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ORIGINAL PAPER

Abiodun O. Adewuya · Ayotunde A. Oguntade

Doctors' attitude towards people with mental illness in Western Nigeria

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Abstract *Introduction:* It had been suggested that those more knowledgeable about mental illness are less likely to endorse negative or stigmatizing attitudes. This study aimed to evaluate the attitude of doctors in Nigeria towards the mentally ill. *Methods*: Medical doctors ($n = 312$) from eight selected health institutions in Nigeria completed various questionnaires on knowledge and attitude towards people with mental illness. *Results*: Beliefs in supernatural causes were prevalent. The mentally ill were perceived as dangerous and their prognosis perceived as poor. High social distance was found amongst 64.1% and the associated factors include not having a family member/friend with mental illness (OR 7.12, 95% CI 3.71–13.65), age less than 45 years (OR 2.33, 95% CI 1.23–4.40), less than 10 years of clinical experience (OR 6.75, 95% CI 3.86–11.82) and female sex (OR 4.98, 95% CI 2.70–9.18). *Conclusion*: Culturally enshrined beliefs about mental illness were prevalent among Nigerian doctors. A review of medical curriculum is needed and the present anti-stigma campaigns should start from the doctors.

Key words stigma – attitude – medical doctors – developing countries – mental illness

Introduction

The negative attitude and rejecting behaviour of the public towards the mentally ill has a negative impact on patients' income, work status, and may increases their environmental stress and decrease their ability to cope [13]. Several assumptions had been made about stigma towards people with mental illness. Earlier studies had suggested that stigma and social discrimination were less evident in Africa [7]. Recent works among university students and the community in Nigeria [1, 8] have, however challenged this notion. It was also widely believed that those who have more knowledge about mental illness (like medical doctors and mental health professionals) are less likely to endorse negative or stigmatizing attitudes [6]. This notion had been challenged in recent studies, which had not shown a clear difference in the attitude and social distance of health professionals and the public towards people with mental illness [4, 12, 16]. If the physicians' attitudes towards people with mental illness are not better than the public, then the strategy to use them as role models or opinion leaders in anti-stigma campaigns cannot be easily realised. We aimed to evaluate the perception and social distance of doctors, in South-western Nigeria towards people with mental illness.

Methods

Sample characteristics

The participants were medical doctors selected by random sampling in eight selected health institutions in three states in south-western Nigeria (Ekiti, Ondo and Osun). The health institutions consisted of two university teaching hospitals, two federal medical centres and four general hospitals. Out of about 600 medical doctors in these institutions, 350 were targeted with house-officers (with less than one year post-qualification experience) excluded from the study.

Assessments

Proforma

The participants completed a semi-structured questionnaire inquiring about sociodemographic data like age, sex, ethnicity, religion, marital status, department, years of practise, having managed a patient with mental illness before and having a family member or friend who has or has had mental illness.

Dr. A.O. Adewuya, MBChB (✉) · A.A. Oguntade, MBChB
Dept. of Psychiatry
Lagos State University
College of Medicine
Ikeja, Lagos, Nigeria
Tel.: +234-80/5561-7605
E-Mail: biodunwuya@yahoo.com

Causal attribution

Respondents' attribution of the possible causal factors of mental illness were assessed by responses to 12 items, three items each from social factors, personal factors, supernatural factors and biological factors. Using a 4-point likert scale ("not a cause", "rarely a cause", "likely a cause" and "definitely a cause"), the respondents were asked to indicate how relevant they considered each potential cause to be. Responses of "Likely a cause" and "definitely a cause" are counted as signifying a cause.

Personal attributes

Respondents' perception of the personal attributes of people with mental illness was measured by a list of nine personal attributes generated by factor analysis to cover the two important components of the stereotypes of mental illness [3]. They were asked to indicate with the help of a 4-point likert scale ("definitely not true", "probably not true", "probably true" and "definitely true"), to what extent these attributes apply to people with mental illness. The stereotype components include perceived dangerousness (dangerous, aggressive, unpredictable, lacking self-control, frightened, strange) and perceived dependency (dependent on others, needy, helpless). Responses of "probably true" and "definitely true" are counted as signifying attribution.

