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ORIGINAL ARTICLE

Knowledge and Perception of Mental Disorders among relatives of mentally ill persons in a rural community in South-South Nigeria

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ABSTRACT

Background: In Nigeria, mental disorders (MDs) are prevalent in the population and compounding the problem is the misconceptions and poor perceptions associated with these conditions. Consequently, the study was designed to assess the knowledge and perception of mental disorders among relatives of mentally ill persons in Amai community, Ukwuani Local Government Area, Delta State Nigeria.

Methods: This was a descriptive study utilising qualitative method of data collection. An in-depth interview was conducted among 20 relatives of mentally ill people selected purposively from four quarters in Amai community. An in-depth interview guide was used to collect the data and was analysed manually for themes and content.

Results: The age range of the participants was 25-75 years, comprising 11 females and nine males. The participants demonstrated some form of knowledge of the critical element of MDs, but showed misconceptions on the causes of MDs. Most of the participants preferred traditional (unorthodox) medicine for the treatment of MDs. Furthermore, despite their affirmative perception of MDs as a serious illness, the majority exhibited negative perception towards people with MDs.

Conclusion: Misconceptions and myths about the causes of mental disorder are very prevalent among rural dwellers. Poor perception towards mentally challenged persons among relatives of mentally challenged persons was also common. Therefore, these misconceptions and myths should be corrected through organized strategic awareness campaigns among rural dwellers aimed at eliminating these misconceptions and myths, thereby improving the quality of life of persons suffering from MDs.

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INTRODUCTION

Mental Disorders (MDs) include any illness with significant psychological or behavioural manifestations that are associated with either a painful/distressing symptoms or impairment in one or more critical areas of functioning.[1] Generally, the characteristics of MDs include a combination of abnormal thoughts, perceptions, emotions, behaviour, and relationships with others.[2] MDs include depression, bipolar affective disorder, schizophrenia and other psychoses,

dementia, intellectual disabilities and developmental disorders including autism.[2] Also, genetic and environmental factors are the varied causes of MDs, which include inherited traits from the family, exposure to environmental stressors, inflammatory conditions, toxins, alcohol or drugs and impairment of the brain chemistry.[3] Globally, MDs are gradually becoming an issue of public health importance. This is because these disorders exist in all countries irrespective of age, gender, income, and socio-economic status.[4, 5] Also, about one in four people are affected by mental or neurological disorders at some point in their lives; with an estimated 450 million people currently suffering from such conditions, placing MDs among the leading causes of ill-health and disability worldwide.[6] Furthermore, around 15.5% suffer from any mental or substance use disorder affecting 16% of males and 15% females.[7] In Nigeria 20-30% of its population experiences some form of MDs in their lifetime.[8] As significant as this figure, many of these persons have little recourse in terms of treatment, protection of their rights, rehabilitation or other support.[9]

The public health role of the health system is to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment. Additionally, removing the stigma associated with receiving treatment, eliminates health disparities, and improves access to mental health services for all persons, particularly among populations that are disproportionately affected.[6] Nevertheless, the World Health Organisation-Assessment Instrument for Mental Health Systems report on the mental health system in Nigeria, reveals that mental health remains a neglected issue in the country. The report showed a weak mental health policy, health care institutions, funding of mental health and inadequate support from all levels of government in Nigeria.[10] This has resulted in the absence of a range of well-coordinated preventive, promotive, curative and rehabilitation services. Consequently, leading to cost implication for the individual and the society coupled with the co-morbidity of mental disorders affecting the individual, family, health system and their community.[11]

Generally, the community's perception of mental illness varies across traditions and cultures. Thus, this belief system tends to influence the pre-, intra-, or post-mental disorder treatment among members of a community.[4, 7] For instance, in Nigeria some patients are frequently readmitted because their relatives keep them at a distance (social distance) from their vicinity to avoid "social embarrassment". Consequently, this brings to the fore the issue of stigmatisation and negative labeling (negative stereotyping) of patients with an MDs. Stigma against people with an MDs is a significant barrier to positive outcomes in terms of recovery and rehabilitation of patients back to their families and the society at large.[12] Besides, the development of a mental health program depends on the role of each community's perception of the prevention and care of the mentally ill. This role is influenced by the

norms, beliefs, and customs within each community's cultural environment, which play a role in determining help and health-seeking behaviour and successful treatment of the mentally ill. For example, the residents of Karfi village in northern Nigeria perceived causes of mental illness to be a misuse of drugs, divine punishment or Gods will.[5] Whereas, a study among residents of Gimbi town in Oromia region of Ethiopia perceived the causes of mental illness to be an evil spirit, Gods punishment, and witchcraft.[4]

