International Journal of Medical and Health Research
ISSN: 2454-9142
www.medicalsciencejournal.com
Volume 4; Issue 8; August 2018; Page No. 84-93

Perception of mental illness among residents of Awka south local government area of Anambra state, southeast Nigeria

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Abstract
This work investigated the perception of mental illness among residents of Awka South Local Government Area, Anambra state, Nigeria. A survey research design was used for the study in which 198 respondents constituted the study participants. Such participants were selected using multi-stage and cluster sampling techniques. The sources of data were questionnaire schedule and in-depth interview guide. However, secondary data was also gotten from textbooks, journals, and e-books. The quantitative data from the questionnaire were processed using Statistical Package for Social Sciences (SPSS) version 20. Also, percentages and contingency/ frequency tables were employed to present data, while the hypothesis was tested using chi-square test statistic. Findings show that mental illness was perceived to originate from the gods. Also, environmental and socio-economic factors were perceived to fuel its occurrence and progression, hence the condition was identified to be common among the lower class. The hypotheses tested showed that males tend to associate a relationship between anger of the gods and mental illness than their female counterparts do. It was therefore recommended that the general public should be enlightened on what constitutes mental illness and the appropriate responses for its management. Also the mass media should be cautioned on how they portray the mentally ill in their programmes and adverts to minimize stigmatization of those afflicted.

Keywords: mental illness, stigmatization, psychiatry, rehabilitation centres, mental health treatment centres

Introduction

Over the years, popular views of the causes of abnormal behaviour have changed. In pre-historic times, people believed in the existence of good and evil spirits that made them see strange things and behave in unusual ways (Karen Huffman, Mark Vernoy, & Judith Vernoy, 1994) [18]. For hundreds of years in ancient Greece, mental illness was viewed with awe. Even the famous philosopher Socrates believed that mental illness was the greatest blessing, for which both states and the individuals should be thankful. Epilepsy, which was then equated with mental illness, was sacred- a sign of divine favour. Later in the middle ages, the mental patient was sometimes portrayed by artists and writers as the only one in touch with ultimate reality (Alex, 1995:268) [2].

During the Stone Age, for example it was believed that demons could possess a person's body and soul and the only recognised treatment was "trephining". In the operation, stone instruments were used to chip away an area of the skull, presumably to allow the troublesome evil spirit to escape (Huffman *et al*, 1994) [18]. During the Middle Ages (from about fifth to the fifteenth century A.D), supernatural explanations for abnormal behaviour once again dominated. (Huffman *et al*, 1994) [18]. The fear surrounding the mentally ill is affected in the bible "a man also or woman that hath a familiar spirit, or that is a wizard must be put to death" (Leviticus, 20:27). This pronouncement later provided the rationale for witch burning in medieval Europe, when the church defined the insane as witches who had invited the devil to reside in their bodies. Witch burning took several forms; some witches were burned alive, others were strangled and or beheaded before being and thrown into the fire. (Alex, 1995: 265) [2]. during this time also, the devil was the major evil spirit believed to possess the people, and the afflicted person was treated with religious practice known as "exorcism". Exorcism involved prayers, fasting, noise making, beatings and drinking terrible tasting brews (Huffman *et al*, 1994) [18].

In 1636, a man in Konigsberg, Germany, claimed that he was God, and the authorities treated his "demon possession" by cutting of his tongue, chopping off his head and burning his body. Some 300 years later, though, this approach to treating mental illness was refined by Hitler, who felt that mental patients deserve "mercy killing". He built gas chambers in mental hospitals and managed to exterminate 50,000 patients (who were non- Jewish Germans) within only 2years. (Alex, 1995: 268) [2].

By the middle 1700's, demonology and witch burning began to disappear, but the mentally ill were still harshly treated. Those who were believed to be dangerous were kept in jails and poorhouses, while those considered less violent were allowed to beg in the streets. There were also a few institutions for treating the mentally ill. One such institution, Bethlehem Hospitals in London, became widely known as "bedlam". It handcuffed and chained patients to the walls. It even put patients on display for the amusement of the public. Tickets were sold for a sideshow featuring the wider, more agitated patients. Similarly, in France not only were the mentally ill treated like animals, but their asylums were much worse than zoos (Alex, 1995) [2].

As the middle Ages came to a close, some advancement was made in the treatment of mental disorders. By the eighteenth century, specialised hospital began to appear in Europe. Initially designed to provide quite retreat from the world, the

asylum quickly became overcrowded and noisy (Huffman *et al*, 1994) [18].

