therefore be stated that literature has not focused adequately on the stigma faced by family members of people with mental illness, especially in Benue State. Better understanding of experienced and self-courtesy stigma will reduce and alleviate the psychological distress and isolation that family members often experience, assist members of the public to show more empathy to family members of people with mental illness and help shape public policy in the prevention of stigma in patients and their family members.

There is therefore a need to carry out a study in the study area to fill the identified gaps in knowledge on the social stigma and discrimination against people living with mental illness.

### **1.3 Research Questions**

Derived from the statement of the problem, the following research questions were stated to aid the study:

- i. What is the attitude of members of the public towards people living with mental illness in Benue State?
- ii. What is the level of internalized stigma among people living with mental illness in Benue State?
- iii. Do mental health care professionals also discriminate against people living with mental illness?
- iv. How do stigma and discrimination affect the family members and relatives of people living with mental illness in Benue State?
- v. What are the coping strategies employed by people living with mental illness in managing stigma and discrimination?
- vi. How can the stigma and discrimination against people living with mental illness be reduced in Benue State?

### **1.4 Objectives of the Study**

The main objective of this study was to examine the social stigma and discrimination against people living with mental illness. The specific objectives are:

- i. To determine the attitude of members of the public towards people living with mental illness in Benue State.
- ii. To investigate the prevalence of internalized stigma among people with mental illness in Benue State.
- iii. To examine the level of discrimination against people living with mental illness by mental health care professionals.
- iv. To investigate how stigma and discrimination affect the family members of people living with mental illness in Benue State.
- v. To identify the strategies used by people living with mental illness in coping with stigma and discrimination.
- vi. To ascertain possible areas of intervention for reducing social stigma attached to people living with mental illness and their families in Benue state.

### **1.5 Significance of the Study**

The problem of social stigma and discrimination against people with mental illness and their family members have been the concern of governments, individuals and nongovernmental organizations. However, the goal of reducing social stigma and discrimination has not been achieved because of the attitude of members of the public against people with mental illness. Studies have been conducted on stigma of mental illness among the Tiv people, but studies on social stigma among the ethnic groups in Benue State have not been given attention. Moreover, the experiences of people who suffer from mental illness and their family members have not been given attention. This study therefore examined the attitude of the ethnic groups in Benue State towards people with mental illness, the experiences of people who suffer from mental illness and their family members. The result of this study served both theoretical and practical

purposes. Theoretically, the study gave an insight into the social stigma and discrimination prevalent among the ethnic groups in Benue State. The study also brought to fore the experiences of people suffering from mental illness as a result of public stigma, especially those treated at the traditional psychiatric centers. This has no doubt added to literally knowledge on social stigma and discrimination against mental illness.

This study is important to policy formulation because it revealed that the prevalence of elevated internalized stigma among the people living with mental illness who attended traditional health care is more than those who attended orthodox care. This finding is important to policy formulation because further interventions to reduce social stigma should include people receiving traditional psychiatric care.

Furthermore, social advocates, campaigners and activists for the rights of the mentally sick may find the work helpful as the recommendations of the study help them focus their anti stigma campaigns on not just members of the general public but on family members of people living with mental illness as well. Members of the public may be interested in the work because it may help them have a better understanding of stigma against people living with mental illness.

## **1.6 Scope and Delimitation of the Study**

The study examined social stigma and discrimination towards people living with mental illness and their family members in Benue State, Nigeria. Specifically, the study examined the attitudes of members of the public in Benue State towards people with mental illness and their family members. The study also determined the prevalence of

internalized stigma among people living with mental illness accessing treatment at both orthodox and traditional psychiatric health care centres. The study also determined attitude of healthcare professionals towards people living with mental illness. The scope also included identifying the strategies used by people living with mental illness to cope with stigma and discrimination, and suggesting possible areas of intervention to reduce stigma.

### **1.7 Justification of the Study**

The study was carried out to examine social stigma and discrimination against people living with mental illness in Benue State. This study was carried out to provide an understanding of the attitude towards mental illness among the different tribes in Benue State. The study was essential because it served as a baseline for the developing of awareness among members of public and healthcare professionals about stigma and discrimination of mental illness.

### **1.8 Limitations of the Study**

The study had the following limitations. First, the study was carried out in only two orthodox hospitals in Benue State: Benue State University Teaching Hospital Makurdi and Federal Medical Centre Makurdi, and in six traditional psychiatric hospitals in Benue State. Hence, the findings cannot be generalized; this is because the study setting, sample size and particulars of people with mental illness receiving care in the hospital, especially their social class, were not representative of the entire population. This also means that only people with mental illness receiving care at these health centers were included in the study, if a survey were made of people affected by mental

illness not receiving care in hospital, different results could be obtained. Secondly, the study is a cross-sectional study, which is just a snapshot of what took place within the time of the study. A different result could be obtained if the study were longitudinal.

Notwithstanding these limitations, the strength of this present study lies in its large sample size and its ability to study different ethnic groups in Benue State which have brought out varied perspectives in the study of stigmatization of mental illness. Moreover, the study used a mixed method and this is expected to produce a better result.

### **1.9 Operational Definition of Terms**

**1.9.1 Social stigma.** For the purpose of this study, social stigma is used to refer to negative behavior of members of the public towards a person with an attribute that violates the norms of the society for example, a person who has mental illness.

**1.9.2 Social stigma of mental illness.** For the purpose of this study, the social stigma of mental illness refers to a negative perception and reaction against a person who has lost social status as a result of having suffered from mental illness and is thus devalued, and considered inferior by members of the public. Such a person carries the label wherever he or she goes. Such a person is referred to as “mad” “crazy” “lunatic”. The social stigma is manifested when members of the public refuse to associate with them, refuse to give them responsibilities, use of denigrating words against such persons, refusing to marry from families with members who are suffering from mental illness, and refusing to share accommodation with those affected.

**1.9.3 Discrimination of mental illness.** For the purpose of this study, discrimination refers to how people are scorned or treated unfairly in the society because they have mental illness.

**1.9.4 Mental illness.** Mental illness is here referred to as “ihundugh” in Tiv language and is synonymous to mental disorder and psychiatric disorders. These concepts will be used interchangeably except where otherwise stated. For the purpose of this study, mental illness refers to a disease that affects the mind, mood, brain and behavior of the affected person and involves a change in emotion, thinking and is characterized by awkward and bizarre behavior such as talking to oneself, mood swing, untidy appearance, inappropriate effect and often disruptive behavior which makes the person less acceptable by members of the public. Mental illness is derogatively known by different names such as craziness, lunacy, madness, abnormality etc. As used in this study, mental illnesses refer to: mood disorders (such as depression or bipolar disorder), personality disorders, psychotic disorders (such as schizophrenia), trauma-related disorders (such as post-traumatic stress disorder) substance abuse disorders. These groups of mental illness are chosen because they are perceived to be aggressive and dangerous and are therefore stigmatized and discriminated more by members of the public more.

**1.9.5 Family members.** These are also referred to as caregivers or significant others. These are individuals who are biologically or socially related and who have been living with the person having mental illness for a period of six months or more. They include father, mother, sister, brother, son, daughter and other family members or friends.

**1.9.6 People living with mental illness** or mentally sick persons refers to individual(s) who are 18 years and above and have been diagnosed with mood disorders (such as depression or bipolar disorder), personality disorders, psychotic disorders (such as schizophrenia), trauma-related disorders (such as post-traumatic stress disorder), substance abuse disorders, have been treated for a period of one year or more and recovered and are well enough to engage in an intelligible discussion as adjudged by an orthodox or traditional psychiatric doctor. These groups of mental illness are chosen because the patients are perceived to be aggressive and dangerous and are therefore stigmatized and discriminated against by members of the public.

**1.9.7 Public attitude towards people with mental illness.** For this study, it refers to negative or positive behavior of members of the community towards people with mental illness.

**1.9.8 Internalized stigma of mental illness** refers to an endorsement of the negative behavior of members of the public towards people having mental illness.

**1.9.9 Stereotypes** are defined as negative expectations of members of the public about a person with mental illness.

**1.9.10 Prejudice** refers to unpleasant emotional affective attitude towards people with mental illness. It implies association with derogatory or pejorative attitude

## CHAPTER TWO

### 2.0: Literature Review and Theoretical Framework

#### 2.1 Public attitude towards mental illness

Nigeria formulated a mental health policy for the first time in 1991 with the following components: advocacy, promotion, prevention, treatment, and rehabilitation. The policy recommended among other things that persons with mental, neurological and psychosocial disorders should have the same rights to treatment as individuals with physical illnesses, elimination of stigma through the promotion of positive attitudes towards the mentally ill in the general population (WHO- AIMS Report, 2006). Long after this policy was formulated, available literatures suggest that much progress has not been made to address the issue of stigma of mental health around the world. Literature on mental health shows that stigma and discrimination by members of the public remains a major challenge faced by people with mental illness among all nations of the world.

For example, a study by Link, *et al.*, (1997) on stigma and its consequences with evidence from a longitudinal study of men diagnosed with mental illness and substance abuse, revealed that 72% of employers interviewed disclosed that they would not employ a person with a history of mental illness, while 6% of the former employees reported having lost their jobs as a result of having mental illness.

In a study by Latalola, *et al.*, (2014), respondents revealed that they would not employ a person who had suffered from mental illness to care for their children even if the symptoms had disappeared. This shows lack of public trust in the ability of people with

mental illness to recover well and perform social roles. This lack of public trust in the ability of people living with mental illness to recover fully is also expressed by public institutions. Employers for example expressed concern over the ability of people living with mental illness to maintain work ethics such as regularity and punctuality, the ability of the mental patients to follow work regulation, e.g. trusting the employee with information, and also clinical issues such as severity of illness and incidences of relapse (Biggs, *et al.*, 2010). Similarly, studies by *Struch, et al.*, (2008) on stigma experienced by persons with mental illness showed that fewer people (20%) expected employers to be willing to employ a person who has been discharged from a mental hospital, and only 17% of the participants disclosed that they would be willing to have a person with mental illness as their boss at work. The negative perception by members of the public is based on deep rooted beliefs and misconception about mental illness.

A study of employers' attitudes towards mental illness by *Corrigan, et al.*, (2005), shows that people living with mental illnesses are not normally considered for employment. According to *Konzin and Eaton* (1994), people living with mental illness are more likely to miss work than those who suffer other forms of disabilities. Given this public perception and behavior, even when people with mental illness are employed, their mean wages are significantly less than those of people who have never had mental illness doing the same jobs (*Baldwin and Marcus*, 2006). However, *Thornicroft, et al.*, (2013) have stated that refusing to offer employment to people with mental illness may vary from one country to another depending on the extent of the attitude towards mental illness; the rates of unemployment among people with mental illness will therefore vary considerably across cultures and countries. With the negative attitude of members of the public, People with mental illness are likely to encounter

devaluation, discrimination, social exclusion and social distance from members of their community at large (Pamela, 1999; Corrigan, 2004b; Byrne, 2001).

A study by Mostafa, *et al.*, (2018), aimed to determine levels of knowledge, perception, and attitudes toward mental illness among the Saudi public. The study was across-sectional survey conducted on 650 Saudi adults aged >18 years who attended the Saudi Jenadriyah annual cultural and heritage festival during February 2016. The previously validated Attitudes to Mental Illness Questionnaire were used. Multiple regression analyses were applied, and statistical significance considered at  $P < 0.05$ .

The study revealed that majority of the Saudi public reported lack of knowledge about the nature of mental illness (87.5%, percentage mean score  $45.02 \pm 19.98$ ), negative perception (59%,  $59.76 \pm 9.16$ ), negative attitudes to mental illness (66.5%,  $65.86 \pm 7.77$ ), and negative attitudes to professional help-seeking (54.5%,  $62.45 \pm 8.54$ ). Marital status was a predictor of knowledge ( $t = -3.12$ ,  $P = 0.002$ ), attitudes to mental illness ( $t = 2.93$ ,  $P = 0.003$ ), and attitudes to help-seeking ( $t = 2.20$ ,  $P = 0.03$ ). Attitudes to help-seeking were also predicted by sex ( $t = -2.72$ ,  $P = 0.007$ ), employment ( $t = 3.05$ ,  $P = 0.002$ ), and monthly income ( $t = 2.79$ ,  $P = 0.005$ ). Perceptions toward the mentally ill were not predicted by these socioeconomic characteristics ( $P > 0.05$ ).

The study concluded that the Saudi public reported lack of knowledge of mental illness and stigmatizing attitudes toward people with mental illness in relation to treatment, work, marriage and recovery, and toward professional help-seeking. Socio-demographic characteristics predicted correct knowledge and favorable attitudes, while Saudi culture was the likely factor behind negative judgments about mentally ill persons. The study recommended that negative publicity and stigma should be challenged through anti

stigma campaigns and public education in schools and mass media were. However the cross-sectional nature of the data did not allow a strict causal interpretation of the results.

In a similar vein, studies by Elbur, *et al.*, (2014), on relatives' perception of mental illness, services and treatment in Tiaf, Saudi Arabia, revealed that over 65% of the relatives agreed that they could maintain a friendship with a mentally ill person, and only 72 (27.1%) of the relatives agreed to marry a person who has suffered from mental illness. The different results show that the experience of people living with mental illness in social life is not always negative.

A study by Zolezzi, *et al.*, (2017), on stigma associated with mental illness in Qatar used a convenience sample of students. A total of 282 students completed the survey. The result of the study revealed that there is poor attitude and beliefs about mental illness. Beliefs reflecting poor mental health literacy, such as “medications to treat mental illness can cause addiction”, “mental illness is not like any other illness”, or that “mental illness is a punishment from God”, were reported by a majority of students (84.4%, 56.7%, and 50.2%, respectively). Stigmatizing attitudes that were endorsed by a majority of students included believing that people with mental illness cannot have regular jobs (60.2%), that people with mental illness are dangerous (65.7%), and that they would not marry someone with a mental illness (88.9%). Additionally, 33.6% of students indicated they would be ashamed to mention if someone in their family had a mental illness. A vast majority of students (86.3%) indicated to prefer family and friend's support as treatment options. However, the sample of the study was small and as such, larger studies from a randomly selected population are needed to confirm these findings. A study by Eyasu, *et al.*, (2018) examined attitudes towards mental illness

among senior secondary school students in Asmara, Eritrea. The study used a cross-sectional study design employing stratified random sampling to select a sample of 402 students. Data were obtained using a self-administered Belief towards Mental Illness questionnaire. Independent sample t-tests and one-way ANOVA were used to determine possible differences in scores of attitude. From a total of 21 scale items, positive attitudes were found in eight items and negative attitudes were found in the remaining thirteen. The mean score of the scale was 2.47 (95% CI: 2.41, 2.54). The mean (95% CI) scores of dangerousness, poor social relations and incurability, and shame subscales were 2.68 (2.60, 2.76), 2.55 (2.48, 2.62), and 1.22 (1.09, 1.34), respectively. A significant negative correlation was found between attitude scores and the average mark of students ( $r = -0.257, p < 0.0001$ ). Moreover, significant differences in attitude scores were observed between students with a relative suffering from mental illness and those without such a relative ( $p = 0.004$ ). There was an increasing trend of positive attitudes with increased educational level among 9th, 10th, and 11th graders ( $p\text{-trend} < 0.0001$ ) and with an increase in the educational level of the students father ( $p\text{-trend} = 0.028$ ). However, no significant difference in attitude score was found across categories of sex, religion, living condition of father, presence of a mentally ill neighbor, educational level of mother, or ethnicity.

Evidence from studies presented above shows that stigma is prevalent in all societies of the world, but it is imperative to note that the attitude to mental illness by members of the public may vary based on the context and environment where the study is conducted.

A study by Igbinomwanhia, *et al.*, (2013,) on the attitude of the Clergy in Benin City, Nigeria against persons with mental illness using a cross-sectional survey of 107 clergy men revealed that stigmatizing attitude are evident among the clergy. The result of the study showed that most (71%) of the respondents believed that the mentally ill were different from “normal people”, and 68% of the respondents were of the view that every mentally sick persons should be looked after like a child. Furthermore, 80% of the respondents were not comfortable with the mentally sick living with them in the neighborhood and were against locating mental hospitals in their same neighborhood. Almost half of the respondents (43.8%) were uncomfortable with women who were once mentally ill babysitting, while 63% of the respondents agreed that mental hospitals in Nigeria seem more like prisons than where people are treated. This study was limited by small sample size which limited generalization.

A study by Ugo, *et al.*, (2016) investigated the attitudes of the Igbo people of Southeastern Nigeria toward mental illness. A Multistage sampling method was used to select participants (n = 602) for the study. The result of the study revealed that more than half of all the demographic groups demonstrated authoritarian attitude and primary social distance. A third of the participants equally endorsed social restrictiveness, anti community care, and secondary social distance. The study also revealed that low education, male gender, older age, Protestant denomination, and not being familiar with people with mental illness predicted more negative attitudes. Culture, stereotypes, causal explanations, and poor mental health knowledge were the leading causes of negative attitudes. This implies that with the determinant role of culture and demographic variables in the stigma dynamics, contextualized and targeted interventions could be more helpful in reducing stigma and discrimination than general campaigns.

A cross-sectional study by Ibrahim and Yar (2017) was conducted to evaluate relatives' knowledge, beliefs and attitude on mental illness in Kano State. Data were collected through face to face interview and focused group discussion method using semi-structured questionnaire guide. In all, 266 participants participated in the study, of which 216 (81.2%) were males. The result revealed that 132 (49.6%) of the participants thought that evil spirits were the major cause of mental illness, followed by personal weakness 126 (47.4%). While majority of the respondents 196 (73.7%) preferred home treatment, 192 (72.2%), believed in spiritual treatment for mental illnesses, of this number, 99 (51.6%) believed in Quran, and 88 (45.8%) in both Quran and herbs. The study showed that negative beliefs about the causes and signs of mental illnesses were rampant. The study recommended health education in communities for a better knowledge of mental illness and good beliefs and attitude. The study was however limited by a non randomized sample which affects generalization. It is noteworthy that these studies have documented literature on stigma associated with mental illness and it's far reaching consequences, but little progress has been made to systematically address the problems associated with mental illness in Nigeria and its resultant discrimination. This means that there is still need for empirical studies to fill the available gap in existing knowledge on mental illness in Nigeria, hence the importance of this study.

Gureje, *et al.*, (1995) reported in a study in south west Nigeria that participants were not willing to interact with people having mental illness; 83% of the respondents reported that they would be afraid to have a conversation, 78% reported that they would not live in the same room with a person who has suffered from mental illness, and 83% reported being ashamed if people knew that their family member was diagnosed with a mental illness. A study by Ofonime and Benson, (2016) among the residents of Obio Offot

community in Southern Nigeria showed that almost half of the respondents (40 %) felt mental illness could not be cured. The attitude of the respondents to mental illness include shame (80.3%), unwillingness to share rooms (62.2%), avoiding contact (41.9%), and considering them as public nuisance (73.5%). The study was done in a small homogeneous community and there is a need to undertake the study in a diverse community to bring out the different perspectives.

A cross sectional study by Audu *et al.*, (2011) examined the knowledge, attitude and beliefs about causes, manifestations and treatment of mental illness among adults in Karfi village, in Kaduna, northern Nigeria. A pre-tested, semi-structured questionnaire was administered to 250 adults. The most common symptoms proffered by respondents as manifestations of mental illness included aggression/destructiveness (22.0%), loquaciousness (21.2%), eccentric behavior (16.1%) and wandering (13.3%). Drug misuse including alcohol, cannabis, and other street drugs was identified in 34.3% of the responses as a major cause of mental illness, followed by divine wrath/ God's will (19%), and magic/spirit possession (18.0%). About 46% of respondents preferred orthodox medical care for the mentally sick while 34% were more inclined to spiritual healing. Almost half of the respondents' harbored negative feelings towards the mentally ill; only 9.6% expressed their willingness to have a person with mental illness as a friend.

The finding was also related to gender as female respondents avoided social interaction more than males; 12.3% of the respondents also reported their unwillingness to marry someone with a history of mental illness. Literate respondents were seven times more likely to exhibit positive feelings towards the mentally ill as compared to non-literate subjects (OR = 7.6, 95% confidence interval = 3.8–15.1). The study demonstrates the

need for community educational programs in Nigeria aimed to demystifying mental illness. The study was however limited by the use of only qualitative method which limited triangulation of findings. A better understanding of mental disorders among the public would allay fears and mistrust about mentally ill persons in the community as well as lessen stigmatization towards such persons. Such understanding could be attained through anti stigma campaigns among members of the public.

A study by Abasiuobong *et al.*, (2007), in Oyo State revealed a negative attitude by journalists towards mental illness (70%) than nurses (60%). 97% of journalists and 89% of nurses believed people with mental illness are dangerous, violent and should not be married. However, poor sample size limits generalization of the study. Similarly, a study by Reta, *et al.*, (2016), in Ethiopia revealed that majority of the respondents had socially restrictive views about mental illness as most of them could not come close to or marry a person with mental illness. The respondents had high scores for stigmatizing attitude on all the subscales as indicated by mean (SD): authoritarianism, 21.17 (4.92); social restrictiveness, 32.4 (14.20); benevolence, 35.34 (4.42); and community health care ideology 33, 95 (5.82). The result also revealed that single respondents had lower social restrictiveness scores than married people and participants' educational status correlated inversely with stigma scores. The study was limited by generalization, poor sample size and lack of control group.

Similarly, studies by Bark *et al.*, (2011) on the stigma of mental illness in Southern Ghana, showed that about 50.7% of the respondents felt that people who suffer from mental illness should be separated from the neighborhood because staying with them in the same compound poses a serious threat to the neighbors. 39.7% of the respondents

indicated that they would not want to live in the same compound with someone who has a history of mental illness.

The following studies in Nigeria also show that there is negative attitude towards people with mental illness. Audu *et al.*, (2011) conducted a study on stigmatization of people with mental illness among inhabitants of Malali Village in Kaduna North Local Government Area of Kaduna State. The study examined the stigmatization against people with mental illness. A cross-sectional descriptive study using multi-staged random sampling was used to obtain data through interviewer administered questionnaire on 325 adult inhabitants. The major findings of the study showed that stigmatization of the mentally ill was high among the respondents as only 9.6% were willing to have a mentally sick person as a friend while only 12.3% would accept to marry them. The study was done in a small homogeneous community and used only the quantitative method.

Another study by Omoaregba, *et al.*, (2015) on the attitude of the police against people with mental illness in Benin City, Nigeria, showed that attitudes expressed by respondents on the authoritarian scale were stigmatizing. 90% of the respondents who participated in the study agreed that there is something about the mentally ill which makes them easily distinguishable from people who are normal, and 90% of the respondents say they would want people who show signs of mental illness to be hospitalized. Almost 70% of the respondents felt that people living with mental illness should be controlled like young children while 68% also agreed that persons with mental illness should be locked behind closed doors. On the social restrictiveness scale, the findings of the study indicated that over 50% of the participants sampled did not consider people living with mental illness capable of holding public offices or even

menial jobs such as baby sitting. Also 65% of the respondents considered the location of mental hospitals in residential areas as risky and frightening. The biases of the profession might have influenced the responses. The police always portray people with mental illness as criminals.

A study by Aina, *et al.*, (2015) in the University of Nigeria Teaching Hospital found that 51.6% of the respondents were unsure of how they would relate to mentally sick persons, 64% admitted that they would not live with or get married to a person with mental illness. However, a study by Aghukwa (2010) on secondary school teachers' attitude to mental illness in Ogun State, Nigeria showed that members of the public show positive attitude towards people having mental illness. The study revealed that out of 325 respondents, 251(77.2%) agreed to enter into a relationship with a person treated for mental illness in a hospital.

These studies have provided literature on public stigma of mental illness; however, it is noteworthy that most of the reviewed studies are quantitative, only collecting data, through issuing of questionnaires, thus neglecting the quality data that could have been collected in depth to know the feelings of members of the public about mental illness and the reasons for their negative perception. The present study will address that gap in knowledge by combining quantitative and qualitative methods to bring out a robust result.

A study by Ihaji, *et al.*, (2013) examined the attitude of the Tiv people of Benue State of Nigeria towards mental illness. The study used a 21-Item developed questionnaire measuring demographic variables and attitude towards mental illness to collect the data. A total of 569 participants took part in the study from Tiv speaking local government

areas of Benue state. The study tested three hypotheses using t-test for independent group. Results of the study revealed that there was a significant difference between youth and the elderly on their attitude towards mental illness ( $t (df = 566) = 2.05, P < .01$ ). Also, there was a significant difference between male and female Tiv people on their attitude towards mental illness ( $t (df = 564) = 5.65; P < .01$ ). Furthermore, there was a significant difference between the attitude of Tiv people in rural area and urban areas of Benue State ( $t (df = 565) = 3.70; P < .01$ ). The study recommended that more awareness should be created and people should be sensitized about mental illness and see it as curable and manageable from the scientific point of view.

Another study by Tormusa (2015) using focused group discussion in Benue and Nassarawa States revealed that mental illness is highly stigmatized in the study areas. According to the study, it is believed that mental illness runs in the family and is incurable. The participants of the study stressed that once the father has mental illness, the children are also likely to be affected by the disease. The study also found that people with mental illness cannot be considered for political appointment, because their ability for good reasoning has been impaired. However, the study failed to take the views of other ethnic groups in Benue State like Igede, Abakwa, Etulo Nyifon etc, thereby limiting the power of generalization of the study. Moreover, the study only used a focused group discussion among 30 participants, thus, findings could not be triangulated with other methods to obtain a robust result. Furthermore, the sample size of 30 participants among the Tiv and Idoma was too small to permit a generalization of the study. While these existing studies provided a platform for scholars interested in stigma of mental illness, notwithstanding, the studies did not consider the attitude of people in other ethnic groups in Benue State to enable it get a holistic view of

stigmatization and discrimination in the State. This present study has included the views of people from all the ethnic groups in Benue State.

Scholars like Cechnicki, *et al.*, (2011), have argued that stigma of mental illness significantly continue to affect many life opportunities of those people suffering from mental illness. They particularly highlighted the danger of stigma emphasizing that the general public prejudicial and discriminatory practices stemming from stigma, prevents people living with mental illness from obtaining work. This is because of the general view that once people receive treatment from the mental health care hospital, their ability to make right decisions is impaired (Osei-Hwedie, 1989). Similarly, Parle (2012) found that many people with mental illness experienced stigma and discrimination from employers when applying for jobs. She said that they experienced this when trying to explain gaps in their curriculum vitae, due to episodes of psychiatric illness and when returning to work after psychiatric treatment.

People living with mental illness have reported difficulty securing employment, and some have even lost their jobs upon disclosing their history of mental illness (Lyons, *et al.*, 2009). The stigma of mental illness significantly affects the life chances of people who have mental illness. It results in a number of consequences. It has pernicious implications for the prevention and treatment of mental illness, including rehabilitation and quality of life of people that suffer from mental illness (Corrigan & Watson, 2002; Baumann, 2007; Ferri, *et al.*, 2004). Despite the effects of stigma on people with mental illness, considerably less attention has been paid to it worldwide (Struch *et al.*, 2008). The World Health Organization (2001) highlighted the effects of stigma on people with mental illness pointing out that those who are being stigmatized experience rejection, isolation and discrimination from friends, relatives, neighbors, landlords and employers.

A qualitative study by Taira (2007), found out that people with mental illness who were discharged from hospital said that disclosing that one was a user of drugs put them out of employment. Some of the respondents disclosed that they had to lie in their curriculum vitae, that they had never experienced mental illness. According to Lyons, Hopley and Horrocks, (2009), some job seekers who disclosed that they had been in a mental hospital for care complained of being asked inappropriate questions when they attend interviews, such as how would they control their behavior if challenged by work colleagues.

People with mental illness face challenges returning to work after discharge from the hospital. According to Redding (2012), people living with mental illness returning to work after treatment reported being treated differently in their places of work, and being looked at with disdain, isolated and avoided by co-workers. The probable reason is that once a person is labeled mentally sick, he is believed to be a danger to the society and to himself, and therefore, incapable of performing tasks as required. Such people should be isolated from the rest of the society and from participation in societal activities, including employment. This perception creates a vicious cycle of institutionalization of those labeled mentally sick, irrespective of whether they were employed before the sickness, or whether they can still perform the job. All doors to life opportunities including employment are closed (Osei-Hwedie, 1989).

### **2.1.1 Internalized stigma of mental illness**

Internalized stigma of mental illness or self stigma refers to a situation where people with mental illness accept the negative way they are perceived by members of the public as a result of the mental illness they have and consequently lose their self concept and

become devalued in the society. It is a process by which people living with mental illness internalize public stigma and accept the negative portrayal of people with mental illness (Michaels *et al.*, 2012). It is a common phenomenon that takes place among people diagnosed with mental illness.

The internalization of stigma of mental illness has far reaching impact on self concept and ultimately on the well being of the person living with mental illness (Corrigan *et al.*, 2006). People living with mental illness accept and internalize highly negative stereotypes about themselves, and this influences every perception about their lives. Because of this, they confine their social network in anticipation of rejection due to the public stigma. This can lead to isolation, unemployment, low income and inability to seek treatment (Wringley, *et al.*, 2005).

Goffman (1963) refers to self-stigma as an internal feeling of guilt, shame, inferiority and the wish for secrecy experienced by people with mental illness. Like the public, people having mental illness will endorse the public stereotype and apply it against themselves, and experience feelings of diminished hope, limited self esteem and self efficacy (Livingston and Boyd, 2010). People living with mental illness internalize stigmatizing ideas that are widely endorsed by members of the public and come to believe that they are less valued because of their psychiatric disorder (Link & Phelan, 2006). Consequently, they exhibit behavioral responses like avoiding social gatherings and declining to pursue life goals (Reddings, 2012). The predictors of self stigma include poor social support, low educational attainment, weak social support, as well as diminished self efficacy and low self esteem (Adewuya, *et al.*, 2010; Girma, *et al.*, 2013; Gerlinger, *et al.*, 2013). People having mental illness experience possible denial

of equal participations in family life, normal social networks and productive employment leading to reduced chances of recovery and integration into the society.

According to Loch (2014) people living with mental illness going home after treatment from the hospital always encounter stigma as a persistent outcome. Accordingly, once the mentally sick persons are back in the community from the hospital, they experience some forms of social rejection from friends, relatives and members of the public which perpetuate internalized stigma. According to Lyons *et al.*, (2009) mentally sick patients coming home after psychiatric treatment in the hospital also complained of different types of unjust treatment from members of the public like physical and verbal attacks, and destruction of their properties and sometimes being barred from public places like shops and pubs.