Anticipated prognosis

Five different possibilities were suggested concerning the prognosis of mental illness: complete cure, partial remission, persistence of the problem, progressive deterioration or do not know. The respondents were asked to choose a single category to indicate their assessment of prognosis.

Social acceptance and social stigmatisation

Social acceptance and social stigmatisation was measured by a modified version of Link's Discrimination–Devaluation Scale [14]. The scale comprises 12 items and includes six statement on the perceived social acceptance of psychiatric patients and six statements on perceived social stigmatisation and discrimination of former mental patients. The original scale has a 5-point scale (1-strongly disagree to 5-strongly agreed) in agreement to the statements about other peoples' perception. The statements were modified to questions about the participants' acceptance and stigmatisation and the options were modified to a 4-point scale (1-definitely yes to 4-definitely no). For example, "Most people would accept a former mental patient as a close friend" was modified to "Would you accept a former mental patient as a close friend?" Responses of "probably not" and "definitely not" are counted as signifying poor social acceptance and high social stigmatization.

Social distance

The respondents' social distance towards people with mental illness was measured with a modified version of the Borgadus Social Distance Scale [5, 17]. It included six questions evolving along a Guttman scale of increasing personal intimacy. The six questions were rated on a 4-point scale (1-definitely not to 4-definitely yes). It had been widely used in Nigeria [1, 8]. Responses of "probably yes" and "definitely yes" are counted as signifying high social distance.

Procedure

Written informed consents were obtained from the participants after the aims and objectives of the study had been explained. The Ethics and Research Committee of the Obafemi Awolowo University Teaching Hospitals Complex approved the study protocol. Research assistants who are medical students in psychiatry postings distributed the questionnaires to the sample population.

Data analysis

The data were analysed using the Statistical Package for Social Sciences (SPSS) version 11. Results were calculated as frequencies (%), means and standard deviations (SD). The age of the participants and years of clinical practise were grouped. Group's comparisons were by chi-square test. Significance was calculated at $P < 0.05$. Significant variables were then entered into a logistic regression analysis to determine independent correlates. Odds ratio (OR) and 95% confidence interval (95% CI) were reported.

Results

Sociodemographic details

Out of the 350 doctors approached, only 312 completed set of questionnaires and were used for the analysis. The mean age of the participants in years was 36.7 (SD = 8.8) with range 25 to 62. There were 210 (67.3%) males. There were 201 (64.4%) Christians and 201 (64.4% of the participants were married. They were mainly (84.9%) from the Yoruba ethnic group. There were 68 (27.8%) participants from surgical specialities, 102 (32.7%) form medical specialities, 59 (18.9%) form laboratory/pathology specialities and 83 (26.6%) from general practise. Two hundred and one (64.4%) were trained in universities situated in the southern part of the country, 83 (26.6%) were trained in universities situated in the northern part of Nigeria while the rest 28 (9.0%) were trained outside Nigeria. The average years of clinical practise was 8.4 (SD 6.9) with range 2 to 35 years. Only 128 (41.0%) had managed a case of mental disorder before and only 56 (17.9%) admitted to having a family member or friend with mental illness.

Causal attribution, perceived personal attributes and progression of mental illness

The 5 most endorsed causes of mental illness by the participants (Table 1) were abuse of drugs, cannabis or alcohol; personal, financial or marital stress; evil spirits, witches and sorcery; brain injury and infections of the brain; and heredity. In addition, the 5 most endorsed personal attributes of the mentally ill (Table 2) include unpredictability; dangerous; lacking self control; aggressive and dependent on others. Most of the participants believed that if left untreated, the progression of mental illness include deterioration and persistence and if treated, partial remission and persistence (Table 3).

