

Mental illness and stigma in plateau state, Nigeria

Authors:

Duwap M. Makput¹, Anna B. Gyang¹, Friday P. Tungchama^{1,2}, Christopher G. Piwuna^{1,2}, Charles N. Nwoga^{1,2}, Suwa G. Goar^{1,2}, James T. Obindo^{1,2}

¹Department of Psychiatry, Jos University Teaching Hospital.

²Department of Psychiatry, University of Jos, Nigeria.

Corresponding Author:

Duwap M. Makput, Department of Psychiatry, Jos University Teaching Hospital, PMB 2076, Jos, Plateau State, Nigeria .

<https://doi.org/10.5281/zenodo.17180849>

Article Received: 13-August-2025, Revised: 02-September-2025, Accepted: 22-September-2025, Online First: 25-September-2025

ABSTRACT:

Background: Mental illnesses have been associated with shame, rejection and discrimination right from ancient times. This rejection and stigma is even more common in African societies. **Aim and Objectives:** To investigate stigma to mental illness among members of a community in Nigeria. **Methods:** A cross-sectional descriptive study was carried out among members of Shaka community, in Jos, Plateau state, Nigeria. A self-administered questionnaire was used to collect socio-demo graphic data and information on mental illness. A questionnaire designed by the researchers was used to assess knowledge of mental illnesses and the Community Attitude towards Mental illness (CAMI) questionnaire was used to assess stigma. **Results:** A total of 152 people participated in this study with more males than females. there was poor knowledge of mental illness. Many showed stigma and negative attitude towards people who have mental illness. **Conclusion:** Inadequate knowledge about mental illness exists in this community together with a high rate of stigma towards mental illness.

Keywords: Stigma, Mental illness, Plateau State, Nigeria.

INTRODUCTION:

Mental illnesses are among diseases that attract a lot of stigma. The word stigma means a mark, a stain or a blemish. Mental health stigma can happen when someone stereotypes or labels a person with mental health challenges based on their symptoms or illness.

Stigma in mental illness happens when someone has an unfair attitude or belief about a person with mental health challenges. Stigma, prejudice and discrimination against people with mental illness can be subtle or obvious but no matter the magnitude, they can lead to harm.

Many definitions of stigma exist, stigma occurs when people are mocked, labeled negatively and segregated at the same time ¹.

The stigma on mental illnesses can manifest in many different ways across cultures as a result of various factors². It operates at individual, family, and society levels. It is a broad concept comprising of negative stereotypes, prejudices and discriminatory attitudes against people with mental health problems³. It can

manifest when a person lost status in society because of their mental health⁴. Stigma also involves feelings of humiliation that one is at fault, degraded, or the object of displeasure which causes one to feel devalued, rejected, and stressed⁵.

No universally accepted definition of stigma exists, but it can be seen as a multidimensional construct composed of negative elements of knowledge, attitudes, feelings, beliefs, and behaviours towards a group of people⁶.

According to Arboleda-Florez⁷, stigma may be a result of lack of knowledge and from the perceived causes of the illness.

The phenomenon of stigma is present in many countries, for instance , in France, a study found resident doctors maintain a distance from patients with mental illnesses and the doctors felt much more uneasy when they are examining psychiatric patients ⁸. Stigma can prevent seeking for treatment⁹ and can also delay their recovery from the illness according to Oexle et al¹⁰.

Research indicates that poor knowledge among people is a key underlying cause of stigma ¹¹

It is therefore important to assess knowledge and attitude of people towards mental illness to help in developing policies and strategies to mitigate against the problem of stigma.

MATERIALS AND METHOD:

A cross-sectional descriptive study was carried out among people who reside in Shaka, an urban area in Jos metropolis located within Jos South Local Government Area of Plateau State in Northern Nigeria. The area is cosmopolitan in nature and the inhabitants are Nigerians from almost all parts of the country. It's population consists of people from diverse ethnic and socio- cultural backgrounds. The community is well structured with a wide range of settlements. It is divided into zones, from Zone A,B,C,D,E etc. with thousands of residents . This study took place in Zone A, one of the biggest zones. This zone has a leadership structure comprising of a community Chairman, Secretary, Treasurer and other leaders who coordinate the activities of people in the community such as collection of levies to pay security men employed by the community. The study took place in the third and fourth week of December, 2024 which coincides with Christmas holiday, a period when most people are on holiday at home to celebrate.

