American Journal of Humanities and Social Sciences Research (AJHSSR)
e-ISSN : 2378-703X
Volume-5, Issue-12, pp-216-228
www.ajhssr.com
Research Paper Open Access

Tertiary Health Care Nurses' Attitude towards People with Mental Illness in Enugu, South-East Nigeria

Paul C. Odinka[1] , Appolos C. Ndukuba[1], Rosemary C. Muomah[1], Thecla O. Iyidobi[2], Ujunwa C. Nduanya[2], Kennedy U. Amadi[1], Jaclyn I. Odinka[3], Chukwuma Oraegbunam[4], Michael U. Osika[5]

[1]*Department of Psychological Medicine, College of Medicine, University of Nigeria Ituku-Ozalla Campus, Enugu State, Nigeria.*
[2]*Department of Psychological Medicine, University of Nigeria Teaching Hospital Ituku-Ozalla, Enugu State, Nigeria.*
[3]*Social Sciences Unit, School of General Studies, University of Nigeria, Nsukka.*
[4]*Lancashire and South Cumbria NHS Foundation Trust, Sceptre Point, Sceptre Way, Walton Summit, Preston, United Kingdom.*
5*Department of Psychiatry, Rivers State University of Science and Technology, Port Harcourt.*

Corresponding author: *Chukwuma Oraegbunam*

ABSTRACT: Nurses working in the general hospital setting do not feel adequately prepared by their training to cope with nursing patients with common comorbid mental health problems. Such patients may elicit negative emotions such as fear, leading to patient segregation. The negative attitudes of healthcare professionals, especially nurses, worsen people's mental health problems. Empathy is a vital resource for supporting the patient's recovery. The study explored nurses' attitudes towards people with severe mental disorders in tertiary hospitals. The cross-sectional survey was designed within the Community Attitudes towards Mental Illness (CAMI) model. Information was collected from 152 nurses working in two university teaching hospitals in Enugu, Southeast Nigeria. The median age of the participants was 33.0, and the age range was 20-58 years; 30 – 39 years were the majority (39.5%). The females constituted 86.2% of the respondents. The majority of the participants (46.1%) occupied the position of Nursing Officers II. All but one, 151(99.3%), had at least three weeks of psychiatry experience during basic nursing training. Multiple linear regression showed that the duration of post-qualification, work experience and training in psychiatry were significantly associated with predicting positive community mental health ideology. In contrast, gender was significantly associated with predicting social restrictiveness. The study may have highlighted a greater and urgent need to facilitate in-service training for other less experienced staff. Greater psychiatric experience might help equip the nurses better and give them confidence in dealing with patients with mental illness.

KEYWORD: *Tertiary Health Care, Nurses, Attitude, People With Mental Illness, Enugu Southeast Nigeria*

I. INTRODUCTION

A significant disease burden is attributable to mental illness globally (Vigo, Thornicroft and Atun, 2016), which account for 14% of the global burden of disease (Prince et al., 2007). Lack of access to quality mental health services is a significant contributor to disease burden (Thornicroft, 2008). Mental disorders are common and can affect anyone. Many adults with common chronic conditions such as arthritis, cancer, diabetes, heart disease, and epilepsy experience concurrent depression and anxiety, and comorbid mental disorders can further complicate the self-management of these disorders and adversely affect the quality of life (Chapman et al., 2005; El-Gabalawy et al., 2010; IOM, 2012).

Stigma and discrimination limit access to mental health care (Thornicroft, 2008). The stigma, myths and misconceptions surrounding mental illness are the root cause of much of the discrimination and human rights violations experienced by people with mental disabilities daily (Baldwin and Marcus, 2011). Stigma can be considered as an amalgamation of three related problems: a lack of knowledge (ignorance and misinformation), negative attitudes (prejudice), and excluding or avoiding behaviours (discrimination)

(Thornicroft, 2007, Sartorius & Schulze, 2005; Corrigan, 2005). Stigma has been described as a cluster of negative attitudes and beliefs (Corrigan and Shapiro, 2010; Corrigan and Watson, 2002) that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses (President's New Freedom Commission on Mental Health, 2003). When stigma leads to social exclusion or discrimination ("experienced" stigma), it results in unequal access to resources that all people need to function well: educational opportunities, employment, a supportive community, including friends and family, and access to quality health care (Link & Phelan, 2001; Corrigan et al., 2004). These types of disparities in education, employment, and access to care can have cumulative long-term negative consequences.

The public beliefs and attitudes toward mental illness set the stage for how they interact with, provide opportunities, and help support people with mental illness (CDCP, 2012). In this case, the public refers to the general public, such as the community and institutions like hospitals and co-workers, friends and family members of people with mental illness (Schnittker, 2008). People's beliefs and attitudes toward mental illness also frame how they experience and express their own emotional problems and psychological distress and whether they disclose these symptoms and seek care (CDCP, 2012). Attitudes towards people with mental disorders refer to individual beliefs about what people with mental illness are like and how they should be treated (Labate, 2012; Nunnally, 1961), and these attitudes could vary from the acceptance, tolerance, stigma and to even fear (Angermeyer et al., 2011; Parra, 1985; Corrigan and Watson, 2002; Brockington et al., 1993).

When attitudes and beliefs are expressed positively, they can lead to supportive and inclusive behaviours (e.g. willingness to hire a person with mental illness). Still, when they are expressed negatively, they can cause avoidance, exclusion from daily activities, exploitation, and discrimination (CDCP, 2012). Rüsch et al. (2011) reported that after controlling for demographics, people's intentions to seek help were positively associated with the tolerance and support for community care of mental illness. In addition, how people with mental illness experience and express their own psychological problems and whether they are willing to disclose their symptoms and seek help can also contribute to social exclusion or perceived discrimination. (CDCP, 2012; Schnittker, 2008).

