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Community Understanding, Perception and Attitude towards Mental Illness among Residents of Enugu North Senatorial District, Nigeria

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Abstract: *Mentally-ill patients struggle not only from the symptoms and disabilities of the disease but also the challenges from the stereotypes and prejudice that result from the misconceptions about mental illness. The general objective of this study was to assess peoples' understanding, perception and attitude towards mental illness in Enugu North Senatorial District, Nigeria. The study was cross-sectional by design, and conducted in Enugu North Senatorial District, Nigeria, from May to August 2016. Data were collected by 36-item structured, interviewer-administered questionnaires and analyzed using the IBM SPSS for Windows, Version 20.0. Both descriptive and inferential statistics were utilized with p-value ≤ 0.05 considered statistically significant. Majority of the respondents had poor understanding (53.7%), wrong perception (55.3%), and bad attitudes (57.3%) towards mentally-ill patients. More males (49.6%) had good attitudes than females (37.6%) (χ^2 = 4.02; df = 1; P = 0.045). There was a positive correlation between perception and attitude (r = 0.262; P < 0.001). Majority of the respondents chose orthodox medicine (33.6%) or its combination with traditional medicine (32.3%) as preferred treatments. In conclusion, the people of Enugu North Senatorial District in South-eastern Nigeria had a fair understanding of the causes of mental illness, but poor perception and attitudes towards the mentally ill.*

Keywords *- attitudes, emergency contraceptives, knowledge, use, University of Nigeria Nsukka*

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I. Introduction

In its 2001 report, the World Health Organization (WHO) defined mental health to be a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to the community [1]. The 2014 update of this definition incorporates it to that of health which it defines as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [2]. Thus, mental health is not necessarily the absence of a mental disease or infirmity, but a condition of complete mental wellbeing that involves self-consciousness, having positive stress coping ability that ensures meaningful contribution to the society. Good mental health is an inseparable component of good health.

A mental illness is a disease that causes mild to severe disturbances in thought and/or behaviour, resulting in an inability to cope with life's ordinary demands and routines. It affects a person's thinking, feeling or mood. Such conditions may also affect the individual's ability to relate to others and function each day. Mental illnesses refer to disorders generally characterized by dysregulation of mood, thought, and/or behaviour, as recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV) [3, 4]. The identification/definition of a problem forms the first step in its resolution [5]. For the mentally ill, this realization is more complex and impedes the necessity to seek medical attention. Their disease state continuously poses a threat, not just to them, but to the society as a whole [6].

Community understanding and recognition of mental disorders, in most cases, are deficient. When vignettes of a person suffering from major depression or schizophrenia were shown to a representative sample of the Australian public, depression was correctly used as the label by only 39% and schizophrenia by 27% [7, 8]. Most of the respondents recognized the presence of a mental health problem, but only 11% thought that the depression vignette had a physical disorder. Similarly, surveys in Europe have found a lack of understanding of schizophrenia and mania, such that schizophrenia is commonly associated with a split personality [9, 10]. A US

study found that the public are reasonably knowledgeable about the mood symptoms of depression, but less likely to know the associated somatic changes [11]. The exact cause of mental illness was not known until recently that it was proven to be associated with three factors: biological, psychological and environmental [12]. In the developed countries, depression and schizophrenia are most often seen by the public to be caused by environmental factors, particularly recent stressors. While many studies concur with the role of stressful life events in depression, they are regarded more as triggers than causes in schizophrenia [10]. The general populace considers biological factors to be less important than environmental ones, although relatives of schizophrenic patients are more likely to see biological factors as important [10]. Labeling the condition as schizophrenia has also been found to increase the likelihood that biological factors rather than psychosocial are considered to be the causes of mental ill-health [13].