A turning point came in 1792 when Philippe Pinel, a French physician was put in charge of a Parisian asylum, were the mentally ill were shackled to the walls of unlighted and unheated cells. Pinel removed some of the inmates from their dungeons and insisted they be treated humanely. Many inmates improved so dramatically, they were able to be released. Pinel's belief that abnormal behaviour was caused by sick minds, soon became the accepted way of viewing people who had previously been feared and punished for their abnormality (Huffman *et al*, 1994) [18]. His ideas that disturbed individuals had an underlying physical illness also served to resurrect the medical model first conceptualized by Hippocrates (Huffman *et al*, 1994) [18].

Pinel's medical model eventually gave rise to the modern specialty of psychiatry and to the founding mental hospitals specifically designed to treat mental patients. In these hospitals, disorders are diagnosed as physical illness and treatment are prescribed (Huffman *et al*, 1994) [18].

Unfortunately when we assume that a mental "disease" exists and labels people "mentally ill", we can increase rather than alleviate their problem (Huffman *et al*, 1994) [18]. Nigerians believe in gods and spirit, they believe people can be possessed by good spirit and this will bring out good luck and productivity. They equally believe that people can be possessed, by bad spirits, which are the reasons for the numerous human problems. If you are going through a rather difficult situation then the evil gods must be at work, they reason you have offended the gods or have been cursed by some wicked spirit. This often led to condemnation and scorn of those affected. There is the believe that every human problem has some spiritual sides to it and top among those that believed to be possessed by very evil and dangerous spirit are those with mental illness. Mental health victims are regularly stigmatized, scorned and neglected, they are seen everywhere in Nigeria as being unfortunate, sinistral and possessed by evil powers and not fit to be classed as normal human beings. Most of the people suffering from mental illness are often shackled, locked up and beaten. A lot of these victims are everywhere on the streets of Nigeria, in their own little confused world, cut out from others and related as being obsessed with evil spirits that must be ignored and done away with. They are regularly beaten and no one wants to come near them or offer any assistance. When the victims are hungry and go to people for assistance, they are often ignored and the people they went to are advised to register for spiritual cleansing and deliverance in the various spiritual places so they can be cleansed of the evil spirit that have just visited them (Abiola, 2011, Para. 2) [1].

The mental health victims are often taken to traditional herbalist, spiritualist, witch doctors, and other religious places, where it is believed that the priest can consult the gods, to drive away the evil spirit they have been bewitched with. In these places the mental patients are subjected to the worst human treatment, because of the belief that they are possessed by evil spirits. They are given bad, concoctions made from various incogitable herbs and spices, and they are made to sleep outside in the worst of weathers, while others are incarcerated in dark, lonely, damp cells with no light. There is the belief that victims are not capable of their own reasoning and only will reason if beaten. Some of these priests turn the victims into beggars taking them round the streets in shackles, begging alms and making money out of them. It could not get worse and these have gone on for so long in Nigeria's various communities, because everybody considers it acceptable (Abiola 2011, Para. 3) [1]. In conclusion, this study examined the perception of mental illness among residents of Awka South Local Government Area of Anambra state, southeast Nigeria.

Statement of the problem

Mental illness in our society is not new. Historically, it has taken different forms of interpretation and origin. Mental illness is a behavioural pattern or anomaly that causes distress, or disability and which is not developmentally or socially normative (Huffman *et al*, 1994) [18].

Mental illness or disorders are generally defined by a combination of how a person feels, acts, thinks, or perceives. This may be associated with a particular region or functions of the brain or the rest of the nervous system, often in a social context. Mental disorder is one aspect of mental health. Anxiety, schizophrenia, mood disorders, dissociative disorders, somatoform disorder, personality disorders and substance related disorders are different categories of psychological disorder or mental disorder (environmental Health perspective, 2007) [13].

The word stigma referred originally to a mark or brand on Greek slaves, clearly separating them from free men. In common usage todayend to behave toward or in accordance to the identity given to them by the society (Huffman *et al*, 1994) [18].

The term label refers to individuals whose actions or behaviour deviates from social norms and what is acceptable in the society. These individuals are labelled and develop a stigma attached; this can have an overall impact on the individual's behaviour once the label has taken form. Being labelled as mentally ill can have significant effects on different aspects of the individual's life. It has been found that the way in which the public respond to people with mental disorders has been influenced by the generic label applied to mental disorders (link, 1997). Scheff (1974, 1986), argues that people labelled mentally ill internalize the negative societal conceptions of mental illness. Eventually the labelled person's identity crystallizes around the label; In effect, the negative societal reactions create the mental disorder.