Many studies have reported discrimination against psychiatric patients by health care professionals, including doctors, nurses and social workers Rao et al., 2009; Lauber e al, 2004; Schulze and Angermeyer, 2003; Brinn, 2000). Moreover, some studies have reported that health care professionals hold more negative attitudes toward mental illness than the general public. Such negative attitudes will further restrict the recovery rates and quality of care (Chambers et al., 2010; Caldwell and Jorm, 2000; Jorm et al., 1999). While positive attitudes in nurses will inspire hope, encourage individuals to take control of their lives and engage in proactive decision making about their future (Repper and Perkins, 2009). Nurses play a critical role in patient care, as they are the biggest group of health care professionals involved in the direct care of patients, including those with mental health problems (WHO and ICN, 2007). They play an important role in patient recovery (Horsfall *et al*. 2010) and quality of care in the area of mental health (Thornicroft *et al*. 2007). Nurses with higher levels of education and those with specialised psychiatric training have more positive attitudes than unqualified staff and those without any psychiatric training (Brinn, 2000; Mavundla and Uys, 1997; Scott and Philip, 1985). A highly skilled, flexible, and culturally aware nursing workforce can ultimately positively impact practice (Ludvigsen, 1997).

Previous studies suggested that socio-demographic characteristics could affect public attitudes to mental illness. Socio-demographic factors such as age, gender, education and cultural background could contribute to social distances (Yuan et al., 2016; Lauber et al., 2004; Parra, 1985).

The exposure of nurses and other healthcare professionals and increased personal contact with patients with mental illness in a psychiatric setting during training has been associated with positive attitudes toward patients with mental illness (Couture and Penn, 2003; Read and Law, 1999; McLaughlin,1997; Bairan and Farnsworth, 1989).

Few studies in Nigeria focused on the attitude of nurses toward people with mental illness, and most were done outside the Southeast. Studies in Nigeria involving different socio-demographic groups suggested that the attitude of Nigerians to people with the disease were mostly negative (Mosaku and Wallymahmed, 2017; Sheikh et al., 2015; Ukpong and Abasiubong, 2010; Abasiubong et al., 2007; Gureje et al., 2005). Given the critical role that nurses play in patient care, the direct roles they play in the care of patients, including those with mental health problems (WHO and ICN, 2007), the study of the attitude of nurses in tertiary health care towards people with mental illness in this region become very relevant. The study aimed to explore nurses' attitudes towards people with severe mental disorders in tertiary health care. The findings from this study will add to the existing body of knowledge.

II. METHODS

Setting

The University of Nigeria Teaching Hospital (UNTH), Ituku-Ozalla, Enugu and Enugu State University of Science and Technology (ESUT) Teaching Hospital Enugu were the sites for the study. The two hospitals are among the seven government-owned university teaching hospitals in the Southeast. They provide medical services to Enugu state residents and receive referrals from the southeastern region and other parts of Nigeria.

Enugu is a regional and state capital and a major cosmopolitan city in Igbo land. It has a very high concentration of tertiary educational institutions and civil servants. The population of Enugu State was put at 3.3 million people during the 2006 population census. Igbos constitute 95% of the people, with about 59% living in rural areas (NPC, 2013).

Nigeria's 36 states are grouped into six geopolitical zones for political convenience, and Southeast is one of the six zones, though the 36 states are the federating units. Southeast is predominantly inhabited by the people of the Igbo ethnic group, who speak Igbo. Igbo is one of Nigeria's three largest most influential ethnic groups (Odinka et al., 2014) and constitutes 18% of the Nigerian population of 170 million, approximately 30 million (CIA, 2015). Igbo people are predominantly Christians (Odinka et al., 2014).

In Igbo culture and tradition, ofo is a ritual and religious symbol, the highest moral principle. Alongside ogu (innocence), its twin forms the bastion of moral order (Ajaebili et al., 2020; Ikegwu, 2018). Ofo also serves as a legal seal in judicial and political affairs among Igbo communities. It is the highest principle of justice, law and morality, binding both the living and supernatural powers of the gods and ancestors (Ajaebili et al., 2020).

Historically, Igbo people (Ndi-Igbo) are indigenous to a large part of half of the tropical rainforest of southern Nigeria, mainly on the eastern side of the Niger River. In present-day Delta State, their territory extends westward across the Niger to Aniocha, Ndokwa, Ukwuani, and Ika. A significant part of Rivers State constitutes part of the larger Igbo ethnic group (NEPABOX, 2021). The Ikwerre constitute the majority of Rivers state; they speak the Ikwerre language and are predominantly settled in the Ikwerre, Obio-Akpor, Port Harcourt and Emohua local government areas Rivers states, and small parts of Edo, Benue, Akwa Ibom and Kogi (NEPABOX, 2021).

Sample identification and recruitment procedures

The data for this study was collected as part of a nationwide survey restricted to registered nurses in tertiary health institutions in Nigeria. It was a cross-sectional study that used a convenience sampling technique.

Inclusion and exclusion criteria

All nurses working in the two tertiary health institutions were included in the study during the data collection period. The participants must be 18 years and above and have the physical and mental capacity to undergo the interview process. A previous history of mental illness does not exclude any nurse from participating in the study.

Instruments

Socio-demographic questionnaire

The socio-demographic questionnaire collected basic information such as age, gender, rank, and previous training in mental illness and mentally ill during basic and post-basic training.

Community attitudes towards mental illness (CAMI)

Community attitudes towards mental illness (CAMI) is a standardised instrument developed by Taylor & Dear (1981) to assess attitudes to mental illness (Taylor & Dear, 1981). CAMI was used to systematically gain insights into the communities' attitudes towards individuals with mental illness. The CAMI originally measures four factors: 1) Authoritarianism, 2) Benevolence, 3) Social Restrictiveness, and 4) Community Mental Health Ideology. The statements of the CAMI expressed 5 pro- and 5 anti-sentiments for each dimension (i.e. four sets of ten statements). For instance, the statement "As soon as a person shows signs of mental disturbance, he should be hospitalised" represents pro-authoritarianism, whereas "The mentally ill should not be treated as outcasts of society" indicates anti-authoritarianism attitudes. The questionnaire comprised 40 items with four subscales. Each of the subscales: authoritarianism, benevolence, social restrictiveness, and community mental health ideology, has ten questions, respectively. The 40 statements inventory has a 5-point Likert scale. The participants were asked to rate each statement on a five-point scale (1 = strongly agree, 2 = agree, 3 = neutral, 4= disagree, and 5 = strongly disagree).