In some third-world countries, supernatural phenomena, such as witchcraft and possession by evil spirits, are seen as important causes of mental disorders. This belief is uncommon in the West. Beliefs about causes may determine help-seeking behaviours and responses to conventional treatment. In Malaysia, belief by psychiatric patients in supernatural causes was associated with greater use of traditional healers and poorer adherence with medication [14]. In a trial about psychotherapy for depression in US, belief in relationship causes was associated with a better outcome in behavioral therapy, while belief in existential causes was associated with a better outcome in cognitive therapy [15]. Good understanding of mental illness facilitates early detection which is important to curbing progression and enhancing rehabilitation.

The perception of mental illness affects the choice of where to seek help and the attitudes of people towards those with mental illness affects them psychologically. This can enhance or impair rehabilitation process and outcomes. Many people with serious mental illness struggle not only from the symptoms and disabilities of the disease but also the challenges that stem from the stereotypes and prejudice that result from the misconceptions about mental illness [16]. With an estimated 5-20% of Nigerians being mentally ill [17, 18] wherein mental and behavioural disorders due to the use of psychoactive substances is 74.4% in men and 59.4% in women [18, 19], it is necessary to assess the understanding, perception and attitude of people towards those with mental illness in the country.

This study was conducted to assess the peoples' understanding, perception and attitudes towards mental health problems among residents of Enugu North Senatorial District in South-eastern Nigeria.

II. Methods

The study was a cross-sectional descriptive study conducted in Enugu North Senatorial District, Enugu State, Nigeria, from May to August 2016.

All adults who were residents of the district for at least three years were included in the study, while individuals who were present only for temporary purposes were exempted.

The only official population figures for the constituent local government areas of the district were from the 2006 census. Considering that such a figure will not be a true reflection of the population after a decade, three hundred houses were conveniently sampled across the senatorial district, from where one participant was chosen at random.

A 36-item structured questionnaire, adopted and modified from a pre-existing validated questionnaire was used to elicit responses from the participants [20]. The questionnaire had three major sections. The first section obtained demographic data. The second section checked awareness of the existence of mental illness in the community, knowledge of the causes of mental illness, manifestation of the disorder and preference of treatment options. The third section explored the attitudes, beliefs and perception of the respondents towards the mentally ill. Negative attitudes included: fear, avoidance, anger, suspicion, mistrust, hostility whereas positive attitudes comprised: sympathy, willingness to care for a mentally ill relative or friend and tolerance.

Ethical approval was obtained from the Health Research Ethics Committee of the University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu Sate. The questionnaires were interviewer-administered to the respondents from whom oral and written consents were obtained prior to their enrollment. Confidentiality was ensured throughout the study.

Upon the receipt of the filled questionnaires, the responses were entered into the IBM Statistical Products and Services Solution (SPSS) for Windows, Version 20.0 (IBM Corp., Version 20.0, New York, USA) which was utilized for analysis. Descriptive statistics were used to summarize data into frequency and percentage. For inferential statistics, the independent t-test and analysis of variance (ANOVA) were utilized to determine the differences between the demographic variables in their mean knowledge and attitude scores. Pearson chi-square and correlation tests were applied to show the association and relationship between variables. For all results, p-value ≤ 0.05 was considered statistically significant.