Mental disorder among young men and women is pervasive in most communities in both Ndokwa West and Ukwuani Local Government Areas of Delta State and other areas of the Niger-Delta region.[13] The perceptions in these places is that the availability of the cannabis plant is probably responsible for the high prevalence of MD in these areas. Besides, the lack of proper care services and poor health-seeking behaviour among the residents, especially in seeking formal orthodox care for these mentally ill patients in these communities is alarming. Furthermore, the stigma of mentally ill, negative labeling and stereotyping is also prevalent in these areas. Resulting in sick mentally patients roaming the streets with little or no proper care, looking dirty and unkempt. Possibly, it may be due to a poor perception of mental illness in these communities contributing to low health-seeking and stigmatisation of people with mental illness.[4]

For this reason, it is necessary to assess the community's perception of MDs in designing and implementing health promotion programmes as well as creating awareness among rural communities of the health services available for mentally ill patients. This is a good strategy of perceived improvements in the community's understanding of mental health, community support for people with mental illness, and management of mental health problems.[14] Therefore, this study was designed to assess the knowledge and perception of mental disorders among relatives of mentally ill persons in Amai community. As this would provide evidence-based information for the design of future health promotion intervention programs in the community.

METHODOLOGY

The study was a descriptive study that utilised qualitative methods of data collection. The study was carried out in Amai kingdom located in Ukwuani Local Government Area of Delta State in the Southern part of Nigeria. Amai community lies between Latitude 6^0.04 and 6^0.40 and Longitude 7.05^{0}E and 7.30^{0}E with a population of 1,780 (2006 census estimate) and an estimated population of 2275 persons as at 2017 going by 2.5% annual growth. It is rural and a predominantly agrarian society. Amai was selected for the study because mental illness is widespread in the community. In Amai community, one of the most grown plants is Cannabis plant popularly known as marijuana. Casual observation reveals that the availability of this hemp plant is perceived as one of the likely reasons for the increase in mental illness in the community. Amai community

has five quarters namely; Amainge, Umuekum, Umubu, Ishikaguma, and Umuosele. The community has a Primary Health Care facility available for members of the community and the private tertiary institution called Novena University.

Participants of the study were those who had at least one family member with a mental disorder. The sample size comprises 20 members of families of mentally challenged individuals from four quarters of Amai kingdom chosen purposively because at the time the study was carried out in the year 2017; these were the people available and were willing to partake in the study. The participants comprised nine males and eleven females from Ishikaguma, Umuekum, Amainge and Umuosele quarters of Amai kingdom. The instrument for data collection was a developed in-depth interview guide comprising of eight questions drafted based on the objectives of the research and relevant literature. The researcher, accompanied by a research assistant who is an indigene of the community, assisted in identifying the families of the mentally ill persons in each quarter. Afterward, the researcher visited the families and explained in details the purpose and benefit of the research and assuring the families of their privacy and confidentiality of whatever information they would provide.

Informed consent was obtained from all participants before the commencement of the interview. The data was collected on scheduled dates and time with each of the interviewees at their various homes. The researcher ensured the environment was conducive on each day of the data collection without interference from other members of the family. Research assistants were recruited who assisted in tape-recording the discussion sessions and also taking down additional notes as supporting documents to ensure comprehensive documentation of the interview process. Each interview lasted between 30-45 minutes. Upon the conclusion of the sessions, all interviews were transcribed by the research team. After that, transcripts of interviews were reviewed subsequently, while interview session and responses were coded and analysed manually for themes and content. The main themes developed from the discussion were the demographic profile of the discussants, knowledge of MDs, which included the definition of MDs and understanding of the causes of MDs; health-seeking behaviour and perception of MD.

All participants agreed to take part in this study voluntarily without undue pressure and inducement. In the study context, a participant is knowledgeable if their definition includes the critical element of MDs such as the psychological and behavioural manifestations, signs and symptoms and can identify some causes of MDs such as environmental and psychosocial factors. Ethical approval was obtained from the Department of Public and Community Health Ethical Review Committee, Novena University. This letter was presented to the community head and the study participants before obtaining their

verbal informed consent to participate in the study.

RESULTS

Profile of the participants

A total of 20 participants were selected for the in-depth interview comprising family members of people who have a mental disorder. They included parents, siblings, uncles, aunties, and cousins chosen from four quarters of Amai kingdom. The age range of the interviewees was 25-75 years. The participants comprised 11 females and nine males **(Table 1)**.