The authoritarianism subscale suggested that respondents are inferior and need coercion and supervision. Hence, the higher the score, the more negative attitude, while the lower the score, the less negative attitude. The same applies to social restrictiveness. This subscale suggested that mentally ill subjects are dangerous and should be avoided. Benevolence and Community Mental Health ideology would indicate more

supportive and inclusive attitudes towards individuals with mental illness; hence the higher the score, the more positive attitude to the mentally ill. The benevolence component refers to humanistic and sympathetic approaches to the mentally ill. At the same time, the community mental health ideology emphasises that mental health services should be established in the community while individuals who have a mental illness should be integrated into the community (Barke et al., 2011; Taylor and Dear, 1981). The possible score on each subscale of CAMI ranged from 10 to 50. It is divided by 10 to obtain a score fraction ranging from 1.0 to 5.0. The higher the scores on authoritarianism or social restrictiveness subscale, the more the negative attitude of the participants to mental illness. While on the benevolence and the community mental health ideology, the higher the score, the more positive attitude. Reverse scoring was done for the anti-sentiment statements for each dimension. CAMI has been used in many studies across the globe, including Nigeria, with high reliability and validity of the instrument (Mosaku and Wallymahmed, 2017; Ikwuka et al., 2016; Reta et al., 2016; Ukpong and Abasiubong, 2010; Chambers et al., 2010). For the study, the Cronbach's α values for the four subscales were as follows: authoritarianism, 0.75; benevolence, 0.80; social restrictiveness, 0.80; and community mental health ideology, 0.85.

Recruitment procedures and Ethical Issues

The Ethical Review Board of Usmanu Danfodiyo University Teaching Hospital Sokoto, Nigeria, approved the study. Participants were recruited among students that came to the Main Hall of the University of Nigeria. The nature and purpose of the study were explained to the nurses. Participants were assured that their responses would be kept confidential. And that all the results would be presented as an aggregate. Voluntary consent was obtained before the questionnaires were given to every nurse recruited for the study for completion.

Data-collection procedures

The study was a cross-sectional design. Self-administered questionnaires were used to collect information from the nurses who consented to participate in the study. Many nurses in different internal hospital nursing positions that may involve working directly or indirectly daily with patients were approached to be part of the study. Nurses in the clinic, wards, critical care, anaesthesia care, oncology, etc., working with physicians, other nurses, and other hospital personnel in the two hospitals, were approached to be part of the study. However, 20 declined consent due to the demands of their duties, while five returned poorly completed questionnaires.

Data analysis

The data were analysed using Statistical Package for Social Sciences (SPSS), version 20.0. Descriptive frequency distribution was used to assess the distribution of nurses according to age, gender, marital status, religion, number of years as a registered nurse, work experience. Frequency distribution was also used to assess the psychiatry experience during basic nursing training, duration, and current position of the nurses. Nurses' Attitude and Knowledge of Mental Illness, and the distribution of Nurses According to the Scaling of their Attitude Towards Mental Illness were analysed. The four attitude factor scores were calculated by adding the ten relevant items for each factor and dividing by ten to arrive at the mean score. The scoring of each scale ranges from one (strongly disagree) to five (strongly agree). The distribution of the scores was reasonably normal on all four subscales. The four dependent variables, including authoritarian, benevolence, social restriction and community mental health ideology, were compared between two independent groups using the Student's t-test. The multiple linear regression analysis was performed to determine if the four subscales were associated with individual socio-demographic characteristics. The socio-demographic variables include age, gender, marital status, religion, number of years as a registered nurse, work experience, psychiatry experience during basic nursing training and duration, current position. The level of significance was set as $p<0.05$.

III. RESULTS

The data of 152 participants who correctly completed the questionnaires were analysed. Table 1 showed that 21 (13.8%) were males and 131 (86.2%) were females. The age group 30 – 39 years were in the majority, 60 (39.5%), and was followed by age groups 20-29, 46(30.3%). The median age of the participants was 33.0, and the age range was 20-58 years. One hundred and three (67.8%) of the participants were married, and 45(29.6%) were single. The professional status of the participants showed that the majority of the participants, 70(46.1%), occupied the position of Nursing Officers II and were followed by Chief Nursing Officers, 24(15.8%). Nursing Officer I cadre occupied the third position in the same order, 21(13.8). All but one, 151(99.3), had at least three weeks of psychiatry experience during basic nursing training.

Table 1: Distribution of Nurses According to Socio-demographic characteristics				
Variables		N	%	Median
Age (years)				
	Age Range			
	20-29	46	30.3	33.0
	30 – 39	60	39.5	
	40 – 49	33	21.7	
	50 – 58	13	8.6	
Gender				
	male	21	13.8	
	female	131	86.2	
Marital Status				
	Single	45	29.6	
	Married	103	67.8	
	Separated	3	2.0	
	Widow	1	.7	
Religion				
	Islam	2	1.3	
	Christianity	150	98.7	
Number of Years as a Registered Nurse				
	Age Range			
	0-9	73	48.0	10.0
	10-19	49	32.2	
	20-29	25	16.3	
	30-34	5	3.3	
Years of Work Experience Post Qualification				
	0-9	94	61.8	7.0
	10-19	34	22.4	
	20-29	21	13.8	
	30-34	3	2.0	
Had Psychiatry Experience during Basic Nursing Training				
	Yes	151	99.3	
	No	1	0.7	
Duration of Psychiatry Experience During Basic Nursing Training				
	0 week	1	0.7	
	3 weeks - 8 weeks	110	72.4	
	9 weeks - 14 weeks	31	20.4	
	21 weeks - 26 weeks	10	6.6	
Current Position				
	Nursing Officer II	70	46.1	
	Nursing Officer I	21	13.8	
	Senior Nursing Officer	18	11.8	
	Principal Nursing Officer	14	9.2	
	Assistant Chief Nursing Officer	5	3.3	
	Chief Nursing Officer	24	15.8	

Table 2 showed that a remarkable number, 123(80.9%), of the respondents agreed that mental hospitals are outdated for treating the mentally ill. And almost the same number 121(79.6%) agreed that the best therapy for many people with a mental health condition is to be part of a normal community. Furthermore, 124(81.6%) of the respondents agreed on a need to adopt a far more tolerant attitude toward the mentally ill in our society. However, a more significant number, 126(82.9%) of the respondents, disagreed that people with mental health problems should be encouraged to assume normal life responsibilities. Almost the same number, 124(81.6%) disagree that the mentally ill should not be denied their individual rights.