III. Results

Almost all the respondents (99.3%) were less than 60 years, with majority being females (61.2%) and Christians (99.0%) while about half (47.1%) had post-secondary school education. Table 1 contains the details of the demographic characteristics of the respondents. According to the respondents, mental illnesses were more predominant (60.8%) in the area, compared to heart diseases and cancers. Madness was the most common mental disease (42.5%) in the district. The relative occurrences of other diseases as well as mental illnesses are shown in Table 2. As shown in Table 3, the most common respondents' perceived manifestations of mental illnesses were wandering (93.9%) and talkativeness (90.8%). Loss of consciousness was perceived to be the least occurring problem (53.2%). Overall, only about half (46.3%) had good understanding of the causes of mental illness. Most of the respondents believed excessive use of marijuana or hard drugs were the major causal factors for mental illness. About one-fifth of the respondents attributed mental illness to magic or spiritual possession of the victim. See Table 4 for more details. Figure 1 displays the responses of the respondents on the preferred treatment options for the mentally ill. The use of orthodox medicine alone or in combination with traditional medicine, with almost the same preference level (33.6% and 32.3% respectively), were their treatment options of choice. Only 44.7% of the respondents had total good perception about mental illnesses. Good perception referred to those who did not view mental illness in the negative, as indicated in Table 5. Overall, 42.7% of the respondents displayed good attitudes towards the mentally ill with more than 70% claiming to show kindness and sympathize with them (82.2%). However, a similar percentage finds it hard to trust them, Table 6. No demographic characteristic showed a statistically significant difference with the mean scores of the study dependent variables: understanding, perception and attitudes scores. Table 7 shows the complete mean difference analysis for all variables. Only the correlation between attitude and perception showed a statistically significant (positive) relationship between the dependent variables, Table 8. Table 9 reveals that, in general, more males (49.6%) had good attitudes towards mental health problems compared to females (37.6%).

IV. Tables And Figures

The tables (Tables 1 – 9) and figure (Figure 1) are attached.

V. Discussion

This study revealed that the respondents perceived mental illnesses were more predominant in their district, compared to heart diseases and cancers, with madness as the most common mental disease. The most common perceived manifestations of mental illnesses were wandering and talkativeness. Overall, only about half of the respondents had good understanding of the causes of mental illness. Most of them believed excessive use of marijuana or hard drugs were the major causes. About one-fifth attributed mental illness to magic or spiritual possession of the victim. The use of orthodox medicine alone or in combination with traditional medicine were the treatment options of choice. A little less than half of the respondents had total good perception about mental illnesses. Although many respondents claimed to show kindness and sympathize with the mentally ill, a similar percentage found it hard to trust them. No demographic characteristic showed a statistically significant difference with the mean scores of the study dependent variables: understanding, perception and attitudes scores.

The sample size used for this study sufficiently represented the district. The gender and educational level distributions of the respondents are similar to findings in Nigeria and other countries, but differ in the age distribution [21 – 23]. Majority of the respondents were students which is not surprising as a Federal University is in the District. The most common perceived manifestations of mental illnesses were wandering and talkativeness. This is likely because most people associate mental illness with aggressiveness, while being insomniac or unconscious which are not socially disruptive and do not attract public attention, are not regarded as serious mental illnesses. This finding is similar to that documented in Tanzania [24].

Less than half of the respondents had good understanding of the causes of mental illnesses, similar to the low knowledge reported in many other studies, Nigeria inclusive [22, 25]. Since it was mostly a student population, better knowledge and perception of mental illnesses were expected. The increasing use of illicit drugs among youths may be responsible for its ranking highest among the respondents as a perceived cause of mental illness. Many of the respondents believed spiritual possession may result in mental illness. This might be largely due to the African myth that mental illness is a punishment from the gods for evil committed, as many of the respondents believed mental illness was God's will. This was similar to a previous Nigerian study where beliefs in supernatural factors and the misuse of psychoactive substances were the most prevalent perceived causes of mental illness [26].

The level of perception of mental illness reported in this study was also reported in some works in a wide range of population [27, 28]. The result obtained, however, differed from the outcome of an Iraqi study which discovered that the majority of the respondents had good perception of mental illness [29]. The wrong

perception of mental illness by the respondents might be largely due to the belief that one can never fully recover from mental illness. More than half of the respondents believe mentally ill patients should not have the same rights as other citizens. This might be because people with mental illness are usually seen wandering the streets with no social welfare. In many cases, even those who have mild conditions turn for the worse as no therapy is initiated for them. Thus, there may be the need to take steps to protect and promote the human rights of people with mental illness through the provision of care, education of communities in that regard, and strengthening the legislations that reduce stigmatization [30]

The outcome of the attitude assessment showed that majority of the respondents had bad attitudes towards the mentally ill. They avoid, suspect, fear and can do anything to scare those with mental illness away from their presence. A similar result was obtained in Northern Ireland which revealed that majority of the respondents had bad attitudes towards the mentally deranged [21].

