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IN THIS ISSUE

- OUTCOMES IN PALLIATIVE CARE FOR ADVANCED PROSTATE CANCER IN THE RADIOTHERAPY AND ONCOLOGY DEPARTMENT OF THE AHMADU BELLO UNIVERSITY TEACHING HOSPITAL, ZARIA.
- THE PREVALENCE AND CORRELATIONS OF ELECTROCARDIOGRAPHIC-LEFT VENTRICULAR HYPERTROPHY IN A RURAL COMMUNITY IN AFRICA.
- CONTROL AND PREVENTION OF CHOLERA TRANSMISSION IN LOW RESOURCE CLINICAL SETTING
- SKELETAL INJURIES IN CHILDREN PRESENTING IN A TERTIARY HEALTH FACILITY IN LAGOS STATE, NIGERIA
- ANTIBIOGRAM OF BACTERIAL AGENTS OF LOWER RESPIRATORY TRACT INFECTIONS IN A CENTRAL NIGERIAN HOSPITAL
- SURVEY OF EARLY PREDICTIVE SIGNS OF POOR MENTAL HEALTH AND SOCIO-CULTURAL BELIEFS ABOUT MENTAL ILLNESS IN ENUGU STATE, NIGERIA
- RUPTURED UTERUS: FETOMATERNAL OUTCOME AMONG UNBOOKED MOTHERS AND ANTENATAL CARE DEFAULTERS AT THE UNIVERSITY OF PORTHARCOURT TEACHING HOSPITAL.

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Contents

The Nigerian Journal of Medicine Board and NARD Executive Committee.. i

Editorial Notices.. ii

Writing for the Nigerian Journal of Medicine.. iii

Original Articles

Outcomes in Palliative Care for Advanced Prostate Cancer in the Radiotherapy and Oncology Department of the Ahmadu Bello University Teaching Hospital, Zaria.
Adamu A, Chukwuocha IC, Jimeta JD, Olasinde TA. 1

The Prevalence and Correlations of Electrocardiographic-left Ventricular Hypertrophy in a Rural Community in Africa.
Alikor Chizindu A, Emem-Chioma Pedro 7

Control and Prevention of Cholera Transmission in Low Resource Clinical Setting
Owoeye David, Adebayo Oladimeji 14

Skeletal Injuries in Children Presenting in a Tertiary Health Facility in Lagos State, Nigeria
Akinmokun OI, Giwa SO, Bode CO. 20

Antibiogram of Bacterial Agents of Lower Respiratory Tract Infections in a Central Nigerian Hospital
Abdullahi N, Iregbu KC. 29

Survey of Early Predictive Signs of Poor Mental Health and Socio-cultural Beliefs about Mental Illness in Enugu State, Nigeria
Ekwueme OC, Chukwueneke F, Ekwueme AC, Ndu AC, Idoko CA, Nwobi EA. 35

Ruptured Uterus: Fetomaternal Outcome among Unbooked Mothers and Antenatal Care Defaulters at the University Of Portharcourt Teaching Hospital.
Eli S, Abam DS, Kalio DGB, Oriji V, Allagua DO, Green K, Ikimalo J. 46

Extraction of Mesioangularly Impacted Third Molar: Dental Drill Versus Crane Pick Elevator on Treatment Outcome.
Dr. Charles E. Anyanechi. 52

Exploring Actors Roles in Formulation of the Human Resources for Health Policy in Nigeria
Nkoli Uguru, Enyi Etiaba, Benjamin Uzochukwu, Miriam Ajuba, Giuliano Russo, Reinhard Huss, Obinna Onwujekwe. 59

Prevalence of Obesity and Ethno-geographic Variation in Body Sizes of Nigerians with Type 2 Diabetes Mellitus - A Multi-Centre Study.
Balogun WO, Uloko AE, Ipadeola A, Enang O, Adamu AN, Mubi BM, Okafor CI, Odeniyi I, Lawal IU, Adeleye JO, Fasanmade OA. 69

Prevalence and Predisposing Factors to Birth Fractures and Brachial Plexus Injuries Seen in a Tertiary Hospital in Calabar, Nigeria.
Asuquo JE, Abang IE, Urom SE, Anisi CO, Eyong ME, Agweye PU. 78

Knowledge and Use of Tuberculosis Treatment Guidelines in Endemic Settings: A Cross-sectional Study among Primary Health Care Workers in Ogbomoso, Oyo State, Nigeria.
Sunday Olakunle Olarewaju, Wasiu Olalekan Adebimpe, Abiodun Oluwatoyin Olarewaju, Medinat Omobola Osinubi 84