They have also reported being spoken to as if they were stupid, or like children, and people directing questions to those accompanying them. People having mental illness have also reported that they are excluded in decision making process in the family because they are assumed to lack capacity to be responsible for their own lives (Thornicroft, *et al.*, 2010). Hermen and Smith (1989) conducted a research among 139 formerly institutionalized Canadian mentally sick persons, aimed at examining their life experiences of social stigma after discharge from hospital. The main problem identified was their perception of being stigmatized by the public because of mental illness, but the study was limited by poor sample size which limited generalization.

In a study by Struch *et al.*, (2008) on stigma against persons undergoing psychiatric care in Jerusalem, Israel, 40% of people with mental illness who had received treatment and 35% of those who were mentally sick but had never been hospitalized responded

that people may cease to relate with them in the usual way if they knew that they were undergoing psychiatric treatment. Again, 42% of the people having mental illness perceived that other people would be reluctant to relate with them after learning that they attended hospital for treatment of psychiatric sickness. This perception will affect people with mental illness in seeking healthcare and interacting with other members of the society.

Corrigan (1998) observed that been viewed negatively by the majority of the people around may elicit a feeling of anger or self reproach. He added further that the worst form of discrimination that affected people living with mental illness include loss of jobs, denial of housing, diminished income, physical violence and verbal abuse that cause pain to the person who has mental illness. Because of this prejudice and discrimination, people with mental illness experience negative feelings about themselves. They may begin to consider themselves as unintelligent, unworthy and begin to experience shame, low self confidence and diminished self esteem because of the stigma and discrimination (Corrigan *et al.*, 2006).

The person with mental illness thus becomes devalued and demoralized because of discrimination (Link, 1987). Consequently, they withdraw from social contact with members of the community. Pamela (1999) explained that expectation of devaluation and discrimination from members of the community was inversely related to social and psychological integration of the mental patients. According to her, the more the person with mental illness perceives discrimination from the community, the fewer the social contacts the person can make. This loss of hope, confidence and self esteem can diminish an individual's perceived competence which may lead to withdrawal from pursuing educational, social and career goals (Michaels *et al.*, 2012). Stigma and

discrimination also has effect on access to treatment as people that suffer from mental illness are unwilling to attend hospital and adhere to treatment regimes which lead to frequent cases of relapse (Horton, 2007). Studies by Leff and Warner (2007) Esfroff, *et al.*, (2004), highlighted the enormous damage that follow untreated mental illness, such as lost jobs, reduced productivity and homelessness etc.

The prevalence of internalized stigma in sub-Saharan Africa ranged between 21.6% in Nigeria and 46.7% in Ethiopia (Adewuya, *et al.*, 2010; Assefa, *et al.*, 2012). The prevalence of internalized stigma in India is, 34.1% and 40% in Iran compared to African countries like Nigeria and Ethiopia ( Ghanean, *et al.*, 2015). But the prevalence of internalized stigma in Nigeria could be more because most people attend traditional psychiatric care because of the absence of orthodox treatment facilities in Nigeria, and may not be given attention.

The pervasiveness of internalized stigma among people having mental illness had been reported by a study on perceived stigma by Bifftu and Dachew (2014) in Ethiopia. The study showed that the prevalence of internalized stigma was high (83.5%); and patients who had difficulty adhering to antipsychotic (95%) were more likely to experience internalized stigma than those who adhered to medication. The study was hospital based and cultural differences between Ethiopia and other study areas may limit generalization. Another study by Assefa, *et al.*, (2012) in Ethiopia showed that there was high level of internalized stigma among people with mental illness attending the hospital, as most of the respondents had experienced at least some level of internalized stigma and three-quarter of the respondents endorsed at least one internalized stigma item. The experience of stigma in each stigma domain was also high (50 to 72%). The study also confirmed the hypothesis that stigma is an important obstacle in the recovery

process; 62% of the mentally sick persons that discontinued their medication attributed it to stigma related to their mental illness. Another study by Michelle, *et al.*, (2011) on the prevalence of internalized stigma among persons with severe mental illnesses in Indianapolis and New York sampled a population of 144 people. The result of the study indicated that 36.1% of the participants had elevated scores. Of the participants in the New York site, 31.1% had elevated internalized stigma scores; in contrast to 41.4% of the participants in Indiana with elevated scores.

A cross-sectional study in Southern Ethiopia involving 317 participants, by Aserat, *et al.*, (2018), revealed that the prevalence of internalized stigma was 32.1%, and female participants experienced more Internalized stigma more than male participants. Another study by Adeosun, *et al.*, (2014) on experience of discrimination of people with schizophrenia in Lagos, Nigeria revealed that 87% of the participants have been discriminated and avoided by people who found they had schizophrenia. 71% experienced unfair treatment from family members, 63% from friend, 32% from members of public, and 29% from intimate relationships. The overrepresentation of educated participants and hospital based study limit generalization of findings.

A study by Redding (2012) on the lived experience of being discharged from psychiatric care in Southampton also indicated that most of the respondents in the study reported a feeling of shame and diminished self-esteem because of self-stigma. For example, a respondent narrated how she experienced shame because of her mental illness explaining how she had indulged in alcohol to cope with life as a result of public stigma. According to her, the shame experienced as a result of her mental illness had made her to contemplate committing suicide.

A similar study by Ghanean, *et al.*, (2011) on Internalized stigma of mental illness in Iran made use of a sample of 138 respondents. The study used internalized stigma of mental illness scale by Ritsher, *et al.*, (2003). The result of the study showed that 72% of the respondents strongly agreed that they face discrimination from members of the public because of their mental illness; 50% of the respondents strongly agreed that people treat them like children because they have mental illness, and 40% felt disappointed in life having experienced mental illness.

A study by Ibrahim, *et al.*, (2016) in Maiduguri showed that the respondents with poor social support were 4.5% times more likely to have high internalized stigma than those with good social support. Four-fifth of the respondents with poor level of social support had high internalized stigma scores as against less than one-fifth of those with good social support base. This means that good social support may decrease the feeling of alienation and discrimination which are critical parameters of internalized stigma. Also, the respondents with extra pyramidal adverse effects of psychotropic medication were twelve times more likely to have high internalized stigma than those without it. According to the study, the presence of symptoms such as rigidity and tremors increase the feeling of being different from 'normal people' that in turn increases their sense of alienation and ultimately the internalized stigma.

Some scholars have however argued that not all people with mental illness experience self-stigma. According to Michaels *et al.*, (2012) people with psychiatric illness are confronted with three alternatives: to endorse the public stigma as valid; not to accept it; or to shun it. A study by Struch, *et al.*, (2008) on stigma experienced by persons in psychiatric hospitals showed that about 69% of the respondents reported neither fear nor experience of self stigma. Similarly, Deegan (1990) argued that rather than feeling

diminished by self-stigma, people living with mental illness reject the way they are treated by society, and accordingly become advocates against the public stigma and discrimination they experienced. 76% of the respondents disagreed with the statement that “due to my family members’ mental illness, I have sense of being unequal in my relationship with others”. Other scholars like Croker and Masar, (1989) have argued that it is not all people who suffer from stigma that experience diminished self-esteem and hope. He further stated that the impact of stigma on a person depends on the attitude of the people stigmatizing the person with mental illness; a positive evaluation of the self worth of the people living with mental illness by members of public will likely strengthen their self-esteem.

A critical look at the various studies reviewed above shows that internalized stigma is prevalent among people with mental illness. However, most of the reviewed studies were carried out in the orthodox hospitals. None has reported about stigma experienced by people who attend treatment at the traditional psychiatric hospitals. In Nigeria, psychiatric hospitals are located in urban areas, far away from people in the rural areas. Thus majority of people attend traditional care for their health problems.

### **2.1.2 Stigma of mental health care professionals**

Health care professionals are first line of contact for treatment of people with mental illness. They are divided into traditional and orthodox psychiatric healthcare professionals. Their familiarity and frequent contact with people having mental illness have been identified as the strongest predictor of more positive attitude (Angermeyer, and Dietrich, 2006). Their frequent contact with people living with mental illness should therefore show positive attitude towards mental illness. However, it has been

reported that mental health care professionals despite their regular contact have negative attitude and discrimination towards those affected by mental illness (Ewhrudjakpor, 2009). This negative attitude could be because of the aggression/ hostility of the patient to the mental healthcare practitioners, which create fear and anxiety for their own safety (Staniuliene, *et al.*, 2013). Stigma of mental illness is also found among the mental healthcare professionals and such attitude by mental healthcare professionals remains a barrier to quality care, treatment and recovery (Wallace, 2010). People living with mental illness and their families have complained that the attitude of mental health care professionals have exacerbated the stigma that they experience, through practices such as avoiding contact with them, rejection and adopting a paternalistic stance towards mental patients (Stuart, *et al.*, 2012).

A study by Nordt, *et al.*, (2006) in Switzerland revealed that mental health care professionals have negative stereotypes about people with mental illness just like lay members of the public. The mental healthcare workers maintained same social distance from people living with mental illness as members of the public. This showed that mental healthcare professionals, though mental health experts, have the same attitude towards people with mental illness as lay members of the general public.

A cross sectional study by Sahile, *et al.*, (2019) on primary health care nurses' attitude towards people with mental disorders in Addis Ababa, Ethiopia, revealed that nearly half of the participants had negative attitude towards people with severe mental disorders. The study revealed that the most frequently reported factors for negative attitude of mental healthcare professionals were being male, having less psychiatric nursing training and holding junior positions. It was revealed that primary healthcare nurses with less training, less exposure and experience in mental healthcare reported

negative, intolerant and fearful attitudes and perceptions towards people with mental illness.

A descriptive study of the attitude of 88 female nurses towards caring for the mentally ill at a rural General Hospital by Mathew, *et al.*, (2016) revealed that most of the nurses (70.5%) had a negative attitude towards caring for the mentally ill. A study by Kapungwa, *et al.*, (2010), on the Attitude of primary healthcare providers towards people with mental illness: evidence from two districts in Zambia shows that there is widespread stigmatizing and discriminatory attitude among the primary health care providers towards people who suffer from mental illness. The disturbing finding of the study was that clinical psychiatrist displayed more discriminatory attitude towards people with mental illness than other categories of primary healthcare workers. It was also found that a greater proportion of general clinical officers expressed discomfort in dealing with people with mental illness more than other categories of health workers. This attitude by the mental healthcare professionals will likely have effect on help seeking by people living with mental illness accessing care.

Another study by Hansson *et al.*, (2013) in Sweden revealed that mental healthcare professionals have negative attitude towards people with mental illness. Mental health care professionals with median age (30-40 years) had more negative attitude than older staff, also work setting had influence on beliefs held by the healthcare professionals as staff treating psychotic illness, and staff in the in-patient department had more negative attitude than other staff in other departments. This may be because those in the in-patient department have more frequent contact with those with severe long term and recurring mental illness, thereby seeing them exhibit behavior that makes the health care professionals think of them as being dangerous, less trustworthy or less capable of

holding employment. The study also found less stigmatizing attitudes among nurses whose work places were in the county council.

A study by Sathyanath, *et al.*, (2016) assessed the attitudes towards people with mental illness among the medical professionals (N = 130) in a medical university in Nigeria using shortened version of the 40-item Community Attitudes toward the Mentally Ill (CAMI) scale. The study revealed that socially restrictive attitudes were endorsed by quite a number of faculty members and trainees. Significantly higher number of faculty members (22.5%) compared to the trainees (9.1%) endorsed unfavorable attitudes towards previously mentally ill man getting married. Similarly, significantly more number of faculties (22.5%) was averse to the idea of living next door to someone who has been mentally ill compared to the trainees (9.1%). However, significantly lesser number of faculty members (16.1%) compared to the trainees (30.3%) believed that previously mentally ill people should be excluded from taking public office. Personal acquaintance with a mentally ill individual was the only variable that was associated with significantly lesser socially restrictive attitudes among the medical professionals, irrespective of their age, gender and clinical exposure to people with mental illness. Personal acquaintance with people who have mental illness appears to be the only significant factor that reduces medical professionals' socially restrictive attitudes towards them.

A descriptive, cross-sectional study by Chukwuemeka, *et al.*, (2018) assessed attitudinal views of health professionals (doctors, pharmacists, and nurses) regarding mental illness in two hospitals in Eastern Nigeria. The survey utilized the 40-item Community Attitude to Mental Illness, CAMI-2 questionnaire. The prevalence and the factors that contribute to negative attitudes among this cohort were assessed. Statistical analysis

using T-tests, ANOVA and Pearson Correlation were conducted. The study revealed that attitudes to all the four constructs of the CAMI-2 were non-stigmatizing. Stigmatizing attitudes were significantly higher among pharmacists, doctors and then nurses ( $p < 0.006$ ). Health professionals who did not have contact with the mentally ill ( $p < 0.0001$ ), who were males ( $p = 0.008$ ) and had lower years of working experience ( $p = 0.031$ ) expressed significantly higher stigmatizing attitudes towards the mentally ill. Nigerian health professionals were largely non-stigmatizing towards the mentally ill. However, being a pharmacist, of male gender, and working in a non-psychiatric hospital were associated with stigmatizing attitudes when they exist. This study however has some limitations. First the arbitrary classification of respondents into non-stigmatizes and stigmatizes in this study using a cut-off point of 3.0 for each dimension's mean scores should be treated with caution. The use of other cut-off points (e.g. median score) could most likely alter the interpretations of the results of this study. The low response rate seen among the health professionals surveyed and some poorly represented population subsets in this study could likely affect the strength of the results.

A study by Ewhrudjakpor (2009) on knowledge, beliefs and attitudes of healthcare providers towards the mentally ill in Delta State, Nigeria shows that despite medical knowledge, healthcare providers still hold negative cultural beliefs about mental illness. Another study by Adewuyi (2007) aimed to evaluate the attitude of doctors in Nigeria towards the mentally ill. Medical doctors ( $n = 312$ ) from eight selected health institutions in Nigeria completed various questionnaires on knowledge and attitude towards people with mental illness. The result of the study revealed that beliefs in supernatural causes were prevalent among the study participants. The mentally ill were perceived as dangerous and their prognosis perceived as poor. High social distance was

found amongst 64.1% of the respondents. The associated factors include not having a family member/friend with mental illness (OR 7.12, 95% CI 3.71-13.65), age less than 45 years (OR 2.33, 95% CI 1.23-4.40), less than 10 years of clinical experience (OR 6.75, 95% CI 3.86-11.82) and female sex (OR 4.98, 95% CI 2.70-9.18). This means that culturally enshrined negative beliefs about mental illness were prevalent among Nigerian doctors despite their exposure to the mentally sick. There is a need to review the medical curriculum to eliminate the negative cultural beliefs against mental illness.

A study by Olatunji, *et al.*, (2015) in Lagos, Nigeria however revealed that medical students have positive attitude towards people living with mental illness. The study found that most of the medical students who participated in the study believed that mental illness can be treated, and those affected can become normal. The study also found that most of the students believed people living with mental illness should have equal chance of employment with those that have not suffered from the disease. Stigma affects the quality of life of the mentally ill, and health professionals are considered to be involved in possessing negative attitudes towards them.

### **2.1.3 Discrimination against family members of people having mental illness**

Stigma and discrimination does not only affect people who are suffering from mental illness; it also affects their families through courtesy stigma (Redding, 2012). Family members of people living with mental illness play an integral role in caring for their mentally sick relatives (Goldman, 1982). Family members provide the necessary emotional and physical support and often pay for the treatment of people with mental illness (Link and Phelan, 2006). Because of their closeness to the person having mental illness, it is important to examine their experiences with members of the public.

According to Phelan *et al.*, (1998) Stigma remains a burden for families of people living with mental illness. This means that stigma, prejudice and discrimination do not only affect people living with mental illness, but also their family members as well. Mehta and Faring (1988) refer to this as “associative” stigma. Corrigan and Miller (2006) observed that families and friends of people with mental illness experience an emotional feeling of guilt, anxiety, fear, frustration, anger and sadness because of the mental illness of their relative (Panayiotopoulos, *et al.*, 2013).

Corrigan *et al.*, (2014) conceptualize the effect of stigma on the family of people living with mental illness in terms of both objective and subjective components. They explain that the objective burden which families face can be reflected in the everyday constraints that they encounter because of the stigma of mental illness. The subjective burden on the other hand refers to the psychological distress engendered by the disease. Families have complained that they experienced financial hardship due to payment of hospital bills for the mentally ill members, and the patients’ economic dependency. Families also complained that household functioning is disrupted; social activities are curtailed and relationships altered with friends and relatives because of looking after their member who has mental illness (Lefley, 1989). For example, finances that can be used for other aspects of family life are channeled to paying hospital bills of their member with mental illness and this puts a burden on family finances.

According to Corrigan *et al.*, (2014) family members also complained that they are ashamed and they keep the experience of mental illness of their relatives a secret. The researchers explained further that family members also complained of significant distress as a result of stigma, and this disrupts interaction among the family members, thus alienating them from other members of the society. This may affect help-seeking as

the family members may be afraid to seek for medical treatment for their member who has mental illness, because of fear of being stigmatized. It may also lead to discontinuation of treatment thereby leading to relapse. Lefley (1989) reported in his study of mental health care professionals with mentally ill relatives that the mental health professionals reportedly heard people and even their colleagues make derogatory remarks about families of people living with mental illness. Accordingly this makes the health care professionals' hide their relative' condition from their colleagues. As reported by Reddy (2014) in Asian countries, stigma associated with mental illness brought shame to the family and affected the marriage potentials of other relatives. So family members keep the illness private and are often reluctant to seek professional help.

A study by Celenkosin and Gugu (2017) explored the stigma related experience of family members of persons with mental illness in selected community in Ilembe district in South Africa. The study revealed that Participants reported experiencing stigma from the community in the form of isolation, blame and exploitation, community neglect, as well as labeling and stereotyping. The majority of the participants reported using emotion-focused coping mechanisms to deal with the stigma they faced. Participants suggested that education of communities regarding the myths and facts about mental illness may help to curb the stigma faced by the family members of persons with mental illness.

A study by Panayiotopoulos *et al.*, (2013) in Cyprus determined the effect of severe mental illness on the relatives of people living with mental illness. The study revealed that 55% of the respondents indicated that they worried quite often about the security of their relatives; 63.7% of the respondents were concerned that family members will have

challenges of paying for medical bills in the event that caregivers are no longer able to provide support. On the result concerning the dimension and supervision, the mean score 1.6 (SD=55) was reported indicating that the relative's mental disorder imposes low supervision demands to the patients. The dimension of worry, showed a mean score of 3.13 (SD=53) indicating that participants have an above average level of worry for their relatives welfare. In relation to the encouragement dimension, the mean score was 3.07 (SD=96) indicating that the participants in the study have to devote energy to encouraging their mentally ill relatives to look after themselves. Participants in the study were asked to indicate the money they expend on the needs of their relatives with mental illness, 33.6% reported that they spent less than 50 euros; 29.3% between 50 and 60 Euros, 22.4% between 80 and 200 Euros, while 8.6% spent above 200 and 400 Euros.

A study by Phelan *et al.*, (1998) showed that half of the relatives reported making effort to conceal the illness because of shame. Hiding of mental illness was significantly higher among family members of people living with mental illness with less severe symptoms, and also higher among family members of female patients. However, majority (95%) of the respondents reported that people interacted with them well. Another study by Issah, *et al.*, (2009) indicated that 59.6% of the respondents would not be ashamed if people knew that their relatives had mental illness.

Shibre, *et al.*, (2001) investigated perception of stigma among family members of mentally ill patients in rural Ethiopia. A total of 178 relatives of individuals who were diagnosed as suffering from schizophrenia or major affective disorders in a community-based survey were interviewed using the Family Interview Schedule. The result revealed that 75% of the family members interviewed expressed concern that other

people would know about the mental illness of their relative. Furthermore, 42% of the respondents were also concerned that they might be treated differently by members of the public because of the mental illness of their relative, 37% wanted to conceal the fact that a relative is ill. However, the study was limited because of its small sample size; because of this the findings cannot be generalized. The present study aimed to use a mix method and higher sample size to achieve a robust result.

Similarly, studies by Elbur *et al.*, (2014) on relatives' perception of mental illnesses, services and treatment in Taif, Saudi Arabia, showed that 35% of the respondents reported that they would be ashamed if their family member were diagnosed with mental illness. This showed that the respondents were concerned about the social rejection that would result if other people knew about their relatives' mental illness.

People living with mental illness themselves are aware of the effect of their mental illness on their families. An interviewee in a study by Taira (2007) titled *Challenging Stigma and Discrimination: The Experience of Mental Health Services in Japan* has this to say:

“I thought it would get my family into trouble actually. As I was living by myself (people would say things like) “the son of that person is mentally disabled”. “Their family line has a history of mental illness” (Taira, 2007, 8).

#### **2.1.4 Coping strategies for stigma and discrimination**

Coping strategies are ways in which people with mental illness contend with the negative attitude of members of the public towards them. Stigma can pose serious challenges to one's humanity and it can be damaging personally, interpersonally and

socially (Biernat and Dovidio, 2000). People with mental illness who experience the adverse effect of public stigma devise various ways to contend with the situation. Brehm's (1966) theory states that being stigmatized can generate a psychological reactance. This means that rather than submit to the threat of stigma, the individual develops a conception of self and a righteous anger against the way he has been unjustly labeled (Corrigan *et al.*, 2002).

Some scholars have provided different mechanisms for managing the threat of stigma. Struch *et al.*, (2008) identified four of such coping strategies, namely, Denial, secrecy, withdrawal, education and positive distinctiveness. Link *et al.*, (1991) identified only the first three above mentioned by Struch *et al.*, (2008). Redding (2012) further identified psychological resources, help seeking resources, constraints and level of threat. The person with a mental illness conceals the fact that he/she has been treated for mental illness in a psychiatric hospital (Struch *et al.*, 2008). Such a person with mental illness may decide to hide their history of treatment from employers, relatives, landlords or potential lovers to avoid discrimination or rejection (Link, *et al.*, 1991).

According to Goffman (1963) people with discreditable conditions have labels that can be hidden or concealed. Accordingly, such stigmatized people can 'pass' or 'cover' as 'normals' so that no one finds out. Passing refers to concealment of the label. Covering refers to employing subtle means to keep the mark from manifesting (Redding, 2012). This enables them to maintain a façade, through impression management (Asbring & Narvanen, 2012). According to Goffman, such people face the risk of being exposed as someone who was formerly stigmatized. Morgan (2005) also reported that the mental patients will have the challenge of telling lies and living with fear that they may be

discovered. People with mental illness live with the fear that if exposed, they face the risk of isolation and discrimination from members of the public (Wahl, 1999).

Through proper information management, the stigmatized persons may decide to whom and how much information to divulge about their condition. They may choose to disclose their condition to only trusted people like family members, friends and other people sharing the same condition with them (Wahl, 1999).

The following studies have identified strategies used by people living with mental illness to help them maintain their secrecy. Peterson, *et al.*, (2011) and Taira, (2007) endorsed non -disclosure for fear of being stigmatized. For example, a respondent in Taira's study said: "If I reveal my face, friends would recognize me, wouldn't they? I do not want them to find out (how I am) indirectly and think oh, that person has become like that" (p.83).

In Herman's (1993) study, participants adopted coping strategies like avoiding some selected 'normals', redirecting conversations, withdrawal from social interaction and making jokes about psychiatric illness in the presence of people without mental illness. Others avoid disclosing their history of mental illness in their curriculum vitae on job applications (Peterson *et al.*, 2011). On the contrary, it has been argued that disclosure of one's mental health status to the public can remove the burden of secrecy and also liberate and empower the mentally sick person (Thornicroft, *et al.*, 2007).

The stigmatized people limit their social interaction to prevent possible discrimination and rejection by others (Struch *et al.*, 2008). People living with mental illness adopt this strategy against the rejection that will occur if they go out to seek friends, jobs and other

needs in the wider society (Link *et al.* 1997). They may gradually give up hope of employment (Taira, 2007), seeking new friends, going to places that they 'pass' as normals (Green and Thorogood, 2008). A study by Barke *et al.*, (2011) in Southern Ghana revealed that most of the mentally ill people (68.9%) pre-empted rejection and distanced themselves from people they felt thoughtless of them because they had attended a psychiatric hospital, and that had devaluing views about psychiatric hospital generally (60.0%). Furthermore, about 49.0% of the respondents in the study agreed that people with mental illness find it easier to socialize among them than interacting with "normals". This is to avoid the rejection that might occur if they mix up with other members of the community.

However, studies have shown that withdrawal can have detrimental effect on the wellbeing of the stigmatized. A study by Barnes and Shardlow (1996) revealed that social isolation could hinder people with mental illness from developing themselves, and limit their opportunities for growth. People with mental illness may be constrained by stigma from looking for employment, seeking treatment, seeking accommodation and engaging in social relationship.

Education has also been identified as one of the coping strategies employed by people having mental illness (Link *et al.*, 1991). Here, the stigmatized person attempts to provide the non-stigmatized people with information about the nature and care of mental illnesses (Struch *et al.*, 2008). Education as a coping strategy seeks to change negative stereotypes about mental illness by replacing them with information to members of the public. Mechanisms that are used here include public service advocacy, books, flyers, movies, videos on ways of ending stigma (Corrigan, *et al.*, 2012). Such advocacy will help people living with mental illness to cope with the stigma of mental

illness (Wahl, 1999). The emphasis here is that rather than conceal one's mental illness, some people with mental illness come out and grab public control over their lives. Such groups are engaged in advocacy to challenge the shame and discrimination that occur because of mental illness (Corrigan, 1998).

People living with mental illness may be harmed by prejudice and rejection because of membership of such a group. As a coping strategy therefore, they may engage in actions that may enhance their self-esteem and self-worth by trying to promote the positive attribute of the group to which they belong. For example, "people receiving mental health care are more sensitive and care more about other members suffering from mental illness (Struch *et al.*, 2008:211). This means that an enhanced image of the group of affiliation will further enhance the self-esteem of the members of that group.

In a study by Struch *et al.*, (2008) on the stigma experienced by persons under psychiatric care, positive distinctiveness (84.4%) was the most used mechanism by people living with mental illness in coping with stigma and discrimination of mental illness. No significant difference was found between the other three coping strategies: withdrawal 73.1%, secrecy 81.4% and education 80.8%. The only significant difference was that the use of withdrawal (80%) was more popular among discharged mentally sick people than among those who had not been hospitalized (60%). No reason was given for the preference of positive distinctiveness as coping strategy for respondents in the study.

In a qualitative study by Taira (2007) in Japan, most of the respondents used concealment and withdrawal. No participant reported the use of challenge as a strategy. In Tairas' study, the use of other coping strategies was discovered. Some participants

reported reintegrating into the superior non-disabled group. This is definitely to enhance their self-esteem and keep away from the tainted status of a mentally sick person.

In another study by Redding (2012) some participants disclosed the shame they encountered as a result of mental illness, and their struggle to cope by consuming alcohol. However, this is likely to exacerbate their mental health condition. One of the participants even considered committing suicide because she felt the family would be better off without her. This is one of the reasons why suicide is common post discharge (Struch *et al.*, 2008).

### **2.1.5 Minimizing the stigma of mental illness**

Due to the damage of stigma and discrimination to the mentally ill, many international agencies and governments have taken up the initiatives to combat the pandemic. The World Health Organization (WHO, 2001) has realized the damage of stigma and discrimination and has stressed the need to fight and eliminate stigma and discrimination against mental illness. The World Psychiatric Association has also initiated a global campaign to combat stigma and discrimination. About twenty countries are participating in the program (Schulze, 2007). However, Nigeria is not among the countries staging a fight against stigma. These public campaigns have focused more on assessing public beliefs and perception of people with mental illness. There is therefore the urgent need for such initiatives in Nigeria to eliminate stigma and discrimination against people living with mental illness. Such initiatives will need to adopt contact, education and protest as strategies to combat stigma of mental illness. This is because contact, education and protest have been identified as important strategies in the influential stigma reduction process (Corrigan and Penn, 1999).

Sustained Interpersonal contact among members of a stigmatized group and the general population can change stereotypes about mental illness. This is because it will help to debunk the myth that persons with mental illness are responsible for their condition. Integrating mental health into the primary health care system will enhance the care and treatment of people with mental illness and their relatives in the community. It will also encourage greater contact between the mentally sick people and the community, thereby reducing the stigma of mental illness.

Corrigan (1998) also stated that stigma and discrimination may be eliminated when members of the public come in constant contact with people with mental illness. Similarly, Thornicroft *et al.*, (2010) added that direct contact between the public and people with mental illness is a strategy that helps in stigma reduction. For the contact strategy to be successful in changing stereotype, the following conditions must be present in the interaction process between the two groups. There must be conditions of equal status and shared goals, and people in higher positions of authority must support the contact, and there must be no competition among the two groups (Pettigrew and Tropp, 2006).

However, Penn and Couture (2002) reported two problems related to studies using contact strategy. Not much attention has been paid to how direct interpersonal contact can bring down stigma during an ongoing relationship. Some studies (Collins, *et al.*, 2012), have only examined the effects of previous self reported contact on stigma instead of how contact can change stigma. Secondly, the studies have not explained the mechanisms through which contact can change stereotype on mental illness. The main goal of education as a strategy for reducing stigma is to provide factual and useful information about mental illness to members of public. This seeks to eliminate negative

stereotypes, ignorance and replace them with affirming attitudes such as empowerment, recovery and social inclusion (Collins, *et al.*, 2012). Education provides useful information about mental illness so that members of the public can make informed decisions (Corrigan, 1998).

A qualitative study by Taira (2007) highlighted the need to educate the general public and make them understand mental issues in order to reduce stigma and discrimination among people with mental illness. Gaebel and Baumann (2003) emphasized the relevance of education in reducing stigma. According to them, factual information through education can modify negative attitude among general populations as well as specific target groups, for example people who are working in mental hospitals. In addition, they argued that education can provide useful information to members of the public about the nature, causes and treatment of mental illness. They added that educational interventions should place more emphasis on positive media campaigns about mental illness and promoting one to one contact among the mentally sick people and members of the public. Audu *et al.*, (2011) also emphasized the relevance of education which will help to enlighten the community about the causes, and treatment options available to the mentally sick. According to them, this will greatly minimize stigma. The benefits of educational interventions are that they can reach a wider population at a lower cost (Michael *et al.*, 2012). However, Penn and Couture (2002) argued that education is most effective only in reducing stigma and discrimination among people with mental illness in general than towards individuals.

