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Attitude towards Epilepsy and Mental Illness in Ekiti State, Nigeria (pp. 1-12)

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Abstract

This study was designed to find out the attitude of people in Ekiti State Nigeria, towards epilepsy and mental illness in terms of work opportunities and marriage options and to examine whether the level of education, gender and religious affiliation would affect people's attitude towards person with these disorders. 200 participants were used and it comprised 106 literate and 94 illiterate persons. The independent t-test and the Pearson Product Moment Correlation were used to test the hypotheses. The result showed that literate respondents had more positive attitude towards epilepsy and mental illness with mean scores of 9.78 and 8.11 respectively. Also, male respondents showed a significantly positive attitude towards epilepsy with a mean score of 11.09 as against the mean score of the female respondents (10.57). No significant difference was found between the attitudes of males and females towards mental illness, while religious affiliation had a significant effect on the respondent's attitudes. 78.3% (for mental illness) and 43.9% (for epilepsy) of the respondents were of the opinion that people with the disorders should not be employed while 55.6% (for mental illness) and 60.3% (for epilepsy) believed that they should not marry. Recommendations were made in the light of the need for more research concerning the effect of gender on the attitude towards epilepsy and mental illness and that educating the general public will reduce the negative attitudes towards those disorders.

Introduction

Mental disorders are now widely recognized as a major contributor to the global burden of disease. One in every four people or 25% of individuals, develop one or more mental or behavioural disorders at some stages in life, both in the developed and developing countries (WHO, 2001). At least 40 million people in the world suffer from severe forms of mental disorders such as schizophrenia and dementia. No fewer than 20 million people around the globe suffer from epilepsy which is also a mental disorder; and a further 200 million are incapacitated by less severe mental and neurological disorders such as neuroses and peripheral neuropathy (WHO, 1994).

At the onset, it is essential to recognize that the term “mental illness” encompasses a broad spectrum of disorders, which differ vastly from one another in terms of their distribution, symptoms, causes, outcomes and treatments. According to Department of Health and Human Services (1999) mental disorders are characterized by alterations in thinking, moods or behaviour (or some combination) associated with distress and or impaired functioning. A mental disorder can be experienced long-term or short-term with mild to intensities. The diagnosis and characteristics vary from person to person. The center for psychiatric Rehabilitation (1997) indicates that the most common forms of mental illness include anxiety disorders, depressive disorders and schizophrenia. Among the major mental disorders are those that can be classified under the following categories viz: substance use disorders, Alzheimer’s disease, disorders of childhood and adolescence eating disorder, Epilepsy etc.

Epilepsy is basically a chronic brain disorder characterized by recurrent dearrangement of the nervous systems due to sudden excessive disorderly discharge of cerebral neurons. The discharge results in almost instantaneous disturbance of sensation, loss of consciousness or psychic function, convulsive movements or some combination of these (Behrman, Kleigman and Jensen, 1987). A person who is predisposed to epilepsy has attacks when the basal level of excitability of the nervous system (or of the part that is susceptible to epileptic state) rises above a certain critical threshold. Epilepsy can be classified into three major types; grand mal epilepsy, petit mal epilepsy and focal epilepsy.

Grandmal epilepsy is characterized by extreme neuronal discharge in all areas of the brain in the cortex, in the deeper parts of the cerebrum, and even

in the brain stem and thalamus. Often the person bites or “swallow” the tongue and may have difficulty breathing, sometimes to the extent of developing cyanosis. The grandmal seizure lasts from a few seconds to 3 to 4 minutes. Most people who have grandmal attacks have a hereditary predisposition to epilepsy, a predisposition that occurs in about one of every 50 to 100 persons.

Petit mal epilepsy almost certainly involves the basic thalamocortical brain activating system. It is usually characterized by 3 to 30 seconds of unconsciousness or diminished consciousness during which the person has several twitch-like contractions of the muscle, usually in the head region, especially blinking of the eyes: this is followed by return of consciousness and resumption of previous activities.

Focal epilepsy can involve almost any part of the brain either localized region of the cerebral cortex or deeper structures of both the cerebrum and brain stem. Almost always, focal epilepsy results from some localized organic lesion or functional abnormality, such as scar tissue in the brain that pulls on the local circuitry. Another type of focal epilepsy is the so called psychomotor seizure, which may cause (1) a short period of amnesia; (2) an attack of abnormal rage; (3) sudden anxiety, discomfort of fear; (4) a moment of incoherent speech or mumbling of some trite phrase; or (5) a motor act to attack someone, to rub the face with the hand, and so forth. Sometimes the person cannot remember his activities during the attack, but at other times, he will have been conscious of everything that he had been doing but unable to control it.