Permission for this study was obtained from the community leaders who in turn informed community members about the study. Those who consented to participate were administered the socio-demographic questionnaire and the questionnaire designed by the authors was used to assess knowledge about mental illness as well as the forty-item Community Attitudes Towards Mental Illness (CAMI) scale¹².

Study instrument:

The original version of the CAMI was initially developed to predict the reactions of the general population to local services for people with severe mental disorders. It consists of 40 items. The responses are indicated on a 5-point Likert scale, ranging from “strongly agree” to “strongly disagree”, the CAMI contains four subscales each containing items on opinions on people with mental illnesses. The subscale scores can range from 10 to 50, higher scores indicate less stigma towards people with mental disorders.

Right from the time it was first published in 1981, the CAMI has been the gold standard measure for assessing stigma towards people with mental illnesses. It has been translated into several languages (Portuguese, Greek, Spanish, Swedish, Italian, among others) and used to measure stigma in a wide variety of populations.

Procedure for data collection:

A house to house visit was conducted on randomly selected houses in Shaka Zone A.

Inclusion criteria:

In each selected house, permission was obtained from the head of the house or the eldest adult at home. Members of each household who agreed to participate, who were 18 years and above were informed of the study were given the questionnaires to fill individually and return to the researchers.

Exclusion criteria:

Those aged below 18 years and those who refused to participate in the study.

Data Analysis:

Data was analyzed using SPSS version 23 (IBM, 2016.).

RESULTS:

A total one hundred and fifty two people participated in the study comprising of 82 females and seventy (70) Males. Majority of the respondents were female. Their mean age was 34.9 years indicating a young population and 42.1% have had secondary education. An overwhelming majority (75%) were Christians in line with the demographic structure of the state. Most of the people were married as shown in table 1.

The respondents have a mixed knowledge about the possible causes of mental illness. Many believed that drugs and alcohol can cause mental illnesses (57.9%) but a substantial number of the respondents still hold the erroneous, age long belief (prevalent in Africa) that mental illnesses are caused by evil spirits (5.3%), human enemies (2.5%) and a punishment from God (17.8%).

They identified mental illness by the signs and symptoms, however, concerning treatment, 7.8% said there is no treatment for mental illness and 23.7% were of the opinion that traditional treatment was the best option.

Many of the people had negative attitudes toward mental illness and the patients. Such negative attitudes were observed from their responses which include comments like “I am afraid of people with mental illness”; “I would feel ashamed if I have mental illness”; “I would avoid any contact with the mentally ill”; “I can’t marry a person with mental illness” etc.

The average score on the CAMI scale for each respondent from his /her score on the four subscales namely: benevolence, authoritarianism, social restrictiveness and community attitude to mental health, is as shown in table 3. The young and the very old (18-29 60 showed higher levels of stigma compared to the middle age group. There was a higher rate of stigma from the female respondents as seen in table 3. Security personnel showed the lowest stigma.

Table 1. Socio- demographic characteristics of the respondents.

Variables	Frequency	Percent %
Gender		
Male	70	46.1
Female	82	53.9
Age (mean $\pm$ S.D) (years)	34 $\pm$ 9	
Level of education		
None	6	3.9
Primary	12	7.9
Secondary	64	42.1
Tertiary	55	36.2
Post graduate	15	9.9
Religion		
Christianity	115	75.7
Islam	37	24.3
Others	0	0
Marital status		
Married	89	58.5
Single	54	35.5
Widowed	3	2.1
Divorced	6	3.9
Occupation		
Unemployed	15	9.9
Student	26	17.1
Farming	22	14.5
Civil service	31	20.4
Business	42	27.6
Security personnel	12	7.9
Others	4	2.6