Table 2. Nurses' Attitude and Knowledge of Mental Illness (N=152)				
		Disagree n (%)	**Agree n (%)**	**Neutral n (%)**
1	Mental patients need the same kind of control and discipline as a young child	56(36.8)	79(52.0)	17(11.2)
2	Mental illness is an illness like any other	39(25.7)	102(67.1)	11(7.2)
3	Less emphasis should be placed on protecting the public from the mentally ill	92(60.5)	46(30.2)	14(9.2)
4	Mental hospitals are an outdated means of treating the mentally ill	23(15.1)	123(80.9)	6(3.9)
5	Virtually anyone can become mentally ill	116(76.3)	25(16.4)	11(7.2)
6	More tax money should be spent on the care and treatment of the mentally ill	69(63.2)	25(16.4)	31(20.4)
7	We need to adopt a far more tolerant attitude toward the mentally ill in our society	19(12.5)	124(81.6)	9(5.9)
8	There are sufficient existing services for the mentally ill	26(17.1)	107(70.4)	19(12.5)
9	The mentally ill should not be denied their individual rights	124(81.6)	21(13.8)	7(4.6)
10	Mental patients should be encouraged to assume the responsibilities of normal life	126(82.9)	14(9.2)	12(7.9)
11	No one has the right to exclude the mentally ill from their neighbourhood	112(73.7)	24(15.8)	16(10.5)
12	The mentally ill are far less of a danger than most people suppose	47(30.9)	68(44.7)	37(24.3)
13	The best therapy for many mental patients is to be part of a normal community	18(11.8)	121(79.6)	13(8.6)
14	As far as possible, mental health services should be provided through community based facilities	27(17.8)	119(78.3)	6(3.9)
15	Locating mental health services in residential neighbourhoods does not endanger local residents	97(63.8)	36(23.7)	19(12.5)
16	Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services	85(55.9)	45(29.6)	22(14.5)

Nurses' attitude toward mental illness

Table 3 captured the mean scores on the four subscales that reflected the nurses' negative attitudes toward mentally ill patients. Note that the possible score on each subscale of CAMI ranged from 1.0 to 5.0. The "authoritarian" subscale had the highest scores (mean = 3.23; SD = 0.42) relative to the other subscales (the higher the score, the more unfavourable the attitude), suggesting that the nurses may have been viewing the mentally ill as being somewhat "inferior" needing a "coercive" strategy. The "social restrictive" subscale score (2.97 ± 0.35) was also on the higher side (the higher the score, the more unfavourable the attitude), suggesting "disapproval" of the mentally ill living in the immediate neighbourhood. The "benevolence" subscale score (3.01 ± 0.37) came after the score of the "authoritarian" subscale (the higher the score, the more positive the attitude), suggesting that the nurses may harbour more sympathetic views of those who have mental health problems. Finally, The "community mental health ideology" subscale score (2.72± 0.38) was also on the higher side (the higher the score, the more positive attitude.), suggesting their favourable disposition to accept the presence of the mentally ill in the neighbourhood.

Table 3: Distribution of Nurses According to the Scaling of their Attitude Towards Mental Illness					
Scale	**N**	**Mean**	**Std. Deviation**	**Median**	**Mode**
AUTHORITARIANISM	152	3.2329	.42062	3.2500	3.20
SOCIAL RESTRICTIVENESS	152	2.9664	.35115	2.9500	2.90
BENEVOLENCE	152	3.0118	.37185	3.0000	2.80
COMMUNITY MENTAL HEALTH IDEOLOGY	152	2.7243	.37856	2.7000	2.70

Multiple linear regression was run to predict each of the four attitudes composite scale (1) Authoritarianism, (2) Benevolence,(3) Social Restrictiveness, and (4) Community Mental Health Ideology), from age, gender, marital status, religion, duration of post-qualification, duration of post qualification work experience, present post, and received training in psychiatry. There was linearity as assessed by partial regression plots and a plot of studentised residuals against the predicted values. The assumption of normality was met, as assessed by a Q-Q Plot. Social Restrictiveness and Community Mental Health Ideology, two of the four variables (four attitudes composite scale), added statistically significantly to the prediction, $p < .05$. Regression coefficients and standard errors can be found in Table 4 (below).

The multiple linear regression analyses results suggest that the duration of post-qualification, duration of post-qualification work experience and duration of training in psychiatry during basic nursing were significantly associated with predicting the community mental health ideology. In contrast, gender was significantly associated with predicting social restrictiveness.

Table 4: Socio-Demographic Characteristics as Predictors of Attitudes Towards Mental Illness

Variable	Authoritarianism			Benevolence			Social Restrictiveness			Community Mental Health Ideology		
	B	SE_B	*B*	B	SE_B	*B*	B	SE_B	*B*	B	SE_B	*B*
Intercept (Constant)	1.977	.832		2.866	.741		1.834	.680		3.723	.704	
Age	-.004	.007	-.091	.004	.006	.085	.003	.006	.086	.004	.006	.087
Gender	.201	.104	.166	.025	.093	.023	.216	.085	.213*	.062	.088	.057
Marital Status	.040	.071	.053	-.084	.064	-.127	-.103	.058	-.164	-.073	.060	-.107
Religion	.288	.308	.078	-.215	.274	-.066	.223	.251	.073	-.471	.260	-.142
Duration of Training in Psychiatry During Basic Nursing	.002	.007	.028	.004	.006	.059	-.004	.006	-.060	.013	.006	.183*
Duration of post qualification	-.020	.013	-.392	.003	.012	.059	.000	.011	-.005	-.040	.011	-.888***
Duration of Post Qualification Work Experience	.016	.013	.311	.002	.012	.042	-.004	.011	-.090	.032	.011	.703**
Present Post	.039	.034	.171	-.012	.030	-.058	.043	.028	.226	.043	.029	.209
Received Training in Psychiatry	.352	.435	.068	.490	.387	.107	.312	.355	.072	-.240	.368	-.051

Note *$p < .05$ **$p < .01$ ***$p < .001$; B = Unstandardized regression coefficients; *B* = Standardized coefficients; SE_B = Standard error of the coefficients.