Predictors of Lower Extremity Amputation Among Patients with Diabetic Foot Ulcer in a Tertiary Health Facility in North Central Nigeria.
Enamino M, Odoh G, Uwakwe JN, Puepet FH. 92

Original Article

SURVEY OF EARLY PREDICTIVE SIGNS OF POOR MENTAL HEALTH AND SOCIO-CULTURAL BELIEFS ABOUT MENTAL ILLNESS IN ENUGU STATE, NIGERIA

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ABSTRACT

BACKGROUND: The rising prevalence of mental disorder and the enormous emotional, financial, socio-economic and developmental burden is a source of concern and challenge to the global community. This study assessed the prevalence of major warning signs of poor mental health and socio-cultural beliefs about the mental illness among the urban and rural dwellers in Enugu State, Nigeria.

METHODS: This was a descriptive, cross sectional study, using multistage sampling to recruit a total of 724 respondents, 371 from urban and 353 from rural Local Government Areas. A researcher constructed and pre-tested semi-structured questionnaire was the instrument of data collection used. William C. Menninger's questions for assessing warning signs of poor mental health was modified and adapted. Data was analysed using Epi-info version 3.5.3. Chi-square test and Student T-test statistics were used. Level of significant was set at p ≤0.05.

RESULTS: Socio-cultural factors mostly believed to cause mental illness were evil spirits (51.8% Urban: 34.28% rural, X2 = 22.51, p= 0.000) and native charm (47.7% urban: 43.1% rural; X2 = 1.58, p = 0.209). Major alternative treatments recommended for the mentally ill were prayer/deliverance (59.8% urban: 54.7% rural, p=0.160) and herbal drugs/ traditional healers (31.0% urban: 35.7% rural, p=0.180). Mean scores of the signs of poor mental health among the urban and rural dwellers were 80.82±41.66 and 119.55±37.06 (t=13.19, p= 0.000); and prevalence of early warning signals of poor mental health were 21.7% for the urban and 33.87% for the rural respondents.

CONCLUSION: Traditional beliefs about mental illness are still prevalent in the 21st century Nigeria. The rural dwellers have more warning signs of poor mental health than their urban counterparts. In-depth psychiatric evaluation, mental health education and counselling are advocated.

Key Words: beliefs, mental health, mental illness, rural, signs, urban

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INTRODUCTION

The rising prevalence of mental disorder associated with chronic diseases and disabling conditions has been a source of concern and challenge, globally. About 450 million people in the world are said to be suffering from mental, neurological or from the psychosocial problems such as those related to alcohol and drug abuse [1, 2]. In Nigeria, health indicators show that 20-30% of the general population has one form of mental or psychological problems [1].

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Mental health, according to world health organization (WHO) is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully and is able to make contributions to his or her community[3]. Thus, a mentally healthy person feels comfortable about self, feels right towards others and is able to meet the demands of life [4]. Good mental health is a state of well-being in which an individual is at peace with himself, his family, neighbour and environments. It is the embodiment of social, emotional and spiritual well-being, enabling an individual to live an active life, achieve goals and interact with one another in a respectful and just manner[5]. Good mental health enables one to hold a job, secure a family, avoid trouble with the law and enjoys the usual opportunity for pleasure. [6]

Mental illness or disorder is anything that disturbs the inward serenity and outward gaiety.[5] It is a pattern of behaviour or feeling or thinking which interferes significantly with the individuals' ability to work, to get along with other people or to enjoy life.[7] Mental disorders are not exclusive to any special group. They are truly universal and are found in people of all regions, all countries and all societies[2]; with over a third of people in most countries reporting sufficient criteria at some point in their life, up to the time they were assessed.[8] A recent WHO global survey indicates that anxiety disorders are the most common in all but [one country], followed by mood disorders in all but [two countries] while substance abuse and impulse-control disorders were consistently less prevalent.[8]

Mental disorder has multi-factorial causes ranging from a combination of environmental, biological and psychosocial causes.[8] The psycho-social or socio-cultural environments of the individual have been recognized to play a prominent role in determining the state of his or her mental health. Social stresses can often be identified as initiating and precipitating factors of acute mental disorder. Although patterns of non-organic psychoses are similar in many communities, their manifestations are conditioned by cultural factors. Thus, the recognition of mental disorder depends on a careful evaluation of the norms, beliefs and customs within the particular culture.[2,8,9]