More recently, a modified labelling theory (Link 1987: Link, Cullen Struening, Shrout and Dohrewend (1939) suggests that even if societal reactions does not directly create mental illness, negative societal reactions does not create mental illness, negative societal reactions do exist and engender self-devaluation and expectation by others, these effects can then increase further vulnerability to mental disorder.

Many people's problems are made worse by the stigma and discrimination they experience from society, but also from families, friends, and employers. Nearly nine out of ten people with mental health problem says that stigma and discrimination have a negative effect on their lives. Stigma of mental illness remains barrier to treatment ("Healthy day, 2014).

The word stigma referred originally to a mark or brand on Greek slaves, clearly separating them from free men. In common usage today, the word signifies a disgrace or defect. In response to societal stigmatization, people with mental problems may internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment. Stigma also lowers their access to resources and opportunities (such as housing and employment), it leads to diminished self–esteem and increased isolation and hopelessness, and retards recovery (Irwin g. Sarason & Barbara R. Sarason, 2005) [33]. The stigma often associated with mental illness prevents many people from getting the care they need. Stigma of many illnesses remains a barrier to treatment (healthy day news, 2014).

The burden of caring for the mentally ill individual often falls on the patient's immediate family or relatives. Families and care givers of individuals with psychological disorders are often unable to work at full capacity due to the demands of caring for a mentally ill individual, leading to decreased economic output and a reduction in household income. Loss of income and the financial costs of caring for a mentally ill person put these households at an increased risk of poverty. Care givers also reported social isolation due to their family member's mental illness, as care giving duties prevented them from attending social events (unite for sight, 2014).

The issues militating against mental health care has always been availability and access. Most mental health care institutions and units are located in urban areas, whereas most of the people who have mental disorders are located in rural areas (Olugbile, 2014) [30]

According to Olugbile (2014) [30], the Chief Medical Director, Lagos state university Teaching hospital(LASUTH), "it has been estimated that at least, about ninety (90%) percent of people with clear cut mental health syndromes do not even get any treatment at all in Nigeria. The specialists, psychiatrist nurses, social welfare officers, occupational therapists and all those who form members of the mental health team are very few in numbers, grossly inadequate. Numbers of Hospital units available for the treatment of mental disorders is also very low, even if the numbers were massively increased, most of these numbers will still reside in urban areas.

Most of the people at the level of the primary health care do not know much about the mental health, do not have interest in it and do not have facilities, including simple drugs for treating mental illness (Olugbile, 2014) [30].

Research questions

1. What do people associate with the occurrence of mental illness in Awka South Local government Area?
2. Which socio-economic group is perceived to be mostly affected by mental illness in Awka South Local Government Area?

Theoretical framework

The labelling theory is adopted as the theoretical framework for this study. This theory stems from the work of W.I Thomas, who in 1928 wrote, "If men define situations as real, they are real in their consequences''. Labelling theory begins with the assumption that no act is intrinsically criminal. By applying labels to people, and in the process creating categories of deviance, these people are reinforcing the power structure of society.

In relation to this research work, the labelling theory believes that mental disorder is not a sickness but only a label imposed on some disturbing behaviour (Theo, 1995). Scheff (1966) argues that there is no such thing as mental illness. Instead, it is better understood as a category for all bizarre behaviour which cannot be explained through other means (such as alcohol or drug use). Scheff (1966), says, 'a stereotyped image of mental illness is learned in early childhood and continually reaffirmed inadvently, in ordinary social interaction'.

The way we view and respond to mental illness is the result of the wider socialization process in childhood. Example, going mad, acting like a lunatic, etc, and then this is strengthened by media images of mental illness, especially in films and in press reporting of crimes committed by ''mentally ill'' people. According to Scheff, not only do most people then recognise mental illness through these stereotypes, also people who are labelled as mentally ill will be influenced by these same stereotypical images, which will guide their behaviour (Haralambos & Holborn, 2008:314) [17].

However, labelling theory has been criticized based on the fact that:

1. It does not adequately explain the reasons why only some people develop mental illness and others do not, even when they come from similar social backgrounds, experience similar family histories and have similar lifestyles.
2. Secondly, Gove (1982) rejects the view that most people respond to mental illness in a negative way, arguing instead that many people around the mentally ill persons are supportive.
3. Third, Gove (1982) argues that in the vast majority of cases, people who receive psychiatric treatment have a serious mental problem which needs treatment and exists before any label applied.

Mental illness in Thomas Szasz's view can be more accurately referred to as ''a problem in living'', a moral conflict in humans relations, or a communication expressing some socially unacceptable idea (Theo, 1995).