The reported prevalence of active epilepsy in developing countries ranges from 5 to 10 per 1,000 (Ozer, 1991). However worldwide prevalence rate of the general population and is more prevalence among children (Bouchier et al, 1996). In Nigeria the estimated prevalence of epilepsy is 8 to 13 per thousand people (Azubuike and Nkangienieme, 1996). In developing countries the disorder is to a significant degree associated with a host of parasitic and bacterial infectious disease that are largely absent in industrialized countries (Matuja and Rwiza, 1994).

Mental disorders often co-exist with others health problems and are known to worsen the outcomes of other medical conditions. Socio-cultural attitude have a negative impact in the management of epilepsy (Nbuko et al, 2003) and mental illness in many African countries. This stigma reduces the

opportunities of treatment seeking behaviours by affected persons, this undoubtedly worsens the situation. Simister and Duncan (2002) revealed that the increasing rate of mortality in patient with epilepsy is two-to-three fold higher than in the general population.

Previous works in Africa have indicated wrong beliefs in their writing on epilepsy in Africans (Dada and Odeku, 1966; Giel, 1968; Osuntokun & Odeku, 1970; Osuntokun 1979). Epilepsy is regarded by many Nigerians as a sign of visitation by the devil or evil spirits and can therefore not be treated by modern medicine (Dada and Odeku, 1966). Many believe it is infectious and transmitted through the saliva of a patient having an attack, hence may run away instead of giving a first aid to an epilepsy patient having a seizure.

Similarly, mental illness was considered “ a punishment God gave to sinner, as a spiritual torment due to possession by the devil, or as a moral defect due to weakness of will” (Garke and Stewart, 1997). Blame was also brought upon parents and family members with the views that mental illness was due to poor parenting skills, weak character and inadequate upbringing.

Today the majority of these myths have dissipated but feelings such as fear, mistrust, and anxiety still linger within the society. The public tends to misperceive individuals with mental illness as having disturbing and life-threatening behaviours and at times feelings that the illness is unreal since it cannot be seen physically.

Wright and Woodruff (1995); Heyman and Murray, (1992); Kendlyer and Diehl (1993); and Littrel and Schneiderhan, (1996) studies also show some similarities in the socio-cultural perception of schizophrenia either “gifted” or curse” depending on religious criteria and early hypothesis considered the possibility that brain damage or malformation could account for these behaviours.

Stigma has long been recognized as a major burden to people with epilepsy and their families (Temkin, 1991 & Whitman, 1986). According to Jallon (1977) and Rwiza et al (1992), nowhere is epilepsy associated stigma more disabling than in sub-Saharan Africa, where epilepsy rate far exceed those in develop countries.

People with mental illness exhibit limitations in everyday functioning which includes difficulties with concentrating and lack of energy or initiative (Garske, 1999). These limitations can result in barriers to adequate housing, meaningful work, routine social interactions, education, loans, health insurance and obtaining a drivers license (Garske & Stewart, 1999). Individuals with mental illness also face barriers to employment which include societal stigmatic attitudes of professionals, family members, consumers, and employers, economic incentives of social insurance programs; lack of access to vocational services; and services that emphasize assessment and prevocational goals rather than competitive employment and following supports (Garske & Stewart, 1999).

As regards marriage, Jilek-Aail, Kaaya, Kombachepa & Hillary (1997) found people with epilepsy unwilling to discuss their disadvantaged marital choices, but community informants reported that women with epilepsy are unable to properly take care of children, cook on fire, and fetch water, making them poor choices for a wife. Birbeck (1994) also related that in addition to limited marital options, data from a hospital-based study revealed that people with epilepsy of normal intelligence receive significant less education than their sex matched siblings. Osuntokun & Odeku; Matuja (1970) & Rwiza (1994) reports indicate that teachers frequently expel children with epilepsy from school solely because of their seizure disorder.

The more frequent a disorder, the higher the chance of its coinciding with other frequent disorders. Both epilepsy and mental psychiatric disorder have been found to be common (Betts, 1981; Fenton, 1981; Hermann & Stevens, 1980; Leviton & Cowan, 1981; Parnas & Korsgaad, 1982; Robertson & Trimble, 1983; Stevens, 1982; trimble, 1982). Psychosocial factors may play a causative role in the development of psychiatric problems in epilepsy.

In a study carried out by Benjarowicz & Zielinski (1979), it was revealed that the lowest social acceptance of epilepsy was noted among people with elementary or lower educational and among unskilled workers and the best level of social acceptance was found among senior white collar workers and those with University education.