In Nigeria, as in most other African countries, the physical and socio-cultural factors recognized to promote mental health are fast disappearing due to loss of traditional values, institutions and technological advancement. It is evident that with the growing complexity of the Nigerian society including the population dynamics, a large population of Nigerians are being moved from the protection of this simple traditional environment to the more complex, heterogeneous and less protective modern ones, which encourages emotional stress, anxiety, tension, frustration; cruelty, rejection, neglect and various social injustices.[10] Social problems and issues such as worries, anxieties, emotional stress, poverty, industrialization, urbanization, unemployment, economic and political instability, terrorisms, inflation, overcrowding, crime and social vices, divorce, broken homes, prostitution, drug addition, alcohol abuse, rape, new wave of human slavery, kidnapping, political thuggery, motivated killings, assassinations and lack of educational opportunities now abound across all communities in Nigeria.

All these indices of social disorganization, which have profound and significant implications for mental health cut across all homes, schools and communities in Nigerian [2, 10, 11] Among the so called affluence members of the society, their economic position could contribute to psychological breakdown because they are frequently subjected to strain and stress resulting from the modification of behaviours to meet the demand of their socio-economic environment and to keep up with the pace of affluence. Among the poor, the low level of education, feeling of hopelessness and insecurity exposes them to a greater risk of mental disorders.[2,10]

There is no culture in the world in which at one time or the other, illness in general and mental illness in particular has not been ascribed to the supernatural and preternatural influences such as the devil, evil, spirits, witchcrafts and sorcery. Although, the advent of science and technology had influenced and modified such beliefs in very many cultures of the world, but such beliefs are still very strong in the African culture and reflects both fear and ignorance.[2,12,13] These beliefs influence the people's attitude to the mentally ill, health seeking behaviour, diagnosis and choice of treatment modalities for the mentally ill.

It is against this back drop of the prevailing ignorance and poor-socio-economic

environment in Nigeria and its possible effects on the mental health status of her citizenry that this survey was undertaken using Enugu State as a case study. It is particularly important that the early signs of mental disorders be recognized so that remedial action can be taken promptly. It is equally important to note that the early signs may be misinterpreted by relatives, friends and society as merely antisocial behaviour calling for punishment rather than treatment[9]. Thus, a high index of suspicion and careful analysis of the cultural orientation may be required. Often times, the person who is troublesome may be the person in trouble.[9]

This study compares the mental health status of urban and rural dwellers in Enugu State, and assessed their knowledge and beliefs about mental illness. The findings of this study will serve as a pre-requisite for planning health education intervention and counselling on maintenance of a good mental health. It may also provide evidenced based data for policy making regarding the mental health and illness.

MATERIALS AND METHODS

The study area, Enugu State, is one of the five states in the eastern part of Nigeria. Enugu State has a population of 3,267,837 people consisting of 1,671,795 females. Nigeria's first indigenous University, University of Nigeria, as well as the University of Nigeria Teaching Hospital is located in Enugu State. Other Federal Hospitals Located in Enugu include National Orthopaedic Hospital and Federal Neuropsychiatric Hospital. Federal Neuropsychiatric Hospital offers full and comprehensive psychiatric services to the people of south-eastern Nigeria, and takes referrals from other health institutions within the country. Enugu State has 17 Local Government areas (LGAs), three recognized urban LGAs (Enugu North, Enugu South and Enugu East) and 14 rural LGAs, though with some fast urbanizing cities.

The work was a descriptive cross-sectional study, assessing the presence of major warning signs of poor mental health and beliefs about mental illness among the urban and rural dwellers in Enugu state, Nigeria. The study was done in the month of January, 2013. A minimum sample size of 329 respondents was determined for each group with anticipated response rate of 80%, and a prevalence value for psychiatric morbidity of 21.9% from previous study.[15] The computation was done using a formula for calculating sample size when the population proportion is greater than 10,000 [n=Z2p2/d2].[16]

A multistage sampling method was used in the sample selection. An urban LGA, Enugu North and a rural LGA, Isi-Uzo, was each selected from the five and twelve urban and rural LGAs respectively using simple random sampling technique. A sample frame of each of the communities in the selected LGAs was obtained from the LGA's headquarters. From the sample frame, two urban (Ogui New Layout and Independence Layout) and two rural (Ehamufu and Ikem) communities were randomly selected. A list of streets for the urban and villages for the rural communities were also obtained from the respective LGAs town planning offices.