Social advocacy is also used to fight specific forms of injustice as a result of stigma, and also punish perpetrators of discrimination and stereotypes (Michaels *et al.*, 2012). Protest is a reactive mechanism against stigma and discrimination. It acts to fight

against inaccurate representations of mental illness (Corrigan, 1998). However, Corrigan *et al.*, (2001) argued that protest is not an effective tool because it can result in increased discrimination against people living with mental illness. This is because it tends to focus on instances where Stigma occurs, and fails to promote more positive beliefs that are backed up with facts.

Michaels *et al.* (2012) explained that education and contact have been used more than protest. According to them, education and contact programs have led to significant outcomes in stigma change strategy with contact yielding stronger outcomes most especially among adults than among youth. McCrone, *et al.*, (2009) also argued that empirical research is yet to determine the most cost effective messaging strategy and for what type of audience.

Other stigma change strategies have been proposed by literature. For example, the American Psychological Association (APA, 2013) has identified interaction, cooperative learning or cooperative interaction as other strategies of combating stigma, although most of these strategies have not been tested by empirical research. The APA (2013) report gave other strategies applicable to reducing stigma of mental illness as making people feel guilty for having prejudiced beliefs, inducing empathy for and enhancing the empowerment of the mentally ill and confronting people who have bias and stereotypes against people living with mental illness. Sayce (1998) proposed introduction of anti-stigma laws which can provide a benchmark for discrimination against mental illness.

Corrigan (2000a) added that strategies to end stigma will be most effective if they target specific target sub-groups that involve people who have experienced mental

illness. Further measures to encourage early detection and effective treatment of mental illness so as to reduce deficits and disabilities will greatly reduce stigma. Effective rehabilitation of the homeless and chronically ill people with mental illness by government will also be helpful. Providing medical students with training to enhance their knowledge about the impact of shame and discrimination on family members and people with mental illness should be included in the training manual of psychiatrists. This will equip them with adequate knowledge to address the problem associated with stigma of mental illness (Larson and Corrigan, 2008).

## **2.2 Theoretical Framework**

This section adopts the labeling theory as a theoretical framework for the study. Labeling theory is associated with the concepts of ‘self-fulfilling prophecy’, ‘stereotyping’ and ‘tagging’. It essentially refers to how societal reaction may help to shape the self identity and behavior of a stigmatized person. Labeling is a process through which those who deviate from accepted behavior are marked out for avoidance. The theory was first developed by Tanneubaum in his book *Crime and Community* (1938). The theory was later developed in the 1960s by scholars like Howard Becker, Edwin Lemert, Albert Memmi and Goffman (Macionis and Gerber, 2011). It is closely related to social construction and symbolic interactions theories in Sociology. The basic premise of symbolic interaction is that the meanings of social actions are socially constructed; Responses to social interaction are based on assigned meanings implied from shared cultural knowledge and the generalized attitude of the ‘generalized others’. From the framework of symbolic interaction therefore, the self conception of an individual results from the perception of people around him. This means the self is a

social process which develops because of the reaction of others to the self as a social object (Cooley, 1902).

Labeling theory was first applied to the term mental illness in 1966 by Thomas Scheff in his book, *Being Mentally Ill*, in which he presented a sociological model of mental illness that is the complete opposite of the medical model. In his presentation, rather than seeing mental illness as an abnormal condition which affects the individual, it is rather viewed as a label attached to persons who exhibit certain types of behavior. According to Scheff, the aberrant behaviors are symptoms which are characteristic of the mental illness and are considered as violations of social norms rather than psychopathology. He argued further that mental illness manifest because of the influence of the society. He believed that society has beliefs about people with mental illness, and that individuals learn the stereotype imagery of mental illness through ordinary social interaction, cartoons and media. People learn to use terms like ‘crazy’, ‘Looney’, and ‘nuts’ and often associate them with abnormal behavior. According to Scheff (1974), society considers certain behavior as deviant and often places ‘tags’ or ‘labels’ of mental illness on those who exhibit deviant acts. Scheff added that there are societal expectations placed on people with these labels. Scheff (1974) argued that many behaviors violating the social norms constitute residual forms of deviance, such as social withdrawal, talking to oneself or displaying inappropriate affect- the type of behavior that is considered indicative of mental illness. Based on the theory of self-fulfilling prophecy, people with these labels unconsciously change their behavior to fit societal expectations. White and Meiles (1985) referred to this as “aligning actions”, taken to align one’s behavior to the expectations of the society.

This means that once a person has been labeled as mentally ill by members of the society, he/she consistently receives a set of uniform reactions from members of the public that are considered generally negative reactions in form of discrimination, social rejection and devaluation. These reactions from members of the public compel the role of “mentally sick” on the stigmatized person, and the person begins to act accordingly as a sick person. According to labeling theory therefore, people with mental illness are the objects of stigma and discrimination (Link, 1987).

The labeling theory doubts the legitimacy of psychiatric diagnosis but rather emphasizes the role of formal labeling in setting into motion stigmatization process that produces symptomatic behavior. According to Scheff (1974) mental illness is a social role and the reaction of the society is the fundamental determinant of one’s entry into the role of mental illness. Scheff added that hospitalization of people with mental illness reinforces this social role and forces them to take the role as part of being mad. Once the person is institutionalized, he/she becomes labeled as ‘crazy’ and is forced to become a member of a deviant group. It then becomes difficult for the person to return to his/her former level of functioning as the status of ‘patient’ causes unfavorable evaluation by self and by others. Scholars such as Howitz (1982) have emphasized the role of power in the labeling process; Howitz (1982) argued that behavior becomes labeled as mental illness when people with the dominant power in the society consider certain behavior or actions as unacceptable and incomprehensible.

However, some scholars (Gove, 1982; Link, Struening, *et al.*, 1989) have argued that it is the aberrant behavior of the mentally sick person that is the source of stigma and discrimination. Gove (1982), in particular argued that society has no influence at all on the causes of mental illness. He argued further that societal response to mental illness is

as a result of the aberrant behavior of the mentally ill, illness severity and social skill deficit. Link (1987) conducted a study to find out whether members of the public stigmatize people with mental illness because of their aberrant behavior. The result indicated that members of the public were likely to stigmatize persons that are labeled mentally ill even without the aberrant behavior.

The arguments of sociologists on labeling and mental illness align with either Scheff's or Gove's position. It suffices to argue here that both Scheff and Gove have presented logical arguments on the issue of labeling and mental illness. The major point of departure between Scheff and Gove is that, whereas Scheff attributes the cause of stigmatization and discrimination of people living with mental illness to the influence of the society, Gove and Link attributed it to the aberrant behavior of the mentally sick person. Labeling individuals as mentally ill has deleterious effect on those concerned; however, it will be inappropriate to argue that the label alone causes mental illness. Symptoms of severe mental illness like inappropriate affect, bizarre behavior, language irregularities and talking to oneself aloud, physical appearance of persons with serious mental illness are the indicators of the mental illness that frighten members of the society (Corrigan, 2000b). It is these symptoms that are the cause of stigma and discrimination against mental illness.

A modified labeling theory has been developed by Link (1987). The modified labeling theory argues that although psychiatric label does not lead to mental illness, it leads to negative response from members of the society. The modified labeling theory asserts that the effect of cultural ideas can lead to stigma effect when the label is applied and this can cause people living with mental illness to feel devalued and rejected. The expectations of labeling can have a negative effect on people with mental illness. They

may conceal the mental illness; they may withdraw from psychiatric treatment or seek treatment in churches or from the traditional healers, and they may withdraw from the society. Because they anticipate rejection from members of the public, they act in a way that fosters rejection and this can lead to a feeling of diminished self esteem which becomes a social reality that serves as empirical indicator of the label (Link, *et al.*, 1989). This can make mentally ill people to act defensively or with less confidence. Sometimes they may even avoid social interactions (Link, *et al.* 2001).

There are strengths and weaknesses of the labeling theory. First, the theory has been criticized for ignoring the genetic and socio psychological factors as significant life events which cause mental illness, but rather emphasizing the role of society as cause of mental illness. This therefore trivializes a serious health problem of mental disorder. Gove (1982), for example, argued that mental hospitals have vigorous screening processes before admitting patients in the hospital. People who are admitted in the hospital are those that have been diagnosed with the mental illness are seriously impaired as a result of the disorder and need professional help. Labeling therefore may not be a major factor in chronic mental illness. Secondary, diagnoses are done with utmost confidentiality between the doctor and the patient, and in most cases the result is not disclosed to the patient or family and members of the public. People may therefore not know whether a person has been diagnosed with mental illness. Although the persons with mental illness or their relatives may sometimes disclose the illness to people, it may not be on a large frequency to warrant stigmatization or discrimination.

Despite the shortcomings of the labeling theory, it is still an important framework for understanding the effect of stigma and discrimination associated with the devalued status of person's living with mental illness;

First, the theory explains the mechanism by which labels of mental illness are applied and a person's self conception and opportunities are altered. For example, members of the public attach labels to behavior of people with mental illness which deviate from the acceptable norms of behaving in the society. These behaviors may include unremitting deviation from normal ways of functioning like talking to oneself, exhibiting behavior that is not appropriate to a given situation, dirty appearance, aggressiveness and social skill deficit etc. These aberrations are the behaviors which members of the public consider as signs of mental illness which are violations of societal norms. Based on the cultural beliefs about mental illness, people with these ways of behaving are likely marked out for avoidance and rejection by members of the public. Consequently, members of the public begin to exhibit negative reactions towards people with mental illness. From the findings of the study, members of the public have negative attitude towards mental illness, especially those that are aggressive. These negative attitudes are demonstrated in the study through members of the public refusing to interact with people having mental illness, refusing to share rooms with them, refusing to give sensitive tasks like babysitting, refusing to give them post of responsibility, refusing to marry from such families, refusing to give them jobs, etc. This finding is in line with the assumptions of the labeling theory that people with mental illness are stigmatized and discriminated by members of the public. For example in the study, 58.3% of members of the public indicated that they would vacate their houses if a person with mental illness is staying in the same compound with them.

The theory is also important to this study because it describes the process by which the attitude of members of the public can alter the self concept of people living with mental illness and shape their identity. For example, people living with mental illness are likely to develop the concept of who they are based on the reaction of members of the public

towards them. They may develop a better concept of themselves if the attitude of members of the public towards them is positive; however, they are likely to internalize a negative concept of themselves if the reaction of members of the public towards them is negative. This will likely have effect on their relationship with members of the public, as they are likely to experience negative reaction from them. They are also likely to become alienated and withdraw from public contact to avoid discrimination and avoid seeking treatment for their mental illness. This theory also helps to explain the negative effect of labeling on self concept. In the study it was revealed that 67.9% of people living with mental illness sampled (318 out of 468 of the respondents) had elevated internalized scores while 32.1% of the respondents had minimal levels of internalized stigma. Based on the premise of the labeling theory therefore, it means that the attitude of members of the public have affected the self concept of people with mental illness in the study, especially those attending traditional psychiatric care. Thus in the interview, some people with mental illness complained that they often feel ashamed of themselves because of the attitude of members of the public and avoid going to public places.

This theory explains the way people living with mental illness can cope with the stigma they face from members of the public. From the study, people with mental illness interviewed revealed that they avoid going to public places because of the insults they anticipate from members of the public as a result of their mental illness. Some of them said they hide their mental health condition from members of the public.

## **CHAPTER THREE**

### **3.0 Methodology**

#### **3.1 Location of the Study**

The study was conducted in Benue State, which is located in the North Central geopolitical zone of Nigeria. There are many sub-cultures in the state because it is made up of a wide variety of ethnic group. These are Tiv, Idoma, Igede, and other ethnic groups such as Etulo, Jukun Abakwa, Nyifom, Hausa, Ibo, Yoruba etc. Many factors were taken into consideration before choosing Benue State as the study location. To start with, Benue State was deemed appropriate for the study because of the existence of two tertiary psychiatric hospitals in the state - Federal Medical Center Makurdi, and Benue State University Teaching Hospital Makurdi, Federal Medical Center Makurdi and Benue State University Teaching Hospital Makurdi have psychiatric sections where people with mental illness are treated by trained orthodox health care professionals. People with serious cases of mental illness are hospitalized and given medication until they improve before they are released on parole while they continue to come for checks. There are also many traditional hospitals like Chief Tumba Traditional Psychiatric Hospital, Ugee Mbalav, Ikurav-ya; Ortwer Agishi Traditional Hospital Abakwa, Buruku; Tikaar Adawegh Mental Clinic, Tsegende Saghve Guma Local Government Area; Alhaji Mental Hospital, Eupi, Okpoku and Ichavo traditional Mental Hospital, Oju. These traditional psychiatric doctors are spread throughout the state; both in the urban and rural areas, and they perform different cultural and religious ceremonies for the treatment of mental illnesses although they have not been officially recognized by the ministry of health.

The selection of this location of study was also influenced by previous study by Tormusa (2015) among the Tiv people of Benue and Alago in Nassarawa States that have established the existence of stigma and discrimination but have failed to; 1, include other ethnic groups in Benue State, 2, failed to include the experiences of the people living with mental illness and their family members and 3, ascertain the level of stigmatization of mental healthcare professionals towards people living with mental illness in Benue State. It was assumed that the inclusion of other ethnic groups in the State would give a broader view of stigma and discrimination.

### **3.2 Population of the Study**

The population for this study included;

- i. People living with mental illness. These are people who were 18 years and above, male and female, diagnosed as having a major mental illness (psychosis, mood disorders and substance disorders) by either an orthodox or traditional psychiatric doctor, and were receiving treatment at either the in-patient or out-patient Department (OPD) of the psychiatric units of Federal medical Center Makurdi and Benue State University Teaching Hospital Makurdi. Records from Federal Medical Center Makurdi (FMC, 2015) showed that there were 112,200 names of people on the register receiving treatment for mental illness at the hospital. Similarly, statistics from Benue State University Teaching Hospital Makurdi indicated that about 1478 people living with mental illness attended the hospital between 2013 and 2015 for treatment of mental illness (Medical Records, BSUTH, 2015). Data on the distribution of population by mental illness showed that, 6,642 cases of people living with mental illness were

recorded in the state during the 2006 National Population and Housing Census. This is made up of 3,641 males and 3,001 females (NPC, 2009). Furthermore, people with mental illness receiving treatment at the traditional psychiatric hospitals at Chief Tumba in Ugee Mbalav, Ortwer Agishi in Adi, and Alame Mental Center in Abinste, Alhaji Mental Hospital Eupi Otukpo and Ichavo Traditional Hospital Oju also formed part of the population of the study.

- ii. Family member of people living with mental illness. These were people who were 18 years and above, males and females who were principal caregivers to people living with mental illnesses. The family members of the persons with mental illnesses were those that were biologically related to the mentally sick person and have followed them to the hospital. Such a family member must have stayed with the mentally sick member for a period of not less than one year. The relative or caregiver included parents, brothers, sisters and friends of the person having mental illness.
  
- iii. Mental health care professionals were also selected because of their in-depth knowledge about the experiences of people living with mental illness as a result of their regular contact with them. They must be working in Federal Medical Center Makurdi, Benue State University Teaching Hospital Makurdi or Traditional health care center. They included psychiatric; Doctors, Nurses, Social workers and traditional psychiatric doctors.

- iv. Members of the public included males and females who were 18 years above and residing in Benue State. They were selected for the study because they lived and interacted with people living with mental illness.

### **3.3 The Study Design**

The study was a descriptive cross sectional survey design. A key strategy of the study was the use of both quantitative and qualitative data. The main purpose for adopting this mixed method was to triangulate findings to achieve the aims of the study.

### **3.4 Sample Size Determination**

The sample size for this study was 1405 comprising of 400 members of the public, 468 people living with mental illness (399 attending Orthodox health care centers and 69 from Traditional), 468 of their family members, and 63 orthodox and 6 traditional mental health care professionals.

The sample size for members of the public was determined using Taro Yamane (1967) formula for sample size determination. The total population of members of the public was obtained from the six local government areas selected for the study, thus:

The population of Kwande Local Government was =248,642 (NPC, 2006)

The population of Katsina- Ala Local Government was = 225,471 (NPC, 2006)

The population of Buruku Local Government was = 206,215 (NPC, 2006)

The population of Guma Local Government was = 194,164 (NPC, 2006)

The population of Okpoku Local Government was = 175,596 (NPC, 2006)

The population of Oju Local Government is was = 168,491 (NPC, 2006)

N= 2,738,579 = total population of members of the public in the 6 selected LGAs

$$n = \frac{N}{1 + N(e)^2}$$

Where: n = sample size

e = level of significance (0.05)

$$n = \frac{2,738,579}{1 + 2,738,579(0.05)^2}$$

$$n = \frac{2,738,579}{1 + 2,738,579(0.0025)}$$

$$n = \frac{2,738,579}{1 + 6846.4475}$$

$$n = \frac{2,738,579}{6847.4475}$$

$$n = 399.9415 \approx 400$$

The sample size for people living with mental illness attending clinic at Federal Medical centre Makurdi and Benue State University Teaching Hospital Makurdi was also arrived at using Taro Yamane (1967) formula;

$$n = \frac{N}{1+N(e)^2} \quad e = \text{level of significance (0.05)}$$

Where  $n = 113678$  = total population of people living with mental illness at Federal Medical centre Makurdi and Benue State University Teaching Hospital Makurdi and  $e = 0.05$  is the level of significance.

$$n = \frac{113678}{1 + 113678(0.05)^2}$$

$$n = \frac{113678}{285.195}$$

$$n = 398.59745 \approx 399$$

This sample size for people living with mental illness receiving treatment from traditional hospitals was determined using Taro Yamane (1967) formula

$$n = \frac{N}{1 + N(e)^2}$$

Where;  $n = 83$  = total population of people living with mental illness attending traditional healthcare at the selected centers in the six local government areas, and  $e = 0.05$  is the level of significance.

$$n = \frac{83}{1 + 83(0.05)^2}$$

$$n = \frac{83}{1.2075}$$

$$n = 68.7370 \approx 69$$

The sample size for people living with mental illness receiving treatment at the Orthodox healthcare centers (399) were added to those receiving treatment at the traditional healthcare centers (69) to give a total of 468 which formed the total sample size for people living with mental illness.

The sample size of orthodox mental health care professionals was arrived at using Taro Yamane (1967) formula

$$n = \frac{N}{1 + N(e)^2}$$

Where;  $n = 75$  = total population of orthodox mental health care professionals at Federal Medical centre Makurdi and Benue State University Teaching Hospital Makurdi, and  $e = 0.05$  is the level of significance.

$$n = \frac{75}{1 + 75(0.05)^2}$$

$$n = \frac{75}{1.1875}$$

$$n = 63.1579 \approx 63$$

Furthermore, six traditional mental health care professionals were also selected from the six local government areas for the study, using the availability method. This enabled the researcher to gain an understanding of the different perspectives of health care professionals on social stigma and discrimination among those receiving treatment at the orthodox and traditional hospitals.

### **3.5 Sampling Procedure**

#### **3.5.1 Selection of members of the public for the study**

Multi-stage cluster sampling procedure was used to select 400 members of the public for the quantitative data collection. The multi stage cluster sampling method was used because of its convenience in finding the survey sample. In the first stage, the 23 local government areas in the State were clustered into three existing senatorial zones: Benue North East, Benue North West, and Benue South Senatorial Zones. The Benue north east comprised of seven Local Government Areas; Kwande, Konshisa, Vandeikya, Ushongo, Katsina Ala, Logo and Ukum. All the local government areas in Benue North East are predominantly inhabited by Tiv people except Katsina Ala which has a heterogeneous population. The Benue North West Senatorial District comprised of seven local government areas, namely Buruku, Gboko, Tarka, Guma, Makurdi, Gwer East and Gwer West. The local government areas in Benue North west are predominantly homogeneous except Buruku, Guma and Makurdi, with a heterogeneous population.

At the second stage, two local government areas were selected from each of the three zones in the state based on ethnic group affinity. This was to ensure that all the ethnic groups in the state were covered. In Benue North East, Kwande Local Government Area was selected because it is mostly populated by Tiv people, then Katsina Ala Local Government Area was selected because it is inhabited by the Tiv and Etulo. In the Benue North West Zone, Buruku Local Government Area was selected because the inhabitants are mostly Tiv, Abakwa and Nyifom. Guma Local Government Area was selected because it is inhabited by two different ethnic groups: Tiv, and Jukun.

Furthermore, in Benue South Senatorial District, Otukpo local government Areas was selected because of the Idoma ethnic group, while Oju Local Government Area was selected because of the Igede ethnic group. The reason for selecting the tribes in the state was to get their perspectives on attitude to people living with mental illness.

At the third stage, one council ward each from the six local government areas were selected. The purposive sampling technique was considered appropriate at this stage because of the desire to include all the ethnic groups in the study. The fourth stage was the selection of compounds proportionately to the population of each of the council wards. 41 compounds were selected from Lieve 11 in Kwande Local Government, 37 from Township council ward, 34 from Binev in Buruku Local Government, 32 from Nzorov in Guma Local Government, 29 in Okpokwo Township and 27 in Oju council ward, making a total of 200 compounds from the six council wards. A list of the numbering of housing units was obtained from NPC (2006) and used as the sampling frame and using a table of random numbers, the researcher selected the desired housing units. The final stage was the selection of the respondents. The researcher then proceeded to the sampled compounds and selected two adult males and females in each of the housing units based on availability. This process continued until the required units for all the Local Government Areas were obtained. Thus:

$$\text{Kwande Local Government Area } \frac{248,642 \times 400}{1218579} = 82 \text{ participants}$$

$$\text{Katsina-ala Local Government Area } \frac{225,471 \times 400}{1218579} = 74 \text{ participants}$$

$$\text{Buruku Local Government Area } \frac{206,215 \times 400}{1218579} = 68 \text{ participants}$$

$$\text{Guma Local Government Area } \frac{194,164 \times 400}{1218579} = 64 \text{ participants}$$

$$\text{Okpokwu Local Government Area. } \frac{175,596 \times 400}{1218579} = 58 \text{ participants}$$

$$\text{Oju Local Government Area. } \frac{168,491 \times 400}{1218579} = 55 \text{ participants.}$$

From the above calculation, kwande Local Government Area with a population of 248,642 was allocated 82 respondents; K/Ala Local Government Area with a population of 225,471 accounted for 74 respondents; Buruku Local Government Area with a total population of 206,215 accounted for 68 respondents; Guma Local Government Area with a population of 194,164 accounted for 64 respondents; Okpokwu Local Government Area with a population of 175,596 accounted for 58 respondents and Oju Local Government Area with a population of 168,491 accounted for 55 respondents. Therefore a total of 400 members of the public were selected in the 6 local government areas. Members of the public were considered important for the study because they interacted daily with people living with mental illness, and their attitude towards them helped in their rehabilitation and integration.

### **3.5.2 Selection of people living with mental illness for the study**

To recruit the sample of people living with mental illness, the researcher and his research assistants regularly visited on clinics days, the psychiatric units of Federal Medical Center Makurdi (Tuesdays and Thursdays) and the Benue State University Teaching Hospital Makurdi (Mondays and Fridays): They requested for a register of all the people living with mental illness reporting for treatment at the clinics, and with the assistance of healthcare professionals collected their case files and sorted them out

according to those that met the inclusion criteria. Those that met the inclusion criteria for that day were then used to develop the sampling frame from which the selection was done. The sample obtained from Federal Medical Center Makurdi (FMCM) and Benue State University Teaching Hospital (BSUTH) was done proportionately based on the number of people attending these hospitals as follows;

$$\text{FMCM} = \frac{112200}{113678} \times 399 = 394 \text{ participants}$$

$$\text{BSUTH} = \frac{1487}{113678} \times 399 = 5 \text{ participants}$$

Simple random sampling using a table of random numbers was then used to select ten participants on every clinic day. This selection process was used because it eliminated bias by availing all the participants the opportunity of being selected. This was done by writing names of all the people living with mental illness that met the inclusion criteria with serial numbers. These numbers were then compared with table of random numbers. Those participants with serial numbers that fall within the required range of numbers on the table were selected. This process continued until 399 participants receiving treatment at Federal Medical Center Makurdi (FMCM) and Benue State University Teaching Hospital (BSUTH) were selected respectively. The researcher and his assistants requested for an office in the hospital complex where the selected participants were asked to come after their consultation with the doctors. The selected participants were then issued with the questionnaire and later on interviewed. 24 people living with mental illness were selected purposively for the interview.

The researcher purposively selected six (6) traditional health care centers, one from each of the six local government areas sampled for the study. The selected centers were;

Chief Tumba Mental Hospital Ugee in Kwande local Government Area, Otwer Agishi in Adi, Buruku Local Government Area, Alame mental Hospital, Abinste, Guma Local Government Area, Alhaji Mental Hospital, Eupi, Otukpo Local Government Area, Ichavo Traditional mental Hospital, Idao, Oju Local Government Area and Anyam mental Hospital, in Otukpa. The choice of purposive sampling at this stage was informed on the basis that these traditional health care centers possessed particular characteristics being sought.

The main criteria for selection of the traditional health care centers were those that specialized in treatment of mental illness and must have operated the center for more than six to ten years. It was assumed that within the period of ten years, the traditional health care professional must have obtained adequate experience about people living with mental illness.

The sample obtained from each of the centers was done proportionately based on the number of people with mental illness receiving treatment from each of the selected traditional health care centers.

Chief Tumba Mental Hospital Ugee in Kwande local Government Area:  $\frac{15}{83} \times 69 = 13$  participants

Otwer Agishi in Adi, Buruku Local Government Area:  $\frac{9}{83} \times 69 = 7$  participants

Alame Mental Hospital, Abinste, Guma Local Government Area:  $\frac{21}{83} \times 69 = 17$  participants

Alhaji Mental Hospital, Eupi, Otukpo Local Government Area:  $\frac{12}{83} \times 69 = 10$  participants

Ichavo Traditional Mental Hospital, Idao, Oju Local Government Area:  $\frac{11}{83} \times 69 = 9$  participants

Anyam Mental Hospital, in Otukpa:  $\frac{15}{83} \times 69 = 13$  participants

In order to select the required sample size, the researcher approached traditional psychiatric Doctors in Ugee Mbalav in Kwande Local Government Area, Otwer Agishi in Adi, Buruku Local Government Area, Alame Mental Hospital in Abinste, Alhaji Mental Hospital, Eupi in Otukpo and Ichavo traditional Hospital, Idao in Oju Local Government Area of Benue State, and used a similar table of random numbers in selecting people living with mental illness receiving treatment there. In each traditional hospital, the researcher with the help of his assistants and the traditional psychiatric doctors sorted out the patients that that have suffered from psychosis, mood disorders and substance abuse disorder and have recovered and were able to engage in intelligible discussion. Those selected were listed to form the sampling frame at each center. In the end, 69 people with mental illness were selected using table of random numbers. Specifically, 13 out of 15 were selected at Chief Tumba Mental Hospital Ugee in Kwande local Government Area; 7 out of 9 were selected at Otwer Agishi in Adi, Buruku Local Government Area, 17 out of 21 in Alame mental Hospital, Abinste, Guma Local Government Area; 10 out of 12 in Alhaji Mental Hospital, Eupi, Otukpo Local Government Area; 9 out of 11 in Ichavo Traditional mental Hospital, Idao, Oju Local Government Area and 13 out of 15 in Anyam mental Hospital, in Otukpa.

The main inclusion criteria for selection of people living with mental illness were persons diagnosed with a major mental disorder (psychosis, mood disorders, and substance abuse disorder) by a modern or traditional psychiatrist, as showing gross mental condition (for example evidence of hallucination, delusions and grossly abnormal behavior) but were medication compliant, and were capable of engaging in intelligible discussion as assessed by the healthcare professionals and relatives' of the person with mental illness. Those persons selected gave informed consent, were accompanied by a care giver and were aged 18 years and older.

The principal exclusion criteria was people with mental illnesses that were fairly unstable, as assessed by either the family members or the psychiatrists, as being unable to engage in intelligible discussion. In all, 68 people with mental illness were identified as unintelligible and excluded from the study.

### **3.5.3 Selection of family members of people with mental illness for the study**

As people with mental illness were selected, 468 of their family caregivers who accompanied them to the orthodox and traditional hospitals were also selected based on availability. The criteria for selection were: The person must be a blood relation to the mentally sick person and must have stayed with the mentally sick person for at least six months. The interviews with the family members and people with mental illness in the traditional psychiatric hospitals took place in huts and shades of trees as was provided by the traditional psychiatric doctors. 23 caregivers were selected for the in-depth interview using the purposive method.

### **3.5.4 Selection of mental healthcare professionals for the study**

Samples of mental health care professionals were obtained using a stratified random sampling method. The sampling frame consisted of 44 mental healthcare professionals from Federal Medical Center Makurdi and 31 from Benue State University Teaching Hospital Makurdi. All together, there were 17 doctors, 41 nurses, 5 CHEW and 6 social workers which were considered as the strata, making a total of 75 healthcare professionals from the two Hospitals. Samples were taken proportional to the population size of each group of health care professionals. The stratified random sampling method was used because all categories of mental healthcare professionals were selected thus eliminating bias in the sampling process. On each clinic day, the researcher and his assistants collected the names of staff on duty from the hospital management, stratified them according to their departments, and then used the simple random sampling to select participants from each group of healthcare professionals. Those on duty at the hospital were then selected and interviewed individually in their offices in the Hospital, after obtaining their consent. From this process, 14 Psychiatrist Doctors, 35 psychiatrist nurses 4 community healthcare workers 5 social workers and 5 hospital support staff were selected for the study. Interviews were held with 19 mental healthcare professionals who were purposively selected.

### **3.6 Instruments for Data Collection**

The instruments of data collection for the study were questionnaire, in-depth interview guide and observation checklist. The questionnaire was selected because of their suitability for making statistical inferences from a sample of a parent population (Smith, 1988) The questionnaire included; community attitude towards mental illness scale

(CAMI) developed by Taylor and Dear in (1981), the internalized stigma of mental illness scale developed by Ritsher et al. (2003), questionnaire for family members of people living with mental illness and questionnaire for mental healthcare professionals. To administer questionnaire to the non literate members of the public and people living with mental illness, the study adopted a back translation method. This means that the English version of the questionnaire was translated in the local dialect and back translated into English language by selected lecturers of Benue State University who were from the ethnic groups selected for the study. The persons were knowledgeable in both English and the local dialect; they agreed on the exact translation of the meaning of all the questions in both English and the local dialects. The same questions were then administered to all the respondents for the study.