IV DISCUSSION

People with mental illness face a considerable amount of prevalent and persistent stigma globally (Subramaniam et al., 2017; Corrigan and Watson, 2002) due to negative attitudes toward those with mental illness. One of the many effects of stigmatising attitudes towards mental illness influences help-seeking and recovery (Wahl, 2012). The current study revealed a relatively high occurrence rate of negative attitudes among tertiary health care nurses towards people with mental illness. In Table 2, showing nurses' attitude and knowledge of the mental illness, 9 out of the 15 items showed negative attitude among tertiary health care nurses towards people with mental illness, and similar finding has been reported in previous studies (Chambers et al., 2010; Caldwell and Jorm, 2000; Jorm et al., 1999). However, 67% to 81% of the nurses showed a positive attitude towards mental illness in 6 out of 15 items in Table 2. And similar finding has been reported in a previous study (Sujaritha et al., 2017). The negative attitudes of healthcare professionals, especially nurses, have been known to worsen people's mental health problems and can seriously affect their chances of recovery (Sartorius, 2007; Wang et al., 2005).

The result showed that the "authoritarian" subscale had the highest score (the higher the score, the more unfavourable the attitude), suggesting that the nurses may have been viewing the mentally ill as being somewhat "inferior" needing a "coercive" strategy. The current finding is consistent with previous studies (Ikwuka et al., 2016). The cultural background that insists on conformity to the societal norm (Griffiths et al., 2006) may have contributed to the high authoritarian attitude in Igbo society, where manifestations of mental illness are mostly perceived as deviant behaviour.

In a cross-cultural study concerning five European countries, Lithuanian nurses were harbouring a more negative attitude, while Portuguese nurses had a more positive attitude. The attitude of the nurses may be attributed to the overall public attitudes toward mental illness in the Igbo society (Chambers et al., 2010). The authoritarian attitude may also be a proactive reaction to fear and perceived potential violence among people with mental illness, associated chiefly with the younger age group (Crisp et al., 2000; Pinfold et al., 2003. The majority of the participants (69.8%) in this study could be said to fall within the age range for young adults, 20 - 39 years old (Smith, 2018).

The result also showed that the "social restrictive" subscale score was also on the higher side (the higher the score, the more negative the attitude), suggesting social distancing and "disapproval" of the mentally ill living in the immediate neighbourhood. And similar findings have been reported in a previous study (Sujaritha et al., 2017). The social restrictiveness could be influenced mainly by stereotypes of dangerousness and unpredictability (Gureje et al., 2005; Shibre et al., 2001; Crabb et al., 2012; Grausgruber et al., 2007). And this could then be exacerbated by a cultural perspective that judges the gravity of psychiatric illness on behavioural grounds (Binitie, 1970) hence the belief that people with mental illness should be avoided or restricted (Ikwuka et al., 2016). The score on social restrictiveness does not fit in quite well with the Igbo traditional religion and culture, where ofo represents the religious symbol and the highest moral principle (Ajaebili et al., 2020). In Igbo society, it is perceived as a significant mark of strength, bravery and success for strong members to defend or lend support to the weak (Onwuejeogwu, 1986; Achebe, 1958).

The result also showed that the "benevolence" subscale score was also on the higher side (the higher the score, the more unfavourable the attitude), suggesting that the nurses may harbour more sympathetic views of those who have mental health problems. The score on the "benevolence" subscale signifies that the nurses may hold more sympathetic opinions of those who have mental health problems, which contrasts with a related study in India (Sujaritha et al., 2017). The interaction of culture and causal explanations play a considerable role in shaping attitudes towards people with mental illness.

In Igbo culture, mental illness, especially suicide, is seen as a sign of weakness. In Igbo society, it is a significant mark of strength, bravery and success for strong members to defend or lend support to the weak (Onwuejeogwu, 1986; Achebe, 1958). The culture and causal explanations could suggest that the nurses may harbour more sympathetic views of those who have mental health problems as seen in the "benevolence" subscale, as those with mental illness are perceived as weak. Also, in India, depression and psychosis were consistently associated with the belief that the problems are caused by personal weakness (Kermode et al., 2009).

The "community mental health ideology" subscale score was also on the higher side (the higher the score, the more positive attitude.), suggesting their favourable disposition to accept the presence of mental health services and people with mental illness in the immediate neighbourhood. Our finding also validates the Igbo culturally accepted attitude of "live and let live" (in which people tolerate the opinions and behaviour so that they can similarly tolerate theirs). And "being our brothers' keeper" (brother's keeper" references the Biblical story of Cain and Abel from the book of Genesis. It is commonly understood to mean being responsible for the welfare of a brother or other sibling or, by extension, other human beings in general). A previous study in India reported that the nurses were not receptive to mental health services and people with mental illness in the immediate neighbourhood (Sujaritha et al., 2017).

The study observed that gender predicted an increased risk of social restrictiveness, suggesting that people with mental illness are dangerous and should be avoided or restricted. And this is in line with the previous study that reported that gender was associated with social restrictiveness, with males being more social restrictive than females (Ikwuka et al., 2016). The duration of training in psychiatry during basic nursing was significantly associated with predicting the community mental health ideology among the participants, which has been reported in previous studies. Increasing the psychological component of general nurse training might lead to an increased sense of self-efficacy in providing care for patients who have physical and mental illnesses (Brinn, 2000).

Studies looking at registered nurses indicate that qualified nurses with higher levels of education and those with specialised psychiatric training have more positive attitudes than unqualified staff and those without any psychiatric training (Ikwuka et al., 2016; Brinn, 2000; Mavundla and Uys, 1997; Scott and Philip,1985). Brinn (2000) submitted that qualified staff feel more equipped to cope than non-qualified staff across all disease types. The effect of the length of the psychiatric component of training related to the degree of confidence the nurses would feel in managing different mental health conditions (Brinn, 2000). Qualified nurses who had more

experience in psychiatric nursing as part of the training are most likely to feel better equipped to care for patients with psychiatric diagnoses (Brinn, 2000).