Three streets from each of the two urban and three villages from each of the two rural communities were chosen by simple random sampling technique. A National Population Household numbering was used in selecting households from the communities using a systematic sampling method with a sampling interval of one. In each household, available members who were 18 years and who gave an informed oral consent were interviewed. A semi-structured questionnaire designed by the researchers was used to collect the socio-demographic variables, the beliefs and knowledge of the respondents about mental illness. A set of 22 questions centred on the major warning signals of poor mental health

designed by William Menninger was used to assess the respondents' mental health status[2]. According to William Menninger, psychiatric help is necessary if the answer to any of these questions is definitely "Yes". A definitive "Yes" answer to any of the warning signs scores one point, while "No" answer scores zero point.

Ethical permission for the study was granted by the Board of Ethical Committee of the University of Nigeria Teaching, Enugu, Nigeria. Data entry and analysis was done using SPSS 11 and Epi-info version 3.5.3. Data were presented using frequency distribution tables. Chi-square test and student T-test of significance were used where appropriate. Level of significant was put at $p \leq 0.05$.

RESULTS

Three hundred and eighty questionnaires were distributed to the urban and rural communities each; out of which 371(97.6%) and 353 (92.9%) were completely filled and analysed. Most respondents were within the ages 18 through 42 years; 359 (96.8%) in the urban and 325 (92.1%) in the rural. The mean ages were 29.31 + 8.87 years for the urban and 31.23 + 10.36 years for the rural (t = 2.70, p = 0.007, F = 1.3, p = 0.006). Gender (0.793), marital status (p=0.924) and religion (0.983) showed no statistically significant difference, while the observed differences in educational level and occupation were statistically significant (p = 0.000).Table 1 & 2.

Socio-cultural beliefs about the causes of mental illness were not statistically significant between the urban and rural dwellers (native charm, P=0.209; witchcraft, p=0.609; punishment from gods, p=0.613); except for the belief about evil spirit as the causative agent that was found to defer statistically (p=0.000). The knowledge of the biomedical and or organic causes of mental illness also showed significant difference between the two groups (p=0.000). Table 3

Traditional (p=0.180) and culturally (p=0.160) based preference of the best places for the treatment of the mentally ill showed no statistically significant difference. The observed difference in the preference for Psychiatric hospitals as the best place of treatment for persons with mental illness between the urban and rural respondents was remarkable and statistically significant (p=0.000). Table 4

Twenty two early warning signs of poor mental health were assessed as recorded in table 5. All the warning signs were present in varying degrees between the urban and rural dwellers. Among urban & rural respondents, the most common prevailing warning sign of poor mental health was compulsive and excessive eating, dieting and exercising (urban: 189, 50.9%; rural: 180, 51%, p= 0.987). Among the rural dwellers alone the most prevailing poor mental health signs was being upset when routine activities were being interrupted (198,56.1%) as against compulsive eating, dieting and exercise (189, 50.9%) among the urban dwellers. The prevalence of poor mental health signs or signs of psychiatric morbidity in the urban and rural respondents was 21.8% and 33.9% respectively. The differences in the total positive responses (expected verses observed) to the questions on poor mental health signs in the urban and the rural dwellers was statistically significant ($X2$= 290.24, p = 0.000).

Table 1: Age distribution of the urban and rural respondents

Age group(Years)	Rural population n-371(%)	Urban population n-353(%)
18-22	80(21.56)	115(32.58)
23-27	135(36.9)	110(31.16%)
28-32	74(19.95)	56(15.86)
33-37	47(12.67)	29(8.22)
38-42	23(6.20)	15(4.25)
43-47	5(1.34)	12(3.40)
48 - 52	2(0.54)	7(1.70)
53-57	2(0.54)	6(1.70)
58-62	1(0.27)	3(0.85)
63-67	2(0.54)	0(0.00)
Total	371(100.0)	353(100.0)