The labelling theory or model has often been called anti-psychiatry, because it is a radical critique of what psychiatrists think and do about mental disorder (Theo, 1995). Erving Goffman suggests that people are labelled mentally ill when it is in the interest of others to label them so. According to Goffman, once someone is labelled as mentally ill, then others treat them differently, reinterpreting what the ''mentally ill'' person says or does. Goffman calls this spurious interaction, meaning that whatever action the person undertakes will be evaluated with the knowledge that the person is mentally ill and therefore what they say or do cannot be taken at face level (Haralambos& Holborn, 2008) [17].

Goffman suggests that part of the process of becoming mentally ill is linked to the way in which a person's presenting culture is stripped from them when they enter a mental hospital (i.e. the way people choose to portray themselves to others, through their language, accent, and hair and clothing styles). Once in a mental institution, the patient's self-image is taken away from them and they are expected to conform to the

institution's rules. Failure to conform can be seen as the evidence of mental illness and the need for medication (Haralambos & Holborn, 2008:315) [17].

Study hypothesis

Males are more likely to accept that there is a relationship between anger of the gods and occurrence of mental illnesses than their female counter parts.

Brief review of relevant empirical literature

This section attempts a review of field works based on the topic of study by different scholars.

Attitudes of people towards the mentally Ill

The Department of Psychiatry, University of Ibadan (2002), carried out a community study of knowledge and attitude to mental illness in Nigeria. A multistage, clustered sample of household respondents was studied in three states (Ogun, Oyo and Osun) in the Yoruba- speaking parts of Nigeria (representing 22% of the national population).

Poor knowledge of causation was common. Negative views of mental illness were wide spread, with as many as 96.5% believing that people with mental illness are dangerous because of their violent behaviour. Most would not tolerate even basic social contacts with a mentally ill person. 82.7% would be afraid to have a conversation with a mentally ill person and only 16.9% would consider marrying one. The findings of this study shows that there is wide spread stigmatization of mental illness in the Nigerian community (Corrigan & Watson, 2002) [9].

Socio-economic factors affecting mental illness

Durosaro (1990) [12], carried out a study on calming the storm: stressors and relationship to physical and mental health of Nigeria school administrators. The population for this study was made up of all secondary school principals in Kaduna, Niger, Bendel, Kwara, Oyo, Anambra and Lagos state. These states were randomly selected from the 21 states of Nigeria. The lists of the secondary schools were obtained and a sample of twenty schools was drawn from each state based on age of schools starting with the oldest on the list. In all,104 principals were sampled. The principals were reached by post except those in Kwara and Oyo state, who were visited by this investigator. Sixty percent (60%) of the sample claimed to have been treated or to have experienced reduced mental capacity. 47% of the respondents claimed they had experienced alcoholism. 33% of the sample claimed they had experienced drug addiction, while 15% have experienced psychosis often.

Apparently, as a result of great stresses, some people suffered reduction in their mental capabilities and to cope with such problem, they resorted to visiting club houses to drink alcohol to suppress the problem. Some may become addicted to alcohol, others may prefer to stay home and take sleeping drugs, to relax. Others who do not drink alcohol nor take drugs may continue to face up with the stresses but such people may become touchy and appear psychotic in nature. The findings of this study show that, there are positive relationships between the frequency of the physical and mental health problems of Nigerian school administrators.

Perception of people towards the mentally Ill

Philo *et al* (1996) [31], conducted a content analysis of Scottish (fictional and non-fictional) media coverage of mental illness over a period of one month. They found that over 66% of all images presented showed mentally ill people as violent towards others, and a further 18% as violent as violent towards themselves. Only 4% of coverage was critical of the accepted images of mental illness portrayed in the rest of the media.

The findings of this study show that the majority of people derived their images of mental illness from the media.

Materials and methods

A Cross-sectional survey research design was adopted for this study. It is a type of study in which a sample of the population is taken and the result that is derived becomes applicable to the entire population

The area of this study is Awka South Local Government Area. Awka South L.G.A is made up of nine towns, namely; Amawbia, Awka, Ezinato, Isiagu, Mbaukwu, Nibo, Nise, Okpuno, and Umuawulu. It was created in 1989 from Awka Local Government Area. It is bounded on the north by Awka north local Government Area, on the east by Oji-River L.G.A of Enugu state, on the south by Anocha L.G.A and on the West by Njikoka L.G.A. Awka South has a land area of 180 kilometres.

In the past, the people of Awka South Local Government Area were well known for blacksmithing. Today, they are respected among the Igbo people of Nigeria for their technical and business skills. The geographical coordinate of Awka South is 6.167◦ north, 7.067 east.