In our study, more males had good attitudes towards the mentally ill than females, even when they were more females than males. It contradicted the results of a Turkish University survey which reported the opposite [31]. Men are expected to be outwardly brave and less submissive towards aggression [20]. The mentally ill have an unfavourable public image and even when calm are usually thought as being potentially violent.

The use of orthodox medicine alone or in combination with traditional medicine were their treatment options of choice. This differed from a study in southern Ethiopia where the preferred interventions for severe mental disturbance were mainly indigenous practices such as consulting native healers, prayers, holy water treatment with orthodox medicine as a last resort [32].

VI. Conclusion

The people of Enugu North Senatorial District in South-eastern Nigeria had a fair understanding of the causes of mental illness, but with poor perception and attitudes towards the mentally ill.

References

[1]. World Health Organization (WHO). The World Health Report - Mental Health: New Understanding, New Hope. 2001. [cited 2017 Apr 23] Available from: http://www.who.int/iris/handle/10665/42390.

[2]. World Health Organization (WHO). Mental health: a state of well-being. 2014. [cited 2017 Apr 23] Available from http://www.who.int/features/factfiles/mental_health/en/

[3]. Centers for Disease Control and Prevention. Mental Illness - Mental Health Basics - Mental Health - CDC [Internet]. Centers for Disease Control and Prevention. 2016 [cited 2017 Apr 1]. Available from: https://www.cdc.gov/mentalhealth/basics/mental-illness.htm

[4]. D.J. Stein, K.A. Phillips, D. Bolton, K.W.M. Fulford, J.Z. Sadler, and K.S. Kendler. What is a mental / psychiatric disorder ? From DSM-IV to DSM-V. *Psychoogical Medicine*, *40(11)*, 2010, 1759–1765.

[5]. L.R. Miranda. The first step to solving a problem. The Real Agenda News. 2015 Jun 24; Available from: http://real-agenda.com/the-first-step-to-solving-a-problem-is-recognizing-there-is-one/ (accessed 2017 Apr 2).

[6]. M.C. Angermeyer. Schizophrenia and violence. *Acta Psychiatrica Scandinavica Supplementum,407*, 2000, 63–67.

[7]. Y. Nakane, A.F. Jorm, K. Yoshioka , H. Christensen, H. Nakane, and K.M. Griffiths. Public beliefs about causes and risk factors for mental disorders: a comparison of Japan and Australia. *BMC Psychiatry*, *5(1)*, 2005, 33.

[8]. A.F. Jorm, A.E. Korten, P.A. Jacomb, H. Christensen, B. Rodgers, and P. Pollitt . Public beliefs about causes and risk factors for depression and schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, *32(3)*, 1997, 143–148.

[9]. B. Hans. The Image of Mental Illness in Switzerland. In: Guimón J, Fischer W SN, editor. The Image of Madness The Public Facing Mental Illness and Psychiatric Treatment. Karger Medical and scientific Publishers; 1999. p. 29–37.

[10]. M.C. Angermeyer, and H. Matschinger. Relatives' beliefs about the causes of schizophrenia. *Acta Psychiatrica Scandinavica*, *93(3)*, 1996, 199–204.

[11]. D.A. Regier, R.M. Hirschfeld, F.K. Goodwin, J.D. Burke, J.B. Lazar, and L.L. Judd. The NIMH Depression Awareness, Recognition, and Treatment Program: structure, aims, and scientific basis. *American Journal of Psychiatry*, *145(11)*, 1988, 1351–1357.

[12]. J. Ormel, B.F. Jeronimus, R. Kotov, H. Riese, E.H. Bos, B. Hankin , *et al*. Neuroticism and common mental disorders: Meaning and utility of a complex relationship. *Clinical Psychology Review*, *33(5)*, 2013, 686–697.