Table 2: Socio-demographic characteristic of the respondents

Characteristics	Urban (%) n = 371	Rural (%) n= 353	X^2	p
Gender:				
Male	197 (53.0)	184(52.12)	0.07	0.793
Female	174(46.90)	169(47.88)	0.07	0.793
Marital Status:				
Ever Married	201(54.18)	190)52.12)	0.01	0.924
Single	710(46.90)	163(47.88)	0.01	0.924
Educational Level:				
Non-formal	15(4.04)	63(17.85)	35.86	0.000
Primary	25(6.74)	128(36.26)	94.59	0.000
Secondary	142(38.27)	116(32.86)	2.31	0.128
Tertiary	189(50.94)	46(13.03)	118.60	0.000
Religion:				
Christianity	326(87.87)	310(87.82)	0.00	0.983
Moslem	1(1.89)	2(0.57)	2.57	0.109
Others	38(10.24)	41(11.61)	0.35	0.554
Occupation:				
Civil servants	190(51.21)	88(24.93)	52.83	0.000
Trade	124(33.42)	119(33.71)	0.01	0.935
Farmers	7 (1.89)	126(35.69)	137.87	0.000
Students	12(3.23)	8(2.27)	0.63	0.427
Artisan	38(10.24)	12(3.40)	13.18	0.000

Table 3: Knowledge and beliefs of the respondents about the causes of mental illness

Knowledge/beliefs	Urban n=371 (%)		Rural n=353 (%)	X^2	p
Native charm	177	(47.71)	152 (43.06)	1.58	0.209
Witchcraft	105	(29.75)	106 (30.03)	0.26	0.609
Punishment from gods	103	(27.76)	104 (29.46)	0.26	0.613
Evil spirits	192	(51.75)	121 (34.28)	22.51	0.000
Stress/emotional	259	(69.81)	99 (28.05)	126.23	0.000
Genetic/inherited	225	(60.65)	133 (37.68)	38.18	0.000
Physical illness	205	(55.26)	110 (31.16)	42.73	0.000
Indian hemp	315	(84.91)	115(32.58)	205.37	0.000
Poisoning by enemies	154	(41.51)	93 (26.35)	18.51	0.000
Alcohol drug abuse	274	(73.85)	113 (32.01)	127.29	0.000
Poverty	113	(30.46)	103 (29.18)	0.14	0.707
Environmental	52	(14.02)	49 (13.88)	0.00	0.958

Table 4: Recommended best places of treatment of the mentally ill patients by the respondents.

Place of treatment	Frequency (%)			
	Urban n =371	Rural n=353	X^2	p
Native healer/traditional	155(30.99)	126 (35.69)	1.80	0.180
Prayer house/deliverance churches	222(59.84)	193 (54.67)	1.97	0.160
Patient medicine dealers/shops	96(25.88)	16(4.53)	63.02	0.000
Maternity homes	8(2.16)	17(4.82)	3.84	0.050
Psychiatric hospital	325(87.60)	271 (76.77)	14.58	0.000

Multiple answer questions

Table 5: Distribution of warning signs of poor mental disorders among the urban and rural respondents

Signs of poor mental health	Frequency (%)		X^2	p
	Urban n =371	Rural n=353		
Always worrying	62(16.71)	107 (30.31)	18.70	0.000
Unable to concentrate	65(17.52)	121 (34.24)	26.61	0.000
Loose temper easily	75(20.22)	108 (30.59)	10.32	0.001
Regular insomnia	62(16.71)	74 (20.96)	2.14	0.143
Continually unhappy	55(14.82)	132 (37.39)	48.09	0.000
Continually dislike being with people	41(11.05)	99 (28.05)	33.49	0.000
Upset if routine interrupted	144(38.81)	198 (56.09)	21.66	0.000
Have mood fluctuations (swing)	61(16.44)	109 (30.88)	20.98	0.000
Children constantly upset me	69(18.60)	164 (46.46)	64.33	0.000
Browned off & constantly bitter	38(10.24)	107 (30.13)	45.49	0.000
Always afraid without known cause	46(12.40)	96 (21.20)	25.12	0.000
Always right, others wrong	51(13.75)	117 (33.14)	38.20	0.000
Always pains & aches without physical explanation/cause	58(15.63)	130 (36.83)	42.37	0.000
Always feel insecure	54(14.56)	148 (41.93)	67.37	0.000
Always feel inferior	96(25.88)	153 (43.34)	24.46	0.000
Always suspicious of others	131(35.31)	129 (36.54)	0.12	0.729
Do reckless harmful things	85(22.91)	81 (22.95)	0.00	0.991
Feel grief long after loss or death	148(39.89)	141 (39.94)	0.00	0.989
Think my mind being controlled	96(25.88)	91 (25.78)	0.00	0.976
Use drugs/alcohol of ten	122(32.28)	117 (33.14)	0.01	0.941
Exercise/diet/eat excessively	189(50.94)	180 (50.99)	0.00	0.987
Always hurt people	29(7.82)	28 (7.93)	0.00	0.954

