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PUBLIC ATTITUDE TOWARDS PSYCHIATRISTS: A COMPARISON BETWEEN TWO METROPOLITAN CITIES IN NIGERIA (BIRNIN-KEBBI AND SOKOTO)

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ABSTRACT: ***Background:*** *Many psychiatric patients in need of mental health care have no access to psychiatric care in low and middle-income countries due to negative attitude toward psychiatrist. Public attitudes towards psychiatrists have not been adequately studied in most developing countries like Nigeria, where lack of psychiatrists is well-known. Our study aimed to explore attitudes towards psychiatrists in the general population in two Nigerian metropolitan cities (Birnin-Kebbi and Sokoto) and to identify factors that could influence these attitudes.* ***Methods****: Explorative surveys in the context of public attitudes towards psychiatrists were conducted in a convenience sample from the general population in Birnin-Kebbi (n=187) and Sokoto (n=195). Sampling was balanced for age, gender and school education.* ***Results:*** *We found more negative attitudes towards psychiatrists in Birnin-Kebbi relative to Sokoto ($p < 0.05$) when comparing the two samples using multivariate analysis. Negative attitudes in both cities are associated with lower levels of education ($p<0.05$) and stronger religious beliefs ($p<0.05$).* ***Conclusion:*** *Two major metropolitan cities in Nigeria varied widely in attitudes toward psychiatrist. According to previous research, negative attitude is associated with lower education rates and stronger religious beliefs in both cities. Future research in a diverse country like Nigeria that identifies finer cultural and social factors that play a significant role in attitudes towards psychiatrists.*

KEYWORDS: Mental Health Stigma, Public Attitude, Psychiatrist, Religion, Nigeria

INTRODUCTION

Mental health care continues to be an overlooked concern in most developed countries. The growing interest in the burden of chronic and infirm illnesses, including psychiatric disorders, has grown in the last 30 years. This was accompanied by a dramatic shift in the health needs of the global population over the next two decades. In developing countries, non-communicable diseases, such as mental disorders and heart disease, will overtake infectious diseases and malnutrition as the leading cause of disability by 2020 (National Health and Morbidity Survey [NHMS], 2015).

The World Health Organization has proposed a vicious cycle between poverty and mental disorders, specifically for developing countries (Patel & Kleinman, 2003). Moreover, resources for mental health are inequitably distributed between high and low-income countries. In Nigeria, an estimated 20%–30% of our population is believed to suffer from mental disorders (Onyemelukwe, 2016). Nigeria has Africa's highest caseload of depression and ranks 15th in

the world in the frequency of suicide, according to WHO. There are less than 150 psychiatrists in this country of 200 million, and WHO estimates that fewer than 10 per cent of mentally ill Nigerians have access to the care they need (WHO, 2006).

This is a very significant and unfortunately, the attention given to mental health disorders in Nigeria is at best, fleeting; the level of awareness of the Nigerian public on mental health issues is also understandably poor, and the misconceptions regarding mental health have continued to flourish. It also unearthed other issues related to mental health. These include unavailability of essential medicines at health centres, unavailability of physicians to run primary health care centres and the lack or restrictions to the prescription of psychotropic medications. It also identified that there are only a few nongovernmental organizations involved in individual assistance activities such as counselling, housing, or support groups.

According to the WHO World Mental Health Surveys, there are high levels of unmet needs for mental health in other developing countries as well (Wang et al., 2007). As a result, a large number of patients in need of mental health care seek help from faith healers, traditional medicine practitioners, village health workers, and primary health care centres. A common social challenge is the frequent public stigmatization and discrimination of people with mental illnesses, their relatives and caretakers (Thornicroft et al., 2009), leading to delayed help-seeking within the underfunded medical system and diminished treatment adherence (Clement et al., 2014). Gaebel et al. (2011) stress that stigma not only affects individuals and their families with mental illness but also impacts psychiatric institutions, psychopharmacology and psychiatrists and mental health professionals (Angermeyer et al., 2017; Mungee et al., 2016).