[13]. J. Fuller, J. Edwards, N. Procter,and J. Moss. How Definition of Mental Health Problems can Iinfluence Help Seeking in Rural and Remote Communities. *Australian Journal of Rural Heath*, *8*, 2000, 148–153.

[14]. S.M. Razali, U.A. Khan, and C.I. Hasanah. Belief in supernatural causes of mental illness among Malay patients: impact on treatment. *Acta Psychiatrica Scandinavica*, *94(4)*, 1996, 229–233.

[15]. M.E. Addis, and N.S. Jacobson. Reasons for depression and the process and outcome of cognitive-behavioral psychotherapies. *Journal of Consulting and Clinical Psychology*, *64(6)*, 1996, 1417–1424.

[16]. P.W. Corrigan, and A.C. Watson. Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1(1)*, 2002, 16-20.

[17]. J.O. Abdulmalik, B.O. Adedokun, and O.O. Baiyewu. Prevalence and correlates of mental health problems among awaiting trial inmates in a Prison facility in Ibadan, Nigeria. *African Journal of Medicine and Medical Sciences*, *43(Suppl 1)*, 2014, 193–199.

[18]. World Health Organization (WHO), Federal Ministry of Health Nigeria. WHO - Aims Report on Mental Health System in Nigeria [Internet]. Ibadan; 2006. Available from: http://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf (accessed 2017 Apr 3).

[19]. T. Iheanacho, M. Obiefune, C.O. Ezeanolue, G. Ogedegbe, O.C. Nwanyanwu, J.E. Ehiri, *et al*. Integrating mental health screening into routine community maternal and child health activity: experience from Prevention of Mother-to-child HIV transmission (PMTCT) trial in Nigeria. *Social Psychiatryand Psychiatric Epidemiology, 50(3),* 2014, 489–495.
[20]. M. Kabir, Z. Iliyasu, I.S.Abubakar, and M.H. Aliyu. Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights, 4*, 2004, 3.
[21]. G. Kumar. Knowledge and Attitude of Mental Illness among General Public of Southern India. *National Journal of Community Medicine, 21(1),* 2011, 175–178.
[22]. O.Y.E. Gureje, V.O. Lasebikan, O. Ephraim-Oluwanuga, E.A. Oluwanuga, B.O. Olley, and L. Kola . Community study of knowledge of and attitude to mental illness in Nigeria. *British Journal of Psychiatry, 186*, 2005, 436-441.
[23]. Yongsi HBN. Knowledge and Attitudes Towards Mental Health and Mental Illness Among General Public in Yaoundé. *Scholars Academic and Scientific Society Journal of Medicine, 1(1),* 2015, 26–32.
[24]. S.R. White. Family experience with mental health problems in Tanzania. *Acta Psychiatrica Scandinavica, 83,* 1991, 77-111.
[25]. F.F. Youssef, R. Bachew, D. Bodie, R. Leach , K. Morris, and G. Sherma. Knowledge and attitudes towards mental illness among college students: Insights into the wider English-speaking Caribbean population. *International Journal of Social Psychiatry*, 60(1), 2014.
[26]. A.O. Adewuya, and R.O. Makanjuola. Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. *Social Psychiatry and Psychiatric Epidemiology, 43(4),* 2008, 336-341.
[27]. G. Aruna, S. Mittal, M.B. Yadiyal, C. Acharya, S. Acharya, and C. Uppulari. Perception, knowledge, and attitude toward mental disorders and psychiatry among medical undergraduates in Karnataka: A cross-sectional study. *Indian Journal of Psychiatry, 58(1),* 2016, 70–76.
[28]. M. Benti, J. Ebrahim, T. Awoke, Z. Yohannis, and A. Bedaso. Community Perception towards Mental Illness among Residents of Gimbi Town, Western Ethiopia. *Psychiatry Journal, 2016*, 2016, 1–8.
[29]. S. Sadik, M. Bradley, S. Al-Hasoon, and R. Jenkins. Public perception of mental health in Iraq. *International Journal of Mental Health Systems*, 4(26), 2010.
[30]. V.P. Ramachandra, K. Reddemma, and S.B. Math. People with mental illness and human rights: A developing countries perspective. *Indian Journal of Psychiatry, 55(2),* 2013, 117-124.
[31]. B.M. Savrun, K. Arikan, O. Uysal, G. Cetin, B.C. Poyraz, C. Aksoy, *et al*. Gender effect on attitudes towards the mentally ill: a survey of Turkish university students. *The Israel Journal of Psychiatry and Related Sciences, 44(1),* 2007, 57–61.
[32]. S. Teferra, and T. Shibre. Perceived causes of severe mental disturbance and preferred interventions by the Borana semi-nomadic population in southern Ethiopia: a qualitative study. *BMC Psychiatry, 12,* 2012, 79.

