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MENTAL HEALTH LITERACY ABOUT DEPRESSION AND SCHIZOPHRENIA AMONG ADOLESCENTS IN SECONDARY SCHOOL IN MAKURDI, NIGERIA

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ABSTRACT

A wide gap exists between mental illness sufferers and those who get treated thereby, creating huge disability burden. One important factor creating the gap is mental health literacy which determine help-seeking behaviour. This study aims to determine the mental health literacy about depression and schizophrenia among secondary school adolescents in Makurdi. A total of 228 consenting students were recruited into the study using stratified random sampling technique, case vignettes of depression and schizophrenia followed by open ended questions were administered to assess mental health literacy. The respondents' ages range between 13 to 19 years (mean 15.88 ± 1.55 years) and they were mostly females (51.8%). The recognition of both depression and schizophrenia were low at the rates of 29.8% and 0.4% respectively. More respondents misdiagnosed mental illness for schizophrenia (39.9%) than for depression (5.7%) and on the contrary, more of the respondents misdiagnosed emotional problems, reaction to stress, guilt of undisclosed offence and maltreatment or abuse for depression more than they did for schizophrenia. The recognition rate for depression is greater among female respondents. More respondents recommended help seeking from Psychiatrists for schizophrenia (14.9%) than for depression (1.8%). Support from family and friends was the most recommended source of help seeking both for depression (29.8%) and schizophrenia (25%). Similarly, general practitioners were recommended by 22.8% of respondent for schizophrenia and 25% for depression. Religious and traditional healers were suggested by 7% for schizophrenia and 1.3% for depression. Mental health literacy was found to be low in the current study.

KEYWORDS: Mental health, Literacy, Recognition, Depression, Schizophrenia, Adolescent.

INTRODUCTION

Mental health problems and their attendant consequences, pose issues of increasing global concern. It has been established that mental disorders account for about 13% of the total global burden of diseases[1] and when adolescents between the ages of 10-19 years were considered, the burden increases to 19%.[2] It has also been shown that half of all mental health conditions start by 14 years of age.[2] Nigeria has one of the youngest populations in the world with adolescent between the ages 10-19 years constituting about 23% of its population.[3] The consideration of this, and the global burden together with the allocation of only about 4% of government health expenditures on mental health in Nigeria[4] despite continuous rise in health care cost,[5] shows the enormity of the problem of mental health among adolescents and adults in the country.

Mental and substance use disorders were reported as the leading cause of years lived with disability worldwide, with depressive disorders accounting for 40.5% of disability-adjusted life years.[6] Also, 64% of patients with schizophrenia were reported to have severe to very severe levels of social disability.[7] The reason for this is because a wide treatment gap exists globally, between those who require treatment and those who receive it and this gap is greater in the low- and middle-income countries where it ranges between 76 to 85% as opposed to 35 to 50% in the high-income countries.[1] This treatment gap, is partly due to lack of access to medical facilities especially in the rural area but majorly due to

the lack of knowledge which influence the attitude of the people towards mental illness. Studies in some low- and middle-income countries have shown that less than 10% of patients with schizophrenia receive treatment[8,9] while a community study in Nigeria reported that none of the participants with psychotic disorder had ever received professional mental health care, though, 15% had been to general practitioners and alternative health care practitioners.[10]

To reduce the burdens of mental illness and associated disabilities, cases must have to be treated adequately. The World Health Organization in an attempt to reduce this treatment gap in the low- and middle-income countries, introduced the Mental Health Gap Action Programme (mhGAP)[11] which takes mental health services closer to the people. However, for the programme to be successful, the attitude of people towards mental illness and its treatment must have to change. This attitude result from belief about the etiology of mental illness. A study conducted among Nigerian patients and their relatives as well as a meta-analysis, identified Medical, Psychosocial and spiritual or supernatural etiology of mental illness.[12,13] High levels of ignorance due to belief in supernatural causation of mental illness have been found among Nigerians[14-17] and this has made traditional healers and religious leaders to be the first point of consultation.[15,18]