Methods

Research Design: This is a survey research that adopted the expost facto research design. None of the variables were actively manipulated in the cause of the study. The total respondents for this study comprised 200

persons, 106 literates and 94 illiterates were randomly selected from Ekiti State, Nigeria. The literates selected comprised 56 females and 50 males while the illiterates were made up of 50 females and 44 males. The illiterates comprised apprentices, farmers, tailors, market women, bike riders, traders etc. while the literates included University of Ado-Ekiti students, lecturers, traders, doctors, nurses etc.

Instrument

Data collection in this study was through the use of a structured questionnaire developed by the researcher both for attitudes towards epilepsy and mental illness. The first scale is the Epilepsy Attitude Questionnaire containing 16 items with .96 content validity index and split-half reliability coefficient of .35. The second scale is a 21-item Mental Illness Attitude Questionnaire with a content validity index of .94 and a reliability coefficient of .37. A religious affiliation rating scale ranging from 1-7 whereby one (1) represents not religious at all and seven (7) represents highly religious was also used.

Results

The table 1 shows that there is a significant difference between the attitudes of literates and non-literates towards mental illness, $t(187) = 4.09$, $P < .01$ and epilepsy $t(187) = 5.00$, $P < .01$.

The table 2 indicates that there is no significant difference between the attitudes of males and females towards epilepsy, $t(187) = 1.32$, $P > .05$. a significant difference exist between the attitudes of males and females towards mental illness, $t(187) = 2.794$, $P < .01$

Discussion

This study found that literates showed more positive attitudes towards people with epilepsy and mental illness than illiterates. This finding was supported by the work of Deribow and Tamirat (2005) which established that individuals with lower educational levels show more negative attitudes in the educational opportunities of people with epilepsy and the marital prospects and work opportunities of people with schizophrenia were seen less favourably by the illiterate respondents. Thus, the effects of general education on the beliefs of epilepsy and mental illness and the attitudes towards these disorders have been amply demonstrated by this study.

Furthermore, these findings also found support for the postulation that male respondents show more positive attitude towards people with mental illness

with a mean score of 9.10 as against the mean score of 8.35 for the female respondents. This also concurs with the findings of Deribew and Tamirat (2005) which revealed that females showed negative attitudes on the marital prospects of major depressive disorders more often than their male counterparts.

Attitudes of males towards epilepsy and mental illness is found to be related to the attitude of females towards these disease as the hypothesis tested in table three (3) was significant at $t(188) = .56$, $P < .01$. Deribew and Tarimat (2005) also recorded that schizophrenia, epilepsy generalized anxiety disorder and mood depressive disorder was all perceived to be mental health problems by their respondents. This however, contradicted the findings of Alem-Araya, Kebede and Kullgren, (1999) whose respondents believed schizophrenia to be the most serious mental disorder followed by epilepsy and mental retardation.

According to this study, religious affiliation has a significant effect on people's attitudes towards epilepsy and mental illness. The differences in the attitudes of Christians and Muslim towards epilepsy and mental illness are most likely due to the religious and doctrinal teachings by these religious groups. Therefore to be accepted in these gatherings individuals fashion their beliefs and behaviour to suit the teaching of their religious groups with respect to these disorders.

Conclusion and Recommendation

This study has revealed that ignorance, illiteracy, gender and religious affiliation affect people's attitudes towards people with epilepsy and mental illness. And such attitudes are usually negative and stigmatizing. Therefore to make the society a better place for people with epilepsy and mental illness, there is an urgent need for public education and enlightenment.

The study also revealed that there is a significant difference between religious affiliation and the attitudes of people towards epilepsy and mental illness. This is a challenge for the religious institutions in Nigeria as the solution to the problem lies in the same institution. Religious leaders will achieve more for this group of people by enlightening members on the need to show love, care and support for these groups of people.

More research should be carried out on gender differences in the attitudes towards epilepsy and mental illness as sufficient information in this aspect was not available. The low level of knowledge and misconceptions found among the respondents demonstrates the need for educational programme aimed at demystifying epilepsy and mental illness.

A better understanding of the disorder among the public would allay fears and mistrust about people with epilepsy and mental illness in the community as well as lessen stigmatization towards such person. Therefore the government should launch Information Education communication (IEC) programs to teach the community on the causes, symptoms, first aids and the roles of people with mental health problems in the society.