In the questionnaire for members of the public, the study adopted the community attitude to mental illness scale (CAMI) developed by Taylor and Dear in (1981). The scale is a standardized questionnaire with acceptable reliability and validity for measuring public attitude towards people with mental illness. It consisted of 43 items which were grouped into 4 subscales of 10 items each: 1. The beliefs among members of the public that people with mental illness are inferior to normal people and they need coercive handling; 2. The beliefs among members of the public that people with mental illness needed empathy on account of their mental health condition 3. The beliefs among members of the public that people with mental illness are dangerous and unpredictable and needed to be restricted and 4. The general attitude of members of the public on establishing mental health care facilities in the neighborhood.

The questionnaire was administered to 400 members of the public. The analyses of these questions were based on the percentage of respondents agreeing or disagreeing with each of the statements, but some answers were dichotomous (Yes/No) except when the variable measured the reason for a certain decision. When the variable measured a reason for a certain decision, respondents were expected to provide a short statement indicating justification. Section A of the questionnaire contained the socio-demographic attributes of respondents consisting of age, gender, educational attainments, occupation and religious affiliation, while section B focused on getting information from members of the public on their attitude towards people living with mental illness and interventions that will reduce stigma against people living with mental illness in Benue State. The questionnaires were issued to members of the public by the researcher and the research assistants.

The questionnaires were interviewer administered. This was to take care of non literate participants. This was to make them understand and answer each question as accurately as possible. The questionnaires were read to the interviewee and answers recorded accordingly by the researcher or his assistants. All the items on the sub scale reported high internal consistency as the reliability analysis revealed a Cronbach Alpha coefficient of 0.754 (see Appendix VIII).

The questionnaire for people living with mental illness was adopted from the internalized stigma of mental illness scale developed by Ritsher *et al.*, (2003) designed to examine an individual's personal experience of stigma related to mental illness. The scale was made up of twenty eight items grouped into five subscales viz: alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance. All the subscale measured aspects of stigma experienced by people having

mental illness. The alienation subscale which had six items measured the subjective experience of stigma by people with mental illness. The endorsement subscale had seven items and measured the extent to which people with mental illness agreed with the public stereotype of mental illness. The discrimination experience subscale had five items which measured the way people with mental illness are treated by others. The social withdrawal subscale which has six items, measured the social withdrawal of respondents, and the social resistance subscale with five items measured aspects of stigma resistance.

Each items were rated on a four point Likert scale (1(0) strongly disagree; 2(1) =disagree; 3= (2) agree; and 4(3) =strongly agree). The prevalence of internalized stigma was defined as an item mean scores of 1.5 or above on the aggregate score. Higher aggregate scores indicated elevated internalized stigma. This means that the 1.5 will represent the midpoint on the 0-3 item scale (Brohan, *et al.*, 2010). Open ended questions were also added to enable respondent's state their personal experiences of discrimination they face due to mental illness.

This subscale has been used in previous studies (Ghanean, *et al.*, 2011, Mahmoud and Zaki 2015). All the items on the sub scale reported high internal consistency as the reliability analysis revealed a Cronbach Alpha coefficient of 0.918 (see Appendix VIII).

The fifth stigma subscale (stigma resistance) was not part of aggregate mean score when calculating the prevalence of internalized stigma of mental illness on people living with mental illness because it had a low reliability, possibly because most items on this subscale were scored on a reversed order (were phrased as positive characteristic). More

questions were however used to probe participants answers to enable them provide other necessary information relevant for the study.

The questionnaire for family members of people living with mental illness consisted of 20 items aimed at examining their experience of social stigma and discrimination. The questionnaire for orthodox mental healthcare professionals contained 16 items while the one for traditional mental health care practitioners consisted of 17 items developed by the researcher, aimed at finding out if they reacted differently from other members of the public towards people living with mental illness. Interviews were also held with people living with mental illness, their care givers and mental healthcare professionals. The interview guide for people living with mental illness was made up of 9 questionnaire items aimed at finding out their personal experience of having mental illness, while the interview guide for caregivers had 12 items aimed at finding out their experience of having a relation with mental illness. The guide for healthcare professionals had 12 questionnaire items and was aimed at examining their attitude towards people with mental illness. Each session of the interview lasted between 10 and 25 minutes. The interviews took place in office rooms allocated to the researcher for that purpose. Notes and tape recorders were used to record the interviews.

A structured observation guide was designed and used by the researcher to observe and collect data on attitude of mental healthcare professionals towards people with mental illness during clinic visit, the organization of the hospital. Health care professionals were informed that they were been observed and they were asked to sign a consent form. The observation took place during clinic visits when consultation was going on. Two observations took place each at BSUTH and FMC Makurdi and one each at the traditional psychiatric hospitals. The researcher observed and took notes. The use of the

observation method was to complement the other methods so as to achieve a better result and realize the aim of the study. The information acquired as a result of the observation was interpreted and analyzed to achieve the objectives of the study.

### **3.7 Recruitment and Training of Field Assistants**

The research team comprised of six assistants recruited from each of the major ethnic groups that participated in the study. These ethnic groups were; Tiv, Etulo, Abakwa, Nyifom, Idoma and Igede. The research assistants were undergraduate Sociology students. Further, they were people who were conversant with the terrain and could write in English and the language of the population of the study. The research assistants helped in the data collection for the study, including conduct of interviews. The researcher trained the assistants for three days on how to administer and retrieve the questionnaire. The researcher also supervised the works of the assistants. The research assistants were paid stipends after the data collection for the work done.

### **3.8 Pilot Study**

The researcher and the research assistants conducted a pre-test with selected members of the population of the study, but who were not among the participants. Each assistant administered questionnaire independently to different participants and then compared the consistency of results. This was to ensure good inter-rater reliability of the research instruments. The selected sites for the pretests were FMC Makurdi and Alam Traditional Psychiatric Hospital Ugee, Agboor, behind Modern Market, Makurdi. In the pre-test, participants complained about comprehending the meaning of some questions.

The researcher corrected this problem by changing the difficult words in the questionnaire to make them more comprehensible.

### **3.9 Instruments of Data Analysis**

The data collected from the questionnaire, interviews and observation was computer processed. First data retrieved from the questionnaires were coded appropriately into the Microsoft 2010 Excel Spreadsheet and later transferred into the SPSS version 23, IL, USA for statistical analysis. To obtain the distribution of views of members of the public towards mental illnesses, the responses to the questionnaire (community attitude towards mental illness) instrument were subjected to simple frequency and mean (SD). The analysis was executed at univariate and bivariate levels. At the univariate levels, the data collected was put in tables and analyzed using descriptive statistics such as frequencies and percentages. At the bivariate levels, the chi-square was used to cross tabulate some stigma items with independent variables like sex, age, marital status, occupation and ethnic group. The reason for the cross tabulation was to determine the cross effect of the independent variables on the attitude of members of the public towards mental illness.

Secondly, to obtain the prevalence of internalized stigma among people living with mental illnesses, the responses from each sub-section of the internalized stigma of mental illness questionnaire were grouped proportionally as “minimal internalized stigma” (represented by mean scores below 1.5) and “elevated internalized stigma” (represented by mean scores above 1.5). A mean score of 1.5 and below was considered as a minimal internalized scale, while a mean score of 1.5 and above was considered as elevated internalized stigma. An independent t-test was done to determine the

prevalence of elevated internalized stigma for people living with mental illness attending orthodox and traditional healthcare in Benue State.

For the analysis of the qualitative data, the interviews were tape recorded after consent from the respondents was received. The recorded interviews were then played over and over to make sure that the themes in the interview are captured properly. Each recorded interview was then transcribed into English within 24 hours before the researcher moved on to interview the next participant. The transcription was done by playing the recorded interviews and recording verbatim what was in the tape. Tapes were numbered and coded to differentiate the interview of each respondent. This helped the researcher to reflect on the ideas of the interview before the information may be forgotten. All notes taken during the course of the IDIs were examined to identify the themes that were similar with the recorded interviews.

The researcher then made decisions and conclusions on the data collected by analyzing specific statements from the interview and triangulating them with the quantitative data. This involved presenting the statistical analysis of the quantitative data and complementing it with result of the qualitative data to present a robust result. All areas of convergence and divergence in the quantitative and qualitative data were noted and sociological reasons advanced appropriately.

For the analysis of the observational data, behavior and events acted by people with mental illness that were regular was considered as their way of behaving and recorded. The summary of such recorded events were included in the descriptive analysis. Some sets of data obtained from the quantitative and qualitative data were triangulated in order to cross check findings. The inferences from the interviewed participants and

observation were compared with the survey data with the aim of identifying areas of convergence and divergence. Through this process, conflicting explanations were resolved by advancing probable reasons for such occurrences. This helped the study to provide a better picture of the social stigma and discrimination against people living with mental illness in Benue state.

### **3.10 Ethical Considerations**

Ethical approval for this study was obtained from Health Research Ethical Committees of Benue State University Teaching Hospital Makurdi and Federal Medical Center Makurdi (Appendix V111). Individual consent for participation was obtained through a participation information sheet, which was administered by the researcher and research assistants. The document was presented to the participants. It indicated the aims and objectives of the study. On the sheet, a place was provided for the participants to indicate consent by signing. Participants were not compelled to participate in the study, and the participants were informed that they were at liberty to withdraw from participating in the study at anytime and for any or no reason. This was done to avail the participants the opportunity of withdrawing whenever they began to experience anxiety in the course of the research.

The participants were also assured that the information they provided would be treated with confidentiality and used only for the purpose of this study. They were also assured of anonymity as the researcher promised not to disclose their identity in the publication of the study. The participants were further informed that they were at liberty to stop the audio recording of the interview at anytime them so wished. In addition, they were informed that as soon as the transcription was completed, the recorded cassette was

destroyed. Furthermore, the participants were informed that they are free to arrange for the interview in a place that was convenient and safe for them. This was to make them feel at ease in participating in the interview. Approval for the study was obtained from the Benue State Ministry of Health.

### **3.11 Problems Encountered in the Field**

In the course of collecting data from the field, the following problems were encountered:

1. First was the difficulty of obtaining a letter of ethical approval from the Federal Medical Center Makurdi and Benue State University Teaching Hospital Makurdi. It took more than five months of persistent visits and complaints to the authorities of the hospitals before the ethical approval was issued to the researcher.
2. The second was the problem of granting consent to be interviewed. The people with mental illness were reluctant to volunteer information; most of them denied being ill and refused to be interviewed. The researcher was even attacked by a lady having mental illness who had earlier, before the interview commenced, seemed fairly stable. The lady who was initially cooperating suddenly started accusing the researcher of spying on her and she suddenly moved to attack the researcher. The challenge was resolved through rapport building with the lady and the assistance of the health care professionals. The cooperation from health care professionals enabled the researcher to conduct the interviews in the various hospitals visited.

3. The researcher also had problem with members of the public during data collection. There was a lot of apprehension from members of the households seeing people moving from house to house to collect data. But the presence of the research assistants helped to douse the suspicion since they were indigenes of most of the places visited for the data collection. This helped the researcher to move about in the various compounds in the communities and collect data from members of the public.

## **CHAPTER FOUR**

### **4.0 Data Presentation and Analysis**

#### **Introduction**

This chapter presents results obtained from the quantitative and qualitative data collected for this study. Three sets of questionnaire are analyzed, the first one is on the public stigma against people living with mental illness; the second one is the internalized stigma of mental illness scale and the third one is the questionnaire to mental health care professionals. The result of the interview with people living with mental illness, their family members and mental healthcare professionals is also presented. This chapter was divided into seven sections; the first section is the introduction. The second section is a compendium of the socio demographic variables of the respondents; the third section is the analysis of data collected on the public attitude towards people living with mental illness. The fourth section presents a cross-tabulation of socio demographic attributes with other variables in the questionnaire. The fifth section gave the analysis of data on the internalized stigma of mental illness scale, the sixth section is the cross tabulation of socio-demographic attributes with other variables in the questionnaire. The last section discusses the major findings from the study. The outcome of the analysis from the collected data was used to draw up conclusions, make inferences and offer suggestions.

#### **4.1 Socio- Demographic Characteristics of Respondents**

Socio-demographic characteristics of members of the public and people living with mental illness are presented hereunder.

**Table 4.1.** Socio- Demographic Characteristics of Respondents

<b>Variables</b>	<b>Members of the public</b>		<b>People living with mental illness</b>		
	<b>Frequency</b>	<b>%</b>	<b>Frequency</b>	<b>%</b>	
<b>Age</b>					
n/r	13	3.3	n/r	10	2.2
18-25 years	136	34.3	18 – 25	122	26.1
26-35 years	160	40.4	26 – 35	158	33.7
36 and above	87	22.0	36 – above	178	38.0
<b>Total</b>	<b>396</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>
<b>Gender</b>					
n/r	17	4.3	n/r	14	3.0
Male	212	53.5	Male	254	54.2
Female	167	42.2	Female	200	42.8
<b>Total</b>	<b>396</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>
<b>Marital Status</b>					
n/r	17	4.3	n/r	8	1.7
Married	119	30.1	Married	170	36.4
Single	218	55.1	Single	234	50.1
Divorced	34	8.6	Divorced	27	5.8
Widowed	8	2.0	Widowed	28	6
<b>Total</b>	<b>396</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>
<b>Educational Qualification</b>					
n/r			n/r	15	3.3
No formal	37	9.3	No formal	94	20.1
Primary	23	4.8	Primary	95	20.2
Secondary	161	40.7	Secondary	212	45.4
Tertiary	147	27.1	Tertiary	51	11
<b>Total</b>	<b>369</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>
<b>Religion</b>					
n/r	11	2.8	n/r	5	1
Christianity	279	70.5	Christianity	409	87.4
Islam	52	13.1	Islam	27	5.8
Traditional	29	7.3	Traditional	27	5.8
Others	25	6.3	Others	-	-
<b>Total</b>	<b>396</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>
<b>Occupation</b>					
n/r	32	8.1	n/r	7	1.6
Farming	87	22.0	Farming	166	35.4
Civil servant	109	27.5	Civil servant	89	19.1
Trading	123	31.1	Trading	10	2.1
Others	45	11.4	Others	196	41.8
<b>Total</b>	<b>396</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>
<b>Ethnic group</b>					
n/r	32	8.1	n/r	14	3
Tiv	123	31.1	Tiv	217	46.3
Idoma	69	17.4	Idoma	108	23
Igede	48	12.1	Igede	53	11.4
Etule	33	8.3	Etulo	29	6.1
Abakwa	51	12.9	Abakwa	19	4.1
Nyifom	18	4.5	Nyifom	19	4.1
Jukun	7	1.8	Jukun	9	2
Others	15	3.8	Others	-	-
<b>Total</b>	<b>396</b>	<b>100.0</b>	<b>Total</b>	<b>468</b>	<b>100.0</b>

**Source:** Field survey,

Table 4.1 shows that 136 (34.3) members of the public were between 18 and 25 years, 160 (40.3) were between 26 and 35 years, while 87 (22.0%) the respondents were 36 years and above. This shows that members of the public between 26 and 35 years constitute the highest percentage of respondents. Again, out of 468 people living with mental illness, 122 (26.1%) were between 18 and 25 years, 158 (33.7%) were between 26 and 35 years while those 178 (38.0%) were between 36 years and older. The table therefore shows that respondents who were 36 years or older constitute the greater number of respondents. Majority 212 (53.5%) of members of the public were males, 167 (42.2%) were females, while 17 respondents (4.3%) did not indicate their gender. Of the 468 people living with mental illness, most 254 (54.2%) were males 200 (42.8%) were females.

218 (55.1%) of members of the public were single, 119 (30.1%) were married, 34 (8.5%) were divorced, 8 (2.0%) were widowed while 17 (4.3%) did not indicate their marital status. Majority of people living with mental illness 234 (50.1%) were single, 170 (36.4%) were married, and 27 (5.8%) were divorced while 28 (8.0%) were widowed. 161 (40.7%) of members of the public had secondary education, 147 (37.1%) had tertiary education, 37 (9.3%) had no formal education, 23 (5.8%) had primary education, while 28 (7.1%) did not indicate their educational qualification. This showed that a greater percentage of members of the public were literate. Most people living with mental illness, 212 (45.4%), had secondary education, 95 (20.2%) had primary education, 94 (20.1%) had no formal education, while 51 (11%) had tertiary education. This shows that most of the respondents had only secondary education.

Most members of the public 123 (31.1%), were engaged in other occupations, 109 (27.5%) were civil servants, 87 (22.0%) were farmers, 45 (11.4%) were engaged in trading while 32 (8.1%) of the respondents did not indicate their occupation. Majority 196 (41.8%), of people living with mental illness were engaged in other occupations, 166 (35.4%) were farmers, and only 89 (19.1%) were civil servants.

The study area is a Christian dominated area. Because of this, majority 279 (70.5%) of members of the public were Christians, 52 (13.1%) were Muslims, 29 (7.3%) were traditional worshipers, 25 (6.3%) belonged to other religions, while 11 (2.8%) did not indicate their religion. Majority 409 (87.4%) of people living with mental illness were Christians, 27 (5.8%) were Muslims, while 27 (5.8%) belonged to traditional religions.

A sizable number 123 (31.1%) of members of the public were of the Tiv ethnic group, 69 (17.4%) were Idoma, 51 (12.9%) were Abakwa, 48 (12.1%) were Igede, 33 (8.3%) were Etulo, 18 (4.5%) were Nyifom, 7 (1.8%) were Jukuns, 15 (3.8%) belonging to other ethnic groups while 32 (8.1%) did not indicate their ethnic group. Majority 217 (46.3%) of people living with mental illness were Tiv, 108 (23.0%) were Idoma, 53 (11.4%) were Igede, 29 (6.1%) were Abakwa, 19 (4.1%), were Etulo, 19 (4.1%) were Nyifom whereas 9(2.0%) were members of Jukun ethnic group.

## 4.2 Respondents' Perceived Causes of Mental Illness

This section presents the perceived causes of mental illness by members of the public.

**Table 4. 2:** Causes of mental illness.

Causes of mental illness	Frequency	Percentage (%)
Substance abuse	201	50.8
Attack from enemies	68	17.2
Punishment from gods	21	5.3
Hereditary	50	12.6
Others	44	11.1
N/r	12	3.0

**Source:** Field survey,

Table 4.2 shows that 201 (50.8%) of the members of the public sampled identified substance abuse as the major cause of mental illness, 68(17.2%) stated that mental illness is caused by an enemy, 50 (12.6%) identified heredity, 21 (5.3%) believed it is a punishment from gods, 44 (11.1%) believed it is from other causes which were not mentioned, while 12 did not indicate their response. This means that majority of the respondents identified substance abuse as the major cause of mental illness. Substance abuse is common among people in Nigeria, and a major cause of mental illness.

### **4.3 Public Attitude towards People with Mental Illness**

This section of the chapter examines the behavior of the public towards people living with mental illness in Benue State. To determine this, the section is divided into four sub-sections thus: 1.The beliefs among members of the public that people with mental illness are inferior and need a coercive handling 2.The beliefs among members of the public that people with mental illness needed empathy on account of their mental health condition 3.The beliefs among members of the public that people with mental illness are dangerous and unpredictable and needed to be restricted and 4.The general attitude of members of the public on establishing mental health care facilities in the neighborhood. The statements are worded either in a negative or positive form.

#### **4.3.1 The beliefs among members of the public that people with mental illness are inferior and need coercive handling**

This sub-section reflects a paternalistic view indicating that people with mental illness are of inferior class, cannot take care of themselves, are incapable of making well thought out decisions, and therefore require coercive handling. In this section, Members

of the public were expected to indicate whether they agreed or disagreed with these statements. Analysis of these statements is based on the number of members of the public who positively endorsed the statements in this section.

**Table 4.3** Proportion of members of the public who believed that people with mental illness are inferior and need a coercive handling.

<b>Statement</b>	<b>N/r (%)</b>	<b>Yes (%)</b>	<b>No (%)</b>
As soon as a person shows signs of mental illness he should be locked behind doors.	21 (5.3)	241 (60.9)	134 (33.8)
Less emphasis should be placed on protecting the public from the mentally ill.	19 (4.8)	124 (31.3)	253 (63.9)
Is there anything about people with mental illness that distinguishes them from normal people?	20 (5.1)	248 (62.6)	128 (32.3)
Mentally ill people need the same kind of control and discipline as a young child.	21 (5.3)	219 (55.3)	156 (39.4)
Mental illness is an illness just like any other.	3 (0.8)	163 (41.2)	230 (58.1)
One of the main causes of mental illness is lack of self-discipline and will power.	3 (0.8)	210 (53.0)	174 (43.9)
Keeping them behind locked doors is one of the best ways to handle the mentally ill.	21 (5.3)	241 (60.9)	134 (33.8)
Virtually anyone can become mentally ill.	7 (1.8)	195 (49.2)	194 (49.0)
The mentally ill should not be treated as outcasts.	19 (4.8)	195 (49.2)	182 (46.0)
Do you think the mentally ill should not be denied their individual rights?	27 (6.8)	189 (47.7)	180 (45.5)

**Source:** Field survey, 2018

Table 4.3 shows that most members of the public 241(60.9), agreed that as soon as someone showed signs of mental illness, they should be kept indoors to prevent violent attacks on members of the public. Interviewees expressed fear of attack, especially from mentally sick people that were aggressive, and stressed the need to lock up mentally sick people to prevent them from harming people in the community. Because of this, most members of public 253(63.9) also did not agree with the statement that less emphasis should be placed on protecting members of the public from the mentally ill, and most members of public 248 (62.6) felt there is something about people with mental illness that distinguishes them from normal people. When members of the public were asked the reason why they thought people with mental illness were different, 187(48.7) of them said their dresses are dirty, 144(28.8) said they roam about aimlessly.

Table 4.3 also shows that 210 (55.3) of the respondents agreed that people with mental illness need the same kind of treatment and discipline as young children, this portrays people with mental illness as child like, incapable of taking their own decisions and therefore requiring other people to make the right decisions for them. Most members of the public 230 (58.1), disagreed with the assertion that mental illness is an illness just like any other. This belief most likely makes members of the public to discriminate against mentally sick people for having a disease that is different from other diseases.

Furthermore, 210(53.0) of the respondents felt that one of the main causes of mental illness is lack of self discipline and will power while 241(60.9) felt that keeping people with mental illness indoors is one of the best ways to treat the mentally sick. Members of public 195(49.2) agreed that virtually anyone can become mentally ill. While 195(49.2) of the respondents agreed that mentally ill people should not be treated as

outcasts of the society. Meanwhile, 189(47.7) agreed that the mentally ill should not be denied their human rights.

#### **4.3.2 The beliefs among members of the public that people with mental illness need empathy on account of their mental health condition**

This sub section reflects the view that people living with mental illness are considered childlike and therefore deserving pity from members of the public because of their mental health condition. The aim of Table 4.4 is to ascertain whether members of public show empathy and care for people living with mental illness. The analysis of this table is based on the number of members of the public who positively endorsed the statements.

**Table 4.4:** Belief among members of the public that people with mental illness need empathy on account of their mental health condition

<b>Statements</b>	<b>N/r (%)</b>	<b>Yes (%)</b>	<b>No (%)</b>
The mentally ill are a burden to the society.	20 (5.1)	239 (60.4)	137 (34.6)
It is best to avoid anyone who has mental problems.	13 (3.3)	213 (53.8)	170 (42.9)
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.	21 (5.3)	183 (46.2)	192 (48.5)
Do you think increased spending on mental health services is a waste of tax payers' money?	7 (1.8)	229 (57.8)	160 (40.4)
The mentally ill do not deserve sympathy.	29 (7.3)	183 (46.2)	184 (46.5)
The mentally ill have for so long been a subject of ridicule.	20 (5.1)	184 (46.5)	192 (48.5)
We have the responsibility to provide the best possible care for the mentally ill	32 (8.1)	203 (51.3)	161 (40.7)
We need to adopt a more tolerant attitude towards the mentally ill in the society.	18 (4.5)	201 (50.8)	177 (44.7)
There are sufficient existing services for the mentally ill.	39 (9.8)	192 (48.5)	165 (41.7)
The best therapy for many mental health problems is to be part of a normal community.	14 (3.5)	220 (55.6)	162 (40.9)
People with mental illness should be encouraged to assume the responsibility of a normal life.	14 (3.5)	207 (52.3)	175 (44.2)

**Source:** Field survey, 2018.

Table 4.4 shows that 239(60.3) of the respondents felt that the mentally ill are a burden to the society. Those who subscribe to this stereotyped thinking are likely to have negative attitude towards people with mental illness; 213(53.8) of the respondents felt it is best to avoid someone with mental illness. It was observed that people avoid having social contact with people having mental illness, because of fear of attack from them. For this reason, people with mentally illness are socially excluded by members of the society. This was indicated by a person having mental illness in an interview:

I had friends before, but they have deserted me, all my friends as if I have no link with them. I don't go to public gatherings. When I go, people say bad things. (Male IDI / 30/ Christian /secondary school/ Igede/ single)

192(48.5) of members of the public did not agree that our mental hospitals seem more like prisons than hospitals where people can be treated, while 229(57.8) of the respondents felt that increased spending on mental health services is a waste of tax payer's money. This shows that members of the public will not likely support the spending of money on mental health. However, only 47.0 of the respondents agreed that people with mental illness do not deserve our sympathy, and 192(48.5) of the respondents disagreed with the statement that the mentally ill have for so long been the subject of ridicule.

Furthermore, 203(51.3) of the respondents felt that government should provide the best possible cure for the treatment of the mentally ill, 201(50.8) of the respondents felt that people should adopt a more tolerant attitude towards the mentally ill, and 192(48.5) of the respondents agreed there are sufficient existing health services for the mentally ill. Notably, 220(55.6) of the respondents agreed that the best therapy for mental illness is

to be part of a normal community, while 207(52.3) of the respondents felt that people with mental illness should be encouraged to assume the responsibility of a normal life. Except questions three and ten which indicate favorable responses from members of the public about mental illness, all the other questions on Table 4. 4 show that respondents' attitudes towards mental illness were negative.

#### **4.3.3 Attitude of members of the public on the beliefs that people with mental illness are dangerous and unpredictable and need to be restricted**

This sub-section is concerned with the portrayal of people with mental illness as people who are dangerous, unpredictable, and cannot be entrusted with important tasks and therefore need to be avoided. The aim of Table 4.5 is to show whether members of the public agreed with this common stereotype and avoided people with mental illness. The responses to the statements on table 4.5 were generally negative.

**Table 4.5:** Public attitude on the belief that people with mental illness are dangerous and unpredictable and need to be restricted

<b>Statements</b>	<b>N/r (%)</b>	<b>Yes (%)</b>	<b>No (%)</b>
Can you trust a woman who once suffered from mental illness for a baby sitter?	17 (4.3)	123 (31.1)	256 (64.6)
Do you think the mentally ill should not be given any post of responsibility?	4 (1.0)	244 (61.6)	148 (37.4)
Anyone with a history of mental illness should be excluded from contesting elections.	10 (2.5)	250 (63.1)	136 (34.3)
The mentally ill are less of a danger than most people think.	12 (3.0)	169 (42.7)	215 (54.3)
If you were a landlord, would you let your house out to a person with mental illness?	21 (5.3)	114 (28.8)	261 (65.9)
I will not employ a person with mental illness.	21 (5.3)	163 (41.2)	212 (53.5)
The mentally ill should be isolated from the rest of the community,	12 (3.0)	215 (54.3)	169 (42.7)
No one has the right to exclude the mentally ill from their residence.	27 (6.8)	190 (48.0)	179 (45.2)
Can you marry a man or woman who has suffered from mental illness if he/she seems to have recovered?	14 (3.5)	151 (38.1)	231 (58.3)
Have you ever vacated your house because of a mentally sick person staying in the same compound?	22 (5.6)	231 (58.3)	143 (36.1)

**Source:** Field Survey, 2018.

Table 4.4 shows that most members of the public 256(84.6) would not trust a woman who has suffered from mental illness as a baby sitter. This is because members of the public believed that people with mental illness are unpredictable, and may harm the baby. While 244(61) of the respondents felt that people who suffer from mental illness should not be given any post of responsibility, some members of the public said that people who suffer from mental illness have lost their sense of reasoning and cannot handle sensitive tasks. A greater proportion 250(63.1) of the respondents felt that people with mental illness should not be allowed to contest election.

However, 215(54.3) felt that people with mental illness are a danger to the society, and 261(65.9) and said they would not be willing to let out their houses to people with mental illness because of fear of them disturbing other tenants.

Similarly, 212(53.5) respondents said they would not employ a person with mental illness because of fear of relapse which may lead to loss of man hours at work. Furthermore, 215(54.3) respondents felt that people with mental illnesses should be isolated from the rest of the community, while 190(48.0) members of the public felt that no one has the right to exclude the mentally ill from their residence. Notably, 231(58.3) of the respondents said they would not marry a person who has suffered from mental illness even though the person has recovered.

Respondents interviewed believed that mental illness is hereditary and can be transferred from the affected person to another. Because of this, they were reluctant to marry a person with mental illness. A total of 231(58.3) respondents would vacate a house if a person with mental illness is living in the same compound, because the mentally sick are seen as a threat to people in the community.

#### 4.3.4 The general attitude of members of the public on establishing mental health care facilities in the neighborhood

The statements on this subscale measured the willingness or unwillingness of members of the public to allow the establishment of mental healthcare facilities in their neighborhood. This indicated sentiments of respondents on mental health and mental illness. Table 4.6 indicated that the respondents' attitude to mental health care ideology was generally negative.

**Table 4.6** Attitude of members of the public on establishing mental health care facilities in the neighborhood

Statements	N/r (%)	Yes (%)	No (%)
It is frightening to think of people with mental problems living in a residential neighborhood.	8 (2.0)	244 (61.6)	144(36.4)
Residents should accept the location of mental health facilities in their neighborhood to serve the need of the local community.	8 (2.0)	151 (38.1)	237 (59.8)
Local residents have good reasons to resist the location of mental health services in their neighborhood.	2 (0.5)	230 (58.1)	164 (41.4)
As far as possible, mental health care services should be provided through community based health facilities.	5 (1.3)	195 (49.2)	196 (49.5)
Mental hospitals are an outdated means of treating the mentally ill.	21 (5.3)	183 (46.2)	192 (48.5)
Mental health facilities should be kept out of residential neighborhoods.	7 (1.8)	229 (57.8)	160 (40.4)
Locating mental health care facilities in residential areas downgrades the neighborhood.	29 (7.3)	167 (42.2)	200 (50.5)
Having mental patients living within residential neighborhoods might be good for therapy but the risk to residents is great.	20 (5.1)	230 (58.1)	146 (36.9)
The best therapy for mental health problems is to be part of a normal community.	32 (8.1)	203 (51.3)	161 (40.7)

Source: Field Survey, 2016

Most 244(61.1) members of the public said they would be afraid to stay in the same neighborhood with people having mental illness. It is generally believed that people with mental illness are dangerous and aggressive and because of this, members of the public expressed fear of staying in the same neighborhood with them. However, 237(59.8) felt that residents should accept the location of mental healthcare facilities in the neighborhood to serve the interest of the local community, and 230(58.1) of the respondents felt that local residents have a good reason to resist the location of mental health care facilities in their neighborhood.