Mental health literacy is defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention.[19,20] The definition comprises the ability to recognize specific mental disorder, beliefs and knowledge about the etiology, intervention, management, and availability of mental health services.[20] A high level of mental health literacy will enable people to recognize mental disorders earlier and be more willing to seek professional help.[21] It is also a significant predictor of psychological and pharmacological treatment engagement[22] and therefore, a critical mediator of health and functional outcomes[23] All these supports the finding by Bostock *et al*, which reported that low mental health literacy is associated with increased mortality[24] Mental health literacy has been reported to be poor in the low- and middle-income countries,[25] and studies among adolescents in Nigeria yielded the same finding.[15,26] Similarly, poor mental health literacy was reported among young people in Australia, Sweden, and Portugal.[27-29] Studies have revealed that the levels of mental health literacy are worse for schizophrenia compared to depression[30-33] and that the rates of recognition were greater among females than males[28,29]

It is therefore clear that measures that would increase mental health literacy will reduce treatment gap and mortality and thereby, lessen the burden of mental illness. This will ultimately be of immense benefit to the individuals, their families and the society at large. It has been shown that School based psycho-educational interventions is effective in reducing stigma, promotes young peoples' mental health knowledge, and increase mental health literacy in both higher and lower income countries.[34] Similarly, a study conducted in Germany showed that an information booklet as a low-threshold educational approach can significantly enhance depression-specific knowledge among students.[35,36]

Literature search reveal paucity of studies on mental health literacy in Nigeria and none was found to have been done in the study area. Conducting this study in Benue will help reveal the level of mental health awareness among adolescents which will aid the planning of awareness programmes and thereby, guide interventions by health care professionals, schools, religious institutions, NGO's and government so as to increase the level mental health awareness among adolescents as well as the general population. It will also add to the body of knowledge.

AIM

Lack of adequate knowledge about mental illness is a critical factor militating against the management of mental illness and thereby, creating huge disability. This study aims at assessing the level of mental health literacy about Depression and Schizophrenia among adolescent in secondary school in Makurdi.

OBJECTIVES

- To determine the Knowledge of depression and schizophrenia among secondary school pupil in Makurdi.
- To determine the knowledge of secondary school pupil in Makurdi about the appropriate sources of treatment/ help for depression and schizophrenia.

MATERIALS AND METHODS

Study location and participants: The study was conducted in Makurdi, the capital city of Benue state. Being the capital of the state, Makurdi has significant representation of all the ethnic tribes of Benue state.
Study design: Cross sectional descriptive study

Study Instruments

1. A proforma was designed and administered to the participants which elicits the age, gender and religion of the respondents.
2. Widely used case vignettes of both depression[19] and schizophrenia[20,26,37] was presented to the respondents, each of which was followed by open-ended questions to elicit

a. Participant's knowledge of possible diagnosis
b. Participant's knowledge of appropriate treatment required

Procedure: The secondary schools in the Makurdi Local government area were stratified into two groups (Private and public) out of which one schools each was randomly selected from each stratum. And from the selected

schools, one arm was randomly selected each from the three levels of the senior secondary arms of the schools. The study instrument was administered to all consenting students in the selected arms of each school. Ethical approval was obtained prior to this from the ethical committee of the Benue State University Teaching Hospital and permission was also obtained from the Benue State ministry of health.

Data Analysis: Responses to the open-ended questions were grouped in categories based on similarities of thematic content and presented in tables. Data analysis was carried out using the IBM-SPSS version 23 and descriptive statistics including frequency, percentages, mean and standard deviation were computed for relevant variables.

RESULTS

A total of 228 students participated in the study. Their ages ranged between 13 to 19 years (mean = 15.88 years; sd ± 1.55) with 51.8% being females. With regards to recognition of the diagnosis in the depression case vignettes (Table 1), depression was correctly identified by 29.8% of the respondents while 5.7% interpreted it as Mental illness. Emotional problem was identified in about a fifth of the respondents which was closely followed by maltreatment or abuse and reaction to stress, identified by 13.6% and 12.7% respectively. The respondents also misidentified depression as physical illness among 7.5% of the respondents as well as guilt of undisclosed wrong doing (8.3%) like being pregnant. Other misdiagnosis of depression by 3.1% of the respondents includes academic problems, problem with boyfriend, menstrual pain and thinking too much. The study also revealed that out of the 68 respondents that correctly identified depression in the vignette, close to two-third were females (Table 2).

Table 1: Respondent's perception of the depression vignette.

Variables	Frequency n	Percentage (%)
Psychological/ mental disorder or problem	13	5.7
Emotional problems	44	19.3
Stress	31	13.6
HIV/ Physical infection	17	7.5
Guilty of undisclosed offence	19	8.3
Depression	**68**	**29.8**
Maltreatment/ Abuse	29	12.7
Others	7	3.1
TOTAL	**228**	**100.0**

Table 2: Proportion of respondents who correctly identified depression by their gender.