Also, the duration of basic nursing post-qualification and post qualification work experience was significantly associated with predicting the community mental health ideology. A similar finding has been reported in a related study elsewhere that focused on the stigmatising attitudes of nurses towards people with mental illness in primary healthcare settings in Finland. In the survey, Ihalainen-Tamlander et al. (2016) found that the younger nurses or those without additional mental health training reported more fear, felt more endangered and wanted more segregation for people with mental illness than older nurses.

In an interventional study to improve community attitudes towards depression among University students in Singapore, Goh et al. (2021) reported that experience in a mental health field was associated with higher community mental health ideology scores (Goh et al., 2021). Slevin and Sines (1996) found that nurses who had undertaken more in-depth training and more experience caring for patients with challenging behaviour expressed positive attitudes towards them. Rohde (1996) supported this finding, noting that as nursing students spent more time with mentally ill patients, they ceased to see them as different and could concentrate on the commonalities between them. In time, the students felt less anxious and fearful when caring for these patients. Weller and Grunes (1988) found that nurses who spent more time staying with patients and less time on administrative tasks held more positive attitudes towards patients with mental illness.

Implications of the Study

Despite the high score on the "authoritarian" subscale, suggesting that the nurses may have been viewing the mentally ill as being somewhat "inferior" needing a "coercive" strategy, and the high score on the "social restrictive" suggests anti-community care and social distance. 124(81.6%) of the respondents agreed on a need to adopt a far more tolerant attitude toward the mentally ill in our society. On the contrary, they equally agree that the mentally ill should be denied their rights.

The "benevolence" subscale score was higher, suggesting that the nurses may harbour more sympathetic views of those with mental health problems. The "community mental health ideology" subscale score was also higher, suggesting their favourable disposition to accept the presence of the mentally ill in the neighbourhood. A significant number, 121(79.6%), agreed that the best therapy for many people with a mental health condition is to be part of a regular community.

Duration post-qualification, post-qualification work experience, and training in psychiatry during basic nursing were significantly associated with predicting the community mental health ideology. In contrast, gender was significantly associated with predicting social restrictiveness.

Despite almost all the nurses having at least three weeks of psychiatry experience during basic nursing training, many did not have a positive attitude toward patients with mental health conditions.

The negative attitudes among our nurses highlight a critical mental health issue requiring the media's attention in general and the health care providers, in particular.

The nurses may have felt inadequately prepared by their training to cope with nursing patients who have common comorbid mental health problems. This suggests, to some extent, that the longer the psychiatric component of the training, the better equipped the nurses found themselves to cope with the different disorders. For the ill-equipped nurses, nursing such patients elicits negative emotions such as fear, which may lead to patient segregation or abandonment.

Limitations

The study focused on nurses working in two university teaching hospitals in Enugu, Southeast Nigeria; therefore:

The study sample was selective rather than representative and cannot be generalised to the entire country or population of Southeast Nigeria.

Participants may not have revealed or correctly reported about themselves in a self-report survey. Social desirability bias could have influenced answers to sensitive questions about attitudes towards people with mental illness.

The cross-sectional design prevented us from drawing conclusions on causal relationships.

Previous studies suggested that people tended to have different attitudes towards different types of mental illnesses (Angermeyer and Dietrich, 2006). However, in our study, the participants were asked to answer the questionnaire based on the general term: `mental illness'. As a result, their responses depended on how they interpreted this term and thus might be inconsistent across the sample.

Recommendations

The study may have highlighted a greater and urgent need to facilitate in-service training for other less experienced staff.

Nurse training programmes should include a more significant psychological component.

Greater psychiatric experience might help equip the nurses better and give them confidence in dealing with patients with mental illness.

Additional mental health training could confirm knowledge and skills regarding mental health issues and positively impact attitudes to health care.

Future studies to be designed to address some of the deficiencies of the present work:

Such as replicating the study in different tertiary health institutions within Southeast Nigeria would improve the validity of the work for southeastern Nigeria.

V. CONCLUSION

Recent studies have shown that empathy has been seen as a critical resource for supporting the patient's recovery (Chung et al. 2013, Parvan et al., 2014). Person-centred care is also better practised if nursing staff place patients and their needs at the caregiving centre (Bellchambers & Pelling 2007). A work environment free of fear would also help ensure a future workforce in mental health. Training is a critical issue for capacity building among health care staff. To create more awareness programmes among health care workers about mental illness to eradicate the stigma of mentally ill and mental illness and give them confidence in dealing with patients with mental illness. Additional mental health training to staff could confer knowledge and skills regarding mental health issues and give the staff confidence in dealing with patients with mental illness. Such will lead to positive attitudes and help reduce the mentally ill and mental illness stigma.

Future studies could explore how culturally conceptualised stereotypes influence attitudes towards mental illness among nurses in tertiary healthcare in the Southeast.

Conflict of interest: The authors declare no conflict of interest.

REFERENCES

[1]. Abasiubong, F., Ekott, J. U., & Bassey, E. A. (2007). A comparative study of attitude to mental illness between journalists and nurses in Uyo, Nigeria. *African journal of medicine and medical sciences*, *36*(4), 345-351.

[2]. Achebe, C. (1958) *Things Fall Apart*. London: Penguin.

[3]. Ajaebili, N. C., Eze, O. C., & Omeje, P. U. (2020). Ofo: the tangible and intangible heritage of the Igbo of South-eastern Nigeria. *International Journal Of Intangible Heritage*, *15*, 104-113.

[4]. Al-Awadhi, A., Atawneh, F., Alalyan, M. Z. Y., Shahid, A. A., Al-Alkhadhari, S., & Zahid, M. A. (2017). Nurses' attitude towards patients with mental illness in a general hospital in Kuwait. *Saudi journal of medicine & medical sciences*, *5*(1), 31.

[5]. Angermeyer, M. C., Holzinger, A., Carta, M. G., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: systematic review of population studies. *The British Journal of Psychiatry*, *199*(5), 367-372.

[6]. Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163-179.

[7]. Bairan, A., & Farnsworth, B. (1989). Attitudes toward mental illness: Does a psychiatric nursing course make a difference?. *Archives of Psychiatric Nursing*.