Table 1: Profile of the discussants

Variable	Frequency (n=20)	Percent
Age group (years)		
25-44	9	45.0
45-65	7	35.0
> 65	4	20.0
Sex		
Male	9	45.0
Female	11	55.0
Occupation		
Farmers	17	85.0
Okada riders	3	15.0
Religion		
Christian	8	40.0
Traditional	12	60.0
Category of relationship		
Parents	4	20.0
Siblings	6	30.0
Uncles	4	20.0
Aunties	3	15.0
Cousins	3	15.0
Quarters		
Umuekum	6	30.0
Ishikaguma	4	20.0
Amainge	6	30.0
Umuosole	4	20.0

Definition of mental disorders

Most of the respondents could define MD with the general observation across all the participants that a person who has MD has lost all sense of function:

"Someone who has malfunctioned" ***(Female participant (Aunty) from Umuekum quarters)***

"It means the senses are not correct" ***(Male participant (Parent) from Umuosole quarters)***

"Someone insane" ***(Male participant (Parent) from Amainge quarters)***

Few of them related MD to suffering from depression and loneliness:

"Someone who is emotionally depressed" ***(Female participant (Sibling) from Amainge quarters)***

"Someone who feels lonely" ***(Female participant (Parent) from Umuekum quarters)***

Few of them also related MD to acting and behaving strangely:

*"Someone who act strangely" (****Female participant (Aunty) from Ishikaguma quarters)***

"Someone who acts and behave strangely" ***(Male participant (Uncle) from Amainge quarters)***

Knowledge of what causes mental disorders

The respondents attributed the causes of MD to a variety of factors. For instance, some of the participants attributed the causes of MD to jealousy from a rival person.

"Mental disorder is caused by jealousy" **(*Female participant (Aunty) from Umuosole quarters)***

"Envy and jealousy" ***(Female participant (Aunty) from Ishikaguma quarters)***

Some others were superstitious about the cause of MD by attributing them to stealing from the gods, violation of community rules and swearing by the gods:

"Swearing by the gods" **(*Female participant (Parent) from Umuekum quarters)***

"Spiritual attack" ***(Male participant (Parent) from Umuosole quarters)***

Violation of community rules ***(Female participant (Cousin) from Ishikaguma quarters)***

Furthermore, the opinion of the participants was sought on the likely causes of MD going by the factors of supernatural and psychosocial. Most of the respondents attributed the cause of mental disorders to supernatural agents:

"…especially supernatural agent, e.g. witchcraft, rivals, stealing from the gods" **(*Female participant (Aunty) from Ishikaguma quarters)***

"Supernatural agent witchcraft, wizard, stealing from the gods" **(*Male participant (Parent) from Umuekum quarters)***

*"Supernatural agent, witches, wizard, stealing from gods" (**Male participant (Uncle) from Umuosole quarters)***

Some attributed the causes of MD to psychosocial factors:

"Psychosocial factors such as poverty, laziness, drug abuse." **(*Male participant (Uncle) from Umuekum quarters)***

"Psychosocial factors, e.g. poverty, stress, loss of loved one, alcohol and drug abuse." ***(Male participant (Parent) from Ishikaguma quarters)***

"Psychosocial factors, e.g. poverty, drug abuse, laziness…" ***(Female participant (Cousin) from Umuosole quarters)***

Perception of the respondents towards mental disorder

The respondents were asked about the perceived severity of the MD and why they gave their responses. Most affirmed that MD is a severe illness:

"It is a serious sickness because it is dangerous." **(*Female participant (Sibling) from Umuosole quarters)***

"It is a strong sickness because it is not easy to overcome" **(*Female participant (Aunty) from Ishikaguma quarters)***

"It is a serious sickness because it is hard to cure" ***(Male participant (Parent) from Amainge quarters)***

"It is a serious illness because people will not want to associate with the person" ***(Female participant (Cousin) from Umuekum quarters)***

However, few affirmed they do not consider MD a severe illness and the reasons they gave is as follows:

"No, it is not a serious illness because it comes and goes" **(*Female participant (Sibling) from Amainge quarters)***

"No, I do not believe it is a serious illness because most of the mental disorder is caused by people and they can easily be well if they apologise to them" ***(Female participant (Cousin) from Umuosole quarters)***

The respondents were asked if any member of their family or anybody they know has recovered from mental illness and what treatment they received. Some of the respondents affirmed that they are not aware of anyone who has ever recovered from mental illness:

"Nobody I have not seen" **(*Male participant (Parent) from Amainge quarters)***

"Nobody I have not seen or heard" ***(Female participant (Parent) from Umuosole quarters)***