Gender	Depressed n	Percentage (%)
Male	27	39.7
Female	41	60.3
TOTAL	**68**	**100.0**

Responses to the Schizophrenia vignette on the other hand (Table. 3), showed that only one of the respondents was able to correctly diagnose schizophrenia representing 0.4%. Two-fifth identified schizophrenia as mental illness followed by depression and emotional problems identified by 11.0% and 10.1% of the respondents respectively. They also misidentified schizophrenia as drug addiction (8.8%,), reaction to stress (7.5%), spiritual attack (7.0%), cultism (6.6%), guilt of undisclosed wrong doing (5.3%) and HIV or other physical illness (1.8%). Other misidentifications by 1.8% of the respondent include; accident, sick and cancer.

Table 3: Respondent's perception of the schizophrenia vignette.

Variables	Frequency n	Percentage (%)
Mental disorder or problem	91	39.9
Emotional problems		
Stress	23	10.1
HIV/ Physical infection	17	7.5
Guilty of undisclosed	4	1.8
offence	12	5.3
Spiritual attack	16	7.0
Drug abuse	20	8.8
Depression	**25**	11.0
Schizophrenia	1	0.4
Cultism	15	6,6
Others	4	1.8
TOTAL	**228**	**100.0**

Table. 4 shows respondents' preferred source of help or treatment which revealed that 99.6% of the respondents reported that the characters in both vignettes will need treatment or help. Regarding the depression vignette, only 1.8% preferred Psychiatrists as the source of help seeking. Support from family and friends is the most recommended (29.8%), this is followed by general

practitioners, recommended by a quarter of the respondents and then, Psychologist and Counsellors, each of which was recommended by 17.5% of respondents. Religious leaders were suggested as source of help seeking in 4.8%, followed by teachers in 3.1% while 0.4% reported no need for treatment or help.

Responses to the schizophrenia vignette revealed that Psychiatrist was recommended as the preferred source of help seeking by 14.9% of the respondents, a quarter recommended support from family and friends, over a fifth preferred medical practitioners while 12.7%, 11.8% and 10.1% of respondents recommended religious leaders, Psychologist and Counsellors respectively. Traditional healer was recommended by 1.3% of the respondents, 0.9% recommended teachers while 0.4 reported no need for treatment or help.

Table 4: Respondent's preferred source of treatment or help for cases in the case vignettes.

Variable	Depression		Schizphrenia	
	Frequency n	Percentage (%)	Frequency n	Percentage (%)
Physician/ Doctor	57	25.0	52	22.8
Psychiatrist	4	1.8	34	14.9
Pastor/ Church/ Priest	11	4.8	29	12.7
Traditional healers	0	0.0	3	1.3
Psychologist	40	17.5	27	11.8
Counsellor	40	17.5	23	10.1
Support from family/ friends	68	29.8	57	25.0
Teachers	7	3.1	2	0.9
No need for help	1	0.4	1	0.4
TOTAL	**228**	**100.0**	**228**	**100.0**

DISCUSSION

The current study revealed that the ability to recognize both depression and schizophrenia is low and is in agreement with the widespread ignorance about mental illness reported in previous studies among adults and adolescents in Nigerian.[10,15] Widespread misrepresentation of the ideas about mental illness in films and the mass media has been identified and described as stereotypical, negative or flat-out wrong and has been reported to influence people's opinions.[38-40] As such, it is regarded as one of the main barriers underlying low mental health literacy in low- and middle-income countries.[41] The current study clearly demonstrates the knowledge gap and hence, low mental health literacy (MHL) about depression and schizophrenia among secondary school adolescents in Makurdi, Nigeria and the need to further intensify awareness programs on mental health and mental illness.