Table. 2. Knowledge and attitude to mental illness

Variable	frequency	%
Commonest Cause of mental illness		
Alcohol use	32	21.1
Witches and evil spirits	8	5.3
Emotional Stress	22	14.5
Brain injury	3	2.0
Punishment from God for Evil deeds	27	17.8
Substance/drug abuse	56	36.8
Attack from human enemies	4	2.5
Old age		
Commonest Features of a mental illness		
Aggressive	32	21.1
Easily angered	21	13.8

Meaningless talk	17	11.2
Talkative	14	9.2
Dirty	53	34.2
Sad	8	5.3
Drug use	4	2.6
Suspiciousness	3	2.0
Best form of treatment for mental illness		
Mental health specialist	74	48.7
Prayers	20	13.2
Traditional healers	36	23.7
Religious healers	8	5.3
Restraint with Chains	2	1.3
It has no treatment	12	7.8
Attitude towards mental health help seeking		
The mentally ill should not marry	15	
I am afraid of people with mental illness	107	
I would be embarrassed if I have mental illness	134	
Professional help is effective	111	
I would feel comfortable seeking professional help	18	
I would avoid any contact with the mentally ill	97	
I would be afraid to talk with a mentally ill person	82	
I can marry a person with mental illness	6	

Table 3. Scores on Community Attitudes towards Mental Illness (CAMI) scale.

Variable	Average CAMI score
Gender	
Males	39
Females	24
Age (years)	
18 to 29	22
30 to 39	41
40 to 49	40
50 to 59	37
60 and above	38
Highest level of Education	
No formal education	22
Primary	27
Secondary	36
Tertiary	42
Religion	
Christianity	38
Islam	36
Occupation	
Unemployed	31
Student	27
Farming	33
Civil service	35
Business	38
Security personnel	42

DISCUSSION:

Attitude towards an illness can be a result of the person's ideas about the cause of the illness. Many of the people still hold the erroneous, age long belief (common among Africans) that mental illnesses are caused by evil spirits, enemies and a punishment from God. According to Thornicroft¹³, people who hold traditional views about the causes of mental illness may prefer to patronize traditional healers for treatment. This was observed in our study as some people were of the opinion that traditional treatment was the most effective. This opinion has grave consequences on the way they may seek treatment if they or members of their family has a mental illness, a clear indication for public education about mental illnesses.

Stigma can come from other people as well as self stigma which can lead to delay in recovery according to Oexele¹⁰. It can worsen symptoms and prolong illness leading to social isolation and loss of opportunities for work and school. In Nigeria, the National health insurance scheme initially excluded mental illnesses. It took the efforts of Psychiatrists and other mental health practitioners to change this highly discriminating policy. This study found that females expressed more stigma towards mental illness than the males as evidenced by their lower average CAMI scores, however, there was no

difference between the rate of stigma among adherents of the two religions. The average score on the CAMI scale for each respondent which is inversely proportional to the degree of stigma, i.e higher scores indicate less stigma and vice versa (Taylor et al)¹². High rate of stigma has a negative implication for the patient.

The problem of stigma extends beyond the people who have mental illness to include the families, the community where the health services are located and even involves practitioners who provide care for people with mental illnesses. Family members and friends, who often provide essential help and support for people with mental illness, can also experience stigma. They may internalize stigma and blame themselves, or they may fear that people will blame them for causing a loved one's illness or reject the family socially. This can lead to reduced emotional support, social isolation, and reluctance to seek care for their relative. (Yanos and Mclean, 2023).

The CAMI has been used in a wide variety of settings and in diverse samples from many different countries (e.g Spain, United Kingdom, China etc.) The target population of past studies varied from a few studies on students¹⁴ and primary healthcare workers¹⁵ but mostly in the general population^{16, 17, 18} and a few studies in Africa¹⁹.

There are various types of stigma as enumerated below

Types of stigma .

