Stigmatisation of mental illness among employees of a Northern Nigerian University

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ABSTRACT

Background: Prejudices against people with mental illness are widespread in many societies leading to a number of detrimental consequences. In order to adequately develop programmes and services that will help protect the rights and privileges of people with mental illness, it is imperative to study the nature of stigma and factors associated with it. Our objective in this study was to observe the level of stigmatisation of the mentally ill among employees of a Nigerian University and the factors associated with it. **Materials and Methods:** The study was carried out at the Ahmadu Bello University Teaching Hospital and the Ahmadu Bello University main campus. Employing a two-staged random sampling technique, 15 departments were chosen from both institutions, after which 10 participants were further sampled from each department to obtain a total of 150 participants. All the participants were administered the socio-demographic questionnaire and Mental Illness Clinicians' Attitude 4th version (MICA 4). **Results:** The findings indicate that 53.4% of respondents' classified as high stigmatisation while 46.6% was classified as low stigmatisation. Low scores on stigmatisation were observed among departments of psychiatry, nursing and ophthalmology, while high scores were observed among respondents from administration and engineering. Relationship between variables and predictors of stigmatisation were also established. **Conclusion:** There is a high tendency to stigmatise persons with mental illness except where there has been some contact with mental health practice or among the clinical departments in the hospital. We recommend community psychiatry care for the mentally ill and psycho-education for staff periodically to reduce this level of stigmatisation.

Key words: Employees, mental illness, Nigeria, stigma, stigmatization

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INTRODUCTION

Stigma can be defined as a sign of disgrace or discredit, which sets a person apart from others.[1] The stigmatisation of mental illness is a serious problem affecting patients and their relatives as well as institutions and health care personnel working with persons with mental illness. The more a mentally ill person feels stigmatised, the lower is their self-esteem,[2] social adjustment[3] and quality of life.[4,5] Stigma can adversely affect family relationships,[6] lead to employment discrimination[7] and general social rejection.[8,9] Finally, stigma is also a major reason why sufferers of mental illness fail to acknowledge their illness and it has been described as the underlying factor mitigating against the social re-integration of those recovering from mental illness.[10-12] Negative and stigmatising public attitudes towards mentally ill persons therefore have direct implications for the prevention, treatment, rehabilitation and quality of life of those affected.

Research findings from several countries have confirmed the global nature of negative attitudes towards the mentally ill.[13] Poor community knowledge of causes and the presentation of mental disorders have sometimes been advanced as reasons for stigmatising attitudes.[14] At the workplaces, mental illness is among the most difficult problems to handle. There are several enduring myths about employees with mental illness. The beliefs that they cannot handle stress, do quality work, are unpredictable and potentially violent and that their conditions are incurable. None of these is true, but if an employee senses that an employer believes them that could be enough to discourage a request for help leading to prolonged pain, suffering, decreased productivity and job losses.

Earlier research on stigmatisation of the mentally ill suggested that stigma might be less common in Africa, particularly in Muslim countries.[15] More recent work, however, show the contrary.[16] Indeed more recent studies from across Africa have suggested that the experience of stigma may be prominent in individuals with mental illness, their family and the community at large.[17] A study conducted among staff and medical students in a Nigerian University Teaching Hospital found that the respondents held strongly negative views about the mentally ill.[14] This study supports earlier observations that stigmatisingviews about mental illness are not limited to uninformed members of the general public, but includes people working in the health sector and even those in contact with patients.[18-21]

In Nigeria, orthodox mental health practice is characterised by paucity of facilities and mental health professionals, with concentration of care in the relatively few available psychiatric hospitals and psychiatric units of some general and teaching hospitals.[22] Some studies in Nigeria have shown that lay respondents as well as health workers believe in the effectiveness of orthodox treatment.[23] However, despite the belief, it is found that the general public and health workers still maintain negative attitudes towards people with mental illness with negative consequences. Again, few studies have also shown that familiarity with someone with mental illness is associated with a more positive disposition towards people with mental illness.[21] Thus, it has been suggested that interventions aimed at modifying negative attitudes towards people with mental illness be put in place; such as psychiatric care of patients in the community settings and improving public education about mental illness.

In order to best protect the rights of those with mental disorders and to sensitively develop services, it is vital to gain a more accurate impression of the frequency and nature of stigma across Sub-Saharan Africa. Most of the previous studies on stigmatisation of the mentally ill in Nigeria were carried out in the Southern part of the country and many were among community samples. The objectives of this study were to determine the level of stigmatisation of the mentally ill among employees of a Northern Nigerian University and to study its relationship with socio-demographic variables.

MATERIALS AND METHODS

A descriptive cross-sectional study carried out at the Ahmadu Bello University Teaching Hospital, Shika, Zaria and the Ahmadu Bello University main campus. There are five faculties in the University main campus. One department was randomly selected from each faculty leading to the selection of departments of chemical engineering, economics, history, physical education and chemistry. At the teaching hospital, five clinical departments and five non-clinical departments were randomly selected leading to the selection of the departments of psychiatry, ophthalmology, nursing, physiotherapy and pharmacy and departments of cash office, accounts, medical records, administration and laboratory, respectively. Out of the 15 departments selected in all, 10 employees were randomly selected from the staff list of each department to obtain a total of 150 participants in the study. Informed consent was obtained from all the participants and ethical clearance for the study was granted by the hospital research and ethics committee.