Variables	**n (%)**

Table 1: Demographic characteristics of the respondents

Age (in years)	
18 – 30	223 (78.5)
31-60	59 (20.8)
>60	2 (0.7)
Gender	
Male	113 (38.8)
Female	178 (61.2)
Religion	
Christianity	287 (99.0)
Muslim	3 (1.0)
Educational level	
Informal	3 (1.1)
Primary school	10 (3.6)
Secondary school	130 (47.4)
Post-secondary school	129 (47.1)
Qur'anic school	2 (0.7)
Marital Status	
Married	62 (21.2)
Single	226 (77.1)
Widowed	3 (1.0)
Single Parent	1 (0.3)
Divorced	1 (0.3)
Occupation	
Farming	2 (0.7)
Civil Servant	26 (9.0)
Petty Trader	13 (4.5)
Transporter	1(0.3)
Businessman/woman	78 (27.0)
Student	169 (58.5)
Local Government Area	
Udenu	52 (18.2)
Igbo-Eze North	41 (14.4)
Igbo-Eze south	54 (18.9)
Igbo-Etiti	17 (6.0)
Nsukka	121 (42.5)

Table 2: Awareness of the existence of mental illness in the community

Variables	n (%)
Major health problem in your area	
Mental illness	175 (60.8)
Heart disease	93 (32.3)
Cancers	20 (6.9)
Disease that occur often in your area	
Depression	111 (38.7)
Suicide	12 (4.5)
Madness	122 (42.5)
Alzheimer's disease	41 (14.3)
Those that have cared for a relative or someone with mental health problem	
Yes	118 (40.4)
No	174 (59.6)

Table 3: Respondents' perceived manifestations of mental illnesses

Variables	Yes (%)
People with mental health problems are:	
Very aggressive and/or destructive	205 (70.0)
Always talking often to nobody in particular	267 (90.8)
Always moving from one place to another	278 (93.9)
Hardly sleep at night	176 (59.1)
May go naked without shame	265 (88.9)
Often dirty and careless about the environment	267 (89.6)
May become unconscious	157 (53.2)

Table 4: Respondents' understanding of the causes of mental illness

Variable (correct option)	n (%)
Mental illness may be as a result of:	
Excessive alcohol ingestion by victim (yes)	147 (49.0)
Excessive use of marijuana by victim (yes)	242 (80.7)
Magical/spiritual possession of victim (no)	53 (17.7)
Previous accidents/head injuries to a victim (yes)	232 (77.3)
Madness is common in the victims' extended family (yes)	122 (40.7)

Life crises like unexpected loss of assets, beloved persons etc. (yes)	222 (74.0)
God's punishment to evil people and their descendants (no)	176 (58.7)
God's will for the victim (no)	246 (82.0)
Family and marital persistent conflicts (yes)	150 (50.0)
Victim may have used some hard drugs (yes)	259 (86.3)