DISCUSSION

Most of the respondents were within the productive age, young adults and adulthood, mostly civil servants and traders in the urban and traders and farmers in the rural populations, Table 1. This finding is in line with the urban – rural population distribution in Enugu state where trading and civil service are the dominant occupations in the urban as against farming and trading in the rural populations[17]. This predominant age range (18-42years) in this study is significant because they are mostly affected by rapid socio-economic changes, urbanization, cultural dynamics and globalization. The expected mobility among this group may have accounted for the statistically significant difference observed in their mean age (t = 2.70, p = 0.007). Educational attainment also differs significantly (p=0.000) between the urban and rural dwellers with more people in the urban having secondary and tertiary level

education compared to the rural with more non-formal and primary level education, table 2. This may explain the observed predominant farming and trading occupations among the rural dwellers. The rural- urban migration in search of white collar jobs and opportunities for better living in response to industrialization and urbanization may have also contributed to the observed differences in the educational and occupational distributions.

The age long traditional and cultural beliefs about mental illness is still prevalent among the 21st century urban and rural dwellers in Nigeria; although it is fast disappearing in the developed world[2]. In this study, majority of the respondents in both the urban and rural groups shared the view that mental illness is as a result of native charm, witchcraft, punishment from God and evil spirit possession, table 3. This view may not be unconnected to the traditional belief by the African countries including Nigeria on the role of spirits, supernatural and preternatural forces on the aetiology of many diseases, especially mental illness. The belief on the magic and religious origin of many illnesses is still very rampant among the people, even among the elite members of the Nigerian society.[20,21]

The persistence of these beliefs at this period of national development in Nigeria may show how deep rooted the myths about mental illness is and probably would explain the negative attitude often times observed among the general population. This poor knowledge about the causes and subsequent negative attitudes towards the mentally ill patients has been documented by several researchers within and outside Nigeria.[18, 19 & 20]. Similarly, a study by Baylor University researcher found that clergy often deny or dismiss the existence of the mental illness and where acknowledged, are attributed to spiritual forces.[8] A study published in Mental Health, Religion and Culture, revealed that of 293 Christian church members, more than 32 percent were told by their pastors that they or their loved ones did not really have a mental illness. The study found that these church members were told that the cause of their problem was solely spiritual in nature, such as a personal sin, lack of faith or demonic involvement.[8] The urban group had a better knowledge of the scientifically proven aetiology of mental illness such as organic and genetic predispositions than the rural group, table 3. The observed difference was statistically significant (p=0.000). This could be attributed to influence of mass media, educational level and heterogeneous population of the urban dwellers compared to the rural populace with little or no health information sharing, mass sensitization and lower education attainment.

The health seeking behaviour of the people are more or less influenced by their culture and belief system and level of human development. In this study, the recommended places of treatment for the mentally ill seem to follow the pattern of belief system and knowledge about the causes of the disease. Both the urban and rural respondents shared the similar preference to prayer houses/deliverance churches and traditional healers as the best place of treatment (p=160). However, the urban dwellers had more preference to the use of psychiatric hospitals and patent medicine stores or dealers than the rural population with a statistically significant difference (p=0.000), table 4. This again may not be unconnected to the level of educational attainment, knowledge and awareness of the presence of psychiatric hospitals in urban Enugu. The very large numbers of patent medicine dealers operating in the urban areas in Enugu state and subsequent associations and interaction with the masses may have contributed to the trust and confidence imposed on them. These findings compares favourably with the study conducted by Abiodun and that by Aniebue and Ekwueme

in psychiatric hospitals in Ilorin and Enugu Nigeria respectively. In Abiodun's study, the of 238 patients who had attended a mental health clinic in Ilorin, 95% of the patients had first contact for treatment with traditional or religious healers before finally visiting a psychiatric hospital.[22] Similarly the first point of call by the psychiatric patients in the Enugu studied by Aniebue and Ekwueme was prayer houses, followed by a visit to psychiatric hospital, private clinic, traditional healers and patent medicine dealers in decreasing order.[23] Even the primary healthcare workers who preferred psychiatric hospitals for treatment of the mentally ill in a study conducted by Ekwueme et al[20] in a rural local government, further recommended native and traditional healers and prayer houses/ deliverance churches for additional help.[20] The chronic nature of mental illness and cultural dictates may have also contributed to these findings.