Furthermore, 196(49.2) of the respondents felt that mental health care facilities should not be provided through community based health care facilities; 192(48.5) felt that mental hospitals are not an outdated means of treating the mentally ill, and 229(57.8) felt that mental health facilities should be kept out of residential neighborhoods. Also, 200(50.3) of the respondents thought that locating mental healthcare in a residential area does not downgrade the environment, but 230(58.1) felt that having people with mental illness living within a neighborhood might be risky to residents. However, 203(51.3) felt that the best therapy for mental health problem is to be part of a normal community.

#### **4.3.5 Stigma stereotypes across the ethnic groups in Benue State**

This section used the chi square test to determine the different attitudes towards mental illness across the ethnic groups in the study. Table 4.7 showed a significant difference across the ethnic groups in the study towards stigma of mental illness.

**Table 4.7a** Attitudes towards mental illness across the ethnic groups in Benue State

Sigma items	Responses	Ethnic Groups									Total
		n/r O (E)	Tiv O (E)	Idoma O (E)	Igede O (E)	Etule O (E)	Abakwa O (E)	Nyifom O (E)	Jukun O (E)	Others O (E)	
The mentally ill are a burden to the society	NR	0	5	5	3	1	1	0	2	3	<b>20</b>
		(1.6)	(6.2)	(3.5)	(2.4)	(1.7)	(2.6)	(0.9)	(0.4)	(0.8)	
	Yes	22	69	36	26	21	40	14	4	7	<b>239</b>
		(19.3)	(74.2)	(41.6)	(29.0)	(19.9)	(30.8)	(10.9)	(4.2)	(9.1)	
	No	10	49	28	19	11	10	4	1	5	<b>137</b>
		(11.1)	(42.6)	(23.9)	(16.6)	(11.4)	(17.6)	(6.2)	(2.4)	(5.2)	
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 32.214, df = 16, p = 0.009</math></b>											
It is best to avoid anyone who has mental problems?	NR	1	5	4	0	0	1	0	2	0	<b>13</b>
		(1.1)	4.0	(2.3)	(1.6)	(1.1)	(1.7)	(0.6)	(0.2)	(0.5)	
	Yes	18	62	37	23	16	39	8	2	8	<b>213</b>
		(17.2)	(66.2)	(37.1)	25.8	(17.8)	(27.4)	(9.7)	(3.8)	(8.1)	
	No	13	56	28	25	17	11	10	3	7	<b>170</b>
		(13.7)	(52.8)	(29.6)	(20.6)	(14.2)	(21.9)	(7.7)	(3.0)	(6.4)	
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 33.951, df = 16, p = 0.006</math></b>											
Can you trust a woman who once suffered from mental illness as a baby sitter?	NR	1	5	4	1	2	1	1	1	1	<b>17</b>
		(1.4)	(5.3)	(3.0)	(2.1)	(1.4)	(2.2)	(0.8)	(0.3)	(0.6)	
	Yes	11	37	16	18	11	14	8	3	5	<b>123</b>
		(9.9)	(38.2)	(21.4)	(14.9)	(10.3)	(15.8)	(5.6)	(2.2)	(4.7)	
	No	20	81	49	29	20	36	9	3	9	<b>256</b>
		(20.7)	(79.5)	(44.6)	(31.0)	(21.3)	(33.0)	(11.6)	(4.5)	(9.7)	
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 9.758, df = 16, p = 0.879</math></b>											
Do you think the mentally ill should not be given any post of responsibility	NR	0	1SSS SS (1.2)	1	0	0	1	0	0	1	<b>4</b>
		(0.3)		(0.7)	(0.5)	(0.3)	(0.5)	(0.2)	(0.1)	(0.2)	
	Yes	22	78	38	25	21	38	9	3	10	<b>244</b>
		(19.7)	(75.8)	(42.5)	(29.6)	(20.3)	(31.4)	(11.1)	(4.3)	(9.2)	
	No	10	44	30	23	12	12	9	4	4	<b>148</b>
		(12.0)	(46.0)	(25.8)	(17.9)	(12.3)	(19.1)	(6.7)	(2.6)	(5.6)	
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 17.657, df = 16, p = 0.344</math></b>											

NR = No Response

Source: Field Survey, 2016

Table 4.7a shows that ethnic background is a significant factor in the views of respondents on the stigma items. More Tiv people 69(28.9) than Abakwa 40(16.7), Idoma 36 (15.1) and Igede 26 (10.9), considered people with mental illness as a burden to the society. Furthermore, 66.6% of respondents from the Tiv ethnic group also felt it is better to avoid a person with a history of mental illness more than other ethnic groups in the study. Again, 75.8% of people from the Tiv ethnic group would not trust a woman who has suffered from mental illness as a baby sitter and 75.8% of respondents from Tiv ethnic group believed people living with mental illness should not given posts of responsibility.

**Table 4.7b** Attitudes towards mental illness across the ethnic groups in Benue State

Sigma items	Responses	Ethnic Groups									Total
		n/r O (E)	Tiv O (E)	Idoma O (E)	Igede O (E)	Etule O (E)	Abakwa O (E)	Nyifom O (E)	Jukun O (E)	Others O (E)	
Anyone with a history of mental illness should be excluded from contesting elections?	NR	1 (0.8)	2 (3.1)	1 (1.7)	4 (1.2)	1 (0.8)	0 (1.3)	1 (0.5)	0 (0.2)	0 (0.4)	<b>10</b>
	Yes	27 (20.2)	80 (77.7)	44 (43.6)	22 (30.3)	12 (20.8)	41 (32.2)	9 (11.4)	5 (4.4)	10 (9.5)	<b>250</b>
	No	4 (11.0)	41 (42.2)	24 (23.7)	22 (16.5)	20 (11.3)	10 (17.5)	8 (6.2)	2 (2.4)	5 (5.2)	<b>136</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 37.877, df = 16, p = 0.002</math></b>											
I will not employ a person with mental illness as an employee	NR	2 (1.7)	3 (6.5)	6 (3.7)	5 (2.5)	2 (1.8)	1 (2.7)	1 (1.0)	0 (0.4)	1 (0.8)	<b>21</b>
	Yes	10 (13.2)	62 (50.6)	23 (28.4)	24 (19.8)	15 (13.6)	10 (21.0)	6 (7.4)	4 (2.9)	9 (6.2)	<b>163</b>
	No	20 (17.1)	58 (65.8)	40 (36.9)	19 (25.7)	16 (17.7)	40 (27.3)	11 (9.6)	3 (3.7)	5 (8.0)	<b>212</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 31.475, df = 16, p = 0.012</math></b>											
If you were a landlord, would you let your house out to a person with a mental illness?	NR	1 (1.7)	3 (6.5)	10 (3.7)	2 (2.5)	2 (1.8)	1 (2.7)	0 (1.0)	2 (0.4)	0 (0.8)	<b>21</b>
	Yes	2 (9.2)	34 (35.4)	24 (19.9)	18 (13.8)	12 (9.5)	10 (14.7)	5 (5.2)	2 (2.0)	7 (4.3)	<b>114</b>
	No	29 (21.1)	86 (81.1)	35 (45.5)	28 (31.6)	19 (21.8)	40 (33.6)	13 (11.9)	3 (4.6)	8 (9.9)	<b>261</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 43.645, df = 16, p = 0.000</math></b>											
The mentally ill should be isolated from the rest of the community	NR	6 (1.0)	6 (3.7)	0 (2.1)	0 (1.5)	0 (1.0)	0 (1.5)	0 (0.5)	0 (0.2)	0 (0.5)	<b>12</b>
	Yes	21 (17.4)	69 (66.8)	26 (37.5)	21 (26.1)	15 (17.9)	39 (27.7)	7 (9.8)	4 (3.8)	13 (8.1)	<b>215</b>
	No	5 (13.7)	48 (52.5)	43 (29.4)	27 (20.5)	18 (14.1)	12 (21.8)	11 (7.7)	3 (3.0)	2 (6.4)	<b>169</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
<b><math>\chi^2 = 73.003, df = 16, p = 0.000</math></b>											

NR = No Response

**Source:** Field Survey, 2016

Table 4.7b shows that all the ethnic groups had negative attitude towards the stereotype statements concerning mental illness. However, more respondents from the Tiv ethnic group 80(32.0), felt that people with mental illness should be excluded from contesting

elections more than 44(17.6) Idoma and 41(16.4) Abakwa. Similarly, Tiv people 50(27.4) are more reluctant to employ people with mental illness than Idoma 40(18.9) and Abakwa 40(18.9). A chi-square value of 31.475,df=16,p=0.012 shows that there was a significant association between ethnic groups and views on the stigma item. Again, the Tiv 62(29.1), are more likely to avoid a person with mental illness than Abakwa 39 (18.3), and Idoma 37 (17.4) ethnic groups, A chi-square value of 33.951,df=16,p=0,006 shows that there is significant association between ethnic background and stereotype statements. More Tiv 80(32.0), wanted people with mental illness to be excluded from contesting elections than 44(17.6) Idoma and 41(16.4) Similarly, more Tiv would be more reluctant to 86(33.0) to let their houses to people living with mental illness than Abakwa 40(15.3), Idoma 35(13.4) and Igede 28(10.7).

The chi-square test value of 43.645, df =16, p= 0.000 shows a significant association across the ethnic groups and the respondents views on the stigma item. More Tiv people 69(32.1) preferred people with mental illness isolated from the rest of the community than Abakwa ethnic group 39(18.1), Idoma 26(12.1) and Igede 21(9.8).

Respondents' views from the in-depth interview showed that members of the public are afraid of being attacked by mentally sick people as some are violent and aggressive. Hence, they would rather prefer that mentally sick be restricted. Table 4.6, revealed that the Tiv ethnic group have a more negative attitude towards mental illness than other ethnic groups in the study. This is because of the fear and shame associated with mental illness in the study area. It was noted that among the Tiv ethnic group, people are afraid to marry or associate with people having mental illness and the views of mentally sick people are rarely considered on social issues. This is because they are considered as having lost their sense of reasoning.

**Table 4.7c** Attitudes towards mental illness across the ethnic groups in Benue State

Sigma items	Responses	Ethnic Groups									Total
		n/r O (E)	Tiv O (E)	Idoma O (E)	Igede O (E)	Etule O (E)	Abakwa O (E)	Nyifom O (E)	Jukun O (E)	Others O (E)	
Can you marry a man or woman who has suffered from mental illness even though he/she seems truly recovered?	NR	0 (1.1)	4 (4.3)	4 (2.4)	2 (1.7)	0 (1.2)	1 (1.8)	0 (0.6)	1 (0.2)	2 (0.5)	<b>14</b>
	Yes	3 (12.2)	38 (46.9)	35 (26.3)	21 (18.3)	23 (12.6)	13 (19.4)	7 (6.9)	5 (2.7)	6 (5.7)	<b>151</b>
	No	29 (18.7)	81 (71.8)	30 (40.3)	25 (28.0)	10 (19.3)	37 (29.8)	11 (10.5)	1 (4.1)	7 (8.8)	<b>231</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
	<b><math>\chi^2 = 54.200, df = 16, p = 0.000</math></b>										
Have you ever vacated your house because of a mentally sick person staying in the same compound?	NR	5 (1.8)	2 (6.8)	2 (3.8)	3 (2.7)	1 (1.8)	5 (2.8)	3 (1.0)	0 (0.4)	1 (0.8)	<b>22</b>
	Yes	20 (18.7)	74 (71.8)	43 (40.3)	27 (28.0)	18 (19.3)	25 (29.8)	10 (10.5)	4 (4.1)	10 (8.8)	<b>231</b>
	No	7 (11.6)	47 (44.4)	24 (24.9)	18 (17.3)	14 (11.9)	21 (18.4)	5 (6.5)	3 (2.5)	4 (5.4)	<b>143</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
	<b><math>\chi^2=21.605, df = 16, p= 0.156</math></b>										
Local residents have good reasons to resist the location of mental health services in their neighbor hood	NR	0 (0.2)	1 (0.6)	0 (0.3)	0 (0.2)	1 (0.2)	0 (0.3)	0 (0.1)	0 (0.0)	0 (0.1)	<b>2</b>
	Yes	17 (18.6)	74 (71.4)	37 (40.1)	31 (27.9)	18 (19.2)	29 (29.6)	11 (10.5)	5 (4.1)	8 (8.7)	<b>230</b>
	No	15 (13.3)	4 (50.9)	32 (28.6)	17 (19.9)	14 (13.7)	22 (21.1)	7 (7.5)	2 (2.9)	7 (6.2)	<b>164</b>
	<b>Total</b>	<b>32</b>	<b>123</b>	<b>69</b>	<b>48</b>	<b>33</b>	<b>51</b>	<b>18</b>	<b>7</b>	<b>15</b>	<b>396</b>
	<b><math>\chi^2 = 8.486, df = 16, p = 0.933</math></b>										

O= Observed frequency, E= Expected frequency

NR = No Response

Source: Field Survey, 2018.

Table 4.7c shows that the attitude of the ethnic groups to mental illness in the study was generally negative. 49.7% of people from the Tiv ethnic group will not marry a woman who has suffered from mental illness even though she seemed fully recovered, this is more than 40.3% of Idoma people. 74.3% have vacated their houses because of a mentally sick person staying in the same house and 71.4% felt of The Tiv respondents agreed that local residents have a good reason to resist the location of mental health facilities in their neighborhood.

#### **4.3.6 Socio-demographic characteristics of members of the public and the stereotyping statements about mental illness**

The aim of this sub-section is to examine the socio-demographic characteristics of respondents and stereotyping of people with mental illness. This is to show the difference between the socio-demographic characteristics of respondents and their responses to stereotyping statements. The chi square test was used to examine the difference. Table 4.8a revealed that no statistically significant association was observed between the socio demographic variables of members of public and the strereotype statements.

**Table 4. 8a** Socio-demographic characteristics of members of the public and selected stereotyping statements regarding people living with mental illness

Stereotyping statements		Sex			Total		Age			Total
		n/r	M	F			n/r	18-25 years	26-35 years	
As soon as a person shows signs of mental illness, he should be locked behind doors.	NR	0	12	9	<b>21</b>	0	8	10	3	<b>21</b>
		.9	11.2	8.9		.7	7.2	8.5	4.6	
	Yes	9	135	97	<b>241</b>	6	80	103	52	<b>241</b>
		10.3	129.0	101.6		7.9	82.8	97.4	52.9	
Total	No	8	65	61	<b>134</b>	7	48	47	32	<b>134</b>
		5.8	71.7	56.5		4.4	46.0	54.1	29.4	
	<b>Total</b>	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2 = 3.486, df = 4, p = 0.480$					$\chi^2 = 5.295, df = 6, p = 0.507$			
Is there anything about people with mental illness that distinguishes them from normal people?	NR	1	10	9	<b>20</b>	1	5	10	4	<b>20</b>
		.9	10.7	8.4		.7	6.9	8.1	4.4	
	Yes	10	131	107	<b>248</b>	8	83	95	62	<b>248</b>
		10.6	132.8	104.6		8.1	85.2	100.2	54.5	
Total	No	6	71	51	<b>128</b>	4	48	55	21	<b>128</b>
		5.5	68.5	54.0		4.2	44.0	51.7	28.1	
	<b>Total</b>	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2 = 0.527, df = 4, p = 0.480$					$\chi^2 = 4.936, df = 4, p = 0.480$			
Mentally ill people need the same kind of control and discipline as a young child?	NR	2	9	10	<b>21</b>	2	3	10	6	<b>21</b>
		.9	11.2	8.9		.7	7.2	8.5	4.6	
	Yes	11	107	101	<b>219</b>	8	68	82	61	<b>219</b>
		9.4	117.2	92.4		7.2	75.2	88.5	48.1	
Total	No	4	96	56	<b>156</b>	3	65	68	20	<b>156</b>
		6.7	83.5	65.8		5.1	53.6	63.0	34.3	
	<b>Total</b>	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2 = 8.318, df = 4, p = 0.081$					$\chi^2 = 19.999, df = 6, p = 0.003$			

NR = No Response

Source: Field Survey, 2018.

Table 4.8a shows that more males with an observed frequency of 135 and expected frequency of 129.0 than 97(101.6) female felt that as soon as a person show signs of mental illness they should be put behind bars (chi-square value of 3.485, df= 4 and p=0.48). Furthermore, more respondents 103(97.4) within the age group of 26-35 years than 80(82.8) of those between 18-25 years and above felt that as soon as a person show sign of mental illness he/she should be put behind bars (chi- square value of 5.295, df= 6 and p=0.507).

As observed in Table 4.8a, more males 131(132.8) believed that people with mental illness are different from normal people than 107(104.6) females, (chi-square of 0.572,df=4.p=0.480) More respondents 95(100.4) within the age group of 26 and 35, than those 83(85.2) within the age group of 18 and 25 felt that there is something about people with mental illness that distinguishes them from normal people (chi-square check of 4.936,df=4,p=0.480).

Table 4.8a also shows that a greater proportion of male respondents 107(117.2), felt that mentally ill people need the same kind of control and treatment as young children, than 101(92.4) females (chi-square of 8.318 df=4,p=0.081), Furthermore, respondents within the age group of 26-35 years 82(88.5) believed that mentally ill people need the same kind of control and treatment as young children, more than those between the age group of 18-25, 68 (75.2), (19.999,df=6,p=0.003).

**Table 4. 8b** Socio-demographic characteristics of members of the public and selected stereotyping statements regarding people living with mental illness

Statements	Resp.	N/R	Marital status*				Total	Educational qualification**					Total
			M	S	D	W		n/r	NFE	P	S	Tert.	
As soon as a person shows sign of mental illness he should be locked behind doors?	NR	0 .9	6 6.3	12 11.6	3 1.8	0 .4	<b>21</b>	2 1.5	3 2.0	0 1.2	10 8.6	6 7.7	<b>21</b>
	Yes	9 10.3	70 72.4	135 132.	22 20.7	5 4.9	<b>241</b>	14 17.0	21 22.5	13 14.0	108 98.6	85 88.9	<b>241</b>
	No	8 5.8	43 40.3	71 73.8	9 11.5	3 2.7	<b>134</b>	12 9.5	13 12.5	10 7.8	44 54.8	55 49.4	<b>134</b>
	<b>Total</b>	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
			$\chi^2 = 4.280, df = 8, p = 0.831$					$\chi^2 = 8.443, df = 8, p = 0.391$					
Is there anything about people with mental illness that distinguish them from normal people?	NR	1 .9	5 6.0	11 11.0	2 1.7	1 .4	<b>20</b>	2 1.4	2 1.9	0 1.2	8 8.2	8 7.4	<b>20</b>
	Yes	10 10.6	72 74.5	140 136.5	21 21.3	5 5.0	<b>248</b>	15 17.5	22 23.2	13 14.4	102 101.5	96 91.4	<b>248</b>
	No	6 5.5	42 38.5	67 70.5	11 11.0	2 2.6	<b>128</b>	11 9.1	13 12.0	10 7.4	52 52.4	42 47.2	<b>128</b>
	<b>Total</b>	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
			$\chi^2 = 2.010, df = 8, p = 0.981$					$\chi^2 = 4.234, df = 8, p = 0.835$					
Mentally ill people need the same kind of control and discipline as a young child?	NR	2 .9	3 6.3	14 11.6	2 1.8	0 .4	<b>21</b>	2 1.5	2 2.0	1 1.2	7 8.6	9 7.7	<b>21</b>
	Yes	11 9.4	61 65.8	123 120.6	21 18.8	3 4.4	<b>219</b>	18 15.5	20 20.5	9 12.7	84 89.6	88 80.7	<b>219</b>
	No	4 6.7	55 46.9	81 85.9	11 13.4	5 3.2	<b>156</b>	8 11.0	15 14.6	13 9.1	71 63.8	49 57.5	<b>156</b>
<b>Total</b>	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>	
			$\chi^2 = 9.706, df = 8, p = 0.286$					$\chi^2 = 7.852, df = 8, p = 0.448$					

\*Married (M), Single (S), Divorced (D), Widowed (W)  
Secondary (S), Diploma (HND)

\*\* No formal education (NFE), Primary (P),

NR = No Response

Source: Field Survey, 2018.

Table 4.8b shows that more members of the public who were single 135(132.7) than respondents who were married 70 (72.4), felt that as soon as a person shows signs of mental illness, he should be put behind bars. Furthermore, more 108(98.6) respondents with secondary education felt that as soon as a person shows sign of mental illness, they should be put looked indoors, this is more than 85(88.9) of respondents with tertiary education who felt so, (chi-square test of 4.280,df=8,p=0.831).

Also, more respondents who were single 140(136.5), believed there is something about people with mental illness that distinguishes them from normal people than those who were married 72(74.5). More respondents with secondary education 102(101.0) felt there is something about people with mental illness that distinguishes them from normal people than those with tertiary education 96(91.4), (chi-square check of 4.234,df=8,p=0.835).

More 123(120, 0) respondents who were single agreed that mentally ill people need the same kind of control and discipline as young child, than those who were married 61(65.8). More respondents 88(80.7) with tertiary education thought that mentally ill people need the same kind of control and discipline as young children than those with secondary education 84(89.6).

#### **4.3.7 Socio-demographic characteristics of members of the public and selected stereotyped stigma statements regarding people living with mental illness**

This section examined some socio-demographic characteristics of respondents and stereotype statements on mental illness. The chi-square test score was used to determine the association. Table 4.9a shows that no significant association was observed between

the socio-demographic variables and the selected stereotypical statements regarding people living with mental illness.

**Table 4.9a** Socio-demographic characteristics of members of the public and set of stereotyping statements %

Statements	Resp.	Sex			Total	Age			Total		
		NR	M	F		18-25 NR years	26-35 years	36 and above			
The mentally ill are a burden to the society	NR	0	10	10	<b>20</b>	0	5	9	6	<b>20</b>	
		.9	10.7	8.4		.7	6.9	8.1	4.4		
	Yes	11	119	109	<b>239</b>	7	82	89	61		<b>239</b>
		10.3	127.	100.		7.8	82.1	96.6	52.5		
	No	6	83	48	<b>137</b>	6	49	62	20		<b>137</b>
	5.9	73.3	57.8		4.5	47.1	55.4	30.1			
Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	13	136	160	87	<b>396</b>		
$\chi^2=5.472, df = 4, p = 0.242$						$\chi^2=8.683, df = 6, p = 0.192$					
It is best to avoid anyone who has mental problems?	NR	1	9	3	<b>13</b>	1	5	4	3	<b>13</b>	
		.6	7.0	5.5		.4	4.5	5.3	2.9		
	Yes	12	109	92	<b>213</b>	10	66	84	53		<b>213</b>
		9.1	114.	89.8		7.0	73.2	86.1	46.8		
	No	4	94	72	<b>170</b>	2	65	72	31		<b>170</b>
	7.3	91.0	71.7		5.6	58.4	68.7	37.3			
Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	13	136	160	87	<b>396</b>		

$$\chi^2 = 4.829, df = 4, p = 0.305 \quad \chi^2 = 8.291, df = 6, p = 0.218$$

NR =No Response

Source: Field Survey, 2018

Table 4.9a shows that more males with an observed frequency of 119 and expected frequency of 127.9 than females with an observed frequency of 109 and expected frequency of 100.8 felt that people with mental illness are a burden to the society ( $\chi^2=5.472$ ,  $df = 4$ ,  $p = 0.242$ ). No significant association was observed between gender and the stereotyped statement which said it is best to avoid anyone who has mental problems ( $\chi^2 = 4.829$ ,  $df = 4$ ,  $p = 0.305$ ).

Table 4.9b also shows other socio demographic characteristics (marital status and educational qualification) of respondents and stereotyping statements on mental illness. Table 4.9b shows that there is a significant association between educational attainment, marital status of respondents and their views on whether it is best to avoid anyone who has mental problems.

**Table 4.9b** Socio-demographic characteristics of members of the public and set of stereotyping statements %

Statements	Resp.	*Marital status					Total	**Educational qualification					Total
		n/r	M	S	D	W		n/r	NFE	P	S	HND	
The mentally ill are a burden to the society	NR	0	5	10	3	2	<b>20</b>	0	5	0	6	9	<b>20</b>
		.9	6.0	11.0	1.7	.4		1.4	1.9	1.2	8.2	7.4	
	Yes	11	70	131	22	5	<b>239</b>	19	22	14	85	99	<b>239</b>
		10.3	71.8	131.6	20.5	4.8		16.9	22.3	13.9	97.8	88.1	
	No	6	44	77	9	1	<b>137</b>	9	10	9	71	38	<b>137</b>
	5.9	41.2	75.4	11.8	2.8		9.7	12.8	8.0	56.0	50.5		
<b>Total</b>		<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
		$\chi^2 = 10.606, df = 8, p = 0.225$						$\chi^2 = 19.930, df = 8, p = 0.011$					
It is best to avoid anyone who has mental problems?	NR	1	4	6	2	0	<b>13</b>	1	2	0	7	3	<b>13</b>
		.6	3.9	7.2	1.1	.3		.9	1.2	.8	5.3	4.8	
	Yes	12	59	123	16	3	<b>213</b>	15	20	11	83	84	<b>213</b>
		9.1	64.0	117.3	18.3	4.3		15.1	19.9	12.	87.1	78.5	
	No	4	56	89	16	5	<b>170</b>	12	15	12	72	59	<b>170</b>
	7.3	51.1	93.6	14.6	3.4		12.0	15.9	9.9	69.5	62.7		
<b>Total</b>		<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
		$\chi^2 = 6.784, df = 8, p = 0.560$						$\chi^2 = 4.012, df = 8, p = 0.856$					

\*Married (M), Single (S), Divorced (D), Widowed (W)  
Secondary (S), Diploma (HND)

\*\* No formal education (NFE), Primary (P),

NR = No Response

Source: Field Survey, 2018

Table 4.9b shows that 84 of the respondents with tertiary education felt that people with mental illness are a burden to the society. This was more than those with other educational qualifications ( $\chi^2 = 4.012$ ,  $df = 8$ ,  $p = 0.856$ ). Furthermore, 123 single respondents agreed that it is best to avoid anyone who has mental problems. No noticeable association was however observed between the other socio demographic variables and the selected stereotypical statements regarding people living with mental illness.

#### **4.3.8 Socio-demographic characteristics of members of the public and willingness of members of the public to offer tasks to people living with mental illness**

This section presents a cross-tabulation of socio-demographic variables and stereotyping statements on willingness of respondents to offer responsibilities to people with mental illness. The chi-square test was used to determine the statistical difference between social demographic variables and stigma items. Table 4.10 shows that there is a significant difference between gender, educational status of respondents and their willingness to offer tasks to people with mental illness.

**Table 4.10a** Socio-demographic attributes and statements on willingness of members of the public to offer responsibilities to people living with mental illness

Statements	Resp.	Sex		Total	Age	Age			Total	
		n/r	M			F	n/r	18-25 years		26-35 years
Can you trust a woman who once suffered from mental illness as a baby sitter?	NR	0	10	7	<b>17</b>	0	5	9	3	<b>17</b>
		.7	9.1	7.2		.6	5.8	6.9	3.7	
	Yes	3	64	56	<b>123</b>	3	44	48	28	<b>123</b>
		5.3	65.8	51.9		4.0	42.2	49.7	27.0	
	No	14	138	104	<b>256</b>	10	87	103	56	<b>256</b>
		11.0	137.1	108.0		8.4	87.9	103.4	56.2	
	Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2=3.164, df = 4, p=0.531$				$\chi^2=2.233, df = 6, p = 0.897$				
Do you think the mentally ill should not be given any post of responsibility	NR	0	2	2	<b>4</b>	0	1	2	1	<b>4</b>
		.2	2.1	1.7		.1	1.4	1.6	.9	
	Yes	11	130	103	<b>244</b>	10	86	91	57	<b>244</b>
		10.5	130.6	102.9		8.0	83.8	98.6	53.6	
	No	6	80	62	<b>148</b>	3	49	67	29	<b>148</b>
		6.4	79.2	62.4		4.9	50.8	59.8	32.5	
	Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2=0.298, df=4, p= 0.990$				$\chi^2 = 8.3.716, df = 6, p=0.715$				
Anyone with a history of mental illness should be excluded from contesting elections?	NR	0	4	6	<b>10</b>	0	3	6	1	<b>10</b>
		.4	5.4	4.2		.3	3.4	4.0	2.2	
	Yes	17	138	95	<b>250</b>	13	90	85	62	<b>250</b>
		10.7	133.8	105.4		8.2	85.9	101.0	54.9	
	No	0	70	66	<b>136</b>	0	43	69	24	<b>136</b>
		5.8	72.8	57.4		4.5	46.7	54.9	29.9	
	Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2=13.597,df = 4,p=0.009$				$\chi^2 = 17.942,df = 6, p = 0.006$				

NR = No Response

Source: Field survey, 2018.

Table 4.10a shows that 48% respondents between 26 and 35 years old agreed that they can trust a woman who once suffered from mental illness as a baby sitter. This was more than other age groups in the study. A chi-square value of  $\chi^2=2.233$ ,  $df = 6$ ,  $p = 0.897$  is an indication that there is a statistical significant association in the responses of the respondents across age groups on whether they can trust a woman who once suffered from mental illness as a baby sitter. Furthermore, 138 male respondents agreed that they can trust a woman who once suffered from mental illness as a baby sitter. This was more than 104 females who agreed to the same.

A chi-square value of  $\chi^2=3.164$ ,  $df = 4$ ,  $p=0.531$  shows a significant association in their responses. Noticeably, 130 males and 103 females said that the mentally ill should not be given any post of responsibility. Also, 91 respondents between the ages of 26 to 35 years maintained that the mentally ill should not be given any post of responsibility. This was more than respondents in other age groups. A chi-square value of  $\chi^2 = 8.3.716$ ,  $df = 6$ ,  $p=0.715$  indicates that there is a significant association in their responses on the stereotyped item.

