Attributions and Implications of Interpretive Models of Mental Illness in Southeastern Nigeria

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Abstract

Mental illness is a highly stigmatized illness with minimal resources allocated to it in Nigeria. Individuals as well as families suffer from the social implications of having mental illness which includes reduced access to social network and job opportunities. The level of stigma associated with mental illness in Nigeria is suggestive of a mindset indicating that mental illness is primarily caused by the individual. The current study investigated the perception and attributions of individuals residing in Enugu, Nigeria, about mental illness and its causes. A total of 44 respondents participated in the study. Results showed poor knowledge of causes of mental illness and negative attitude as well as social distance towards persons with mental illness. This calls for continual education of the public on the etiology, treatment, prognosis and nature of mental illness. The stigmatizing attitude towards mental health poses greater illness burden on persons with mental illness and suggests a need for advancement of anti-stigma projects in Nigeria.

Keywords: Mental Illness; Perception; Attitude; Attributions; Stigma; Social Distance.

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Introduction

Mental illness presents with double-barreled challenges because those affected by it also suffer from stigmatization in addition to the burden of the illness itself (Brockington, Hall, Levings, & Murray, 1993; Coringan & Watson, 2002; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). The greatest challenge in Nigeria is that crude methods of treatment of mental illness are still being used. These include chaining, flogging and attempting to use spiritual exorcism methods (personal observation). One Nigerian study of mental illness (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005) found that less than 10% of individuals with mental illness receive treatment and most of the services are provided by non-mental health specialist.

As with other countries, mental illness was ascribed to supernatural causes in the early centuries in Nigeria and treatments were provided by spiritualist and traditional healers whose roles were to drive away the evil spirit or demons possessing individuals with mental illness (Gureje et al., 2005). Till date, supernatural attributions continue to dominate explanatory models of mental illness in the country and spiritualist and traditional healers continue to be primary treatment options. Studies conducted by Adewuya and Makanjuola (2008) and Ukpong and Abasiubong (2010) showed that even medical professionals depict social distance towards persons with mental illness. The Mental Health Foundation of Lagos, Nigeria (n.d.) reported that there are only eight neuropsychiatric hospital in Nigeria to cater for the needs of approximately one million Nigerians with mental health disorders.

Reports in studies of mental illness in Nigeria indicate that the mere mention of the terms, mental health and mental illness, pull negative thoughts and statements from people (Adewuya & Makanjuola, 2008; Gureje et al., 2005). In some instances, families ignore their members who have severe mental illness and these people continue to roam the streets without treatment or any other life support such as food and shelter. On the streets, when they display aggressive behaviour, passers-by also ignore them. Some children when they see individuals with mental illness say unkind things to them such as "onye ara" (meaning mad person). Some pick up stones and throw at the unsuspecting victim (the person with mental illness). Studies have shown that individuals with mental illness experience harassments of varied dimensions (Berzins, Petch, & Atkinson, 2003; Kelly & Mckenna, 1997). Also, once diagnosed with mental illness, whether the illness was for a short duration as in pre or post partum psychosis or long duration as in Schizophrenia, individuals suffer from lifetime stigmatization. Members of their families also suffer with them because in most cases, those who consider themselves mentally well tend to display isolating behaviour towards such families. Getting married or jobs may become very difficult for the recovered individual and family members of current and recovered persons with mental illness (personal observation). Thus, the nation suffers loss of productive workforce due to mental illness.

Studies have shown that poor knowledge of the causes and treatment of mental illness contributes to people's vulnerability to stigmatization attitude. Studies from western regions of Nigeria have supported the findings of high level of social distance and stigma associated with mental illness in Nigeria (Adewuya & Makanjuola, 2008; Gureje et al., 2005; Ukpong & Abasiubong, 2010). The aim of the present study is to examine the perception and attitude of people towards those with mental illness in southeast Nigeria.