All the participants were administered the questionnaire which contained both socio-demographic characteristics and Mental Illness Clinicians' Attitudes Scale version 4 (MICA v4). In each department, a contact person was identified who administered the questionnaire to the selected participants.

The MICA v4 assesses attitudes towards mental illness of students or staff in any health discipline and is a 16-item scale modified from the MICA v2 previously developed for medical students".[24] For each of the 16 questions, the participants had the option to select one of six answers. These six answers are scored on a Likert-like scale and include: Strongly agree, agree, some what agree, some what disagree, disagree and strongly disagree. The lowest possible score on the MICA-4 is 16 and the highest is 96. A low score on the MICA-4 corresponds to a low stigmatising attitude and a high score to a high stigmatising attitude. The 16 questions in the MICA-4 identify five key themes. The first, "health/social care field and mental illness", corresponds to item numbers 3, 5, 8, 10, 11, 12 and 16. The second, mental illness knowledge corresponds to items 1, 2, 5, 6 and 13. The third theme is disclosure and it corresponds to item numbers 4 and 7. The fourth theme is the ability to distinguish between both physical and mental health; it corresponds to item 8, 13, 14 and 15. The last theme, providing care to patients with a mental illness, corresponds to item numbers 9, 11 and 14. Some of the questions contribute to measurement of more than one theme. Of the 16 questions, 10 are reverse scored; they include items 1, 2, 4, 5, 6, 7, 8, 13, 14 and 15. This meant that for these items strongly agree is scored with the highest number (6) and strongly disagree is scored with the lowest number (1). Gabbidon *et al.*, (2012) found the MICA-4 both reliable and valid. "The Cronbach's α value for the 16-item MICA v4 scale was 0.72, indicating good internal consistency". In the analysis of this research data, reliability of the MICA v4 in our pretest study population was evaluated. The Cronbach's α value was 0.76 which was similar to the α value found by Gabbidon *et al.*,[24] Standardisation of the MICA 4 for the intended sample was also carried out resulting in a mean score of 67.70 and this was used as the basis for the cut-off in this study.

The data collected was analysed using SPSS 16.

RESULTS

A total of 150 employees of Ahmadu Bello University participated in the study. The socio-demographic characteristics of participants are presented in Table 1. In this study, males constituted 75.3% and 60.5% of participants belong to age range of 36-45 years. Majority where Muslims (61.3%) and 56.7% had first-stage tertiary education.

The mean stigma scores on the MICA by participants from the various departments are presented in Figure 1.

Table 1: Showing socio-demographic variables

Variables	Frequency	Percentage (%)
Sex:Male	113	75.3
Female	37	24.7
Age:25-35	14	9.4
36-45	75	60.5
46-55	53	27.4
55 and above	8	5.4
Religion:Christian	58	38.7
Muslim	92	61.3
Marital status:Single	5	3.3
Monogamous	103	68.7
Polygamous	42	28.0
Education:1st stage tertiary	85	56.7
2nd stage tertiary	65	43.3
Years of employment:3-5 years	2	2
Above 5 years	148	98
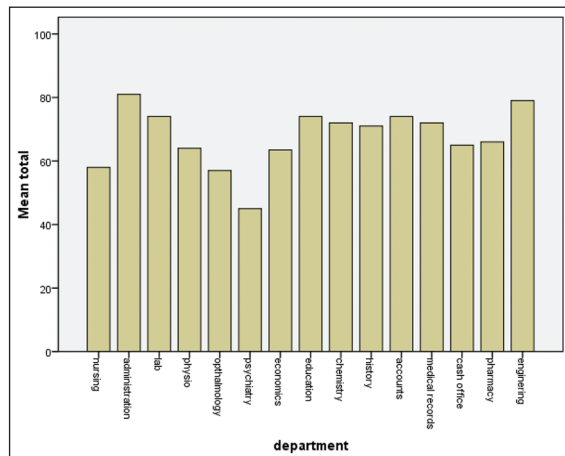
Figure 1: Bar chart showing distribution of stigma scores by departments

The chart shows that high stigma scores were obtained from the Department of Administration in the teaching hospital followed by the Department of Engineering in the university. Low score on stigma was recorded in the department of psychiatry and indeed other clinical departments.

The correlation statistics among the socio-demographic characteristics, number of years of employment and participants' department against their MICA scores were presented in Table 2. There was a significant and strong relationship between department of the respondents and their MICA score while the relationship among religion, age, sex and MICA score though significant was weak. There was, however, no significant relationship between years of employment and all the other variables.

Multiple regression analysis was run to test predictors of stigma scores from the socio-demographic characteristics, years of employment and participants' department as shown in Table 3. There was a 47% contribution at the 0.05 level of significance from all the independent variables on the dependent variable (MICA score). Individually, however, the department of the participants contributed by 36%, educational level contributed by –23%, years of employment contributed by –.03%, religion contributed by 20% while age contributed by 28%.