Table 4.10a also revealed that 138 male respondents felt that anyone with a history of mental illness should be excluded from contesting elections. This is more than 95 females who felt the same. This shows that male respondents were more likely than females to discriminate against people with mental illness. There was no significant association across gender and age groups and respondents views on whether anyone with a history of mental illness should be excluded from contesting elections, with a chi-square value of  $17.942, df=6, p=0.006$ .

Table 4.10b shows that there is a significant association between marital status, educational status of respondents and their willingness to offer tasks to people with mental illness.

**Table 4.10b** Socio-demographic attributes and set of statements on willingness of members of the public to offer responsibilities to people living with mental illness

Statements	Resp.	*Marital status					Total	**Educational qualification					Total
		n/r	M	S	D	W		n/r	NFE	P	S	HND	
Can you trust a woman who once suffered from mental illness as a baby sitter?	NR	0	5	9	2	1	<b>17</b>	0	3	0	7	7	<b>17</b>
		.7	5.1	9.4	1.5	.3		1.2	1.6	1.0	7.0	6.3	
	Yes	3	40	64	14	2	<b>123</b>	8	11	8	48	48	<b>123</b>
		5.3	37.0	67.7	10.6	2.5		8.7	11.5	7.1	50.3	45.3	
	No	14	74	145	18	5	<b>256</b>	20	23	15	107	91	<b>256</b>
		11.0	76.9	140.9	22.0	5.2		18.1	23.9	14.9	104.7	94.4	
	<b>Total</b>	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
		$\chi^2 = 6.634, df = 8, p = 0.577$						$\chi^2 = 4.377, df = 8, p = 0.822$					
Do you think the mentally ill should not be given any post of responsibility	NR	0	1	2	1	0	<b>4</b>	0	1	0	1	2	<b>4</b>
		.2	1.2	2.2	.3	.1		.3	.4	.2	1.6	1.5	
	Yes	11	76	135	14	8	<b>244</b>	19	23	14	99	89	<b>244</b>
		10.5	73.3	134.3	20.9	4.9		17.3	22.8	14.2	99.8	90.0	
	No	6	42	81	19	0	<b>148</b>	9	13	9	62	55	<b>148</b>
		6.4	44.5	81.5	12.7	3.0		10.5	13.8	8.6	60.5	54.6	
	<b>Total</b>	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
		$\chi^2 = 12.172, df = 8, p = 0.144$						$\chi^2 = 2.509, df = 8, p = 0.961$					
Anyone with a history of mental illness should be excluded from contesting elections?	NR	0	3	6	1	0	<b>10</b>	1	1	0	3	5	<b>10</b>
		.4	3.0	5.5	.9	.2		.7	.9	.6	4.1	3.7	
	Yes	17	80	127	20	6	<b>250</b>	23	30	11	104	82	<b>250</b>
		10.7	75.1	137.6	21.5	5.1		17.7	23.4	14.5	102.3	92.2	
	No	0	36	85	13	2	<b>136</b>	4	6	12	55	59	<b>136</b>
		5.8	40.9	74.9	11.7	2.7		9.6	12.7	7.9	55.6	50.1	
	<b>Total</b>	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
		$\chi^2 = 13.917, df = 8, p = 0.084$						$\chi^2 = 17.484, df = 8, p = 0.025$					

\*Married (M), Single (S), Divorced (D), Widowed (W) \*\* No formal education (NFE), Primary (P), Secondary (S), Diploma (HND)

NR = No Response

Source: Field survey, 2018

Table 4.10b revealed that single respondents with an observed frequency of 145 and expected frequency of 140.9 more than married respondents with an observed frequency of 74 and expected frequency of 76.9 maintained that they cannot trust a woman who once suffered from mental illness as a baby sitter. This shows a significant association. Furthermore, a significant association was observed across educational status of respondents as the chi-square value  $\chi^2 = 4.377$ , at  $df = 8$ , and  $p = 0.822$  is greater than the level of significance (0.05). 107 respondents with secondary educational qualification felt that they cannot trust a woman who once suffered from mental illness as a baby sitter. This is more than 91 respondents with tertiary education who felt the same.

Also, 135 single respondents thought that the mentally ill should not be given any post of responsibility. This was more than 76 married respondents who also agreed with the statement. Noticeably, 99 respondents with secondary educational qualification maintained that the mentally ill should not be given any post of responsibility. This was more than respondents with other educational qualifications. A chi-square value of  $\chi^2 = 2.509$ ,  $df = 8$ ,  $p = 0.961$  indicate that there is a significant association in their responses on the stereotyped item.

Furthermore, 104 respondents with secondary education in contrast to 82 respondents with tertiary education felt that anyone with a history of mental illness should be excluded from contesting elections. This implies that respondents with higher education are more likely to support people with mental illness during elections.

#### **4.3.9 Sex, age of respondents and willingness of members of the public to maintain close social contact with people having mental illness**

This subsection used chi-square test to determine whether there is a significant difference between the socio-demographic variables and the respondents' willingness to maintain close contact with people having mental illness.

**Table 4.11a** Views of members of the public on their willingness to maintain close social contact with people having mental illness

Statements	Resp.	Sex			Total	Age			Total	
		n/r	M	F		n/r	18-25 years	26-35 years		36 and above
If you were a landlord, would you let your house out to a person with a mental illness?	NR	1 .9	13 11.2	7 8.9	<b>21</b>	1 .7	3 7.2	14 8.5	3 4.6	<b>21</b>
	Yes	1 4.9	60 61.0	53 48.1	<b>114</b>	0 3.7	36 39.2	54 46.1	24 25.0	<b>114</b>
	No	15 11.2	139 139.7	107 110.1	<b>261</b>	12 8.6	97 89.6	92 105.5	60 57.3	<b>261</b>
	Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2=5.670, df = 4, p=0.225$				$\chi^2=15.977, df = 6, p = 0.014$				
The mentally ill should be isolated from the rest of the community	NR	4 .5	8 6.4	0 5.1	<b>12</b>	3 .4	9 4.1	0 4.8	0 2.6	<b>12</b>
	Yes	12 9.2	105 115.1	98 90.7	<b>215</b>	10 7.1	78 73.8	66 86.9	61 47.2	<b>215</b>
	No	1 7.3	99 90.5	69 71.3	<b>169</b>	0 5.5	49 58.0	94 68.3	26 37.1	<b>169</b>
	Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2=37.60, df=4, p= 0.000$				$\chi^2 = 60.964, df = 6, p=0.000$				
Can you marry a man or woman who has suffered from mental illness even though he/she seems truly recovered?	NR	0 .6	8 7.5	6 5.9	<b>14</b>	0 .5	4 4.8	6 5.7	4 3.1	<b>14</b>
	Yes	0 6.5	79 80.8	72 63.7	<b>151</b>	0 5.0	40 51.9	82 61.0	29 33.2	<b>151</b>
	No	17 9.9	125 123.7	89 97.4	<b>231</b>	13 7.6	92 79.3	72 93.3	54 50.8	<b>231</b>
	Total	<b>17</b>	<b>212</b>	<b>167</b>	<b>396</b>	<b>13</b>	<b>136</b>	<b>160</b>	<b>87</b>	<b>396</b>
		$\chi^2=14.049,df = 4,p=0.007$				$\chi^2 = 27.285,df = 6, p = 0.000$				

NR = No Response  
**Source:** Field survey, 2018

Table 4.11a revealed that 97 respondents between 18 to 25 years felt that they would not let out their houses to a person with mental illness, in contrast to 92 respondents between 26 and 35, and 60 of those between 36 years and older. A chi-square check of  $15.977, df=6, p=0.014$  shows no significant association between respondents' views on the stigma item across their age differences. This implies that people within the age range of 18 and 25 are more likely to stigmatize people with mental illness than people of other age grades. Also, 105 male respondents felt that the mentally ill should be isolated from the rest of the community. This was more than 98 females. Chi-square value of  $37.60, df=4, p=0.000$  shows no significant association. Also, 78 respondents within the age group of 18 and 25 felt that the mentally ill should be isolated from the rest of the community. This was followed by 66 respondents within the age group of 26-35 and 61 respondents who were 36 years and above (chi-square value of  $60.964, df=6, p=0.000$ ).

Table 4.11a revealed that 125 male respondents would be reluctant to marry a person who once suffered from mental illness even though they seem to have fully recovered. This was more than 89 respondents who were females. With a chi-square value of  $14.049, df=1, p=0.007$  there is no significant association across gender and willingness to marry someone with mental illness.

**Table 4.11b** Public views on willingness to maintain close social contact with people living with mental illness

Statements	Resp.	*Marital status					Total	**Educational qualification					Total
		n/r	M	S	D	W		n/r	NFE	P	S	HND	
If you were a landlord, would you let your house out to a person with a mental illness?	NR	1 .9	3 6.3	15 11.6	2 1.8	0 .4	<b>21</b>	1 1.5	2 2.0	0 1.2	13 8.6	5 7.7	<b>21</b>
	Yes	1 4.9	32 34.3	67 62.8	13 9.8	1 2.3	<b>114</b>	2 8.1	15 10.7	7 6.6	43 46.6	47 42.0	<b>114</b>
	No	15 11.2	84 78.4	136 143.7	19 22.4	7 5.3	<b>261</b>	25 18.5	20 24.4	16 15.2	106 106.8	94 96.2	<b>261</b>
	Total	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
						$\chi^2 = 11.718, df = 8, p = 0.164$							$\chi^2 = 15.052, df = 8, p = 0.058$
The mentally ill should be isolated from the rest of the community	NR	4 .5	8 3.6	0 6.6	0 1.0	0 .2	<b>12</b>	6 .8	6 1.1	0 .7	0 4.9	0 4.4	<b>12</b>
	Yes	12 9.2	68 64.6	109 118.4	20 18.5	6 4.3	<b>215</b>	18 15.2	22 20.1	14 12.5	70 88.0	91 79.3	<b>215</b>
	No	1 7.3	43 50.8	109 93.0	14 14.5	2 3.4	<b>169</b>	4 11.9	9 15.8	9 9.8	92 69.1	55 62.3	<b>169</b>
	Total	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
						$\chi^2 = 49.246, df = 8, p = 0.000$							$\chi^2 = 85.513, df = 8, p = 0.000$
Can you marry a man or woman who has suffered from mental illness even though he/she seems truly recovered?	NR	0 .6	4 4.2	7 7.7	2 1.2	1 .3	<b>14</b>	0 1.0	2 1.3	1 .8	6 5.7	5 5.2	<b>14</b>
	Yes	0 6.5	34 45.4	98 83.1	15 13.0	4 3.1	<b>151</b>	2 10.7	10 14.1	5 8.8	72 61.8	62 55.7	<b>151</b>
	No	17 9.9	81 69.4	113 127.2	17 19.8	3 4.7	<b>231</b>	26 16.3	25 21.6	17 13.4	84 94.5	79 85.2	<b>231</b>
	Total	<b>17</b>	<b>119</b>	<b>218</b>	<b>34</b>	<b>8</b>	<b>396</b>	<b>28</b>	<b>37</b>	<b>23</b>	<b>162</b>	<b>146</b>	<b>396</b>
						$\chi^2 = 25.206, df = 8, p = 0.001$							$\chi^2 = 22.530, df = 8, p = 0.004$

\*Married (M), Single (S), Divorced (D), Widowed (W)      \*\* No formal education (NFE), Primary (P), Secondary (S), Diploma (HND)

NR = No Response

Source: Field survey, 2018

Table 4.11a shows that 109 single respondents felt that people with mental illness should be isolated from the rest of the community. This was greater than those who were married 68. It can be observed that 91 respondents who agreed that the mentally ill should be isolated from the rest of the community were those with tertiary education, followed by 70 respondents with secondary education. The result shows a statistically significant difference across educational levels of respondents and the stigma item.

Furthermore, 113 single respondents felt they would not marry a person who has suffered from mental illness even though the person seems to have recovered fully. This was greater than 81 who were married (Chi-square value of 25.206, DF=8, p=0.000). More respondents with secondary educational qualification (84) would not marry a person who once suffered from mental illness even though the person seems to have recovered fully, than 78 with tertiary educational qualification. There was an association between educational qualification and respondents' views on whether they would want to marry a person who had suffered from mental illness (Chi square value of 22.530, DF = 8, p=0.004).

#### **4.4 The Prevalence of Internalized Stigma among People Living with Mental Illness in Benue State**

This section examined the prevalence of internalized stigma among people with mental illness in Benue State. Prevalence reflects the commonness of internalized stigma among people living with mental illness. To achieve this aim, the section was divided into four sub sections, namely; alienation, stereotype endorsement, experience of discrimination and social withdrawal.

The prevalence of internalized stigma was determined using the mean score of the views of people living with mental illness; the mean scores of people living with mental illness were further divided into minimal and elevated internalized stigma. A mean score below 1.5 indicated minimal internalized stigma while a mean score of 1.5 or above indicated elevated internalized stigma.

#### **4.4.1 Views of people living with mental illness on the subjective experience of been less than a full member of the society as a result of their mental health condition.**

To determine this, the scores of the views of people living with mental illness were calculated using mean and standard deviation. A mean score of 1.5 and below is an indication of minimal internalized stigma item score and a mean score of 1.5 and above is an indication of elevated internalized stigma.

**Table 4.12** Views of people living with mental illness on the belief that they withdraw or isolate themselves from the rest of the community

S/N	Items	S A	A	D	SD	N	Mean	Std.	Remarks
1	People without mental illness could not possibly understand me.	92	88	14 6	142	468	1.28	1.2 0	Minimal
2	Having a mental illness has spoiled my life.	17 3	97	13 2	66	468	1.81	1.0 9	Elevated
3	I am embarrassed in myself for having a mental illness.	18 6	103	14 1	38	468	1.93	1.0 1	Elevated
4	I am disappointed in myself for having mental illness.	30 9	85	50	24	468	2.45	0.9 0	Elevated
5	I feel inferior to others who don't have a mental illness.	19 5	100	12 5	48	468	1.94	1.0 5	Elevated
6	I feel out of place in the world because I have mental illness.	16 2	56	19 5	55	468	1.69	1.0 7	Elevated
<b>Grand Mean and standard deviations</b>						<b>468</b>	<b>1.85</b>	<b>0.5 8</b>	<b>Elevated</b>

Source: Field survey, 2018.

Table 4.12 shows that people living with mental illness had elevated internalized stigma mean score of 1.5 and above on all the statements except the statement “People without mental illness cannot possibly understand me” which has a minimal internalized stigma with a mean score of 1.28 and a standard deviation of 1.20. Respondents had the highest mean scores of 2.45 and a standard deviation of .90 on the statement “I am disappointed in myself for having mental illness”. This is followed by mean scores of 1.94 on the statements; “I feel inferior to others who don’t have a mental illness” and “I am embarrassed in myself for having a mental illness”. The fact that respondents mean scores were above the midpoint of 1.5 on almost all the statements on the alienation subscale is an indication that experience of public stigma has affected people living with mental illness, and has decreased their self esteem.

This was expressed in the in-depth interview with people having mental illness. A person having mental illness narrated the problem he faced everyday because of his mental illness:

I feel pity for myself, I feel very bad about my condition, I feel bad about my condition, I also feel bad when I see people that are in the same condition with me, because I take myself in their position. The mental illness has destroyed my life.

(Male IDI/ 43/ married /Tiv/Christianity/ Degree holder)

#### **4.4.2 Mean and standard deviation on views of people living with mental illness on whether they agree with the negative stereotypes from members of the public**

This subsection examines whether people with mental illness accept the public stereotype of mental illnesses. Stereotype endorsement is calculated as a mean score with higher scores suggesting graver stereotype endorsement. A score of 1.5 and below is an indication of minimal stereotype endorsement, a score of 1.5 is an indication of elevated stereotype endorsement.

Table 4.13 shows that mean aggregate scores on all the seven statements on the stereotype endorsement subscale indicated an elevated internalized stigma.

**Table 4.13** Mean and standard deviation on views of people living with mental illness on the public stereotype of mental illness

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	Because I have a mental illness I need others to make decisions for me.	108	104	208	48	468	1.58	0.96	Elevated
2	People can tell that I have a mental illness by the way I look.	108	93	255	12	468	1.63	0.86	Elevated
3	Mentally ill people tend to be violent	94	121	205	48	468	1.56	0.92	Elevated
4	People with mental illness cannot live a good and rewarding life.	107	107	202	52	468	1.57	0.96	Elevated
5	Mentally ill people shouldn't get married.	80	326	46	16	468	2.00	0.64	Elevated
6	I can't contribute anything to the society because I have a mental illness.	123	94	187	64	468	1.59	1.02	Elevated
7	Stereotype about mental illness apply to me.	121	71	212	64		1.53	1.02	Elevated
<b>Grand Mean and standard deviations</b>						<b>468</b>	1.64	0.45	<b>Elevated</b>

**Source:** Field work, 2018

Table 4.13 shows that all the mean scores on the subscale exceeded the midpoint of 1.5 thresholds. The highest mean scores of 2.00 and a standard deviation of 0.64 were found among respondents who felt that “Mentally ill people shouldn’t get married”. This was followed by respondents who believed that people can know they have mental illness just by looking at them, who had a mean score of 1.63 with a standard deviation of .86. The lowest mean scores of 1.53 and standard deviation of 1.02 were found among respondents who believed that stereotypes about mental illness apply to them. This is an indication that respondents have endorsed the negative stereotypes of mental illness among members of the public. This was corroborated by a person having mental illness:

Yes, people look down upon us and I feel bad. I am not yet married; I want to treat the problem I have before I will think of marriage. If I marry now my wife will not understand me, so I will have problem, I applied for job but was not successful, so because of my situation I decided to stay at home because the illness usually occurs but I think that is how God has made it to be.

Male IDI / single / 40yrs / Tiv/Christian / SSCE.

#### **4.4.3 Perception of people living with mental illness on the stigma they experienced in their various communities**

This sub section reflects on their actual experience of stigma by people living with mental illness. The experience of stigma was calculated with mean scores of 1.5 and below indicating a minimal stigma, and scores of 1.5 or higher indicating elevated discrimination experienced.

**Table 4.14** Mean and standard deviation on the discrimination experienced by people having mental illness in Benue State

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	Other people think that I can't achieve much in life because I have a mental illness	152	127	157	32	468	1.85	0.96	Elevated
2	People take me less seriously just because I have a mental illness	135	147	162	24	468	1.84	0.90	Elevated
3	People treat me like a child just because I have mental illness	164	108	144	52	468	1.82	1.04	Elevated
4	People discriminate against me because I have a mental illness	143	97	198	30	468	1.75	0.96	Elevated
5	Nobody would be interested in getting to me because I have a mental illness	91	239	102	36	468	1.82	0.83	Elevated
<b>Grand Mean and standard deviations</b>						<b>468</b>	<b>1.82</b>	<b>0.62</b>	<b>Elevated</b>

**Source:** Field work, 2018

Table 4.14 shows that the highest mean scores of 1.85 and a standard deviation of .96 were recorded by people having mental illness who believed “Other people think I can’t achieve much in life because I have mental illness”. This is followed by respondents who felt other people take them less seriously just because of their mental illness, with a mean score of 1.84 and a standard deviation of 0.90. The least mean scores of 1.75 and a standard deviation of .96 were recorded by respondents who felt that people discriminate against them because of their mental illness.

Generally, there is an elevated score on all the statements on Table 4.15, with a grand mean of 1.82 and a standard deviation of .62. This means that the people with mental illness in the study experienced elevated internalized stigma because of mental illness. People with mental illness interviewed narrated the experience they faced every day because of mental illness. An interviewee said:

Yes, people say I am not well, people don’t talk to me and I feel bad. I don’t go to public places, because of my mental illness, I don’t go to public places, I am afraid. I have not looked for a job, and people say I am not well. Sometimes I will be talking to people and the person will tell me that I am not well. All my friends have run away from me because of my mental illness.

(Female IDI/ 40/ Christian/ primary school/ Tiv/Married.).

Another interviewee also narrated the experience he had with members of the public because of his mental illness:

I had friends before, but they have deserted me, all my friends as if I have no link with them. I don’t go to public gatherings, when I go, people say bad things. If I say something, they tell me that what I say is not correct and

other people will refuse to argue with me. I have not looked for a job before because of my condition. My neighbor calls me a mad man, I feel bad.

(Male IDI / 30/ Christian / secondary school/ Igede/ single)

Another participant in the interview also narrated his experience of stigma and discrimination from members of the public thus:

I don't have a friend, only God is my friend. Wherever I go they reject me, they call me useless man, when I stay with the people, and they insult me. I never marry but only God knows they disagree with anything I say, they tell me, don't mind that mad man. People don't come to my house, they keep away from me because of my problem I have, they will call me names and say when will this mad man die? They hate me.

(Male IDI/ 35/ Christian/ primary school certificate/ Idoma/ single)

A female interviewee also narrated her experience of having been abandoned by her husband because of the mental illness:

Yes, I was married with children but my husband abandoned me, I don't interact with people, I only go to church, I don't go to where people will gather I say I will not marry again, enough is enough. I don't have friends, iam only with my children, I have retired I am not working now. People look down on me, they don't consider me.

(Female IDI / 62/ Christian / Primary School certificate/ Yoruba).

#### **4.4.4 Views of people living with mental illness on their self exclusion from social events due to mental illness**

This subsection examines the views of people with mental illness on excluding from social events due to mental illness. This was calculated using the mean and standard deviation. A score of 1.5 or lower indicates a minimal social withdrawal, while a score of 1.5 or above is an indication of elevated social withdrawal.

**Table 4.15** Mean and standard deviation on views of people living with mental illness on whether they exclude themselves from social events due to mental illness

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	I avoid getting close to people to avoid rejection.	67	187	126	88	468	1.50	0.96	Elevated
2	I don't talk about myself much because I don't want to burden others with my mental illness.	27	18	255	168	468	0.79	0.77	Minimal
3	Negative stereotype about mental illness keep me isolated from the normal world.	99	63	274	32	468	1.49	0.90	Minimal
4	I don't get close to people much because my mental illness might make me look weird to them.	153	72	230	13	468	1.78	0.94	Elevated
5	I stay away from social gatherings in order to protect my family from embarrassment.	179	99	142	48	468	1.87	1.04	Elevated
6	being around with people who don't have mental illness make me feel out of place.	0	0	257	211	468	0.55	0.50	Minimal
<b>Grand Mean and standard deviations</b>						<b>468</b>	<b>1.33</b>	<b>0.43</b>	<b>Minimal</b>

Source: Field Survey, 2018

Table 4.15 revealed that the highest mean scores of 1.87 and a standard deviation of 1.04 was recorded among respondents who stated that they stay away from social gatherings in order to protect their families from embarrassment because of the mental illness. Respondents who said they avoid getting close to people much because the mental illness might make them look weird had a mean score of 1.78 and a standard deviation of .94. However, the lowest mean scores of .55 and a standard deviation of .50 was recorded among respondents who felt that being around people who don't have mental illness makes them feel out of place. The grand mean of 1.33 and a standard deviation of .43 show a minimal score on the social withdrawal sub scale. This means that although the respondents have experienced public stigma, their withdrawal from social interaction is minimal.

#### **4.4.5 The levels of elevated internalized stigma among people living with mental illness.**

This subsection determines the percentages of people living with mental illness who have minimal and elevated stigma.

**Table 4.16** Levels of elevated internalized stigma among people living with mental illness using frequencies and percentages

<b>Levels of Stigma</b>	<b>Frequency (%)</b>	<b>Percent (%)</b>
Minimal Stigma	150	32.1
Elevated	318	67.9
<b>Total</b>	<b>468</b>	<b>100.0</b>

**Source:** Field survey, 2018.

Table 4.16 revealed that 67.9% of people living with mental illness sampled (318 out of 468 of the respondents) had elevated internalized scores while 32.1% of the respondents had minimal levels of internalized stigma. This shows that majority of the respondents had elevated internalized stigma.

**Table 4.17** Socio-demographic attributes and stigma levels of people living with mental illness. The aim of this table was to find out the attributes that has the highest level of internalized stigma

Variables			Level of Stigma		Total	$\chi^2$	Statistics	
			Minimal Stigma	Elevated Stigma			Df	Sig (2-sided)
Age	NR	Count	2	8	10	1.949	3	.583
		Expected Count	3.2	6.8	10.0			
	18-25	Count	37	85	122			
		Expected Count	39.1	82.9	122.0			
	26-35	Count	48	110	158			
		Expected Count	50.6	107.4	158.0			
36 and above	Count	63	115	178				
	Expected Count	57.1	120.9	178.0				
Total	Count	150	318	468				
	Expected Count	150.0	318.0	468.0				
Sex	NR	Count	3	11	14	1.179	2	.555
		Expected Count	4.5	9.5	14.0			
	Male	Count	79	175	254			
		Expected Count	81.4	172.6	254.0			
	Female	Count	68	132	200			
		Expected Count	64.1	135.9	200.0			
Total	Count	150	318	468				
	Expected Count	150.0	318.0	468.0				
Education Qual.	NR	Count	3	12	15	4.288	4	.368
		Expected Count	4.8	10.2	15.0			
	No formal education	Count	32	62	94			
		Expected Count	30.1	63.9	94.0			
	Primary	Count	25	70	95			
		Expected Count	30.4	64.6	95.0			
	Secondary	Count	69	143	212			
		Expected Count	67.9	144.1	212.0			
	Tertiary	Count	21	31	52			
		Expected Count	16.7	35.3	52.0			
Total	Count	150	318	468				
	Expected Count	150.0	318.0	468.0				
Occupation	NR	Count	2	5	7	2.196	4	.700
		Expected Count	2.2	4.8	7.0			
	Farming	Count	48	118	166			
		Expected Count	53.2	112.8	166.0			
	Civil servant	Count	30	59	89			
		Expected Count	28.5	60.5	89.0			
	Trading	Count	2	8	10			
		Expected Count	3.2	6.8	10.0			
	Others	Count	68	128	196			
		Expected Count	62.8	133.2	196.0			
Total	Count	150	318	468				
	Expected Count	150.0	318.0	468.0				

**Source:** Field survey, 2018.

As can be seen in Table 4.17, 115 respondents with expected frequency of 120.9 within the age range of 35 and above had elevated internalized stigma, more than those within the age range of 18 and 25 (85with expected frequency of 82.9). Also, 175 males with expected frequency of 172.6, more than 132 females with expected frequency of 135.9, had elevated internalized stigma. More respondents with secondary education (143with expected frequency of 144.1) had elevated stigma than those without formal education (31with expected frequency of 35.3), and 128 respondents with different occupations not mentioned constituted the highest proportion of those with elevated internalized stigma followed by respondents who were farmers (118with expected frequency of 112.8).

**Table 4.18:** t-test statistics indicating mean differences in the views of people living with mental illness who attended traditional and orthodox health care centers

Nature of Health Care		N	Mean	Std. Dev.	Df	T	Sig. (2tailed)
The views of people living with mental illness on the alienation sub scale of social stigma	Traditional	399	1.86	0.58	466	.497	.619
	Orthodox	69	1.82	0.60			
The views of people living with mental illness on the stereotype endorsement subscale	Traditional	399	1.65	0.44	466	1.817	.070
	Orthodox	69	1.55	0.47			
The views of people living with mental illness on the stigma they experienced in their various communities	Traditional	399	1.82	0.61	466	.176	.861
	Orthodox	69	1.81	0.67			
The views of people living with mental illness on the social withdrawal subscale	Traditional	399	1.34	0.43	466	1.262	.208
	Orthodox	69	1.27	0.45			
Prevalence of elevated internalized stigma among the people living with mental illness	Traditional	399	0.90	0.48	466	4.404	.000
	Orthodox	69	0.63	0.35			

**Source:** Field survey, 2018.

Table 4.18 shows that  $t = .497$ ,  $df = 466$ , sig. 2 tailed ( $p$ ) = .619. This is greater than the significance level of 0.05. Since  $p$  is greater than 0.05, this is an indication that there is no significant difference in the views of people living with mental illness who attended traditional and orthodox health care centers on the alienation sub scale of social stigma. Also, there is no significant difference on the views of people living with mental illness who attend traditional and orthodox health care centers on the stereotype endorsement subscale ( $t = 1.817$ ,  $df = 466$ , sig. 2 tailed ( $p$ ) = .070).

Furthermore, there is no significant difference in the views of people living with mental illness on the stigma they experienced in their various communities irrespective of the health care centers they attended. ( $t = .176$ ,  $df = 466$ , sig. 2 tailed ( $p$ ) = .861). However, Level of prevalence of elevated internalized stigma among the people living with mental illness who attended traditional health care is more than those who attended orthodox. ( $t = 4.404$ ,  $df = 466$ , sig. 2 tailed ( $p$ ) = .000).

#### **4.5 Stigma of Mental Health care Professionals**

This section examined the attitude of health care professionals towards people living with mental illness in Benue State. To determine this, people living with mental illness were asked to state how they were treated by health care professionals when they visited the hospital for care.

**Table 4.19** Treatment meted out to people with mental illness by health care professionals when they visited the hospital

<b>Item</b>	<b>Frequency</b>	<b>Percent</b>
Strongly disagree	340	72.7
Disagree	73	15.7
Agree	27	5.8
Strongly agree	27	5.8
<b>Total</b>	<b>468</b>	<b>100.0</b>

**Source:** Fieldwork, 2018.

Table 4.19 shows that 340 (72.7%) strongly disagreed that health care professionals treated them badly when they visited the hospital because of their mental illness; only 27(5.8%) of the respondents agreed. Even though people living with mental illness indicated that the health care professionals were friendly with them when they visited the hospital; the opinions of some healthcare professionals when interviewed indicated that they still discriminated against people living with mental illness.

#### **4.5.1 Views of mental health professionals by the degree to which they agree or disagree to associate with people living with mental illness**

The aim of this subsection is to examine the extent to which mental health care professionals would be willing to associate with people having mental illness. Health care professionals were expected to state on a 4 point likert scale, the degree to which they were willing to establish contact with a person with mental illness. Their responses are shown in Table 4.20 below.