The stigmatization of physicians leads to a substantial burden by adversely impacting the mental health system, which reduces the need for assistance. Patients and their care choices and hindering the recruitment of young psychiatrists by medical graduates (Gaebel et al., 2011). Stigma can also damage campaigns that advocate for mental health care and, as a result, fewer people with mental illness are diagnosed and treated (WHO, 2001). Such results have a huge impact on the quality of life of people with mental illness and can pose risks and burdens to the public (Link & Phelan, 2006; Hatzenbuehler, Phelan, & Link, 2013). Individuals with mental illness have been shown to have poor health outcomes and even premature deaths (Harris & Barraclough, 1998). The explanations for these complications vary; however, research has shown that medical professionals can misattribute physical symptoms to people with mental illness as part of their mental health, a phenomenon known as "diagnostic overshadow" (Jones, Howard, & Thornicroft, 2008). Therefore, medical problems may be ignored, leading to a lack of adequate diagnosis, likely due to the biased mindset of the health care provider (Sullivan, Han, Moore, & Kotrla, 2006).

Overall, a remarkable lack of professionals in the mental health care system, stigmatization towards people with mental illness and caregivers for mental illness remains a challenge in Nigeria (World Health Organization, 2006). This poses a significant question as to how people view psychiatrists and what factors affecting their perception towards psychiatrists. To further explain this critical public health issue, we examined the attitude of the general population towards psychiatrists in two major metropolitan cities: Birnin-Kebbi and Sokoto. To the best of our knowledge, this is the first research contrasting the attitudes of two cities in Nigeria to psychiatrists in the general population.

MATERIALS AND METHODS

Study Design, Settings and Participants

The quantitative study employed an explorative surveys design. The study was conducted in two selected cities (Birnin-Kebbi and Sokoto) in the north-west geopolitical zone of Nigeria. Birnin-Kebbi, is the capital city of Kebbi State sited in the north-west geopolitical zone in Nigeria, and Hausa and is the most widely spoken language there. Sokoto is also situated in the north-west in the geopolitical zone in Nigeria; the predominant language here is Hausa/Fulani. To the best of our knowledge, this is the first research contrasting the attitudes of two cities in Nigeria to psychiatrists in the general population.

A total of three hundred and eighty-two (382) participants were drawn from two (2) cities in the Northwest geopolitical zone, Nigeria, participated in this study. Of the total number of participants, 195 (51.0%) were from Sokoto, 187 (49.0%) were from Birnin-Kebbi. The mean age of the participants is approximately 25 year with a standard deviation of 2.12. Of the 195 participants in Sokoto, 88 (45.1%) were females while 107 (54.9%) were males. Of the 187 participants in Birnin-Kebbi, 79 (42.2%) were females while 108 (57.8%) were males (Table 1). Our sampling method did not involve a probability-based selection method. Data collection in both cities was carried out in the months of October and November of 2019 with an interview-assisted questionnaire conducted by a psychiatric nurse. All subjects signed an informed consent form before participation and were asked to complete questionnaires under assistance. Birnin-Kebbi was the first city in which participants were recruited, following which participants from Sokoto were recruited to match the gender, age, and educational attainment of Birnin-Kebbi. All returned questionnaires were controlled at the site by the interviewer for missing items or inconsistencies.

Measurement

Since no validated questionnaire was available for determining attitudes towards psychiatrists in Nigeria, we adapted the validated questionnaire published by Gaebel et al. (2015). The fully structured questionnaire was administered by a psychiatric nurse using a combination of guided self-report and interview methods, depending on the literacy and preferences of the respondents. The questionnaire took 10 minutes to complete. The questionnaire consists of eight items with reversed items which were used to avoid systematic response bias patterns. Participants indicated their responses on a balanced five-point Likert scale ranging from ‘totally agree' (1) to ‘totally disagree' (5). The overall measure of negative attitude and perception towards psychiatrists was calculated from eight items. Responses on the scale in the current sample showed acceptable internal consistency (Cronbach´s $\alpha = 0.76$). For the final analyses, we reduced the scale to three categories: „agree‟ (1, 2) „undecided‟ (3), and „disagree‟ (4, 5). Negative attitudes were determined individually for each item, and depending on the item, a high or low score indicated more or less negative attitudes towards psychiatrists. For example, with item 5 „Psychiatrists have too much power over mentally ill patients‟, more people agreeing (1, 2) with the statement would represent stronger negative attitudes, while for item 6 ‘Psychiatrists are seriously interested in the well-being of mentally ill patients’, more people disagreeing (4, 5) with the statement would represent stronger negative attitudes.

Analyses

Statistical analyses were performed using IBM SPSS Version 22.0. Differences concerning socio-demographic characteristics such as age, gender, education, household size, income class, religion and strength of religious beliefs were analysed between two samples using a one-way ANOVA. A MANCOVA (multivariate analysis of variance) was conducted with the 8 items on the questionnaire as dependent variables, the two cities as independent variables and the demographic variables age, sex, education, income class, religion and strength of religious beliefs as covariates. For significant items, detailed descriptive analyses were performed to control for direction of associations with negative attitudes.