	Public stigma	Self stigma	Structural stigma
Stereotypes and prejudices	People with mental illnesses are unpredictable, dangerous, incompetent, to be blamed for their illness.	I am dangerous, incompetent, to be blamed	Stereotypes are embedded in laws and institutions
Discrimination	Therefore, employers may not hire them, landlords may not rent houses to them, health care system may offer a lower standard of care and may budget less money and human resources for their care	These thoughts may lead to low self- esteem and low self- efficacy. why try me? Someone like me is not worthy, is not capable of working. Is unable to live independently and have a good health	Leads to intended and unintended loss of opportunity.

Adapted from Corrigan et al, 2016²⁰.

When stigma surrounding mental health is effectively dealt with, this can enhance the effectiveness of psychiatric care and improve treatment outcome and quality of life of the patients.

There are ethnic and cultural variations in stigma, therefore, stigma surrounding mental illness can manifest differently across cultures²¹.

Table 4. Cultural comparison on Mental health perception and stigma.

Authors	Cultural group	Perception of mental illness	Impact on stigma
Chen & Mak, 2008 ²²	Asian	Seen as a mark of personal weakness or a failure of self control	Stigma leads to family shame , discourages help seeking
Girma et al, 2013 ²³	African	Attributed to spiritual or supernatural causes	High stigma levels deter people from seeking psychiatric help
Karam et al, 2008 ²⁴	Arab	Viewed as a form of divine punishment	Significant stigma leads to delay or avoided treatment .
Alegria et al, 2002 ²⁵	Latin America	Attributed to personal weaknesses or lack of willpower	Stigmatizes individuals and discourages them from seeking psychiatric care.
Corrigan & Watson 2007 ²⁶	Western	Misconceptions about danger or unpredictability	Results in social exclusion and discrimination

Individual and collective actions can help to reduce stigma. There are some useful tips on how we can reduce stigma on mental illness. The **National Alliance on Mental Illness (NAMI)** offers some suggestions about what we can do as individuals to reduce stigma on mental illness. as follows:-

1. **Talk openly** about mental health , e.g sharing on social media .
2. **Educate yourself and others** -respond to misconceptions or negative comments by sharing facts .
3. **Be conscious of language** -remind people that words matter .
4. **Encourage equality** between physical and mental illness -draw comparison to how they would treat someone with cancer or diabetes.
5. **Show compassion** for those with mental illness .
6. **Be honest about treatment** -normalize mental health treatment just like other health care treatment .
7. **Let the media know** when they are using stigmatizing language when presenting stories on mental illness.
8. **Choose empowerment** over shame.

CONCLUSION:

There is a lack of adequate knowledge about mental illness in our society coupled with a high rate of stigma

towards mental illness. Therefore, we need public enlightenment and deliberate efforts by government and individuals to support mental health practitioners through increased funding to enable the right messages about mental illness get to the general public in order to improve care and also reduce the stigma on mental illness.

Conflict of interest: None

Funding:No outside funding.

Acknowledgement:

The leadership and all members of Shaka Zone A, Jos.

REFERENCES:

1. Link BG, Phelan JC. Conceptualizing Stigma. *Annu Rev Sociol* .2001;27: 363-85.
2. Toward a new architecture for global mental health. Kirmayer LJ, Pedersen D. *Transcult Psychiatry*. 2014; 51:759–776.
3. Corrigan PW, Larson JE, Rüsch N. Self-stigma and the “why try” effect: impact on life goals and evidence-based practices. *World Psychiatry*. 2009;8(2):75–81.