References

- Allen, A; Jacobson; Araya, M., M., Kebede, D., Kullgren, G. (1999). How are mental disorders seen and where is help sought in rural Ethiopia Community? *Acta Psychiatrica Scand: 100*, 40-47
- Angermeyer, M.C. & Matschinger, H. (1996). The effect of violent attacks by Schizophrenia persons on the attitude of the public towards the mentally ill. *Social Science and Medicine 43: 1721-1728*
- Behrman, r.E., Kleigman, R.M. & Jensen, H.B (1987). *Nelson's Texbook of pediatrics*. New York: Saunders
- Bejnaravicz, J.H & Zielinski, J.J. (1979). The level of basic human need satisfaction and its various. In J.J. Zielinski (Ed). *Program of Medicine treatment and course of epilepsy and social functioning of patients*. (Rehabilitees sciences administration DHEW report in research program 19, 35-58. Washington D.C. US Government Printing Office
- Betts, T.A. (1981). Depression, anxiety & Epilepsy. In E.H. Reynolds & Trimble M.R. (Eds). *Epilepsy and Psychiatry*, New York: Chruchill living stone
- Boucheir. A.I., Haslett, C.&Chilver, e.R. (1996). *Davidson's principles and practice of medicine*. New York: Saunders
- Center for Psychiatric Rehabilitation (1997). Reasonable Accomodations. What is Psychiatric Disability and Mental illness?
- Dada, T.O. & Odeku, E.L. (1966). Epilepsy in the Nigerian patient. *West African Medical Journal, 153-163*.

- Deribew, A. & Tamirat, S.Y (2005). How are mental health problems perceived by a community in Agaro town? *Ethiopia Health Dew*, 19(2)
- Fenton, G.W (1981). Personality and behavioural disorders in adults with epilepsy. In Reynolds E.H. and Trimble M.R. (Eds). *Epilepsy and Psychiatry Edinburgh*, Churchill-living stone
- Furham, a. & Bower, P. (1992). "A comparism of academic and lay theories of schizophrenia". *British Journal of Psychiatry*, 161, 201-210.
- Garske, G.G. (1999). The chanllenge of Rehabilitation Counsellors: Working with people with psychiatric disabilities. *Journal of Rehabilitation* 65(1) 21-76.
- Garske, G.G. & Stewart, J.R. (1999). Stigmatic and mythical thinking: Barriers to vocational Rehabilitation services for persons with severe mental illness. *Journal of Rehabilitation* 65(4) 4-9.
- Giel, R. (1968). The epileptic outcast. *East Africa Medical Journal* 45,27-31
- Hermann, B.P & Steven, J.R. (1980). Interictal behavioural correlates of the epilepsies. In B.P. Herman (Eds). *A multidisciplinary hard book of epilepsy*. Spring field Thomas.
- Heyman, I & Murray, R.M. (1992). Schizophrenia neurodevelopments. *J.R. Col Physicians Lond* 26, 143-146
- Jacoby, A. Snape, D. & Baker, G.A. (2005). Epilepsy and social identity: the stigma of a chronic neurological disorder. *Lancet Newrol*, 4 171-178
- Jallon, P. (1997). Epilepsy in developing countries. *Epilepsia*, 38: 148-1151
- Jilek-Ail, L., Jilek, M., Kaaya, J.M. Kombachepa, L. & Hillary, K. (1997) Psychosocial study of epilepsy in Africa. *Social Science Medical* 45: 783-95
- Kendler, K.S. & Diehl, s.R. (1993). The genetics of Schizophrenia: a current genetic epidemiologic perspective. *Schizophrenia Bulletin*, 19: 261-285
- Levito, A. & Cowan, L.D. (1981). Methodological Issues in the epidemiology of seizure disorders in children. *Epidemiological Review* 3: 67-89
- Littrel, r.a. & Schneiderhan, M. (1996). *The Neurobiology of Schizophrenia Pharmacotherapy*, 16: 143s-1475
- Matuja, W.B. & Rwiza, H.T. (1994). Knowledge, attitudes and practice (KAP) towards epilepsy in secondary school students in Tanzania. *Central African Journal of Medicine*, 40:13-18