"No, I have not seen" ***(Male participant (Uncle) from Ishikaguma quarters)***

However, some of the respondents affirmed that some of their mentally ill family members have recovered from mental illness and they have seen other people improved:

"Yes I have seen people recovered and they were treated by herbalist" **(*Female participant (Sibling) from Umuosole quarters)***

"Yes and they were treated by a native doctor" ***(Male participant (Parent) from Amainge quarters)***

"Yes and they recovered in the church" ***(Female participant (Sibling) from Ishikaguma quarters)***

"Yes and they were treated by both church and native doctor" ***(Male participant (Uncle) from Amainge quarters)***

The participants were asked if they would oppose marriage with a person who recovered from mental illness and the reasons for their choice. Only one of the participants agreed to allow marriage with their loved ones with a mentally ill recovered person:

"I will agree if I see that the mentally ill person has recovered" **(*Male participant (Uncle) from Amainge quarters)***

For those who disagreed with the idea of allowing their loved ones to marry a mentally ill person who has recovered, their reasons were as follows:

"I will not allow it like the people I have seen that marry them are now regretting because the illness came back, and they are disturbing the family. I do not want my relatives to suffer that fate" **(*Male participant (Siblings) from Umuekum quarters)***

"I will not allow it because if the illness reoccurs, the children and family will suffer and it can result in death" ***(Female participant (Parent) from Amainge quarters)***

"No, I will not allow it because it is shameful and people would mock us and the illness could return resulting in injury or death" ***(Female participant (Cousin) from Ishikaguma quarters)***

"No, because prevention is better than cure and the illness could come back again" ***(Male participant (Uncle) from Amainge quarters)***

"No, because people would use it to insult my family and it would be shameful" ***(Female participant (Parent) from Umuosole quarters)***

The question was also asked if the participants could talk to a mentally ill person. Some of the participants responded in the affirmative that they could speak with a mentally ill person and they gave reasons for making such a decision:

"Yes, I can talk to them because talking to them gives them encouragement" ***(Male participant (Parent) from Amainge quarters)***

"Yes, to encourage them" ***(Female participant (Aunty) from Umuekum quarters)***

"Yes, just to help them" ***(Male participant (Uncle) from Umuosole quarters)***

However, the majority disagreed that they would talk to a mentally ill person and they also gave reasons for their choice:

"No, because shame would not allow me to talk to them" ***(Female participant (Sibling) from Ishikaguma quarters)***

"No, because it is dangerous" ***(Male participant (Parent) from Umuekum quarters)***

"No, because if I start talking with them, it will make me a mad person too" ***(Male participant (Sibling) from Amainge quarters)***

"No, because they act strangely" ***(Female participant (Cousin) from Umuosole quarters)***

One of the participants, however, appeared indifferent citing that he could talk to them because some of the mentally ill persons are calm; while he might not want to talk to them because some of them can be easily upset.

Health seeking behaviour towards mental illness

When asked the health-seeking behaviour for MD, most of the participants affirmed that they take cases of MDs to the native doctor (herbalist):

"Native doctor" **(*Female participant (Aunty) from Umuosole quarters)***

"Herbalist" ***(Female participant (Parent) from Amainge quarters)***

"Herbalist" ***(Male participant (Parent) from Umuekum quarters)***

"Native doctor" ***(Male participant (Uncle) from Amainge quarters)***

The reasons given by the participants for seeking treatment from native doctors (herbalist) include:

"…because they tell them the reason for the madness" **(*Male participant (Parent) from Ishikaguma quarters)***

*"… because it is cheap" (****Female participant (Aunty) from Amainge quarter)***

"Because it is affordable" **(*Female participant (Parent) from Umuosole quarters)***

Some of the participants mentioned church and hospital as other places they take a mentally ill person to:

"Church and hospital" **(*Female participant (Sibling) from Umuekum quarters)***

"Church" ***(Female participant (Sibling) from Amainge quarters)***

"It depends on what people believe some take to church while others take to native doctor" ***(Male participant (Parent) from Ishikaguma quarters)***

The reasons for taking MD patients to the church include:

"Through prayer and fasting the person might get healed" **(*Female participant (Sibling) from Umuekum quarters)***

"Because in the church they get healed" ***(Female participant (Sibling) from Amainge quarters)***