Social distance, social acceptance and social stigmatisation

The social distance towards the mentally ill was seen to increase with the level of intimacy required in the relationship following a Guttmann distribution (Table 4). While only 10.3% would be ashamed if people knew someone in their family has mental illness,

Table 1 The percentage and rank of the reported causes of mental illness among medical doctors

Causes	(n = 312)	Rank
Social factors		
Loneliness	75 (24.0%)	8th
Stress-personal, financial or marital	182 (58.3%)	2nd
Difficulty at school or work	82 (26.1)	7th
Personal factors		
Drugs/cannabis/alcohol abuse	212 (67.9%)	1st
Failure in life	63 (20.2%)	9th
Lack of willpower	10 (3.2%)	12th
Supernatural factors		
Divine punishment/God's will	20 (6.4%)	11th
Evil spirit/witchcraft/sorcery	168 (53.8%)	3rd
Destiny/bad luck	41 (13.1%)	10th
Biological factors		
Heredity	102 (32.7%)	5th
Brain injury/infection of the brain	154 (49.4%)	4th
Childbirth	92 (29.5%)	6th

80.8% would not marry someone with mental illness. In addition, most (77.9%) of the participants would not accept a fully recovered former mental patient as a teacher of young children in a public school (Table 4) and 92.0% would not hire a former mental patient to take care of their children (Table 4).

In line with the method used in previous studies [1, 17], the social distance was grouped into low, moderate or high depending on the number of items answered desirably ("probably not" and "definitely not"). Thus the number of participants with low social distance (all items answered desirably) was 50 (16.0%), the number of participants with moderate social distance (one item answered undesirably) was 62 (19.9%) and the number of participants with high social distance (two or more items answered undesirably) was 200 (64.1%).

Correlates of high social distance towards mentally ill

Univariate analysis showed that the variables significantly associated with high social distance towards the mentally ill include age group of the participants (X^2 = 15.879, df = 2, $P < 0.001$); sex (X^2 = 29.575, df = 1, $P < 0.001$); having managed a patient with mental illness before (X^2 = 11.366, df = 1, P = 0.001); years of clinical practise (X^2 = 50.825, df = 2, $P < 0.001$), and having a friend or family member with mental illness (X^2 = 41.302, df = 1, $P < 0.001$). When these significant variables were then entered into a logistic regression analysis, (Table 5), having managed a patient with mental illness before dropped out of the factors leaving the independently associated variables of age group, sex, years of clinical practise and having a friend or family member with mental illness. Table 6 showed the odds ratio and 95% confidence interval for the independently associated variables.

Table 2 Medical doctors' perception of personal attributes of persons with mental illness in Nigeria

Personal attributes			
Perceived dangerousness (n = 312)		Perceived dependency (n = 312)	
Unpredictable	268 (85.9%)	Needy	98 (31.4%)
Lacking self control	184 (59.0%)	Dependent on others	159 (51.0%)
Aggressive	168 (53.8%)	Helpless	102 (31.7%)
Frightened	117 (37.5%)		
Dangerous	220 (70.5%)		

Table 3 Perceived usual progression of mental illness

Progression	Untreated (n = 312)	Treated (n = 312)
Cure	2 (0.6%)	28 (9.0%)
Partial remission	6 (1.9%)	162 (51.9%)
Persistence	80 (25.6%)	68 (21.8%)
Deterioration	210 (67.3%)	30 (9.6%)
Don't know	14 (4.5%)	24 (7.7%)

Discussion

To our knowledge, our study was the first to examine the attitude of medical doctors in sub-Saharan Africa towards mental illness. Previous studies have examined the attitude of the public in the community [8] or university students [6].

Causal attribution

The first major and surprising finding from our study was that most (67.9%) of our medical doctors believed misuse of drugs and alcohol to be the major cause of mental illness. This was followed in succession by stress (58.3%), evil spirits/witches/sorcery (53.8%), brain injury/infections (49.4%) and heredity (32.7%). Earlier community based studies in Nigeria [8] had suggested that the most commonly endorsed causes of mental illness by the lay public were misuse of drugs and alcohol (80.8%), possession by the evil spirits (30.2%), traumatic event or shock (29.9%) and stress (29.2%). Our finding suggests that this belief was not limited to the public, but also popular among doctors. Although this belief by the public may have some positive effects in restraining the use of psychoactive substances and alcohol in the community, it is definitely inappropriate for doctors who might be involved in the management of the illness and who should enlighten the public. Since misuse of drugs and alcohol could be a causal factor for a very limited number of mental disorders and since the misuse of substances is often viewed as moral failings in Africa, mental illnesses may be viewed as self-inflicted by the doctors and the public and this may elicit condemnation rather than understanding or sympathy [18].