Awka South LGA has a population of 189,654 as at 2006 Nigerian census. This was made up of 96,902 males and 92,752 females. The population of those 18yrs and above is about 127,499. The target population is workers of psychiatric hospitals, relatives of mentally ill patients on treatment and some discharged mentally ill patients.

Due to limited time and financial constrain, this study therefore considered one hundred and ninety eight (198) respondents for quantitative data and ten (10) for qualitative data. This sample size is considered a fair representation of the communities of Awka South LGA. More so, the sample was large enough for the statistical tool of analysis of the study.

Multi-stage sampling technique was adopted in selecting the respondents for the questionnaire. The process incorporated cluster and simple random sampling technique. Awka south local government area consists of nine (9) communities which were divided into three, on the basis of proximity to each other. Three communities make up a cluster. The three communities were put into a container and shuffled, and with the use of simple random sampling technique, one cluster was drawn.

The selected clusters consist of Awka, Nise, and Nibo. Some villages in Awka, Nise and Nibo were numbered. After numbering, the names of the villages were put into different containers and shuffled. Then four villages were picked randomly from each container. Compounds in the selected villages were numbered and 33 households were randomly selected. One respondent from the household was picked and

questionnaire was administered.

Thus, 66 respondents from each of the six villages were selected, giving a total of 198 respondents for the questionnaire. Ten (10) respondents were purposively selected for the in-depth interview, which was made up people between the ages of 18yrs and above. Hence, the sample size for the quantitative instrument is 198 respondents while those for the qualitative instrument were 10 respondents.

The major instruments that were used for collecting data, in this study are the questionnaire schedule (which has close ended question) and in-depth interview schedule with open-ended questions which aimed at exploring the view points of the respondents on issues that are to be raised and probed when necessary.

The researcher and two research assistants administered all instruments on respondents. The Statistical Package for Social Sciences (SPSS) version 20 was used to process quantitative data, while descriptive statistical tools such as percentages, frequencies and contingency tables were used to present and analyse data derived from the questionnaire. The findings from the in-depth interview were analysed using content analysis and the findings were also presented below the table of corresponding questions. The hypothesis formulated for the study was tested using chi-square (X^2) test statistic.

Findings

The researcher distributed one hundred and ninety eight (198) questionnaires on a face to face contact, with the help of her research assistants. However, only 181 (91.4%) of the questionnaire were correctly filled and returned. Fowler (1993), states that it is 75% of response rate that a researcher is expected to obtain before analyses will commence. Consequently, the quantitative analysis of this study was based on the 181 correctly filled and returned questionnaires; also, the analysis was complimented the information gotten from the in-depth interview. The data analysis was done in sub-sections as follows.

Table 1: Distribution of Respondents by socio-demographic characteristics.

	Variables	Frequency	Percentage
Distribution of respondents by age	18-23	89	49.1
	24-28	38	20.9
	29-33	26	14.4
	34-38	12	6.7
	39 and above	13	7.2
	No response	3	1.7
	Total	181	100
Distribution of respondents by religious affiliation	Christianity	171	94.4
	Islam	2	1.1
	African traditional religion	5	7.2
	Others	3	1.7
	Total	181	100
Distribution of respondents by sex	Male	104	57.5
	Female	75	41.4
	No response	2	1.1
	Total	181	100
Distribution of respondents by marital status	Single	89	49
	Married	85	46.8
	Divorced	2	1.2
	Widowed	4	2.3
	No response	1	0.6
	Total	181	100
Distribution of respondents by educational attainment	No formal education	6	3.3
	FSLC	22	12.2
	WASSCE	54	29.8
	NCE/OND	21	11.6
	HND/BS.C	59	32.6
	MSC and Above	13	7.2
	No response	6	3.3
	Total	181	100
Distribution of respondents by occupation	Civil servant	40	22.1
	Farmer	25	13.8
	Student	68	37.5
	Trader	43	23.8
	Others	5	2.8
	Total	181	100
Distribution of respondent by level of income	Low	41	22.7
	Moderate	103	56.9
	High	20	11.0

	Extremely High	3	1.7
	No response	14	7.7
	Total	181	100

Table 1 shows that majority of the respondents (49.1%) were between the ages of 18-23. The mean age of respondents was however 28years old. On religious affiliation, 94.4% are Christians. Also, the table shows that 104 (57.5%) of the respondents are males, while 75 (41.4%) are females. On the other hand, marital status of respondents shows that 49% were single, while 46.8% were married. The educational attainment shows that only 3.3% have no formal education. The rest had one form of education or the other. On the basis of occupation, majority of the respondents (37.5%) were students. With regards to income level, majority of the respondents (56.9%) of the respondents live on moderate income.