4. Crocker J, Major B, Steele C. Social Stigma. In: Gilbert DT, Fiske ST. and Lindzey G, Eds., *The Handbook of Social Psychology*, 4th Edition, Vol. 2. New York: Academic Press; 1998.3. 504-53.
5. Austin JK, MacLeod J, Dunn DW, Shen J, Perkins SM. Measuring stigma in children with epilepsy and their parents: instrument development and testing. *Epilepsy Behav.* 2004;5(4):472–82.
6. Subramaniam M, Abidin E, Picco L, Pang S, Shafie S, Vaingankar J, et al. Stigma: dimensions and correlates in a multi-ethnic population. *Eur Psychiatry.* 2016;33:S522–S522.
7. Arboleda-Florez J. What causes stigma ?. *world Psychiatry* .2002.1(1):25-6.
8. Henderson C, Noblet J, Parke H, Clement S, et al. mental health related stigma in health care and mental health care settings. *Lancet Psychiatry* .2014. 1(6):467-82.
9. Justin FA, Saad T. Mental health beliefs amongst Emirati female college students. *Community Mental Health J.* 2015. 52:233-8.
10. Oexele N, Muller M, Kawohl W, Xu Z, Viering S, Wyss C et al. Self Stigma as a barrier to recovery: A longitudinal study. *Eur Arch Psychiatry Clin Neurosci* .2017. doi:10.1007.07773-2.
11. Girma E, Moller-leimkuhler AM, Muller N, Dehning S, Floeschl G, Tesfaye M. Public stigma against family members of people with mental illness .: findings from the Gilgel Gibe Field Research Center (GGFRC). *South west Ethiopia . BMC. Int Health Hum Right.* 2014.14:1-7.
12. Taylor SM, Dear MJ. Scaling community attitude towards the mentally ill . *schizophr Bull.* 1981;7:225-40
13. Thornicroft G, Deb T, Henderson C. Community mental health care worldwide. Current status and further developments. *World Psychiatry.* 2016. 15:276-86.
14. Ochoa S, Martinez -Zambrano F, Villa-Badia R, Arenas O, Casas-Anguera Garcia-Morales E, et al. Spanish validation of the social stigma scale.: Community Attitude towards Mental Illness (CAMI). *Rev Psiquiatry, Salud Ment.* 2016.9:150-7.
15. Tong Y, Wang Z, Sun Y, Li S. Psychometric properties of the Chinese version of short form Community Attitude towards Mental Illness scale in medical students and primary health care workers. *Front Psychiatry* .2020.; 11:337.
16. Brockington IF, Hall P, Levings J, Murphy C. The community's tolerance of the mentally ill . *Br J Psychiatry.* 1993. 162:93-9.
17. Wolff G, Pathare S, Craig T, Leff J. Community attitude to mental illness . *Br J Psychiatry.* 1996: 168:183-90.
18. Song L-Y, Chang L-Y, Shih C-Y, Lin C-Y, Yang M-J. Community attitudes towards the mentally ill : The results of a national survey of the Taiwanese population. *Int J Soc Psychiatry.* 2005; 51:162-76.
19. Bitta MA, Baariu J, Fondo E, Kariuki SM, Lennox B, Newton CR. Validating measures of stigma against those with mental illness among a community sample in Kilifi Kenya. *Global Mental Health.* 2022;9:241-8.
20. Corrigan PW. Lessons learned from unintended consequences about erasing the stigma of mental illness.. *World Psychiatry.* 2016;15:67–73.
21. Kirmayer LJ, Pedersen D . Toward a new architecture for global mental health.. *Transcult Psychiatry.* 2014;51:759–776. doi: 10.1177/1363461514557202
22. Chen SX, Mak WW .Seeking professional help: Etiology beliefs about mental illness across cultures.. *J Couns Psychol.* 2008;55:442–450
23. Girma E, Tesfaye M, Froeschl G, Möller-Leimkühler AM, Müller N, Dehning S . Public stigma against people with mental illness in the Gilgel Gibe Field Research Center (GGFRC) in Southwest Ethiopia.. *PLoS One.* 2013;8:0. doi: 10.1371/journal.pone.0082116
24. Karam EG, Mneimneh ZN, Dimassi H, et al. Lifetime prevalence of mental disorders in Lebanon: first onset, treatment, and exposure to war. *PLoS Med.* 2008;5:22-9.
25. Alegría M, Canino G, Ríos R, Vera M, Calderón J, Rusch D, Ortega AN.

Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. Corrigan PW, Watson AC. Community Ment Health J. 2007;43:439–458.

26. Corrigan PW, Watson AC .The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver.. Community Ment Health J. 2007;43:439–458.