Table 4 Social distance towards persons with mental illness and social acceptance/social stigmatisation towards persons who had mental illness in the past

Variables	Number (%)
Social distance	
Ashamed if people knew someone in your family has mental illness	32 (10.3%)
Afraid to have conversation with someone who has mental illness	84 (26.9%)
Disturbed about working on same job with someone with mental illness	124 (39.7%)
Unable to maintain friendship with someone with mental illness	184 (59.0%)
Disturbed about sharing a room with someone who has mental illness	200 (64.1%)
Would not marry someone with mental illness	252 (80.8%)
Social acceptance	
Do not believe a person who has been in a mental hospital is just as intelligent as the average person	62 (19.9%)
Would not accept a former mental patient as a close friend	162 (51.9%)
Would not hire a former mental patient, if he/she is qualified for the job	100 (32.1%)
Do not believe a former mental patient is just as trustworthy as the average citizen	149 (47.8%)
Would not treat a former mental patient just as would treat anyone	168 (53.8%)
Would not accept a fully recovered former mental patient as a teacher of young children in a public school	243 (77.9%)
Social stigmatisation	
Would pass over the application of a former mental patient in favour of another applicant	134 (42.9%)
Would not hire a former mental patient to take care of my children	287 (92.0%)
Would be reluctant to date a man/woman who has been hospitalised for a serious mental disorder	200 (64.1%)
Think less of a person who has been in a mental hospital	31 (9.9%)
Would take the opinion of a person who has been in a mental hospital less seriously	25 (8.0%)
Feel that entering a mental hospital is a sign of personal failure	16 (5.1%)

In addition, about half of the doctors believed in the supernatural causation of mental illness. This finding is in agreement with the results from the studies done among the Nigerian public [2, 8, 11]. A supernatural view of the origin of mental illness may imply that orthodox medical care would be futile and spiritualist and traditional healers preferred. Previous studies have suggested that care for mental illness is most often sought from these providers [9]. Our finding suggests that the cultural beliefs about the aetiology of mental illness are pervasive among medical doctors and is not affected by the academic knowledge to the contrary. Psychiatry is part of the undergraduate curriculum in all medical schools in Nigeria with the students having at least a four weeks clinical exposure. It is evident that this is not enough to erode the culturally enshrined supernatural beliefs about mental illness. A review of the curriculum may be necessary to effect any change in the causal attribution of mental illness in Nigerian doctors

Personal attributes and anticipated prognosis

We found that Nigerian doctors perceived people with mental illness as unpredictable, dangerous, lacking self control and aggressive. This is similar to perceived personal attributes of the mentally ill by the public in western culture [3, 17]. Earlier studies in Nigeria found that the public viewed people with mental illness as dangerous and eccentric [11]. It is also noted that only 9.0% of doctors in western Nigeria believed mental illness could be cured, with most anticipating partial remission and persistence even when properly treated. This is in agreement with studies that have found that medical staffs were less optimistic about outcomes of mental illness than the public [10]. These negative attitudes may stem from disappointing professional experience with chronic mentally ill clients.

Table 5 Regression analysis of the variables significantly associated with high social distance towards people with mental illness amongst medical doctors in Nigeria

Variables	B	SE	Wald	Df	*P* value
Family member	3.857	0.846	20.793	1	<0.001
Age group	3.462	0.778	19.798	1	<0.001
Years of practise	−1.533	0.400	14.671	1	<0.001
Sex	1.220	0.438	7.774	1	0.005

Table 6 Odds Ratio (OR) and 95% Confidence Interval (95% CI) of the independent correlates of high social distance towards people with mental illness amongst medical doctors in Nigeria

Variables	Total (n = 312)	High social distance (n = 200)	Moderate/low social distance (n = 112)	OR (95% CI)
Family member with mental illness				
Yes	56	15 (26.8%)	41	1 (reference)
No	256	185 (72.35)	71	7.12 (3.71–13.67)
Age in years				
>45	45	21 (46.7%)	24	1 (reference)
36–45	102	57 (55.9%)	45	1.45 (0.72–2.93)
26–35	165	122 (73.9%)	43	3.24 (1.64–6.41)
Years of practise				
>10	80	25 (31.3%)	55	1 (reference)
6–10	101	74 (73.3%)	27	6.03 (3.16–11.51)
2–5	131	101 (77.9%)	30	7.41 (3.97–13.83)
Sex				
Male	210	113 (53.8%)	97	1 (reference)
Female	102	87 (85.3%)	15	4.98 (2.70–9.18)