Table 5: Perception of mental illness

Variables (perception)	Agree n (%)	Disagree n (%)
Anyone can suffer mental health problem (positive)	168 (56.0)	132 (44.0)
Majority of people with mental health problem recover (positive)	153 (51.0)	147 (49.0)
People with mental health problems should have the same rights as everyone else (positive)	110 (36.7)	190 (63.3)
I would find it hard to talk to someone with mental health problem (negative)	183 (61.0)	117 (39.0)
People with mental problems are largely to blame for their own conditions (negative)	55 (18.3)	245 (81.7)
The public should be better protected from those with mental health problems (negative)	197 (65.5)	103 (34.3)
People with mental illness are often dangerous (negative)	210 (70.0)	90 (30.0)

Table 6: Respondents' attitudes towards the mentally ill

Variables (attitude)	Yes (%)
How do you feel about mentally ill patients	
Avoid mentally ill patient (negative)	156 (52.7)
Angered by the presence of mentally ill patients (negative)	98 (33.2)
Can do anything silly to scare him/her away (negative)	153 (52.2)
Kind towards mentally ill (positive)	229 (79.2)
Always sympathize with mentally ill (positive)	244 (82.2)
Fear mentally ill patients (negative)	190 (65.3)
Find it hard to trust him or her (negative)	227 (76.7)
Suspect mentally ill patients (negative)	189 (64.1)

Table 7: Mean difference analysis of the study variables

Variable	N	Mean understanding scores (SD)	95% CI	P-Value	Mean perception scores (SD)	95% CI	P-Value	Mean attitudes scores (SD)	95% CI	P-Value
Age (years)										
18-30	223	6.11 (1.78)	5.88-6.35	0.189	3.25 (1.41)	3.06-3.44	0.548	4.08 (1.82)	3.84-4.32	0.520
31-60	59	6.51 (1.56)	6.10-6.91		3.47 (1.57)	3.07-3.88		4.12 (1.52)	3.72-4.51	
>60	2	5.00 (2.83)	-20.41-30.41		3.00 (0.00)	3.00-3.00		5.50 (0.71)	-0.85-11.85	
Gender										
Male	113	6.23 (1.49)	-0.35-0.47	0.767	3.34 (1.54)	-0.28-0.41	0.704	4.32 (1.76)	-0.02-0.82	0.063
Female	178	6.17 (1.86)			3.27 (1.40)			3.92 (1.77)		
Local Government										
Udenu	52	6.15 (1.70)	5.68-6.63	0.615	3.21 (1.64)	2.76-3.67	0.816	3.79 (1.70)	3.32-4.26	0.253
Igbo-Eze North	41	1.72 (0.27)	5.95-7.03		3.44 (1.42)	2.99-3.89		3.85 (1.54)	3.37	4.34
Igbo-Eze South	54	1.62 (0.22)	5.59-6.48		3.28 (1.27)	2.93-3.62		4.48 (1.72)	4.01-4.95	
Igbo-Etiti	17	1.59 (0.38)	5.71-7.34		2.94-(1.39)	2.23-3.66		3.88 (2.03)	2.84-4.92	
Nsukka	121	1.86 (0.17)	5.75-6.42		3.28(1.42)	3.03-3.54		4.15 (1.80)	3.82-4.47	
Religion										
Christianity	287	6.20 (1.74)	-1.45-2.52	0.598	3.29 (1.45)	-1.04-2.28	0.461	4.10 (1.78)	-193-2.14	0.922
Muslim	3	5.67 (1.53)	-1.45-		2.67 (1.15)	-1.04-		4.00-	-193-	