Results

The characteristics of the participants are shown in tables 1. While table 2 presents the frequencies of each answer category in percentage and possible differences using a MANCOVA between the two samples (Birnin-Kebbi and Sokoto) for all items. To summarize, 5 out of the 8 items of the questionnaire indicated significantly more negative attitudes towards psychiatrists in Birnin-Kebbi in comparison to the sample from Sokoto. For 3 of the 8 items, there were no significant differences between the Birnin-Kebbi and Sokoto samples. Importantly and underlining the direction of our results, there were no items where participants from Sokoto showed more negative attitudes towards psychiatrists than participants from Birnin-Kebbi. In the multivariate analyses, we found that more negative attitudes towards psychiatrists correlated with being from Birnin-Kebbi (F (2, 102) = 12.43, p<0.0004), lower education (F (2, 102) = 2.17, p<0.001) and strong religious beliefs (F (2, 102) = 2.86, p<0.007). The multivariate analysis was also significant for incomes (F (2, 102) = 2.31, p<0.003), however, follow up tests for between-subjects effect did not show any clear trend for the association of negative attitudes with high, middle or lower incomes.

Table 1: Socio-Demographic Characteristics of Survey Sample (n = 382)

Variable	Minna (n=187) N (%)	Sokoto (n=195) N (%)	ANOVA Sig.
Gender:			
Male	108 (57.8%)	107 (54.9%)	
Female	79 (42.2%)	88 (45.1%)	n.s
Age (range years)			
18-25	92(49.2%)	101(51.8%)	
26-45	36 (19.3%)	48 (24.6%)	n.s.
46-65	42 (22.5%)	31 (15.9%)	
>66	17 (9.0%)	15 (7.7%)	
Education:			
No formal education	28(18.9%)	22(112%)	
Primary School	53 (28.3%)	48 (24.6%)	n.s.
Secondary School	62 (33.2%)	88 (44.1%)	
Tertiary Institution	44 (23.6%)	37 (18.9%)	
Strong religious beliefs:			
Yes	161(86.1%)	159 (81.5%)	<0.001
No	26 (13.9%)	36 (18.5%)	
Religion:			
Islam	174 (93.0%)	181 (92.8%)	
Christianity	13 (7.0%)	14 (7.2%)	n.s.

Income Class:			
Upper	22 (11.7%)	25 (12.8%)	
Middle	34 (18.2%)	30 (15.4%)	n.s.
Lower	131 (70.1%)	140 (71.8%)	

n.s. = not significant

Table 2. Public Attitudes Towards Psychiatrists in Minna and Sokoto: Multivariate Analysis (n = 382)

Item	Response Category	Minna (n=187) %	Sokoto (n=195) %	MANCOVA Sig.
1. Psychiatrists are real medical doctors	Agree	21.5	19.2	
	Undecided	9.5	15.0	n.s.
	Disagree	69.3	65.8	
2. If a doctor is not good enough for other medical professions, he/she can still become a psychiatrist.	Agree	32.8	28.3	
	Undecided	45.1	51.2	*P*=0.0003
	Disagree	22.1	20.5	
3. Psychiatrists have effective treatment methods to help mentally ill patients	Agree	59.0	62.4	
	Undecided	21.4	22.6	*P*=0.0008
	Disagree	19.6	15.0	
4. Most psychiatrists choose their profession because they have personal problems of their own	Agree	30.1	22.4	*P*=0.002
	Undecided	56.7	33.3	
	Disagree	13.2	44.3	
5. Psychiatrists have too much power over mentally ill patients.	Agree	18.9	22.1	n.s.
	Undecided	20.1	14.5	
	Disagree	60.0	63.4	
6. Psychiatrists are seriously interested in the wellbeing of mentally ill patients.	Agree	19.2	46.2	*P*=0.001
	Undecided	42.5	22.3	
	Disagree	38.3	31.5	
7. Psychiatrists prescribe psychiatric medication only to calm down their patients.	Agree	52.1	24.1	*P*=0.0001
	Undecided	22.7	44.2	
	Disagree	25.2	31.7	
8. Most psychiatrists have mental problems themselves.	Agree	11.7	32.0	
	Undecided	32.2	48.2	n.s.
	Disagree	56.1	19.8	

(MANOVA, $\alpha < .05$), n.s. = not significant

DISCUSSION

As to our knowledge, this study is one of the first studies focusing on public attitudes towards psychiatrists in Kebbi and Sokoto State of Nigeria. In this study, we report wide differences regarding public attitudes towards psychiatrists in two metropolitan cities of northern Nigeria (Birnin-Kebbi and Sokoto). Overall, we found more negative attitudes towards psychiatrists in Birnin-Kebbi than in Sokoto. Although differences in stigma against mentally ill patients have been shown in other studies between urban and rural communities in India (Jadhav et al., 2007). It is also important to note that negative attitudes towards psychiatrists differ from stigma towards families or patient relatives, which was described as a courtesy stigma (Angermeyer et al., 2003).