**Table 4.20** Views of mental health care professionals by the degree to which they agree or disagree to associate with people having mental illness

<b>Statements</b>	<b>SD</b>	<b>D</b>	<b>A</b>	<b>SA</b>	<b>N</b>	<b>Mean</b>	<b>Std.</b>
I am willing to marry a person having mental illness	18	6	21	18	63	2.62	1.18
I am willing to make friends with a person having mental illness	2	9	24	28	63	3.24	0.82
I am willing to live with a person having mental illness in the same house.	1	14	24	24	63	3.13	0.81
I would work with a person having mental illness.	4	11	23	25	63	3.09	0.91
<b>Grand Mean and Standard deviation</b>						<b>2.98</b>	<b>0.72</b>

Table 4.20 shows that all the items captured to represent willingness of the mental healthcare professionals to associate with people having mental illness had mean ratings of 2.62, 3.24, 3.13 and 3.09 with a standard deviation of 1.18, 0.82, 0.81 and 0.91 respectively. This showed that all the mean ratings were above the bench mark of 2.50. A grand mean of 2.98 with a standard deviation of 0.72 is an indication that mental health care professionals are willing to marry, make friendship, live in the same house and work with a person having mental illness. However, there were mixed responses from the in-depth interview with healthcare professionals. While some of the participants wanted to associate with people living with mental illness, others would rather not associate with them. For instance some of the health care professionals' indicated that they would not marry a person who has mental illness. A Psychiatrist said:

It will be a very difficult decision to take; before you marry you have to find out. If the family has a trace of mental illness, it is a very difficult decision to take.

(Male/ Healthcare give/32 years)

Another Psychiatrist said:

If I know that a person has mental illness, I won't marry the person because my children may have it.

(Female/ psychiatrist/50 years/ Christian)

Another Psychiatrist nurse said:

I will not marry a person having mental illness; I cannot, unless I don't know. I will not come to the hospital and attend to mad people, go home and attend to a mad person. I don't know whether you will be sleeping and your husband will strangle you in the neck and you die.

(Female/ psychiatrist nurse/30 years/ Christian)

A CHEW said:

If I know that a person have mental illness, I will not marry, because I don't know his mind, how will I sleep on the same bed, I don't know what he will do.

(Female IDI/CHEW/39 years /Christian)

Another Social Worker said:

It is believed that it runs in families, so if you marry one of them, our children will have mental illness. It depends on the type, if it is depression, I will not marry.

(Male IDI/ social worker/ 37 years /Christianity)

A Consultant said:

Well I will have some misgivings, just like if I am interested in another person and the person has chronic conditions, I will find it difficult.

(Female/ consultant /42 years/ Christian.)

But some of the mental health care professionals said that they can marry people with mental illness only if they are medication compliant and are fairly stable. A Psychiatrist said:

I will marry if I love the woman, if nobody marries them who will. But if I see a woman who breaks down regularly, I will not marry her.

(Male/ psychiatrist/44 years/ Christian.)

Another Psychiatrist said:

If I know I won't, I can't marry a person with mental illness, my children will have it.

(Female IDI / psychiatrist nurse/48 years/ Christian.)

Some of the interviewees thought that people with mental illness are different from other people especially when there are not treated. Feeling that they are different from other human beings is an indication that they are being discriminated against. A traditional psychiatrist said:

Yes, they are different. When they are in that state, they will not know what they are, he will not know what he wants himself, and they are dangerous.

(Male, IDI/ Traditional psychiatrist /52 years/ Christian)

However, some mental health care professionals responded that they can marry a person with mental illness and make friendship with them.

A Consultant Psychiatrist said:

I have one that we have been friends for the past ten years.

(Male IDI/ Consultant psychiatrist /42 years/ Christian)

A CHEW said:

We interact with them; I have friends among them. After treatment I give them my phone number, and we communicate, if they keep on taking their drugs they get better.

(Male IDI/ CHEW /42 years/ Christian)

Another CHEW said;

If I love the woman and I see that she has mental illness, I can marry her. The person is a human being, so she should not be left to die.

(Male IDI/ CHEW /44 years/ Christian)

Another Psychiatrist Nurse said;

I have them as friends; we avoid stigmatizing them, if my friend has liver problem will I avoid the person. I will not avoid, it is the same.

(Female IDI/ Psychiatric nurse /43 years/ Christian)

The researcher observed that health care professionals interacted with people living with mental illness as friends, but overtly, they harbored negative feelings against people with mental illness. The researcher observed an incident in the office of a healthcare professional, involving a mentally sick person who was well known to the researcher and a psychiatric nurse. The researcher was discussing with the psychiatric nurse in his office when the person with mental illness entered the office to talk to the researcher. The psychiatric nurse hurriedly asked the researcher that they should leave the office, and he immediately closed the door when the three of them went out. When the researcher inquired to know from the psychiatric nurse why he abruptly left the office, the nurse said he doesn't want the mad man to disturb him. He said: "it is too early, i

don't want disturbance from them, the man talks too much, I don't want their "wahalla". The incident clearly demonstrates how mental health care professionals may overtly exhibit favorable attitude towards people with mental illness; this may likely be done to fulfill the dictates of their profession. But covertly, they may harbor negative attitude towards people with mental illness. Mental healthcare professionals are members of the society; they may likely imbibe the deeply rooted societal discrimination against mental illness

#### **4.5.2 Mean ratings and standard deviations of health care professionals by their job type in the hospital on stereotyping statements**

Table 4.21 shows the distribution of the respondents by type of job in the hospital and their mean responses on some selected stereotyping statements about mental illness. It is deduced from the responses that nurses and social workers displayed more discriminatory attitude towards people with mental illness than other health care workers.

**Table 4.21** Mean and standard deviations of mental health care professionals' responses on some selected stereotyping statements regarding people with mental illness

<b>Statements</b>	<b>Nature of Work</b>	<b>N</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Std. Error</b>
People with mental illness are different from other members of the society	Nurse	35	2.94	0.87	.14749
	Social Worker	5	2.80	0.84	.37417
	CHEW	4	1.75	1.50	.75000
	Support Staff	5	2.80	1.30	.58310
	Doctors	14	2.57	0.94	.25059
	<b>Total</b>	63	2.76	0.98	.12335
Mental hospitals should be built outside place of residence	Nurse	35	2.94	0.97	.16369
	Social Worker	5	2.80	0.84	.37417
	CHEW	4	2.75	0.50	.25000
	Support Staff	5	2.40	0.55	.24495
	Doctors	14	2.29	0.91	.24424
	<b>Total</b>	63	2.73	0.92	.11584
Mental patients should be restrained before treatment	Nurse	35	2.69	1.02	.17282
	Social Worker	5	2.00	1.22	.54772
	CHEW	4	2.25	1.26	.62915
	Support Staff	5	2.00	0.71	.31623
	Doctors	14	2.93	1.07	.28640
	<b>Total</b>	63	2.60	1.06	.13299
The rights of people who have suffered from mental illness should be restricted	Nurse	35	3.34	0.94	.15847
	Social Worker	5	2.60	0.89	.40000
	CHEW	4	2.25	1.26	.62915
	Support Staff	5	2.80	0.84	.37417
	Doctors	14	2.43	1.02	.27163
	<b>Total</b>	63	2.97	1.03	.12993

**Source:** Field survey,

A table 4.21 show that nurses with mean rating of 2.94 and standard deviation of 0.87 agreed that people with mental illness are different from other members of the society. In the in-depth interview, some of the nurses agreed that people with mental illness are different from other members of the society because, they have lost their senses, are aggressive and dangerous.

It can also be deduced from Table 4.22 that social workers also had negative attitude towards people living with mental illness as they maintained that mental hospitals should be built outside place of residence with a mean response of 2.94 and a standard deviation of 0.97. Furthermore, CHEW with a mean response of 1.75 and a standard deviation of 1.50 had more positive attitude towards mental illness than other health workers.

Most of them disagreed with the assertion that people with mental illness are different; most of them agreed that people with mental illness are just like other people with other illnesses. The nurses also displayed negative attitude towards mental healthcare ideology, as a greater proportion of them would not allow the establishment of mental hospitals in the residential areas. Other mental health care workers showed more positive attitude towards the establishment of mental healthcare hospitals than nurses and social workers.

In the in-depth interview, most of the health care professionals were against the use of degrading forms of restraints like chaining and beating. They however agreed that they sedate their people living with mental illness accessing treatment who are aggressive. It was observed by the researcher that at the Federal Medical Center Makurdi, some people with mental illness were chained in the legs, on inquiry the researcher was told

that they had just been brought to the Hospital, and were aggressive and violent; they were chained to prevent them from harming people. The researcher also observed that the Hospital bed was separated by a burglary proof ostensibly to guard against the people with mental illness in the hospital going out. At the Chief Tsumba Psychiatric Hospital in Ugee, mentally sick people were seen lying on the bare floor chained to a wooden Starks on the floor. On inquiry why they were so chained, the researcher was told that it prevents them from attacking other people. These incidences show the negative attitude of mental healthcare providers towards people living with mental illness in both orthodox and traditional psychiatric hospitals.

In order to find out if the differences observed in the mean responses of mental health care professionals is statistically significant, Analysis of Variance (ANOVA) was carried out on their mean responses and is presented in Table 4.22.

**Table 4.22:** Analysis of variance on categories of health care professionals' responses on stereotyping statements regarding people with mental illness

<b>Stigma Statements</b>		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
People with mental illness are different from other members of the society	Between Groups	5.764	4	1.441	1.558	.198
	Within Groups	53.664	58	.925		
	Total	59.429	62			
Mental hospitals should be built outside place of residence	Between Groups	4.920	4	1.230	1.502	.213
	Within Groups	47.493	58	.819		
	Total	52.413	62			
Mental patients should be restrained before treatment	Between Groups	5.858	4	1.464	1.344	.265
	Within Groups	63.221	58	1.090		
	Total	69.079	62			
The rights of people who have suffered from mental illness should be restricted	Between Groups	11.872	4	2.968	3.184	.020
	Within Groups	54.064	58	.932		
	Total					
<b>Total</b>		<b>65.937</b>	<b>62</b>			

**Source:** Field survey, 2018.

Table 4.22 shows that there was no significant association in the mean responses of the mental health care professionals on whether people with mental illness are different from other members of the society ( $F=1.558$ ,  $df= 62$ ,  $p=0.198$ ). Again, there was no significant association in their responses on whether mental hospitals should be built outside places of residence ( $F = 1.502$ ,  $df= 62$ ,  $sig. =.213 =p$ ). This is confirmed since  $p=.213$  is greater than 0.05 level of significance. Furthermore, health care workers maintained that people with mental illness should be restrained before treatment and there was no significant association in their mean responses on this item as  $F=1.344$ ,  $df =62$  and  $p= .265$ .

Also, there was no significant association in the responses of the health care professionals against restraining people living with mental illness during treatment, as some of them disagreed with using any form of restraint like chaining before treatment ( $F = 1.344$ ,  $df = 62$ ,  $sig. =.265$ ). However, there was a significant association in the mean responses on whether the rights of people who have suffered from mental illness should be restricted ( $F = 3.184$ ,  $df =62$ ,  $sig. =.020$ ). This significant mean association on whether the rights of people who have suffered from mental illness should be restricted is shown in the Post Hoc test output in Table 4.22.

**Table 4.23:** Multiple comparisons of mean responses of mental health care professionals on restricting the rights of people living with mental illness.

<b>Dependent Variable</b>	<b>(I) Educational Qualification</b>	<b>(J) Educational Qualification</b>	<b>Mean Difference (I-J)</b>	<b>Std. Error</b>	<b>Sig.</b>
The rights of people who have suffered from mental illness should be restricted	Nurse	Social Worker	.74286	.46159	.113
		CHEW	1.09286*	.50958	.036
		Support Staff	.54286	.46159	.244
		Doctors	.91429*	.30531	.004
	Social Worker	Nurse	-.74286	.46159	.113
		CHEW	.35000	.64766	.591
		Support Staff	-.20000	.61062	.744
		Doctors	.17143	.50300	.734
	CHEW	Nurse	-1.09286*	.50958	.036
		Social Worker	-.35000	.64766	.591
		Support Staff	-.55000	.64766	.399
		Doctors	-.17857	.54737	.745
	Support Staff	Nurse	-.54286	.46159	.244
		Social Worker	.20000	.61062	.744
		CHEW	.55000	.64766	.399
		Doctors	.37143	.50300	.463
	Doctors	Nurse	-.91429*	.30531	.004
		Social Worker	-.17143	.50300	.734
		CHEW	.17857	.54737	.745
		Support Staff	-.37143	.50300	.463

\*. The mean difference is significant at the 0.05 level.

Source: Field survey, 2018.

Table 4.23 revealed clearly that there was a significant association between the responses of nurses and CHEW as well as nurses and doctors at 0.05 level of significance.

#### **4.6 Stigma and Discrimination against the Family Members of People Living with Mental Illness**

This section examined the stigma and discrimination against the family members of people having mental illness.

**Table 4.24** Mean and standard deviations of responses of family members of people living with mental illness on stigma and discrimination they experienced

S/No.	Items	N	Mean	Std. Dev.
1	Worried that others might be reluctant to marry into our family	468	1.9274	.94555
2	Worried about taking him/her out	468	2.0021	.91735
3	Worried that neighbors would treat us differently	468	1.9551	1.03892
4	Feeling ashamed or embarrassed because of the mental illness	468	1.7799	.95994
5	Worried that people would blame you for his/her problem	468	1.4915	1.84922
6	Worried that neighbors would avoid you if they find out	468	2.2650	1.80242
7	Thought somehow it might be your fault	468	1.9060	.96164
<b>Cluster mean and standard deviations</b>		<b>468</b>	<b>1.9038</b>	<b>.65459</b>

**Source:** Field survey, 2018.

Table 4.24 revealed that all the items captured to represent stigma and discrimination experienced by the family members of people living with mental illness had mean scores above 1.50. A cluster mean of 1.8224 with a standard deviation of .53959 is an indication that all the items represent the stigma experienced by family members of people living with mental illness. More respondents with a mean rating of 2.26 and a standard deviation of 1.80242 feel worried that neighbors would avoid them if they found out about the mental illness of their relatives, and as such, they are worried about taking them out (2.00). Respondents with a mean and standard deviation of 1.95 and 1.04 respectively feel worried that neighbors would treat them differently.

The findings of this quantitative analysis were supported by the qualitative analysis of the responses from family members of people living with mental illness on an in-depth interview. The recurring themes in the interviews with family members of people living with mental illness were; feeling of shame, avoidance, worry, blame of family members for the illness, feeling of sympathy. For example, a family member said:

Yes I feel ashamed of myself especially when the thing is happening to him. I do feel ashamed. I am concerned about his security, am always disturbed, but one day I will be better.

(Male IDI / Family member 8/ 45 years / No formal education/ Christian)

Another one said:

I don't know what I am, because when the illness started, I went and told my brother at home. I have suffered; I don't use to sleep in the night at home. I am sad; I don't want to go to where people are. I feel ashamed when the illness is with him.

(Female IDI / Family member 9/ 60 years / No formal education/ Christian)

An interviewee who was a father to the mentally sick patient disclosed that he always feels ashamed and bad because his son dropped out of school. He was thinking that the child, who was bright and would continue with school to eventually become the bread winner of the house. The male family member said:

I feel ashamed because if he had continued with school, he will help me because he was bright, Because of that I don't go to public places, I avoid going to where people gather.

(Male IDI / Family member 2/ 47 years / SSCE/ Christian)

Another interviewee disclosed that he always felt ashamed of having a relative suffering from mental illness. According to him the family has been trying to hide the mental illness from members of the community. The interviewee also disclosed that the family feels disturbed about the security of their mentally sick member whenever he is out of the house. Another family member said:

I feel ashamed that my brother has mental illness; we will be ashamed if people know. I feel disturbed about his security. One day he took machine to the other part of the town, I waited for some time and was disturbed that he may miss his way. Most of the time I sit alone, I avoid going close to people.

(Male IDI / Family member 1/ Tiv/ 37 years / NCE/ Christian)

Another recurring theme in the interview with family members was the avoidance by members of the community in which they live. Family members interviewed complained that members of the community avoid coming close to them since the illness of their relative started. Their responses are presented below.

A family member said:

When the sickness started, he was aggressive, so people stopped coming to our house, people around us are aware of the sickness of my relation, I told them in the house they use to call him mad man.

(Male IDI / Family member 3/ Tiv/40 years / SSCE/ Christian)

A family member said:

People stopped coming as they use to come, but few outside come, I interact with them.

(Male IDI / Family member 6/ Tiv/ 26 years / Degree/ Christian)

Another male family member said:

I am a builder, he helps me to build with some other people, so when I give them money to share, they give him less, they say he cannot work.

(Male IDI / Family member 2/ Tiv/62 years / SSCE/ Christian)

A female family member said:

People don't come to our house again; they are afraid, People stoped coming to buy again, they are afraid, that he will harm them.

(Female IDI / Family member 9/ Tiv/60 years / No formal educ. / Christian)

Yet another family member said that:

When it started, people stopped coming to our house, I used to sell garri and Yams but since his illness started, people have stopped coming to buy. People are afraid to come because he may harm them. People are afraid, he is powerful. Yes, people around us know that my son has mental illness, but I didn't tell anybody, he gets well but whenever he goes back to work, the illness starts again. So I have asked him to stop mechanic work, but nobody has said anything bad about me.

(Female IDI / Family member 2/ Tiv/ 60 years / No formal educ. / Christian)

A family member said:

Yes, many people avoid coming to our house. They think he will attack them, that is how people think, that he will do them something, and they say it is madness, so they avoid coming. But in the neighborhood, people do avoid me, I have not been denied accommodation because of my relative's illness.

(Male IDI / Family member 5/ Tiv/ 31 years / SSCE / Christian)

Responses from family members also show that family members worry a lot about the safety of their mentally sick member. Most of the respondents feel that he/she may be attacked or get missing if they allow the sick relative to go out. They also complained that whenever their drugs finished or they stopped taking drugs, the mental illnesses

relapsed and the person started misbehaving. An interviewee said:

I am worried about his condition, by now he is supposed to be in school. His brother used to protect him but anytime I am not around, I will be worried about what will happen. When the drugs finish and I don't bring him here, his behavior changes.

(Male IDI / Family member 8/ Tiv/ 45 years / N o formal educ. / Christian)

Another interviewee said:

I feel disturbed about his security. One day he took machine to the other part of the town, waited for some times and was disturbed that he may miss his way. Most of the time I sit alone, I avoid going close to people.

(Male IDI / Family member 1/ Tiv/ 37 years / NCE/ Christian)

#### 4.7 Strategies used by People Living with Mental Illness and their Relatives to Cope with Public Stigma and Discrimination

This section examines the strategies used by people with mental illness and their relatives to cope with public stigma and discrimination.

Table 4.23 revealed that majority of people living with mental illness strongly agreed that they stay away from social gathering in order to protect their family members from embarrassment as a result of their mental illness.

**Table 4.25** Responses of People living with mental illness on whether they avoid social gatherings in order to protect their family members from embarrassment as a result of their mental illness

Responses	Frequency	Percent
Strongly Disagree	46	9.9
Disagree	151	32.2
Agree	97	20.7
Strongly Agree	174	37.2
<b>Total</b>	<b>468</b>	<b>100.0</b>

**Source:** Field survey, 2018.

Table 4.25 Shows that some 174(37.2%), of the people living with mental illness strongly agreed that they stay away from social gatherings in order to protect their family members from embarrassment as a result of their mental illness; 97(20.7%) of the respondents agreed. The result highlights the embarrassment mental illness causes in the lives of the people living with mental illness and their family members. This is because having a mentally ill person as a member of the damages the name of the entire family.

#### **4.7.1 Coping strategies by people living with mental illness and their family members to deal with stigma and discrimination against mental illness**

Table 4.24 examines the ways people with mental illness deal with the stigma and discrimination of mental illness from members of the public. Table 4.24 shows that majority of the people living with mental illness use avoidance to cope with public stigma.

**Table 4.26:** Coping strategies against public stigma of mental illness

Coping strategies	Freq. (%)	Age			Sex		Educ. Qual.			
		18- 25yr	26- 35yr	36 above	M	F	No	Pri	Sec	HND
Most of the time I hide the fact that I am receiving mental health care.	40 (8.5)	8	4	28	24	16	12	8	8	12
If I thought someone held a negative opinion about people with mental illness, I would avoid the person.	204 (43.6)	84	72	48	132	72	44	48	40	72
I don't have mental illness (denial).	84 (17.9)	24	36	24	32	52	20	28	24	12
I always explain to people what is meant by having mental illness.	140 (29.9)	44	66	30	84	56	8	16	40	76
<b>Total</b>	<b>468</b>	<b>160</b>	<b>178</b>	<b>130</b>	<b>272</b>	<b>196</b>	<b>84</b>	<b>100</b>	<b>112</b>	<b>172</b>
	<b>(100.0)</b>									

**Source:** Field survey, 2018.

Table 4.26 revealed the frequency distribution of respondents on how they manage to cope with the stigma and discrimination as a result of their mental illness. Results show that majority 204 (43.6), of the respondents said they avoid going close to people to avoid discrimination; 140 (29.9) of the respondents said they rather educate other people who are not affected with mental illness, by telling them what it means to have mental illness. Again, 84 (17.9) of the respondents said that they do not have mental illness, while 40(8.5) of the respondents hide their mental illness from members of the public. The result shows that people who are affected with mental illness isolate themselves from other members of the public by avoiding going to public gatherings. But this attitude has effect on the health outcomes of those affected, like seeking for help. The interview with people living with mental illness revealed the ways they cope with their mental illness.

One of the respondents living with mental illness said:

I control myself when I go close to people, I don't joke with anybody, I control myself so that people will not know. People that get angry I don't talk to them so that they will not embarrass me, I know the people that I talk to .I argue with people but I am careful, and so I don't enforce my views on the people.

(Male IDI / PLWMI 1/ Tiv/ 26 years / SSCE / Christian)

Another one said;

I used to hide, shame use to catch me, If I friend a lady I will not tell her. I avoid going to people, they reject me.

(Male IDI / PLWMI 1/ Tiv/ 35 years / Primary School Cert. / Christian)

A male interviewee said:

I stay away from people because I feel they will insult me. I interact only with people who don't know me because they don't know that I have mental illness. I don't interact with people that know my condition. I am looking for a job; I will not tell them that I have mental illness, because they will refuse to give me the job. Even my girl friend, I hide it from her, I hide it from her,

sometimes I take overdose of the medicine to forget about my condition, especially when a person talk bad thing against me.  
(Male IDI / PLWMI 11 / Tiv/ 38 years / Primary School Cert. / Christian)

A male interviewee said:

I hide, if you see me here, don't go and greet me outside I will not answer if you see me outside I will not answer, because this man is mad he went to psychiatry. I don't tell people that I have come to psychiatry, people will say Iam mad. I will not tell my girl friend that I have mental illness I will hide. If I see a person insulting another person with mental illness will intervene and ask the person to stop doing it. Me I will fight if People call me a mad man.

(Male IDI / PLWMI 5 / Tiv/ 43 years / Degree / Christian)

Another female said:

I don't go to where people are, I avoid going to public gatherings. I stay with my children; I don't interact with other people.

(Female IDI/PLWMI 6/Yoruba / 62 years / Primary School Cert. / Christian)

A male interviewee said:

I am friending a girl; I will tell them that I have mental illness, because if I don't tell her and she discovers, she will feel bad. I am looking for a job; I will tell them that I have the disease. If they don't like they should not give me the job.

(Male IDI / PLWMI 7 / Tiv / 28 years / JSS 1 / Christian)

Some family members Interviewed opined that they cover the mental illness of their relative to avoid the shame that would be on their family if people know. This is because having a person with mental illness in the family is considered a mark of shame and degradation for the entire family. A male family member said:

We hide, we don't want people to know, and I feel bad because of his illness. so I often sit and think about it.

(Male IDI / Family member 1/ Tiv/37 years/NCE/Christian)

Another male family member said;

People around us don't know that he has mental illness, yes we hide, we don't tell people.

(Male IDI / Family member 8 / Tiv / 45 years / NCE / Christian).

**Table 4.27** Mean and standard deviations of responses of family members of people living with mental illness on their coping strategies

<b>Items</b>	<b>N</b>	<b>Mean</b>	<b>Std. Dev.</b>
Need to sometimes hide this fact	468	1.9509	.83020
Special efforts to keep fact a secret when meeting people for the first time	468	1.8120	.98756

**Source:** Field survey, 2018.

Table 4.27 shows that family members of people living with mental illness sometimes had to hide the fact that their relatives are living with mental illness, this was evident in their responses as they had a mean score of 1.95 and standard deviation of .83 on this coping strategy item. Also, their mean responses (1.81) indicates that they sometimes take special efforts to keep the fact that their relatives are living with mental illness a secret when meeting people for the first time to avoid being stigmatized.

#### **4.8 Interventions to End Stigma and Discrimination against People with Mental Illness**

This section examines the perceived interventions towards reducing stigmatization and discrimination against mental illness. Members of the public and people with mental

illness were asked to indicate from a set of sentences what they think should be done to end the stigma and discrimination they faced from members of public. Table 4.25 shows that most of the people living with mental illness identified public enlightenment as a strategy for reducing the stigma of mental illness.

**Table 4.28** Suggestions of people living with mental illness on ways of ending stigma and discrimination against mental illness

<b>Suggestions</b>	<b>Frequency</b>	<b>(%)</b>
Public enlightenment/education.	360	76.9
People with mental illness should be treated in the community clinics.	77	16.5
Members of the public should be encouraged to interact with people living with mental illness.	15	3.3
People should stop looking down on us.	15	3.3
Total	468	100.0

**Source:** Field work; 2018

Table 4.28, shows that a high proportion of the people living with mental illness (76.9) identified public enlightenment/education as a strategy to end stigma of mental illness. On the other hand, 77 (16.5) of the respondents said the best way to reduce stigma and discrimination is for people living with mental illness to be treated in the community clinics.

## CHAPTER FIVE

### 5.0 Discussion of Findings

This study examined the social stigma and discrimination against people with mental illness and their family members in Benue State. The study established that there is generally negative public attitude towards mental illness. These negative views were expressed by 64.6% of the respondents who were not willing to trust a woman who suffered from mental illness as a baby sitter, 58.5% of members of the public who would not marry a person having mental illness, and 69.6% who would not let their house out to a person having mental illness. Such negative views are similar to those cited by Gureje *et al.*, (2005), Omoaregba *et al.*, (2015) and Igbinomwanhia, *et al.*, (2013). One reason for this negative attitude could be lack of understanding on the causes of mental illness by members of the public and the absence of public educational programs concerning mental illness.

Men exhibited more negative attitudes than women in the study. For example, 56.0% of men agreed that as soon as a person shows sign of mental illness, the person should be kept indoors. This is more than 40.7% women who agreed to this statement. Studies by Cook and Wang, (2010) in Canada also found that men had negative attitudes than women. One reason for this could be that women are caring and show more love and compassion in such situations than men.

Negative views about mental illness were expressed more by respondents from Tiv ethnic group than those from other ethnic groups that participated in the study. For example, 30.7% of the respondents from Tiv ethnic group agreed that as soon as a person show signs of mental illness, he should be put behind bars. This was more than

21.2% of respondents from the Idoma ethnic group. Studies by Khulhara and Chakrabarti (2001) have established that stigmatization of mental illness varies according to culture, depending on the way each culture perceived the cause, nature and treatment of mental illness. This is an indication that stigmatization of mental illness is common in the study area because the Tiv ethnic group makes up about 14 local government areas in Benue State.

The study also established that 42.3% of members of the public with tertiary education indicated negative attitude more than 32.6% of those without tertiary education. This means having higher education does not translate to positive attitude towards mental illness. This finding is similar to a previous study in Iraq (Sadik *et al.*, 2010). According to WHO (2001), stigmatization and discrimination of mental illness is not selective, it is universal and prevalent even among the educated members of the society. This attitude towards mental illness, even by educated members of the public is probably because of the deeply rooted socio cultural beliefs about mental illness in the study area.

It was also established from the study that 67.9% of people with mental illness were categorized as having elevated stigma, while 32.1% had minimal stigma. This is relatively high compared to studies by Ibrahim *et al.* (2016), which reported 22.5% in Maidugari, Nigeria and Ghanean *et al.*, (2011) who reported 12% in Sweden. A possible explanation to this high prevalence of internalized stigma is the low level of awareness about prognosis, nature and treatment of mental illness. Another possible reason for the prevalence of elevated internalized stigma among people with mental illness could be the lack of counseling and psycho-education programs at the clinics to reduce the impact of stigma among people receiving treatment. The third possible reason for the

difference could be because of different scoring systems used by other studies and the cultural variation among the different studies.

The study also established that males had higher mean scores than females on elevated internalized stigma. This is different from a study by Khan, *et al.*, (2015) which showed that women experienced more elevated internalized stigma than men. The possible reason for this could be cultural differences between the two study areas. Another probable reason may be that male respondents aspire more in life than female respondents, and interact more with members of the public than their female counterparts. Thus, they may be more affected by public stigma.

People with mental illness that received traditional care had more elevated internalized stigma than those that attended the orthodox psychiatric hospitals ( $t=4.404$ ,  $df =468$ , sig.2 tailed ( $p$ ) =.000). This finding has not previously been covered in the literature. The possible reason for this may be the harsh therapy applied by traditional doctors and the proximity of the traditional treatment centers to communities where mental illness is highly stigmatized. This might be responsible for the feeling of elevated internalized stigma among people with mental illness. Another possible reason might be the harsh treatment given to people with mental illness in the traditional treatment centers, where people with mental illness receiving treatment are chained, beaten and restrained by the traditional doctors in the full glare of members of the community.

It was also revealed that the proportion of people with mental illness reporting been inferior because of mental illness were relatively high. This is an indication that people with mental illness have elevated internalized stigma. The possible reason for this might

be the accumulative effect of stigma from members of the public. This finding has serious implications on the mental health of people living with mental illness; it will affect the self concept and self efficacy of people with mental illness. This finding is corroborated by studies by Koschorke *et al.*, (2014). This is also an indication that people with mental illness have accepted the public stigmatization of mental illness. This finding has implications for policy making as there is an urgent need to reduce the stigma and discrimination experienced by people having mental illness.

Nurses and community health extension workers showed negative attitude towards mental illness than other health workers. This finding was also reported in a study by Nordt *et al.*, (2016) in Switzerland. The possible reason for the negative attitude of nurses could be because of their low level of health education. Nurses maintain a daily contact with people living with mental illness, and by their training, they are supposed to show understanding of mental illness more than the lay members of the public. The negative attitude of nurses and social workers towards mental illness pose a great challenge to the health of mental patients, as their attitude may discourage them from coming to the hospital for treatment. It is also interesting to note that psychiatrist doctors interviewed showed less stigmatizing attitude towards people with mental illness than other health care professionals. Their high academic training may be responsible for this positive attitude to mental illness.