Analysis of research questions

This section deals with the analyses of research questions formulated to guide this study.

Research question 1: What do people associate with the occurrence of mental illness in Awka South Local government Area? The findings are shown in tables 2, 3, 4, 5, 6, 7 and 8 respectively.

Table 2: Distribution of Respondents by their View or Understanding of Mental Illness.

Responses	Frequency	Percentage
An illness that makes the mind abnormal	130	71.5
A punishment by the gods	8	4.4
An illness that makes people crazy and violent	30	16.6
A life-long ailment without cure	13	7.2
Total	181	100

Table 2, indicates that majority (71.8%) of the respondents agreed that mental illness is an illness that makes the mind abnormal, 4.4% of the respondents stated that mental illness is a punishment by the gods, 16.6% of the respondents affirmed that mental illness is an illness that makes people violent and crazy, while 7.2% of the respondents defined mental illness as a life-long ailment without cure. One of the respondents interviewed stated:

Mental illness is a situation whereby people's mind is abnormal; were someone's cognitive process is not working the way it should.

Based on this, the respondents were then asked to assess the magnitude of the problem of mental illness in their area. Their responses are shown in table 3.

Table 3: Distribution of Respondents by their Assessment of what people associate with the occurrence of mental illness in Awka South Local government Area.

Responses	Frequency	Percentage
Very wide-spread affecting many families	58	32.0
Rare occurrence affecting few individuals	53	29.3
Moderate	21	11.6
Don't know	46	25.4
No response	3	1.7
Total	181	100

Table 3 shows that majority of the respondents (32.0%) opined that mental illness is very wide-spread and affects many families. A relative of the mentally illness that was interviewed contended that:

The problems of mental illness includes, Instability, no love, no peace, crisis, no progress, everybody in the family will be sad, a lot of problems will come up. The wife, if affected with mental illness will lead to disorder and disorganisation in the.

The respondents were further asked to evaluate how many people that have been affected by traits of mental illness in their neighbourhood in the last 3years.their response are shown in table 4.

Table 4: Distribution of Respondents by their Opinion on Number of Persons Affected by Traits of Mental Illness in their Neighbourhood in the Last Three Years

Responses	Percentage	Frequency
2-4	44	24.3
5-7	13	7.2
8-10	18	9.9
11-13	28	15.5
None	43	23.8
Others	19	10.5
No response	16	8.8
Total	181	100

Table 4 shows that majority of the respondents (24.3%) know 2-4 people that have been affected by traits of mental illness in their neighbourhood in the last 3 years. Also, 7.2% of the respondents acknowledged knowing 5-7 people with mental health challenges. Another, 18(9.4%)of the respondents acknowledged 8-10 people as mental ill in their neighbourhood, last 3year, 28(15.5%)of the respondents agreed to 11-13 mentally ill patients in their neighbourhood in the last 3year, 43(23.8%)have no knowledge of this fact. One of the respondents that were interviewed posited:

Mental illness has affected a lot of People in my area, including me. I suffered from insomnia when my loved one disappointed me.

The respondents were further asked if they think that, there are effects of mental illness in their locality. Their responses are shown in table 5

Table 5: Distribution of Respondents by their opinion on whether there are effects of mental illness in their locality.

Responses	Frequency	Percentage
Yes	144	79.6
No	30	16.5
No response	7	3.9
Total	181	100

Table 5 shows that majority of the respondents (99.6%) are aware of the effects of mental illness in their locality. Based on this, the respondents were further asked the effects of mental illness. Their responses are shown in table 6.

Table 6: Distribution of Respondents by their opinion on the major effect of mental illness.

Responses	Frequency	Percentage
Victims are vulnerable to low quality care and abuse	61	33.7
A reduction in household income leading to poverty	37	20.4
Stigmatization and discrimination	42	23.2
Increase risk of non-adherence to medical regimen for other health conditions	16	8.8
Others	4	2.2
No response	21	11.6
Total	181	100

Table 6 shows that 61 (33.7%) of the respondents posited that the major effect of mental illness is the victims vulnerability to the low quality care and abuse, however, 23.2% suggested stigmatization and discrimination, while 20.4% identified a reduction in household income leading to poverty. One of the respondents that were interviewed posited thus:

Mental illness affects the family members of the victim. The family members go through lots of stress in taking care of the victim, they also suffer from depression.

According to a respondent that was interviewed: causes of mental illness includes genetic factors, disappointment by fraudsters, head injury in an accident due to pot holes on the road, disease conditions like stressful environment, hard drugs, malaria, rejection by loved ones and friends.