The low depression and schizophrenia literacy in this study is consistent with studies conducted locally in the south-western and south-eastern parts of Nigeria[26,42-43] and internationally.[27,28,31,33] However, the rate of recognition of depression in this study (29.8%) is relatively higher compared to the other local studies identified in literature search (4.8% and 10.4%).[42,43] Similarly, 0.4% of the respondents were able to recognize schizophrenia compared to the only study identified in literature search on schizophrenia literacy among adolescents in Nigeria which was conducted in Lagos and reported that no participant was able to recognize schizophrenia.[26] This disparity may appear unexpected especially considering the studies in south-western part of Nigeria which were conducted in Lagos,[26,43] a more urban society where awareness is expected to be higher. However, the increased awareness in this study may be due to activities of some non-governmental organizations (NGO) in the state that incorporated awareness programs in schools as part of their activities. Notable among such NGO's is the Comprehensive Community Mental Health Program (CCMHP), sponsored by the Australian AID and the Christopher Blind Mission which fashioned its programme after the mhGAP action programme of the World Health Organization. The findings of this study also agree with previous studies that reported that the levels of mental health literacy are worse for schizophrenia compared to depression.[30-33] Also, the recognition of depression among the respondents is greater among females (60.3%) than males (30.7%) which is consistent with reports from previous studies.[28,29]

More respondents in the current study recognized schizophrenia as mental illness (39.9%) than they recognized depression as mental illness (5.7%). This support the notion that depression is seen as normal reaction to adverse life situations and not an illness in majority of the black community.[44] Also, it is in agreement with previous studies in which depression was largely misidentified as reaction to stress,[27,32] more respondents misdiagnosed depression as reaction to stress (13.6%) compared to the proportion that misdiagnosis schizophrenia as reaction to stress (7.5%). It is for the same reason that higher proportion of the respondents misdiagnosed emotional problems, guilt of undisclosed offence like getting pregnant as well as maltreatment or abuse which can be considered as

stressful events for depression than they did for schizophrenia.

The misrecognition of schizophrenia as spiritual attack in this study by 7% of the respondents is consistent with studies reporting high levels of ignorance due to supernatural causation of mental illness in Nigeria,[14-17] Asia,[45,46] and Europe.[47] The same attribution to spiritual attack is not seen with depression in the current study thereby, further supports the view that among blacks, depression is viewed to be a normal reaction to adverse life situations.[44]

Previous studies revealed that beliefs about what a problem is, plays a clear role in guiding individuals toward different formal and informal sources of help.[48] Although low, 14.9% of the respondents recommended psychiatrists as the appropriate source of help seeking for schizophrenia compared to 1.3% for depression, probably due to the relatively higher rate of identification of schizophrenia as mental illness. The low recommendation of help seeking from psychiatrist is consistent with the finding of previous studies conducted in south-western Nigeria,[26] China,[33] Indians[36] and among African-Americans.[49] It however, contrasts the high recommendation of help seeking from psychiatrist reported from studies in some other countries (64.6-86.7%) due to high mental health literacy levels.[50,51]

Help seeking from doctors and hospital was recommended by a quarter of the respondents for depression and over a fifth for schizophrenia, similar to studies rating general practitioners high among helping professionals.[19,52,53]

Psychologists and Counsellors were recommended by about a tenth of the respondents for both depression and schizophrenia. In line with this finding, studies examining patients' preferences in the treatment of depression reported that lay people prefer psychotherapy over medication.[54,55] Similarly, some other studies also reported that psychological interventions are seen by the public as effective for psychotic disorders.[56-58]

Support from family and friends is the most recommended source of help seeking for both depression and schizophrenia at the rates of 29.8% and 25% respectively. This finding supports previous studies reporting that family was the main source of intended help for mental illness among adolescents.[31,59,60] The recommendation of family support together with the relatively high rate of recognition of schizophrenia as mental illness (39.9%) confirms the report of another study which found that the ability to recognize mental illness increase help seeking from friends while recognition of the disease as schizophrenia increases help seeking from professionals.[61]

In agreement with reports of widespread belief of supernatural causation of mental illness that necessitate help seeking from religious and traditional healers,[14-18] the current study revealed that a total of 14% of respondents recommended spiritual healers as source of help seeking for schizophrenia (Religious leaders by 12.7% and Traditional healers by 1.3%) compared to only 4.8% that recommended religious leaders as source of help seeking for depression. When this is related to the fact that 7% of the respondents misdiagnosed schizophrenia as spiritual attack while none misdiagnosed depression as spiritual attack, it is clear that the higher misdiagnosis of spiritual attack in response to the schizophrenia vignette influenced the higher recommendation of spiritual healers as source of help seeking for schizophrenia.

CONCLUSION

The current study revealed low mental health literacy about depression and schizophrenia among secondary school students in Makurdi, Nigeria. The inability to recognize specific mental disorders and identify appropriate source of help seeking shows the need for the intensification of awareness programmes on mental health and mental illness in Benue and Nigeria as a whole.

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This study had no external source of support and there is no conflict of interest by any of the researchers

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