The warning signs and symptoms of poor mental health manifested in different degrees among the urban and rural respondents in this study. However, rural respondents had more morbid signs of poor mental health than their urban counterparts. This is not the usual expectation, considering the fact that the urban dwellers are more exposed to problems of urbanization and industrialization including the inherent social vices, insecurity and stress of urban life. Similar differential observations to the findings in this study were however made in a community based study on the risk factors associated with Mental Illness in Oyo state, Nigeria by Amoran et al[15]. Amoran and colleagues reported 21.9% overall prevalence of psychiatric morbidity (18.4% in the urban areas and 28.4% in the rural areas, p=0.005). This finding according to the authors is in contrast to what was found in similar studies carried out in developed countries such as Great Britain, where mental disorder was commoner in the urban areas than in the rural population.[15]
A contrasting report to our finding was made in a survey study in the United States of America (USA). where some people argued that youngsters living in rural areas of America are better shielded against psychiatric illnesses than are youngsters living among the stresses and anxiety of cities. Some also assumed that if any youngster living in rural areas succumbed to mental ill health, it would more likely be those living in poverty.[25] This thought was however, disproved by Castello et al at Duke University Center in Durham in their assessment of risk factors for mental illness among the black and white children living in four rural counties in North Caroline.

They compared their findings with those studies done among those living in big cities like Boston, Pittsburg, Los Angeles and other big cities in USA. They found out that living in rural areas does not protect young people from psychiatric illnesses. In addition, the investigators discovered that the prevalence of psychiatric disorders among the black subjects appeared to be about the same among their white counterparts, except for the prevalence of depression which was higher among the white children. This finding suggests that young people living in rural areas of the USA are about equally susceptible to mental illness, no matter what their race.[25] The works of Rohland and Rohrer in Iowa U.S.A similarly show that there is no evidence that rural population in Iowa have less mental illness than their urban counterparts.[26] Additionally, available national data in America suggest that the prevalence of clinically defined mental health problems among rural and urban adult populations is similar.[27]

The possible reasons for the higher morbidity signs in the rural respondents in this study may not be immediately clear. However, possible suggestions may be that the quick to get rich attitude, the changes in value system including the erosion of traditional institutions, life style patterns and influence

of urbanization have cut across all fabrics of our society. The high level of insecurity, terrorism, incessant kidnapping, ritual and politically motivated killings, armed robbery and banditry; ethnic and religious crisis, militancy, boundary disputes, civil unrest, stress and strain may have permeated all nooks and crannies of our societal life. The rich, the poor, the urban and rural populations alike are all affected. The high poverty rate, high fertility rate and the increase in family sizes may have lowered the quality of child upbringing, leading to delinquent behaviour and poor mental health status. Thus life in the rural areas may not be free of stress and strain of life as previously inferred. Rural areas may not after all be a safe heaven or a safeguard against mental illness or a yard stick for determining who is more prone to psychiatric disorders or morbidities in the 21st century Nigeria. The goal of achieving good mental health for the teaming population of the Nigerian people may not be realized in the absence of enabling socio-economic and socio-psychological environments required for good mental health to thrive.

The observations and the explanations offered for the findings in this study should be taken in the light of the fact that more advanced psychiatric instruments with definitive criteria for measurement of psychiatric morbidity and mental health status may be required to further elucidate some of the findings and for in-depth interpretations and inferential making. Other predictive factors of mental illness including psychosocial, socio-economic, demographic and constitutional, which were not assessed may have contributed to the findings in this study.

CONCLUSION

There is a high prevalence of signs of poor mental health among the urban and rural dwellers in Enugu state, Nigeria. However, the rural dwellers were found to have a higher prevalence than their urban counterparts. There are still prevailing culturally entrenched and traditional beliefs about mental illness among the people. An expanded or all-inclusive research is however recommended. Training workshops and health education on mental health maintenance including counselling and stress coping strategies are urgently needed for the rural and urban dwellers in Nigeria. Long term goals of improvement in socio-economic conditions of the citizenry are advocated.