- Kleinman, a., Wang, W.Z et al (1995). The social course of epilepsy chronic illness as social experience in interior China. *Social science Medical*, 40: 1319-1330.
- Murray, C.L. & Lopez, a.D. (1996). *The global burden of disease*. Cambridge: Havard University Press.
- Nbukpo, P., Preux, P.M., Clement, J.P. et al. (2003). Comparison of socio-cultural attitudes towards epilepsy in Limousin (France), in togo and in Benin (Africa). *Medical Trop*, (Mars) 63:143-150.
- Osuntokun, B.O. & Odeku, E.L. (1970). Epilepsy in Ibadan, Africa *Journal of Medical Nigerian Science*, 1: 185-200
- Osuntookun, B.O. (1979). Management of Epilepsy in developing countries. *Journal of Medical Nigerians I*, 1-12
- Ozer, I.J. (1991). Images of epilepsy in Literature. *Epilepsia*, 32, 798-809
- Parnas, J. & Korsgaard, S. (1982). Epilepsy and Psychosis. *Acta Psychiatrica Scan divavica* 66, 89-99
- Robertson, M.M. & Trimble, M.R. (1983). Depressive illness in patients with epilepsy: a review. *Epilepsia* 24(2), 109-16
- Rwiza, H.T. et al (1992). Prevalence and incidence of epilepsy in Ulanga a rural Tanzania district: a community based study. *Epilepsia*, 33(105) 1-6.
- Scambler, g.&Hopkins, A. (1986). Being epileptic: coming to terms with stigma. *Social Health Illness*, 8, 26-43
- Simister, r.J. & Duncan, J.s. (2002). Understanding Epilepsy. *Epilepsia*, 17 (10), 10-16.
- Steven, J.R. (1975). Risk of factors for psychopathology in individuals with epilepsy. In W.P. Koella & M.R. Trimble (Eds). *Advances in Biological Psychiatry*, 8, 56-80.
- Temkin, O. (1971). *The falling sickness: a history of epilepsy from the Greek to the beginning of modern neurology*. Baltimore: John Hopkins Press
- Trimble, M.R. (1982). Phrenomenology of epileptic psychosis: a historical introduction to changing concepts. In W.P. Koella and M.R. Trimble (eds) *Advances in Biological Psychiatry*, 8, 1-11.
- Whitman, S. BPH (1986). *Psychopathology in epilepsy social dimensions*. New York: Oxford University Press.
- WHO (1994). Mental health care in developing countries; a critical appraisal in research findings. *Technical Report Series*, 698. Geneva Switzerland.

Wright, T. & Woodruff, P. (1995). Aetiology of Schizophrenia. Review of theories and their clinical and therapeutic implication. *CNS drugs*, 3, 243-246.

Table 1: Summary table of independent t-test showing the difference between the attitudes of literates and non-literates towards mental illness and epilepsy

	N	N	X	sd	se	Df	t	P
Mental Illness	Literates	104	11.65	2.64	.26	187	5.00	< .01
	Non-Literates	85	9.78	2.48	.27			
Epilepsy	Literates	104	9.18	1.77	.17	187	4.09	< .01
	Non-Literates	85	8.11	1.84	.20			

Table 2: t-test table showing the difference between the attitude of males and females towards epilepsy and mental illness

	Variable	N	X	SD	SE	df	t	P
Epilepsy	Male	87	11.09	2.68	.29	187	1.32	>.05
	Female	102	10.57	2.75	.27			
Mental Illness	Male	87	9.10	1.82	.19	187	2.79	< .01
	Female	85	8.35	1.86	.18			

Table 3: t-test table showing the effect of religious affiliation on people's attitude towards mental illness and epilepsy

	Variable	N	X	SD	SE	df	t	P
Mental Illness	Christians	121	8.95	1.94	.18	187	2.501	< .05
	Muslims	68	8.25	1.67	.20			
Epilepsy	Christian	121	11.11	2.69	.24	187	2.501	< .05
	Muslim	68	10.28	2.73	.33			

Table 4: A percentage table showing the attitude of literates and illiterate males and females towards epilepsy and mental illness

	Total Respondent	Literates	Illiterates	Males	Females
Have seen individual with epilepsy	12.2%	17.39%	82.61%	56.52%	43.48%
Epilepsy is contagious	64.02%	40.50%	59.50%	45.45%	55.55%
Epilepsy is caused by witchcraft	74.09%	42.86%	57.14%	45.71%	54.29%
Mental illness is caused by witchcraft	68.25%	41.86%	58.14%	44.19%	55.81%
People with Mental illness should not be employed	78.3%	55.41%	44.59%	43.92%	56.08%

The table 3 shows that religious affiliation has an effect on people's attitude towards epilepsy and mental illness, $t(187) = 2.501, P < .05$

People with epilepsy should not be employed	43.90%	51.22%	48.78%	40.24%	59.76%
People with mental illness should not marry	55.56%	45.71%	54.29%	43.81%	56.19%
People with epilepsy should not marry	60.32%	31.58%	68.42%	38.60%	61.40%