[8]. Barke, A., Nyarko, S., & Klecha, D. (2011). The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views. *Social psychiatry and psychiatric epidemiology*, *46*(11), 1191-1202.

[9]. Bellchambers H. & Pelling C. (2007) Person-centered approach to care (PCA): a philosophy of care and management for carers. Contemporary Nurse 26, 196–197.

[10]. Björkman, T., Angelman, T., & Jönsson, M. (2008). Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian journal of caring sciences*, *22*(2), 170-177.

[11]. Brinn, F. (2000). Patients with mental illness: general nurses' attitudes and expectations. *Nursing Standard (through 2013)*, *14*(27), 32.

[12]. Brockington IF, Hall P, Levings J, Murphy C. (1993). The community's tolerance of the mentally ill. The British Journal of Psychiatry, 162(1), 93–9.

[13]. Caldwell, T. M., & Jorm, A. F. (2000). Mental health nurses' beliefs about interventions for schizophrenia and depression: a comparison with psychiatrists and the public. *Australian & New Zealand Journal of Psychiatry*, *34*(4), 602-611.

[14]. Centers for Disease Control and Prevention (CDCP). (2012). Substance Abuse and Mental Health Services Administration, National Association of County Behavioral Health & Developmental Disability Directors, National Institute of Mental Health, Program TCCMH. Attitudes Toward Mental Illness: Results from the Behavioral Risk Factor Surveillance System. Atlanta (GA): Centers for Disease Control and Prevention.

[15]. Central Intelligence Agency (CIA). (2015). Calculation from percentage and overall population count of Nigeria. *CIA The World Factbook*.

[16]. Chambers, M., Guise, V., Välimäki, M., Botelho, M. A. R., Scott, A., Staniuliene, V., & Zanotti, R. (2010). Nurses' attitudes to mental illness: A comparison of a sample of nurses from five European countries. *International journal of nursing studies*, *47*(3), 350-362.

[17]. Chapman, D.P., Perry, G.S., & Strine, T.W. (2005). The vital link between chronic disease and depressive disorders. Preventing Chronic Disease, 2(1). Available from http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm (accessed December 9, 2021).

[18]. Chung Y.-C., Kim H.-M., Lee K.-H., et al. (2013) Clinical characteristics of patients who have recovered from schizophrenia: the role of empathy and positive-self schema. Early Intervention in Psychiatry 7, 138–145.

[19]. Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical psychology review*, *30*(8), 907-922.

[20]. Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry*, *1*(1), 16.

[21]. Corrigan, P., & Bink, A. B. (2005). *On the stigma of mental illness* (pp. 11-44). American Psychological Association.

[22]. Couture, S., & Penn, D. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of mental health*, *12*(3), 291-305.

[23]. Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. British Journal of Psychiatry, 177, 4–7.

[24]. El-Gabalawy, R., Cox, B., Clara, I., & Mackenzie, C. (2010). Assessing the validity of social anxiety disorder subtypes using a nationally representative sample. Journal of Anxiety Disorders, 24(2), 244-249.

[25]. Goh, C. M. J., Shahwan, S., Lau, J. H., Ong, W. J., Tan, G. T. H., Samari, E., ... & Chong, S. A. (2021). Advancing research to eliminate mental illness stigma: an interventional study to improve community attitudes towards depression among University students in Singapore. *BMC psychiatry*, *21*(1), 1-12.

[26]. Griffiths, K. M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC psychiatry*, *6*(1), 1-12.

[27]. Gureje, O. Y. E., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *The British Journal of Psychiatry*, *186*(5), 436-441.

[28]. Horsfall, J., Cleary, M., & Hunt, G. E. (2010). Stigma in mental health: Patients and professionals. *Issues in mental health nursing*, *31*(7), 450-455.

[29]. Ihalainen-Tamlander, N., Vähäniemi, A., Löyttyniemi, E., Suominen, T., & Välimäki, M. (2016). Stigmatizing attitudes in nurses towards people with mental illness: A cross-sectional study in primary settings in Finland. *Journal of Psychiatric and Mental Health Nursing*, *23*(6-7), 427-437.

[30]. Ikegwu, J. U. (2018). Ofo as a Global Cultural Resource and Its Significance in Igbo Culture Area. *Retrieved from Academia. com*.

[31]. Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyebode, F., & Muomah, R. C. (2016). Attitude towards mental illness in Southeastern Nigeria: the contradictions of a communitarian culture. *Journal of Community Psychology*, *44*(2), 182-198.

[32]. Institute of Medicine (IOM). (2012). Living well with chronic illness: A call for public health action. Washington, DC: The National Academies Press.

[33]. Jenkins, R., Lewis, G., Bebbington, P., Brugha, T., Farrell, M., Gill, B., & Meltzer, H. (1997). The National Psychiatric Morbidity surveys of Great Britain–initial findings from the household survey. *Psychological medicine*, *27*(4), 775-789.

[34]. Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. *Australian & New Zealand Journal of Psychiatry*, *33*(1), 77-83.

[35]. Labate, L. (Ed.). (2012). *Mental illnesses: understanding, prediction and control*. BoD–Books on Demand.

[36]. Lauber, C., Anthony, M., Ajdacic-Gross, V., & Rössler, W. (2004). What about psychiatrists' attitude to mentally ill people?. *European Psychiatry*, *19*(7), 423-427.

[37]. Lindsay, P. H., & Norman, D. A. (2013). *Human information processing: An introduction to psychology*. Academic press.

[38]. Ludvigsen, C. (1997). Enhancing nursemobility in Europe: a case for language skills. *Nurse Education Today*, *17*(2), 87-90.

[39]. Mavundla, T. R., & Uys, L. R. (1997). The attitudes of nurses' mobility in Europe–A case for language skills. *Nurse Educ Today*, *17*, 87-90;

[40]. McLaughlin, C. (1997). The effect of classroom theory and contact with patients on the attitudes of student nurses towards mentally ill people. *Journal of Advanced Nursing*, *26*(6), 1221-1228.

[41]. Mosaku, K. S., & Wallymahmed, A. H. (2017). Attitudes of primary care health workers towards mental health patients: a cross-sectional study in Osun state, Nigeria. *Community mental health journal*, *53*(2), 176-182.