REFERENCES

1. World Health Organization. WHO NEWS LETTER. March, 2001; 16(1): 1-14.
2. Park K. Park's Textbook of Preventive and Social Medicine 20th Edition, M/S Banarsidas Bhanot Publishers, India 2009: 601-614 & 734-736.
3. World Health Organization. Mental Health Concepts. Retrieved from http://www.who.int/en/. January 12, 2012
4. North Eastern Board. Mental Health Definition. Retrieved from http://www.mentalheatthireland.ie. February, 2012
5. Orija OB. Causes and Manifestation of Mental illness. Presented at the 90th anniversary of Psychiatric Hospital, Yaba, Lagos. 1997, 26-27.
6. Ginsburg, SW. The Mental Health Movement and its theoretical Assumptions. In Community Programs for Mental Health. 1995, 12-15.
7. Asuni T, Swift RC, Schoenberg C. Mental Health and Disease in Africa. Spectrum books, Ibadan and Safari books, U.K. 1994.pp 1-83.
8. Wikipedia. Mental Disorder: Classifications & External sources NeSHDO01523. Retrieved from http://en.wikipedia.or/wiki/mental disorder
9. Adetokunbo OL, Herbert M.G. short textbook of public Health Medicine for the tropics, Revised 4th ed. Book power, London 2003 pp240-243.
10. Tuna Lergo Patterns of psychiatric illness: A Study in Kaduna Psychiatric facilities: Journal of social Development in African 1989, 4(1):47-59.
11. Udoh CO, Ajala JA. Mental and Social Health. Moonlight Publishers Ltd. 1st edition, Ibadan, 1987.pp 1-17.
12. Ndetei DM, Okasha, T, Mburu, JM. The African

Textbook of Clinical Psychiatry and Mental Health. Africa Medical and Research foundation. 1st edition, Nairobi Kenya, 2006.pp 3-5.
13. Asuni T, Swift RC, Schoenderg C. Mental Health Disease in Africa. Spectrum books, Ibadan and Safari books U.K. 1994; 1-83
14. Teenmental health organization. Understanding mental health and mental Illness. Available from 14. www.slideshare.net/teenmentalhealth/understanding-mental-health-and-mental-illness-presentation. Assessed May 1, 2018.
15. Amoran OE, Lawoyin TO and Oni OO. Risk factors associated with mental illness in Oyo State, Nigeria. Annual Journal of General Psychiatry 2005. Retrieved from http://pubmedcentral.nih.gov.redirect. Assessed May 1, 2018.
16. Araoye MO. Research Methodology with Statistics for Health and Social sciences. 1st ed., Nathadex Publishers, Ilorin, 2003.pp 115-121.
17. Enugu State-Wikipedia, the free encyclopaedia.17. http:.//en.wikipedia.org /wiki/Enugu State. Retrieved 1/7/2010: 1 - 3. Assessed July 1, 2012.
18. Gureje, O, Victor OL, Olusola EO, Benjamin O, Olley L. Community study of knowledge of and attitude to mental illness in Nigeria. The British Journal of Psychiatry 2005; (186/5): 436-441.Retrieved from http://bjp.rcpsych.org/cgi /content/full/186/5/436. January 14, 2011.
19. Adewuga AO and Makanjuola ROA. Perceived Personal attributes of the mentally ill in South-Western Nigeria. Nigerian Journal of Psychiatry 2009; 7(1):4-8.
20. Ekwueme OC, Aghaji MN and Nwagbo DFE. The Concept and attitude of primary health care workers toward mental illness in rural Igbo land of Nigeria. Journal of College of Medicine 2006. (11)2:125-129.
21. Aniebue N. Introduction to Medical sociology. 1st Ed., Institution for Developmental Studies, Enugu, 2008. pp69-76.
22. Abiodun OA. Pathways to Mental Care in Nigeria. Psychiatric Services 1995; 45/8: 823-826.
23. Aniebue PN and Ekwueme OC. Health-Seeking Behaviour of Mentally Ill Patients in Enugu, Nigeria. South African Journal of Psychiatry, 2009, 15 (1): 19-22.
24. Erhabor SI. Mental Health and Psychotherapy through the eyes of culture: Lesson for Africa Available from .psychotherapy http://inst.at/bio/idemudia_erhabor.htm. January 14. 2011.
25. Joan Arehart - Treichal (American Psychiatric Association), Clinical and Research News. Psychiatric News, 2001; 36:1. http://pn.psychiatryonline.org/index.dtl. Assessed January 12, 2011
26. Rohland BM and Rohrer E. Country Finding Mental Health Services in a Rural State. American Psychiatric Association, May 1998. Retrieved http://pn.psychiatryonline.org/ index. Assessed January 12, 2011
27. National Rural Health Association. The Scope of mental health issues in rural America; May 1998. http://www.nrha.com. Assessed January 14, 2011.