DISCUSSION

Mental disorder is a condition where an individual's mental capacity and faculties are impaired. Individuals in such a state are unable to fulfill his or her potential and cannot live a productive life.[2] Most of the participants demonstrated knowledge of MDs by affirming a mentally ill person to be a malfunctioned or insane person. The source of this definition by the participants is not farfetched as mental illness is very prevalent in Amai community. Consequently, these mentally ill persons are seen roaming the streets with ragtag clothes

looking unkempt and eating from refuse dumps. Besides, some of the participants defined mental illness by relating it to forms of MDs such as emotionally depressed and lonely persons. Revealing some form of knowledge of the critical elements of mental disorder among the respondents. However, this finding was in contrast to that of a study in Kano State Nigeria where the respondents showed little knowledge of the mental illness.[15] Furthermore, most of the participants showed poor knowledge of the causes of MDs by attributing it to supernatural causes such as witchcraft, spiritual attack, stealing from the gods, among others. The outcome is an indication that religious and cultural factors are still influencing the knowledge and understanding of the causes of MD. For this reason, there is a need to carry out more awareness campaign on the medical causes of MD and management among the populace, especially in rural areas to assuage these myths and misunderstanding among rural dwellers. Such messages should target accessing health services for the management of MDs, which is usually not available for the local population and could be one of the factors driving increased neglect and negative sterotyping of people with severe MDs.[16]

In agreement with this finding, a previous study in Akwa Ibom Nigeria showed the causes of MDs to be magic, witchcraft, sorcery, and divine punishments.[12] The finding was also similar to previous studies in Kano State Nigeria, where respondents reported the causes of mental illness to be hereditary and supernatural causes.[15] Similarly, another study from Uganda revealed that respondents attributed causes of schizophrenia to supernatural causes.[17] Moreover, few of the participants attributed mental illness to psychosocial factors such as poverty, stress, loss of loved ones, and alcohol and drug abuse. Previous studies in the United States and Nigeria reported a similar result where few of the respondents also attributed causes of MD to psychosocial factors.[18, 19]

The perception of the participants showed that the majority of them recognized MDs to be a serious illness. However, this perception did not translate to a healthy choice of treatment as most of the respondents' still preferred traditional treatment in the management of mentally ill persons as compared with the orthodox treatment. Public stigma of people with a MD is a growing trend. [16] The participants confirmed this as the majority disagreed with the idea of allowing their loved ones to marry a mentally ill person who has recovered. Their reason is because of the stigma, negative labeling and consequent shame associated with a MD. Furthermore, the majority affirmed that they could not talk to a mentally ill person. The stigma of mentally ill persons is a global problem as previous studies in the United States, and European countries have reported stigma among their population, [20, 21, 22] and even among health professionals.[23, 24] Even in Nigeria discriminatory tendencies against mentally ill persons have been reported.[25, 26]

Also, the health-seeking behaviour of the participants shows that majority assert that they would take cases of MD to a herbalist. Reasons cited for their choice of a herbalist were mainly cost of health care. This implies that the cost of treatment might also be a factor influencing the choice of treatment for the mentally ill among rural dwellers. For this is peculiar in Amai community because the nearest psychiatrist hospital is Benin-City, which is more than 50km from the community. Similarly, findings from a previous study in Osun state Nigeria showed that traditional (unorthodox) medicine was treatment preference among the respondents.[12] However; the study was slightly different from the study in Kano, where the majority of the respondents preferred treatment of mentally ill persons at home.[15] Another study in Kampala Uganda also showed the majority of their respondents preferring hospital-based treatment.[17] In contrast, only a few participants in the current study mentioned hospital as their preferred place of treatment. Few of the participants also mentioned church as a place of seeking treatment for mentally ill patients. Similarly, a study in Kano reported that more than half of the respondents affirmed the use of the Quran in the treatment of the MDs.[15] Undoubtedly, this is not surprising as Kano is a Muslim dominated area, while Amai community the current study area comprises of traditional worshippers with few Christians. Thus, the place of residence could also influence the choice of treatment behaviour. However, as outlined in the guideline of the World Health Organization, a combination of psychotherapy, medication and social support treatment is the best treatment for mentally ill persons.[6]

Limitations of the study: The study was qualitative; thus, it only sampled a few respondents. Also, there was limitation in the selection of the sampled respondents as the study only relied on relatives that were available and were willing to partake in the study, thus possibly leaving out others who do no reside in the community and were not willing to partake but might be more knowledgeable to provide better information on the study objectives.

Conclusion: In conclusion, the study showed that there are misconceptions and myths about the causes of mental disorder, stigmatization of mentally ill persons and poor perception of mental disorder in Amai community. Therefore, awareness campaign aimed at correcting these misconceptions and negative stereotyping of MD patients should be embarked upon by government and non-governmental organizations including traditional and religious institutions in protecting the rights and privileges of mentally ill persons. Further, the family as a unit of care should provide the needed social support for affected family members as this could go a long way in aiding their recovery.

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