The study showed that family members of people living with mental illness experienced shame because of the mental illness of their sick member. Some of the interviewees disclosed that they felt ashamed having a person with mental illness as a member of the family. Studies by Elbur *et al.*, (2014) in Saudi Arabia also reported

feelings of being ashamed if their family member is diagnosed with mental illness. This is because of the stigma and discrimination that is usually attached to mental illness in the study area. For example it is believed among the Tiv, Idoma and Igede that it is shameful to have a family member with mental illness, because mental illness is believed to be a punishment for wrong doing which is also genetically transmitted. This is compounded by the fact that family members are often blamed or accused of being responsible for the mental illness of their relatives. These beliefs are largely caused by ignorance about the nature and causes of mental illness and are the root cause of stigmatization and discrimination.

This finding from the in-depth interview with the family members corroborated those of a study by Shibre *et al.*, (2001) in Ethiopia. The findings of this study highlight the need to recognize family members of people having mental illness in anti-stigma campaigns, this is because of the close contact they have with their relatives, and the courtesy stigma they are likely to experience.

It was also established from the study that the most common strategy employed by people living with mental illness and their family members in coping with public stigma was withdrawal. People with mental illness disclosed that they limited their social interaction, and chose whom to interact with in order to avoid rejection and discrimination. This finding has been discussed in literature by Struch *et al.*, (2008), Link, et al., (2001) and Barke *et al.*, (2011) in southern Ghana. People with mental illness adopt this strategy to avoid the stigmatization that will occur if they go out to seek friends, jobs and other needs in the wider society (Link *et al.*, 1997).

However, studies have shown that withdrawal can have detrimental effect on the wellbeing of the person having mental illness. Barnes and Shardlow (1996) argued that social isolation could hinder people living with mental illness from developing themselves, and also limit their opportunities for growth. It is therefore likely that such people may be constrained by stigma from seeking for employment, treatment, and engaging in social relationship.

The study also established that, some of the people with mental illness also reported they took overdose of the drugs given to them from the hospital. They particularly reported that they took the overdose whenever members of community made uncomplimentary remarks against them concerning their mental illness. This way of coping by people with mental illness has not previously been discussed by literature. This finding has policy implications for treatment of people with mental illness. There is need for health care professionals to concentrate not only on treatment of people with mental illness but also provide psycho-education to them when they come to the hospital to receive treatment.

Another coping strategy identified by people living with mental illness from the study was concealment of their mental illness. Respondents reported that they usually hid their mental illness from members of the public probably to avoid rejection and discrimination. This assertion by people living with mental illness was also corroborated by family members in the in-depth interview. Most family members interviewed indicated that they hid the mental illness of the family member to avoid the shame it would bring on the family. A similar finding has been discussed by Struch *et al.*, (2008) who asserted that a person with mental illness concealed the fact that he/she

had been treated for mental illness in a psychiatric hospital. Such persons with mental illness and their family members may choose to conceal their treatment history from employers, relatives, landlords or potential marriage partners to avoid rejection (Link *et al.*, 1991). This finding is also consistent with the assertion of Goffman (1963) that such people with discreditable conditions have marks or labels that can be hidden or concealed. A possible explanation to this is the fear of being stigmatized by the public. Most of the respondents do not disclose their destination when members of the community meet them on their way to the hospital.

The assumptions of the labeling theory are applicable to the findings of this study. The first assumption of the theory is that mental illness, rather than being seen as an abnormal condition which affects an individual, is viewed as a label which is attached to persons who engage in abnormal behaviors. The abnormal behaviors are labels which are characteristics of mental illness and are considered a violation of social norms rather than psychopathology. Such behavior as social withdrawal, talking to oneself, wearing dirty cloths and wondering are labels which members of the public place on people with mental illness. And once a person has been labeled by the society, the person receives a set of reactions from members of the public in form of discrimination, social rejection and devaluation.

The study indicated that there is a general negative attitude towards mental illness by members of the public in the study area. For example, 62.6% of members of the public agreed that people with mental illness are undesirably different from normal people because they wear dirty clothes, talk to themselves, and roam about. According to labeling theory, these labels or stereotypes are the human perceptions that differentiate people with mental illness from normal people in the society and elicit negative reaction

in form of unwillingness to have social contact with the stigmatized person, unwillingness to marry people who have once suffered from mental illness, unwillingness to entrust them with sensitive tasks like baby sitting, leadership positions etc.

The second assumption of the labeling theory is that the self conception of an individual results from the perception of people around him. According to the theory, mental illness is a social role and the societal reaction is the most important determinant of that role. Gradually, the stigmatized person internalizes the public reaction and takes on the secondary role of mental illness. It therefore becomes difficult for the stigmatized person to return to his/her former state of functioning as the status causes unfavorable evaluation by themselves and by members of the public. This is usually reinforced by the institutionalization of people living with mental illness in a psychiatric hospital, and the pronouncement of mental illness on them. The internalization of public stigma usually has a deleterious effect on the self worth and self efficacy of people having mental illness, this usually affects them in interacting with members of the society, seeking for employment, and seeking for healthcare.

In keeping with the labeling theory, the findings of the study showed that there is an elevated internalized stigma among people having mental illness in the study area. This is because the proportion of respondents that reporting a sense of alienation was high. The respondents agreed with all the statements on the subscale. This is likely to have effect on the lives of these respondents concerned. This was also confirmed by the in-depth interview with people having mental illness. The respondents disclosed in the interview that they feel bad about their condition. They also complained that people

look down on them, and their suggestions are never accepted by people, so they feel bad and withdraw themselves from other members of the community. According to Link and phelan (2001), stigma involves labeling and isolation which can have deleterious effect to the stigmatized person, like lost of self worth.

Another assumption of the theory is that people who are stigmatized anticipate rejection and evolve strategies to cope with the negative labels. These coping strategies may include withdrawal, secrecy and education. Findings of the study highlighted the different measures adopted by people living with mental illness in the study to cope with the stigma of mental illness. Most of the respondents opted for withdrawal as a measure to cope with the discrimination resulting from their mental illness. The respondents disclosed that they refrained from going out to meet with people to avoid the rejection or embarrassment they would have to endure. Other respondents opted to conceal their mental illness as a coping strategy. The respondents disclosed that they felt ashamed disclosing their mental illness to members of the public to avoid rejection. This was again confirmed by the in-depth interview. For example, one of the respondents disclosed that she usually felt bad about having mental illness and because of that she hid her mental illness from others by pretending to be well especially in the presence of other members of the community. This highlights the stigma and discrimination faced by people having mental illness in the study area.

Some respondents hide their mental illness status; others prefer to disclose their status because, according to them, it will be worse if the people they interact with come to know about it. For example, one of the respondents said that he will disclose his status to the girl he wants to marry because if he did not tell her and the girl discovers, it will be worse. The girl will feel bad.

## CHAPTER SIX

### 6.0 Summary, Conclusion and Recommendations

#### 6.1 Summary of Key Findings

This study investigated the forms of social stigma against people living with mental illness in Benue state. The study adopted a cross-sectional descriptive research design using both quantitative and qualitative research approaches.

Result of the study shows a general negative attitude of members of the public towards people with mental illness in the study area as 62.6% of members of the public consider people with mental illness as distinguishable from normal people in the society, 64.6% of members of the public were not willing to trust a woman who suffered from mental illness as a baby sitter, 58.5% would not marry a person having mental illness, and 69.6% would not let their house out to a person having mental illness.

The prevalence of internalized stigma among people living with mental illness was also obtained. The result shows that 67.9% of people with mental illness have elevated internalized stigma; however, the level of elevated internalized stigma among people with mental illness who attended treatment at traditional psychiatric care was more than those who attended at the orthodox health care ( $t=4.404, df=466, sig.2tailed(p) = 000$ ).

Results on the stigma and discrimination of health care professionals against people with mental illness were also obtained. In the in-depth interview, People with mental illness who attended hospital for treatment disclosed that health care professionals do not show negative attitude towards them. But interview sessions with health care

professionals indicated negative attitude of the health care professionals towards people living with mental illness. An ANOVA statistic showed that nurses with a mean rating of 2.94 and standard deviation of 0.97 exhibited negative attitude more than other category of health care professionals.

The results of stigma and discrimination against family members of people living with mental illness were also obtained. Results of the in-depth interview with family members of people living with mental illness indicated experiences of stigma and discrimination against people living with mental illness. Family members disclosed that they experienced shame, and seclusion from members of the public as a result of their relatives' mental sickness.

The result of the study on strategies used by people with mental illness and their family members to cope with stigma and discrimination were obtained. In-depth interview with the family members reveals that people living with mental illness and their family members withdraw from other members of the community to avoid stigma and discrimination. Some of the people with mental illness interviewed also reported that they take overdose of the drugs given to them from the hospital. One of them particularly reported that he takes the overdose whenever members of community say uncomplimentary remarks against him concerning his illness status. He said he normally take the overdose to forget the insult from members of the community.

## 6.2 Conclusion

Mental health is an important precursor of human health and is fundamental in our ability to live well with other members of the society and contribute meaningfully to the development of the society. The maintenance and protection of good mental health should therefore be a fundamental concern of individuals, society and nations over the globe. The absence of good mental health can constitute a serious problem to the global health and is a consequence of poverty, ill health and stigma. Stigma is a central challenge to integrity of the people who are affected, their family members and the society at large. It affects individuals' capacity to perform social roles and their capacity to contribute meaningfully to the development of the society. Stigma also distorts the normal social relationship among members of the society. The findings of this study therefore provided evidence to the effects of stigma on the individuals with mental illness and the society at large.

The negative attitudes of stigma in the study has no doubt altered the self conception of people living with mental illness, thus making them devalued members of the society, and affecting them in contributing meaningfully to the development of the society. The problems of stigma therefore highlight the need for Nigeria and other nations of the world to pay more attention to mental health. This would entail proper funding of mental health, putting in place necessary legal framework to protect the rights of people with mental illness.

### 6.3 Recommendations

Based on the findings of this study, the following recommendations are made with policy implications and implementation strategies.

- i. There is a negative public attitude towards mental illness in the study area. There is therefore the need for government to develop a well articulated policy on mental health in Nigeria. This will include enacting relevant regulations to end stigma and discrimination in work places, schools and in public social life. Government and non-governmental organizations should also embark on public awareness on the causes, course and treatment of mental illness. The public awareness should be aimed at changing the negative stereotypes of members of the public towards mental illness. The anti stigma interventions should target factors that promote discrimination and social distance between members of the public and people living with mental illness; like fear, ignorance, traditional norms, and wrong media portrayal etc.
- ii. The study also reveals that 67.9% of people with mental illness have elevated internalized stigma; with people attending treatment at traditional psychiatric care having elevated internalized stigma more than those who attended orthodox health care ( $t=4.404, df= 466, sig. 2 \text{ tailed } (p) = 000$ ). There is therefore the need for Government and non-governmental organizations to undertake psycho educational programs and counseling targeted at people with mental illness receiving traditional psychiatric care. The psycho-social programs should be aimed at reducing stigma among people living with mental illness which is informed by what matters most to them in terms of their sense of worth and acceptance. It is hoped that the psycho

educational programs and counseling will help to boost the self worth and self efficacy of people with mental illness.

- iii. Interviews with health care professionals reveal a covert negative attitude by health care professionals towards people with mental illness. Nurses exhibited negative attitude more than other category of health care professionals. There is need for the government to increase awareness through seminars, conferences and symposiums, on the problem of stigma among healthcare professional groups working with people living with mental illness. These seminars, conferences and symposia should bring together experts to educate healthcare professionals on the dangers of stigma and discrimination against people with mental illness. The relevant regulatory boards should incorporate anti stigma as integral part of the curricular of medical education for healthcare professionals, especially the junior cadre like nursing psychiatrist and community health extension workers, since it was discovered that they hold more stigmatizing attitude towards mental illness.
- iv. It was further revealed in the study that family members of people living with mental illness experienced shame because of the mental illness of their relative. This finding has implications for research policy and stigma intervention. It demonstrates the significant impact stigma has on the lives of family caregivers of people having mental illness. There is therefore an urgent need to target family members of people living with mental illness in the planning and implementation of anti stigma campaigns. There is also the need to engage family members of people living with mental illness in psycho educational programs regarding the etiology and management of mental illness. This will be aimed at helping them to have a better

understanding of mental illness so that they can better manage their sick relatives and reduce the stigma and discrimination they face.

- v. Interview session with people having mental illness indicates that they withdraw from other members of the public to avoid public insult; others take overdose of the drug to sleep and forget about their mental sickness. Government and non-governmental organizations should also introduce interventions to end stigma among people living with mental illness. These interventions should focus on helping people to overcome feeling of alienation and low self esteem, this means involving people with mental illness in stigma intervention support groups where people with mental illness can share their experiences of stigma and ways to cope with stigma of mental illness.

#### **6.4 Contributions to Knowledge**

The study has contributed to knowledge in the following ways:

1. The study established that stigma and discrimination against mental illness is a health challenge among the people in the various ethnic groups. There are no laws to protect the rights of people with mental illness.
2. Deep negative cultural beliefs among members of the public are responsible for the stigma and discrimination against people with mental illness in Benue State.

3. Prevalence of internalized stigma is high among people suffering from mental illness especially those attending treatment at the traditional psychiatric centers.
4. There is stigma among healthcare professionals against people living with mental illness, especially nurses and social workers.
5. Family members of people living with mental illness face tremendous challenges of taking care of their sick relative. There is no social support to family members to take care of their sick relative.
6. It was established that some of the people living with mental illness take overdose of the depressants to cope with the stigma they face from members of the public.

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## **APPENDIX I**

### **QUESTIONNAIRE ON COMMUNITY ATTITUDE TOWARDS MENTAL ILLNESS**

Department of Sociology,  
Ahmadu Bello University,  
Zaria.  
20 – June -2016

Dear Respondent,

I am a Post Graduate student of Ahmadu Bello University Zaria, undertaking a study on Stigma and Discrimination against People Living with Mental illness in Benue State. Kindly provide answers to the questions below. Your responses will be treated with utmost confidentiality and used only for the purpose of this study.

Thanks

Yours faithfully,

Mpem, Terungwa.

Please read the questions carefully and tick (✓) where applicable against the appropriate multiple responses suggested, or fill the blank spaces with your responses.

**Section ‘A’: Socio-demographic characteristic of the respondents**

1. Age, 18- 25[  ] 26- 35 [  ] 36- above [  ] years
2. Sex: Male[  ] Female [  ]
3. Marital Status: Married [  ] Single [  ] Divorced [  ] Widow
4. Educational Qualification: No formal education[  ] Primary[  ]Secondary[  ]  
Diploma HND [  ]
5. Religion: Christianity [  ] Islam [  ] Traditional [  ] Others [  ]
6. Occupation: Farming [  ] Civil servant [  ] Others[  ] Trading[  ]
7. Ethnic Group : Tiv [  ] Idoma [  ] Igede [  ] Etulo [  ] Abakwa [  ] Nyifom [  ]  
] Others [specify] -----
8. What do you think is the cause of mental illness?
  - A. Substance abuse [  ]
  - B. Superstition [  ]
  - c. Punishment from the gods [  ]
  - d. Hereditary [  ]
  - e. Others (Specify) -----

**Section B: The beliefs among members of the public that people with mental illness are inferior and need coercive handling**

*Please tick Yes or No as appropriate*

S/N	Statement	Yes	No
9.	As soon as a person shows signs of mental illness he should be locked behind doors.		
10.	Less emphasis should be placed on protecting the public from the mentally ill.		
11.	Is there anything about people with mental illness that distinguishes them from normal people?		
12.	Mentally ill people need the same kind of control and discipline as young children.		
13.	Mental illness is an illness just like any other.		
14.	One of the main causes of mental illness is lack of self-discipline and will power.		
15.	Keeping them behind locked doors is one of the best ways to handle the mentally ill.		
16.	Virtually anyone can become mentally ill.		
17.	The mentally ill should not be treated as outcasts.		
18.	Do you think the mentally ill should not be denied their individual rights?		

19. With respect to question 9 above, state the reasons for your answer. -----

-----

20. With respect to question 11 above, what is it that makes them different? -----

-----

**Beliefs among members of the public that people with mental illness needed  
emphathy on account of their mental health condition**

	<b>Statements</b>	<b>Yes</b>	<b>No</b>
21.	The mentally ill are a burden to the society		
22.	It is best to avoid anyone who has mental problems.		
23.	Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.		
24.	Do you think increased spending on mental health services is a waste of tax payers' money?		
25.	The mentally ill do not deserve sympathy.		
26.	The mentally ill have for so long been a subject of ridicule .		
27.	We have the responsibility to provide best possible care for the mentally ill.		
28.	We need to adopt a more tolerant attitude towards the mentally ill in the society?		
29.	There are sufficient existing services for the mentally ill.		
30.	The best therapy for many mental health problems is to be part of a normal community.		
31.	People with mental illness should be encouraged to assume the responsibility of a normal life.		

**Trust and social restriction to be imposed by respondents on people with mental illness in everyday life.**

	<b>Statements</b>	<b>Yes</b>	<b>No</b>
32.	Can you trust a woman who once suffered from mental illness for a baby sitter?		
33.	Do you think the mentally ill should not be given any post of responsibility?		
34.	Anyone with a history of mental illness should be excluded from contesting elections.		
35.	The mentally ill are less of a danger than most people think.		
36.	If you were a landlord, would you let your house out to a person with mental illness.		
37.	I will not employ a person with mental illness.		
38.	The mentally ill should be isolated from the rest of the community.		
39.	No one has the right to exclude the mentally ill from their resident .		
40.	Can you marry a man or woman who has suffered from mental illness if he/she seems surely recovered?		
41.	Have you ever vacated your house because of a mentally sick person staying in the same compound?		

<b>Attitude of respondents on mental healthcare ideology.</b>			
	<b>Statements</b>	<b>Yes</b>	<b>No</b>
42.	It is frightening to think of people with mental problems living in a residential neighborhood.		
43.	Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.		
44.	Local residents have good reasons to resist the location of mental health services in their neighborhood.		
45.	As far as possible, mental health care services should be provided through community based health facilities.		
46.	Mental hospitals are an outdated means of treating the mentally ill.		
47.	Mental health facilities should be kept out of residential neighborhoods.		
48.	Locating mental health care facilities in residential areas downgrades the neighborhood?		
49.	Having mental patients living within residential neighborhoods might be good therapy but the risk to residents is great?		
50.	The best therapy for mental health problems is to be part of a normal community.		

51. Anyone with a history of mental illness should be excluded from contesting elections. Yes [ ] No [ ]

52. Can you trust a woman who once suffered from mental illness as baby-sitter?  
Yes [ ] No [ ]

53. Do you think the mentally ill should not be denied their individual rights?  
Yes [ ] No [ ]

54. Give reasons for your answer -----

55. Do you think the mentally ill should not be given any post of responsibility?  
 Yes [ ] No [ ]
56. Give reasons for your answer -----
57. Can you marry a man or woman who has suffered from mental illness even though he/she seems truly recovered? Yes [ ] No [ ]
58. Give reasons-----
59. Having mental patients living within residential neighborhoods might be good therapy but the risk to residents is great. Yes [ ] No [ ]
60. If you agree, what are your reasons? -----
61. Have you ever lived in the same compound with a person having mental illness?  
 Yes [ ] No [ ]
62. If you were a Landlord, would you let your house out to a person with mental illness  
 Yes [ ] No [ ].
63. If your answer to question 35 is yes, give reason, -----
64. Do you think increased spending on mental health services is a waste of tax payers' money? Yes [ ] No [ ]
65. Why do you think so? -----

## APENDIX II

### IN-DEPH INTERVIEW FOR MENTAL PATIENT RELATIVES (PRINCIPAL CAREGIVERS).

#### SECTION 'A': Socio-demographic characteristic of the informants

Age: [ ]

1. Sex: Male [ ] Female [ ]
2. Marital Status: Married [ ] Single [ ] Divorced [ ] Widow [ ]
3. Educational Qualification: No formal education [ ] Primary [ ] Secondary [ ] OND [ ] HND [ ] Degree [ ] Others [ ]
4. Religion :Christianity [ ] Islam [ ] Traditional [ ] Others [ ]
5. Occupation: Farming [ ] Civil servant [ ] Others

Ethnic Group: Tiv [ ] Idoma [ ] Igede [ ] Etule [ ] Abakwa [ ] Nyifom [ ]  
others [specify] -----

6. What is your relationship to the person having mental illness? Sibling [ ]  
parent [ ] others, specify-----
7. What do you think is the cause of your relative's mental illness?
8. Do people outside the family know that your relative have mental illness? How  
did they know?
9. Do you think some people have avoided you on account of your relative's  
mental illness?
10. If the answer to the above question is yes, how soon did this happen after the  
manifestation of the mental illness?
11. Have you heard of members of the community talk about the cause of your  
relative's mental illness?
12. Will you be ashamed if people know that your relative has mental illness?

13. Do you avoid going close to people because of the illness of your relative? Why did you avoid going close to the people? What is your relationship to the person you avoided
14. Do you think the mental illness of your relative has affected your family members? If yes how has it affected them?
15. Have you ever been denied appointment/employment as a result of the mental illness of your relative? If yes, briefly explain why
16. Have you ever been denied accommodation because of the illness of your relative?
17. Are you worried about the safety of your mentally ill relative?  
If yes, state any two of such worries.
18. How do you cope with the mentally illness of your relative (a) cover (b) avoid
19. What do you think should be done to reduce the problems you face as a result of your relative's mental illness?

**APPENDIX III**

**INTERVIEW ADMINISTERED QUESTIONNAIRE FOR PEOPLE HAVING MENTAL ILLNESS**

**SECTION ‘A’: Socio-demographic characteristic of the respondents**

1. Age: 18 – 25  26 – 35  36 and above
2. Sex: Male  Female
3. Marital Status: Married  Single  Divorce
4. Educational Qualification: No formal education  Primary  Secondary  Tertiary
5. Religion: Christianity  Islam  Others
6. Occupation: Farming  Civil servant  Others
7. Duration of mental problem  
 ≤ 6 m  2—5 yrs  6----10 yrs
8. Nature of health care. Traditional  Orthodox
9. Ethnic Group: Tiv  Idoma  Igede  Etule  Abakwa  Nyifom  others  
 [specify] -----

S/N	<b>Alienation</b>	Disagree	Agree	Strongly agree	Disagree
10	People without mental illness could not possibly understand me.				
11	Having a mental illness has spoiled my life				
12	I am embarrassed in myself for having a mental illness.				
13	I feel pity about people that have mental illness				
14	I feel inferior to others who don't have a mental illness.				
15	I stay away from public gathering because of my mental illness.				

16 Give reason for your answer

---

	<b>Stereotype endorsement</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly agree</b>	<b>Disagree</b>
17	Because I have mental illness, I need others to make decisions for me.				
18	People can tell that I have a mental illness by the way I look.				
19	Mentally ill people tend to be violent.				
20	People with mental illness cannot live a good rewarding life.				
21	Mentally ill people shouldn't get married.				
22	I can't contribute anything to society because I have mental illness.				
23	People avoid coming close to me because I have a mental illness.				
24	Other people think that I can't achieve much in life because I have a mental illness.				
25	People take me less seriously just because I have a mental illness.				
26	I don't talk about myself much because I don't want to burden others with my mental illness.				
27	I don't get close to people much because my mental illness might make me look weird to them.				
	<b>Stereotype endorsement</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly agree</b>	<b>Disagree</b>
28	I don't apply for jobs because I feel my				

	employer would deny me the job because of my mental illness.				
29	I don't like going to the hospital because people will think I have mental illness.				
30	Healthcare professionals treat me badly when I visit the hospital because of my illness.				
31	My suggestions are not accepted by other members of the community.				
32	I avoid getting close to people who don't have a mental illness to avoid rejection.				
33	Living with a mental illness has made me a tough survivor.				

34 Have you ever discontinued medication? Yes [ ] No [ ]

35. If your answer to no 34 is yes, did your experience of stigma contribute to your decision to your discontinuing medication? Yes [ ] No [ ]

36. Have you ever felt so desperate that you have attempted to harm yourself because of your mental illness? Yes [ ] No [ ]

37. Do you have friends among the people in your community? Yes [ ] No [ ]

38. What do you think should be done to reduce the way others treat people with mental illness

## APENDIX IV

### INTERVIEW SCHEDULE FOR MENTAL HEALTH CARE PROFESSIONALS

1. Educational qualification
2. Religion
3. Age
4. Designation/ Job title
5. Do you think the training you received is enough to help you work with people having mental illness
6. What do you think is the cause of mental illness?
7. Do you think people with mental illness are different from other members of the public
8. Do you think the rights of people who have suffered from mental illness be restricted? If yes, why? How?
9. Have you ever experienced any form of attack by a mental patient?
  - Ever insulted you
  - Frowned at you
  - Ever slapped you
  - Made passes
10. Is there any time you feel you should not be working with people having mental illness why?
11. Do you support the idea that mental patients should be restrained before treatment?  
Why?
12. Can you be make friends with a person having mental illness? If no why?
13. Do you believe that a person having mental illness can be completely cured?

14. Can you marry a person having mental illness? If yes, have you ever met such a person? Provide details
15. Do you think mental care hospitals should be built outside places of residence?
16. What do you think should be done to reduce negative attitude towards people living with mental illness?

## APPENDIX V

### INDEPTH INTERVIEW GUIDE FOR TRADITIONAL MENTAL HEALTHCARE PROFESSIONALS

1. Educational qualification
2. Religion
3. Age
4. How long have you been on the job?
5. How were you trained?
6. What do you think is the cause of mental illness?
7. Do you think the training you received is enough to help you work with people having mental illness?
8. What do you think is the cause of mental illness?
9. Do you think people with mental illness are different from other members of the public?  
  
Have any of the people you treated been completely cured?  
  
Dangerousness  
  
Unpredictable
10. Do you think the rights of people who have suffered from mental illness be restricted?
11. Have you ever experienced any form of verbal or physical attack by a mental patient?
  - Ever insulted you
  - Frowned at you
  - Ever slapped you
  - Make passes

12. Has there been any time you felt you should not be working with people having mental illness why?
13. Can you marry a person with mental illness?
14. Do you support that mental patients should be chained before treatment? Why?
15. Can you make friendship with a person having mental illness? If no why?
16. Do you think mental care treatment centers should be built outside places of residence?
17. What do you think should be done to reduce negative attitude towards people living with mental illness?

## **APPENDIX VI**

### **STRUCTURED OBSERVATION GUIDE FOR STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH MENTAL ILLNESS**

1. Observe the mental health care professionals as they attend to mentally ill patients.
2. Observe the mentally ill patients as they attend clinic.
3. Observe the organization of the hospital
4. Observe the care givers as they attend to their relative attending clinic
5. Observe the interaction between the mental healthcare workers and and the person having mental illness

**APPENDIX VII**

**BSUTH/MKD/HREC/2013B/2017/0015**

**PARTICIPANT CONSENT FORM**

**CONSENT FORM**

**Social Stigma and Discrimination against people living with mental illness in**

**Benue State**

**BY**

**Mpem Terungwa**

1. I confirm that I have read and understand the information sheet dated March 2017 for the above study and have the opportunity to ask questions
2. I understand that my participation is voluntary and that I am free to withdraw at anytime, without giving any reason.
3. I agree to take part in the above study.
4. I agree to be audio- recorded if I participated in a fellow-up interview.

\_\_\_\_\_

**Name of participant:**

**Signature:**\_\_\_\_\_

**Date:**\_\_\_\_\_

\_\_\_\_\_


**Name of researcher**

**Signature:**\_\_\_\_\_

**Date:**\_\_\_\_\_

## APENDIX VIII

### ETHICAL APPROVAL

<b>BENUE STATE UNIVERSITY TEACHING HOSPITAL</b> <b>MAKURDI - NIGERIA.</b>		
<b>BOARD CHAIRMAN</b>		<b>CHIEF MEDICAL DIRECTOR</b> Prof A. O. Malu (OON) MB, FMCP, FWACP
<b>DIRECTOR OF ADMINISTRATION</b> Mr. Terkaa Luga, (JP) NCE, B.A, MSc, AHAN, MNIM, FCAI		<b>CHAIRMAN MEDICAL ADVISORY COMMITTEE</b> Dr. Hembah-Hilekaan S. K. MBBS, FIIA, FWACS
<b>POSTAL ADDRESS</b> P. M. B 102131 Makurdi	BSUTH/MKD/HREC/2013B/2017/0015	E-mail: bsuth_estab@yahoo.com Tel: 07036586094, 08071771989
<b>Ref:</b>		22 <sup>nd</sup> February, 2017 <b>Date:</b>

**HEALTH RESEARCH ETHICS COMMITTEE**


**Mpem Terungwa** (Ph.D SOC-SCI/39352/2012-2013)  
Department of Sociology  
Benue State University, Makurdi.

**ETHICAL APPROVAL**  
Research Title: "*Social Stigma and Discrimination among People Living with Mental Illness in Benue State*".

This is to inform you that the research described in the submitted protocol, the consent forms and other participant information materials have been received and given **approval** by the Health Research Ethics Committee.

This approval dates from 22<sup>nd</sup> February, 2017 to 22<sup>nd</sup> February, 2018. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside these dates. All informed consent forms used in this study must carry the HREC assigned number and the duration of HREC approval of the study.

The **National Code for Health Research Ethics** requires you to comply with all institutional guidelines, rules and regulations and with the tenet of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit to your research site without previous notification.

 22/2/17  
**Dr. Andu Onyemocho** (FWACP, MBBS)  
Chairman, HREC



FEDERAL REPUBLIC OF NIGERIA  
**FEDERAL MEDICAL CENTRE MAKURDI**  
HOSPITAL ROAD, MAKURDI, BENUE STATE

P.M.B. 102004

E-mail: fmcmkd@yahoo.com

Ref. No.....*FMH/FMC/MED/108/I/X*

Date:.....*19<sup>th</sup> August, 2015*

Mr. Mpem Terungwa,  
Department of Sociology,  
Benue State University,  
Makurdi.


**LETTER OF ETHICAL APPROVAL**

On the directives of Management, Health Research Ethics Committee sat to consider your study proposal "The state of Social Stigma among Out – Patients Psychiatric in Benue State."

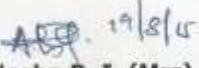
The committee has not seen any adverse ethical problem arising from your methodology.

In view of above, you are hereby permitted to go on with the study and work within the time limit given to you.

Please note that a copy of your final work must be submitted to the committee on completion of your work.

  
*19/8/2015*  
**Pharm. Richard I. Injor**

For: Chairman HREC

  
*19/8/15*  
**Alocha R. I. (Mrs)**

Secretary HREC