DISCUSSION

This study was carried out among an elite population working in a Nigerian University. One would expect that this population is enlightened and exposed to various aspects of life issues. However, the study found that stigmatisation of the mentally ill was high among participants in support of earlier observations that stigmatising views about mental illness are not limited to uninformed members of the general public, but includes people working in the health sector and even those in contact with patients.[18-20]

Participants working in the department of psychiatry and the other clinical departments in the teaching hospital had relatively lower MICA scores on stigmatisation compared to the non-clinical departments in both the teaching hospital and the University main campus. The likely reason for this difference is that participants from the clinical departments are more likely to have had contact with someone on

Table 2: Showing correlation matrix between variables

Variables	MICA Total	Religion	Department	Years of employment	Age	Sex
MICA Total	1	0.25**	0.56**	−0.06	0.23**	0.25**
Religion	0.25**	1	0.26**	−0.13	0.15	0.12
Department	0.56**	0.26**	1	−0.04	−0.16	−0.11
Years of employment	−0.06	−0.13	−0.04	1	−0.17	−0.13
Age	0.23**	0.15	−0.16	−0.17	1	−0.11
Sex	0.25**	0.12	−0.11	−0.13	− 0.11	1

**Correlation is significant at the 0.01 level (2-tailed)

Table 3: Showing regression analysis result

Variables	Beta	R	Adjusted R	F	Sig
Department	0.36	0.47	0.13	6.67	.000
Education	−0.23				
Years of employment	−0.03				
Religion	0.20				
Age	0.28				

F (5, 95) = 6.67, *P* < 0.05, R = 0.47. The dependent variable is the total MICA score

treatment or recovering from mental illness. To further buttress this finding, participants from the Department of Psychiatry had the least score on stigma compared to the other clinical departments because they are directly involved in the care and management of the mentally ill within the hospital. They are also more likely to be the ones more enlightened about the nature of mental illness in terms of the causes, symptoms, treatment and prognosis. This finding is in keeping with other studies that showed that familiarity with someone with mental illness is associated with a more positive disposition towards people with mental illness.[21]

Another significant but worrisome observation from this study was finding of the highest MICA scores (80) on stigmatisation in the administration department of the teaching hospital. This department is the one responsible for employment, termination of appointment and promotion of staff in the teaching hospital. The implication is that people with mental illness are likely to be discriminated against during staff recruitment, promotions or may even have their appointments unduly terminated. This will be in support of studies that have linked stigmatisation of the mentally ill to employment discrimination.[7]

The study found a significant and strong relationship between participants' department and their MICA scores with the clinical departments having lower scores on stigma. The participants' department was also found to be the highest contributor to the prediction of stigma scores (36%). This is in support of the notion that knowledge about mental illness and familiarity with the mentally ill is associated with a more positive disposition towards people with mental illness and lower scores on the MICA. The study also found that the participants' age, sex, education and religion had a significant but weak relationship with their MICA scores and all significantly contributed to the prediction of MICA score in support of some other studies.[21]

What is most evident from this study is that stigmatisation of people with mental illness is common among the elite population and healthcare workers in a Northern Nigerian University. Some other studies have attributed this to the fact that culturally enshrined beliefs about mental illness were prevalent among Nigerians.[21] This study also showed that knowledge about mental illness and familiarity with the mentally ill is associated with a

lower tendency to stigmatise the mentally ill as shown by lower stigma scores from participants in psychiatry and other clinical departments of the teaching hospital. The importance of this finding is that policies or programmes aimed at reducing stigmatisation of the mentally ill in Nigeria must include measures that will improve the knowledge of Nigerians about mental illness and increase their familiarity or contact with people with mental illness. A strategy to reduce stigma is to educate the public about the causes, symptoms, treatment and prognosis of mental illness. The public must know that mental disorders have a biological and neurological basis, and are not a character flaw or personal weakness. Another strategy is increased outreach to affected individuals and their families. Public health education campaigns should encourage people to recognise signs of mental illness in their loved ones and urge them to seek treatment. Campaigns that will engage celebrities, athletes and community members who have been affected by a mental illness to come forward as role models for those who are silently struggling will be very helpful. The Nigerian film industry often portrays the mentally ill as suffering from a disease that is incurable and caused by demonic possession in their movies. Strategies that will educate film makers about mental illness so that they act movies that will correctly enlighten the public about mental illness will help in reducing stigma.

Effective integration of mental health into primary healthcare in Nigeria is another strategy that will significantly reduce stigmatisation of the mentally ill. This will improve case detection and psychiatric management of the mentally ill within the community where people are more likely to have contact with them as they recover from their illness.

CONCLUSION

Stigmatisation of people with mental illness is common among employees of a Nigerian university. Knowledge about mental illness and familiarity or contact with the mentally ill is important in reducing stigma. Mental health policies of countries in Africa must include anti-stigma educational programmes and encourage diagnosis, treatment and care of people with mental illness in the community.

ACKNOWLEDGEMENT

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