Our study includes questions relating to the stigma of courtesy (items 4 and 8); however, other topics deal with mental health literacy and attitudes towards psychiatric treatment. Negative attitudes towards psychiatrists are correlated with lower school education and stronger religious beliefs across all religions and in both cities. The previous study has also shown an association of stigma-related mental health with religiosity (Thimmaiah et al., 2016) and lower education (Cook & Wang, 2010). Nonetheless, participants from Birnin-Kebbi registered significantly stronger religious beliefs compared with participants from Sokoto. This correlation suggests that stronger religious beliefs may be a contributing factor to more negative attitudes towards psychiatrists, as stated by Birnin-Kebbi participants. Interestingly, belonging to a specific religion (in our study mainly Islam and Christianity) was not associated with negative attitudes towards psychiatrists, but it was associated with negative attitudes towards psychiatrists expressing stronger religious convictions in all religions.

According to international epidemiological surveys, 20.9 % people with a severe mental disorder in low/ lower-middle-income countries (LLMI) had contact with a religious advisor, compared to 12.3% in upper-middle-income countries and 9.5% in high-income countries (Kovess-Masfety et al., 2017). 16.2% of people with a severe mental illness considered religious providers as the only resource in LLMI countries (Kovess-Masfety et al., 2017). The important role of the informal sector including religious providers in LLMI can be explained by the scarcity of both outpatient and inpatient treatment facilities and the lack of formal mental health care resources in those countries (Kovess-Masfety et al., 2017).

While we have found a correlation between stronger religious beliefs and low education with negative attitudes towards psychiatrists, measuring complex cultural, social, and linguistic factors that might influence these negative attitudes remains a challenge. An important point to emphasize is the heterogeneity concerning mental health perception in a large and diverse country such as India, where finer-grained local cultural issues have not been thoroughly studied and yet can play a very important role. The authors found that a person identified by schizophrenia vignette was associated with the lowest public stigma in a slum area of Calcutta while the highest stigmatization rates were observed in Trinidad, Port of Spain (Littlewood, 1998).

This negative attitude towards psychiatrists among religious communities LLMI cannot be neglected, while a considerable proportion of people with mental illness are seeking help and advice from religious providers and communities (Kovess-Masfety et al., 2017). It is therefore important to have a psychoeducational program in religious communities to increase awareness

of psychiatric disorders and mental health services and to reduce negative attitudes towards mental health systems in the religious communities of LLMI and Nigeria.

Limitation

The present study has several limitations which suggest and provide significant opportunities for future research. First, the study was conducted in urban areas of large and diverse states in the North-West geopolitical region of Nigeria. Consequently, the results cannot be generalized or seen as representative for all regions of the north-western state of Nigeria, bearing in mind its social and cultural diversity. More studies in multiple cities and rural areas are needed to draw a general conclusion on the spectrum of attitudes towards psychiatrists in Nigeria. Also, self-report questionnaires could be taken into account for a further limitation, we used a questionnaire that has not yet been validated, however, and our questionnaire was adapted from and shared with a validated questionnaire published by Gaebel et al. (2015). Although we have checked for possible confounding factors such as age, gender and education, we cannot rule out other factors that may lead to bias in our outcomes.

CONCLUSION

Our findings show the need for awareness-raising programs to improve public attitudes towards psychiatrists. Religious institutions should be integrated into the process of destigmatization campaigns and education programs, while at the same time showing the drawbacks of inadequate psychiatric treatment. Involving religious leaders to help raise awareness about mental health could be important in countries like Nigeria, where a lot of patients turn to priests, religious healers, etc. to seek help. The willingness to seek help from mental health professionals has been shown to have increased and the general public has seen psychiatric hospitals in a more positive light (Angermeyer et al., 2013). It would be interesting to know if such a trend is limited to high-income countries, or if rapidly developing societies like Nigeria are also showing a positive change in attitudes towards psychiatry and psychiatrists.

Conflict of Interest

No conflict of interest has been declared by the authors

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