[42]. Murray L, Lopez A (1996): The Global Burden of Diseases – Joint Publication of the World Bank and Harvard University. Cambridge, Mass.: Harvard University Press.

[43]. National Population Commission (NPC). (2013). *Nigeria demographic and health survey 2013*. National Population Commission, ICF International.

[44]. Nunnally Jr, J. C. (1961). Popular conceptions of mental health: Their development and change.

[45]. Odinka, P. C., Ndukuba, A. C., Muomah, R. C., Oche, M., Osika, M. U., Bakare, M. O., ... & Uwakwe, R. (2014). Positive and negative symptoms of schizophrenia as correlates of help-seeking behaviour and the duration of untreated psychosis in south-east Nigeria. *South African Journal of Psychiatry*, *20*(4), 166-171.

[46]. Onwuejeogwu, M. A. (1986). African indigenous ideology: Communal-individualism. University of Benin Inaugural Lecture, Series 24.

[47]. Parra, F. (1985). Social tolerance of the mentally ill in the Mexican American community. *International Journal of Social Psychiatry*, *31*(1), 37-45.

[48]. Parvan K., Ebrahimi H., Zamanzadeh V., et al. (2014) Empathy from the nurses' viewpoint in Teaching Hospitals of Tabriz University of Medical Sciences, Iran. Journal of Caring Sciences 3, 29–36

[49]. Pickens, J. (2005). Attitudes and perceptions. *Organizational behavior in health care*, *4*(7), 43-76.

[50]. Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H., & Graham, T. (2003). Reducing psychiatric stigma and discrimination–Evaluating an educational intervention with the police force in England. Social Psychiatry and Psychiatric Epidemiology, 38, 337–344.

[51]. President's New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Author. Available from http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf (accessed December 9, 2021).

[52]. Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The lancet*, *370*(9590), 859-877.

[53]. Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of psychiatric and mental health nursing*, *16*(3), 279-284.

[54]. Read, J., & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the'mentally ill'. *International journal of social psychiatry*, *45*(3), 216-229.

[55]. Repper, J., & Perkins, R. (2009). Recovery and social inclusion. *Mental health nursing skills*, 85-95.

[56]. Reta, Y., Tesfaye, M., Girma, E., Dehning, S., & Adorjan, K. (2016). Public stigma against people with mental illness in Jimma Town, Southwest Ethiopia. *PloS one*, *11*(11), e0163103.

[57]. Rohde D (1996) Uncovering a world of mental illness: an analysis in perceptual transformation in undergraduate nursing students. Archives of Psychiatric Nursing. 10, 6, 347-354.

[58]. Sharp T (1990) Unpopular psychiatric patients. Nursing Times. 86, 8, 65

[59]. Rüsch, N., Evans-Lacko, S. E., Henderson, C., Flach, C., & Thornicroft, G. (2011). Knowledge and attitudes as predictors of intentions to seek help for and disclose a mental illness. *Psychiatric Services*, *62*(6), 675-678.

[60]. Sartorius N. (2007) Stigma and mental health. Lancet, 370:810-1 Sartorius, N., & Schulze, H. (2005). *Reducing the stigma of mental illness: A report from a global association*. Cambridge University Press.

[61]. Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social science & medicine*, *67*(9), 1370-1381.

[62]. Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social science & medicine*, *56*(2), 299-312.

[63]. Scott, D. J., & Philip, A. E. (1985). Attitudes of psychiatric nurses to treatment and patients. *British Journal of Medical Psychology*, *58*(2), 169-173.

[64]. Sheikh, T. L., Adekeye, O., Olisah, V. O., & Mohammed, A. (2015). Stigmatisation of mental illness among employees of a Northern Nigerian University. *Nigerian medical journal: journal of the Nigeria Medical Association*, *56*(4), 244.

[65]. Slevin E, Sines D (1996) Attitudes of nurses in a general hospital towards people with learning disabilities, influences of control and graduate/ non-graduate status, a comparative study. Journal of Advanced Nursing. 24, 6, 1116-1126.

[66]. Smith, M. (2018). How young are "young people"? And at what age does a person become "old". Accessed December 2021 from https://yougov.co.uk/topics/politics/articles-reports/2018/03/06/how-young-are-young-people-and-what-age-does-perso

[67]. Subramaniam, M., Abdin, E., Picco, L., Pang, S., Shafie, S., Vaingankar, J. A., ... & Chong, S. A. (2017). Stigma towards people with mental disorders and its components–a perspective from multi-ethnic Singapore. *Epidemiology and psychiatric sciences*, *26*(4), 371-382.

[68]. Sujaritha, V., Partheeban, M., Thiviya, T., & Sowmiya, M. (2017). Attitude towards mental illness among doctors and nurses in a tertiary care centre, Pondicherry, India. *Int J Res Med Sci*, *5*(7), 3059-3064.

[69]. Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia bulletin*, *7*(2), 225-240.

[70]. Thornicroft G., Rose D. & Kassam A. (2007) Discrimination in health care against people with mental illness. International Review of Psychiatry 19, 113–122

[71]. Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiology and Psychiatric Sciences*, *17*(1), 14-19.

[72]. Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination?. *The British Journal of Psychiatry*, *190*(3), 192-193.

[73]. Ukpong, D. I., & Abasiubong, F. (2010). Stigmatising attitudes towards the mentally ill: A survey in a Nigerian university teaching hospital. *South African Journal of Psychiatry*, *16*(2), 56-60.

[74]. Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *The Lancet Psychiatry*, *3*(2), 171-178.

[75]. Wahl, O. F. (2012). Stigma as a barrier to recovery from mental illness. *Trends in cognitive sciences*, *16*(1), 9-10.

[76]. Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 603-613.

[77]. Weller L, Grunes S (1988) Does contact with the mentally ill affect nurses attitudes to mental illness? British Journal of Medical Psychology. 61, 3, 277-284.

[78]. World Health Organization (WHO), & International Council of Nurses (ICN). (2007). *Atlas: nurses in mental health 2007*. World Health Organization.

[79]. Yuan, Q., Abdin, E., Picco, L., Vaingankar, J. A., Shahwan, S., Jeyagurunathan, A., ... & Subramaniam, M. (2016). Attitudes to mental illness and its demographic correlates among general population in Singapore. *PloS one*, *11*(11), e0167297.