Based on this, respondents were further asked to enumerate the factors they consider as a major determinant of mental illness. Their responses are shown in table 7.

Table 7: Distribution of Respondents by their perception on major causess of mental illness.

Responses	Frequency	Percentage
Biological factors	25	13.8
Psychological factors	41	22.7
Social Factors	24	13.3
Religious	16	8.8
All of the above	60	33.1
Others	3	1.7
No response	12	6.6
Total	181	100

Table 7 shows that majority of the respondents (33.7%) were of the view that biological, psychological, social or environmental, and religious factors are major causes of mental illness. According to one of the respondents that were interviewed:

There are internal and external factors that can cause mental illness; sickle cell as a factor can cause abnormality that can then lead to Mental illness. External factors like post-natal. A baby whose father and mother are very much older, when delivered can have a mental illness as result of excessive chromosome. Family upbringing can also cause mental illness not going for ultrasound can also lead to mental illness.

The respondents were further asked to identify the socio-economic group perceived to be mostly affected by mental illness in Awka Local government area.

Question 2: Which socio-economic group is mostly affected by mental illness in Awka south Local Government Area? The findings are shown in tables 9, 10, 11, 12, and 13.

Table 8: Distribution of Respondents by their opinion on Socio-Economic Group Perceived to Be Mostly Affected by Mental Illness in Awka South Local Government Area.

Responses	Frequency	Percentage
Members of upper class families	31	17.1
Middle class persons	53	29.3
Lower class people or peasants	65	35.9
Others	28	15.5
No response	4	2.2
Total	181	100

Table 8 shows that 35.7% of the respondents which constitute the majority, affirmed that the lower class persons or peasants are mostly afflicted by mental illness. According to one of the respondents that were interviewed:

Small children can have mental illness, adolescents and males especially are more likely to have mental illness. Females are not also excluded.

The respondents were then asked to consider the most important socio- economic factor that affects mental illness. Their responses are shown in table 9.

Table 9: Distribution of Respondents by their Opinion on the most important Socio-Economic Factor that Affects Mental Illness.

Responses	Frequency	Percentage
Poverty or low income	66	36.5
Violence and racism	26	14.4
Low education	10	5.5
Poor occupation	23	12.7
Hereditary	40	22.0
Others	9	5.0
No response	7	3.9
Total	181	100

Table 9 indicates that majority of the respondents (36.5%) affirmed that poverty or low income is the most important socio-economic factor that affects mental illness. According to one of the respondents interviewed:

Culture, peer group, social club, and religion can also affect a person and cause mental illness. External factors like pre-natal and post-natal. Pre-natal, when the germinatic fluid is excess, it can affect the baby which will then lead to mental illness. Family upbringing, frustration, and segregation can also lead to mental disorder.

Based on this the respondents were asked to indicate if social class is a high determinant of mental illness. Their responses are shown in table 10 below.

Table 10: Distribution of Respondents by their Opinion on whether Social Class as a High Determinant of Mental Illness.

Responses	Frequency	Percentage
Yes	97	53.6
No	72	39.8
No response	12	6.6
Total	181	100

Table 11 shows that of the respondents (53.6%) agreed that social class is a major or high determinant of mental illness. A respondent that was interviewed said: The lower income earners suffer most from mental illness.

The respondents were further asked, if they think major mental illness are shaped or affected by gender. Their responses will be shown in table 11.

Table 11: Distribution of Respondents by Their opinion on major mental illness that are shaped or affected by gender

Responses	Frequency	Percentage
Yes	75	41.4
No	98	54.1
No response	8	4.4
Total	181	100

Table 11 shows that majority of respondents (55.1%) gave a negative response to the fact that major mental illness is shaped or affected by gender. However, a respondent that was interviewed opined that:

Females are likely to be mentally ill and can also be made to develop mental illness through social inequality.

Based on this, the respondents were further asked to enumerate how women could be affected. This response is shown in table 12.

Table 12: Distribution of Respondents by their Opinion on How Gender is affected by Mental illness.

Responses	Frequency	Percentage
Women are poor	10	5.5
Women are seen but not heard	21	11.6
They are discriminated upon	51	28.2
Others	19	10.5
No response	80	44.2
Total	181	100

Table 12 shows that 51or 28.2% of the respondents believe that the high level of discrimination among women leads to mental illness. A respondent that was interviewed posits:

Poor women suffer from depression a lot and it's a form of mental illness (female respondent, 27yrs).

Test of Hypothesis

The researcher tested the two hypothesis postulated for this study. The hypothesis are restated and tested as follows:

Hypothesis 1: Male respondents are more likely to accept that there is a relationship between anger of the gods and occurrence of mental illnesses. Data in table 14 formed the basis for testing hypothesis 1.