Social acceptance and social stigmatisation

Our study showed that most doctors would not accept a former mental patient in many social situations especially when the situations are personal. Whereas only 19.9% do not believe a person who has been in a mental hospital is just as intelligent as the average person is, 77.9% would not accept a fully recovered former mental patient as a teacher of young children in a public school. In the same vein, social stigmatisation of former mental patients is quite high among Nigerian doctors especially when it comes to personal issues. While only 5.1% would feel that entering a mental hospital is a sign of personal failure, 92.0% would not hire a former mental patient to take care of their children. Our findings may suggest that although their professional ideology forces them to express "tolerant" opinions about some social acceptance and stigmatisation of the mentally ill, Nigerian doctors nonetheless would not extend such tolerance to issues that personally touch their lives.

Social distance

We found that a large percentage (61.4%) of our doctors have a high social distance towards the mentally ill. This is comparable to 65.1% found amongst Nigerian university students [1]. Above 80 % of the doctors would not marry someone with mental illness and 64.1% would be unwilling to share a room with someone with mental illness. This is comparable to 79.0% and 64.5% respectively found among Nigerian university students [1]. These figures were however slightly lower than the 96.6% and 81.2% respectively found amongst the Nigerian communities [8]. Our study supports the earlier findings that medical professional (including psychiatrist) and the public do not differ in their social distance to mentally ill people [12].

We found that having a family member with mental illness lessened the social distance towards the mentally ill amongst our doctors. This is in agreement with earlier findings amongst university students [1]. Having a family member probably, increases contact with mentally ill which had been shown to be associated with a more positive attitude [3]. We also found older age and longer years of practising experience to be associated with a lesser social distance towards people with mental illness. Although most community studies from the western cultures have found that older people are more socially distancing [17, 19], it is to be noted that in these community studies, the older respondents were significantly less knowledgeable than their younger counterparts were, which was not the case amongst the doctors in our study. Moreover, older age had been associated with more positive attitude towards mentally ill in Nigeria communities [11]. Older and more experienced physicians may be more exposed and may have had more contact with the mentally ill thereby making them more positively disposed to people with mental illness. In addition, we found a higher social distance among the female doctors. This is agreement with the results of other community-based studies both in Nigeria [1, 11] and in western cultures [17]. Since our respondents also perceived people with mental illness as dangerous and aggressive, it should not be surprising that females are more socially distancing than males as traditionally; men are expected to be outwardly braver than women are.

Limitations

Our study has some limitations. We had limited our sample area to the south-western Nigeria and over 80.0% of our respondents were of the Yoruba ethnic group. In a country with many ethnic groups and diverse cultural orientations and beliefs, the views expressed by our respondents may not be representative of doctors from other ethnic groups in Nigeria. However, though working in south western Nigeria, the doctors were trained in different medical schools all over Nigeria and abroad. So largely, our findings could be said to reflect the general situation in Nigeria.

A major limitation of this study had been our focus on mental illness in general. Respondents might have answered our questions with a mind-set on a particular mental illness. Because many of our respondents endorsed non-biological causal factors, knowledge of their preferred help-seeking pathways for mental illness would have been helpful.

Clinical implications

The negative attitude towards people with mental illness is pervasive, both in the community and among doctors, and may form a real barrier to optimal recovery from the illness. Culturally enshrined beliefs about the aetiology, personal attributes and anticipated prognosis of mental illness are prevalent among medical doctors and are not affected by the academic knowledge to the contrary. Although most universities have 4–6 weeks of mental health undergraduate training, the postings were mainly done in teaching hospitals or psychiatric hospitals where the students encounter mainly psychotic cases. The minor mental illnesses are mostly treated by the General practitioners and never referred to the psychiatrist. This may have significant impact on the doctors' view of mental illness. Academic curriculum in medical schools needs to be expended to include programmes dealing with the impact of culture on medical education. Medical doctors must be aware that their attitudes towards the mentally ill do not differ from the public and, as role models in the society, they have a responsibility to improve their own attitudes and behaviour towards people with

mental illness to make the present anti-stigma campaigns a reality.

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