			2.52			2.28		(1.73)	2.14	
Marital status										
Married	62	6.55 (1.60)	6.14-6.59	0.267	3.39 (1.43)	3.02-3.75	0.524	4.10 (1.54)	3.70-4.49	0.201
Single	226	6.12 (1.76)	5.89-6.35		3.25 (1.46)	3.06-3.44		4.11 (1.83)	3.87-4.35	
Widowed	3	6.33 (1.53)	2.54-10.13		3.33 (1.53)	-0.46-7.13		2.67 (2.08)		
Single parent	1	5.00 (nil)	Nil		5.00 (nil)	Nil		2.00 (nil)	Nil	
Divorced	1	4.00 (nil)	Nil		5.00 (nil)	Nil		7.00 (nil)	Nil	
Educational level										
Informal	3	5.67 (1.53)	1.87-9.46	0.976	3.67 (1.53)	-0.13-7.46	0.984	2.00 (1.00)		0.179
Primary school	10	6.40 (1.35)	5.43-7.37		3.20 (1.93)	1.82-4.98		4.30 (1.89)		
Secondary school	130	6.21 (1.69)	5.91-6.50		3.23 (1.38)	2.99-3.47		4.08 (1.64)		
Post-sec school	129	6.16 (1.90)	5.82-6.49		3.28 (1.51)	3.02-3.54		4.14 (1.81)		
Qur'anic school	2	6.00 (2.83)	-19.41-31.41		3.50 (0.71)	-2.85-9.85		2.50 (0.71)		
Occupation[a]										
Farming	2	7.00 (1.41)	-5.71-19.71	0.628	3.50 (0.71)	-2.85-9.85	0.195	6.00 (0.00)	6.00-6.00	0.546
Civil servant	26	6.50 (1.33)	5.95-7.04		2.73(1.69)	2.05-3.41		4.04 (1.31)	3.51-4.57	
Petty trader	13	6.08 (1.89)	4.93-7.22		3.77 (1.30)	2.98-4.56		4.62 (2.14)	3.32-5.91	
Transporter	1	7.00 (nil)	Nil		2.00 (nil)	Nil		3.00 (nil)	Nil	
Business man/woman	78	6.38 (1.58)	6.03-6.74		3.46 (1.41)	3.14-3.78		4.03 (1.58)	3.67-4.38	
Student	169	6.06 (1.84)	5.78-6.34		3.24 (1.43)	3.03-3.46		4.05 (1.89)	3.77-4.34	

Table 8: Correlation of dependent study variables

Variable	**Correlation Coefficient (r)**	**P-Value**
Attitude-Perception	0.262	*<0.001
Perception-Understanding	-0.032	0.581
Attitude-Understanding	0.03	0.631

$P \leq 0.05$ is statistically significant

Table 9: Association between gender and attitude

		Male	Female	Total	χ^2	Df	P-Value
Attitudes	Good	57	111	168	4.02	1	*0.045
	Bad	56	67	123			
	Total	113	178	291			

Phi = 0.118; $P \leq 0.05$ is statistically significant

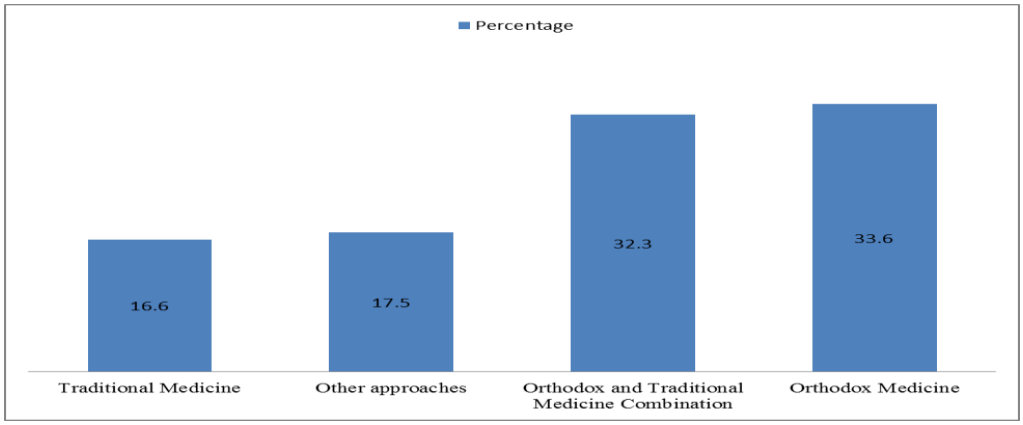

Figure 1: Preferred Treatment for Mental Illnesses

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