Table 14: Distribution of Respondents based on the Relationship between Anger of gods and occurrence of Mental Illness in Awka South L.G.A.

Sex	Are mental illnesses caused by the gods?			Total
	Yes	No	No Response	
Male	104	0	0	104
Female	56	13	6	75
Total	160	13	8	181

The computed value of chi-square is 71.435 while the table value of chi-square at 0.05 level of significance with a degree of freedom (df) of 4 is 9.488. Since the computed chi-square is greater than the table value, the researcher accepted the alternative hypothesis. It implies that male respondents accept that there is a relationship between anger of the gods and mental illness in Awka South LGA than their female counterparts.

Discussion of findings

It was found in this study that most people in Awka South LGA perceive the problem of mental illness as very wide-spread and affecting many families. This is in agreement with Wood and Wilson (2005) who opined that mental illness is a major health challenge affecting families. It leads to inability to work at full capacity due to demands of caring for a mentally ill individual. This in turn leads to decreased economics output and a reduction in income. Furthermore, loss or death of mentally ill person puts these households at an increased risk of poverty and emotional devastation

This study also found that the magnitude of the problem of mental illness is is perceived to be fuelled or engendered by socio-economic factors. Accordingly, the group perceived to be mostly affected by mental illness in the study area are lower class people or peasants etc. This finding is in line with earlier findings of Roger Gomm (1996) who submitted that for nearly every kind of mental illness, poorer people top the list of those afflicted. The poor are also more than often, more seriously affected and for longer period of time, than the rich (Haralambos & Holborn, 2008:316) [17].

Fryer (1995) also reviewed the evidence of the relationship between employment patterns and mental health and concluded that unemployment has a direct effect on an unemployed person's health, and also on that of their family. For instance, if children's school performance deteriorates, they are more likely to exhibit mental health problems. People in low-paid and insecure employment similarly demonstrate high levels of mental illness (Haralambos & Holborn, 2008) [17].

Further findings in this study show that biological factors, Psychological factors, social or environmental factors and religious factors are major determinants of mental illness in Awka South Local Government Area. This findings supports the views of Santroct (2003) [19] who stated that infections, brain defects or injury, prenatal damage, substance abuse, depression that results from a tragic family death, stressors

like death or divorce, self-harm, low self-esteem, belief system, unemployment, socio-economic inequality, lack of social cohesion, anxiety among others, can all be linked to mental illness.

Given the above findings, the need for mental health services provided by psychiatric hospitals, community mental health institutions, rehabilitation centres, general hospitals, prayer houses and traditional healers or herbalists to be coordinated in the study area. This is with a view to optimally serve those afflicted. Aniebue and Ekwueme (2009) [5], had opined that there are lots of treatment services for the mentally ill persons to adopt.

Nonetheless, the perception that mental illnesses are caused by demonic attack often makes them to totally resort to doubtful approaches, including prayer houses. Also non-existence of mental rehabilitation home in Awka South Local Government is a major problem. The researchers however anticipates that

Educational programmes, passage of mental health bill in Nigeria, and supporting parenting skills could go a long a long way to reduce the problem of mental illness in Awka South L.G.A. This position align with agree Owoyemi (2013) [11], who urged the National Assembly to ensure the speedy passage of the mental health bill, to reduce high rate of mental case in Nigeria.

Conclusions and recommendations

Although mental illness could be related to biological, psychological, social, environmental and religious factors, the dominating mode of perception in the area studied is to link it to actions of gods.

Furthermore, social class, level of income, gender, were perceived to have implications for occurrence and progression of mental health challenges in a community. Based on the findings in this study, the following recommendations are put forward:

1. Education and proper awareness should be created on the cause and preventive measures for mental illness in Awka South LGA.
2. Expectant mothers should be advised to seek proper medical care, to avoid imbalances that could result to mental illness.
3. There should be youth empowerment programmes and skill acquisition seminars. This will keep the youths busy and prevent them from staying in their hideouts, where they learn how to smoke and take drugs, which could cause mental illness.
4. The government should subsidize the price of the drugs given to victims of mental illness. Drugs like narcotics and anti-depressants. This will make the drugs more affordable.
5. The general public should be enlightened on what actually constitutes mental illness. This will help in reducing the level of stigma and discrimination, victims of mental illness encounter.
6. The mass media should be cautioned on how they portray the mentally ill to the general public.
7. The federal government should build a mental health treatment and research institute in Awka South Local Government Area to handle rising cases of the problem in the area.

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