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Method

Procedure

This study was carried out in Enugu and participants were drawn primarily from students and staff representing varied southeastern states who were studying or working at a local private university in Enugu, Enugu State. Permission to conduct the study was obtained from the university management responsible for ethical conduct of research. All adults above 18 years of age within the sampled area were eligible to participate in the study. The researcher administered an informed consent to the respondents before giving them the study measures to complete. The participants could refuse or accept to participate in the study. Only participants who signed the informed consent were allowed to complete the study questionnaires.

Participants

This study surveyed 44 individuals. The sample was 45.5% female and 54.5% male. The mean age was 25.26 years, SD = 8.0. All but one participant had at least three years of university education.

Measures

The questionnaire used for the study comprised a section for demographical information, the Community Attitude Toward Mental Illness, the Mental Health Knowledge Schedule and the Reported and Intended Behaviour Scale.

Community Attitude Toward Mental Illness (CAMI; Taylor & Dear, 1981). The CAMI is a self-report inventory designed to measure people's attitude towards individuals with mental illness. The CAMI includes four subscales, authoritarian, benevolence, social restrictiveness, and community mental health ideology (Taylor, Dear, & Hall, 1979). The respondents were asked to rate each statement on a 5-point scale (strongly agree, agree, neither, strongly disagree, disagree). Previous studies indicate that the CAMI has acceptable reliability ranging from 0.68 to 0.88 and concurrent validity (Sevigny et al., 1999). Gureje et al. (2005) and Ukpong & Abasiubong (2010) had used the CAMI scale for studies in Nigeria.

Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010). MAKS was used to assess the mental health knowledge of respondents. The items are scored on an ordinal scale (1 to 5). Items in which the respondent strongly agrees with a correct statement have a value of 5 points while 1 point reflects a response in which the respondent strongly disagrees with a correct statement. “Don’t know” is coded as neutral (that is, 3) for the purposes of determining a total score. The total score for each participant was calculated by adding together the response values of each item. Items 1-6 were used to determine the total score. Items 7 to 12 were used to establish levels of recognition and familiarity with various conditions and also to help contextualize the responses to other items.

Reported and Intended Behaviour Scale (RIBS; Evans-Lacko et al., 2011). The RIBS is a measure of mental health stigma related behaviour that is based on *The Star Social Distance Scale,* which can be used with the general public. RIBS items 5-8 are scored on an ordinal scale (1-5). Items in which the respondent strongly agrees with engaging in the stated behaviour have a value of 5 while individuals who strongly disagree that they could engage in the stated behaviour receive 1 point. The total score for each participant is calculated by adding together the response values for items 5-8. ‘Don’t know’ is coded as neutral (i.e., 3) for the purposes of determining a total score. As items 1-4 only calculate the prevalence of behaviours and respondents may or may not have engaged in those behaviours, they are not given a score value.

Statistical Analysis

The data was analysed with the Statistical Package for Social Sciences (SPSS 20.0). Sample means and frequencies were examined for the causes of mental illness, social distance, attitude towards individuals with mental illness and treatment of mental illness.

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Results

Causes of Mental Illness

In terms of causes of mental illness, the most commonly cited cause of mental illness was use of drugs (72.7%) and drugs such as marijuana, cocaine, tramadol, rephnol, rochy, codine and heroine were indicated as the causes of mental illness. The next factor commonly endorsed by the participants was traumatic events (47.7%), followed by use of alcohol (43.2%). See Table 1 for participants' responses to all the possible causes in the questionnaire in frequency order. All the respondents endorsed multiple causes of mental illness.

Contact with People who have Mental Illness And Social Distance

The level of contact with individuals who have mental illness was assessed with RIBS items 1-4. 51.2% of the participants indicated that they are currently living with, or have lived with someone with a mental health problem. A quarter (15.9%) reported that they are currently working with, or have worked with someone with a mental problem. For the item that asks, "do you currently have or have you ever had, a neighbour with a mental health problem?", 59% of the participants responded affirmatively while 25% indicated that they currently have, or have had a close friend with a mental health problem. On the RIBS specific questions measuring social distance and stigma, results indicate that only 6.8% reported that they would be willing to live with someone with a mental health problem in the future, 13.6% indicated willingness to work with someone who had a mental health problem, 20.5% agreed that they would be willing to live nearby a person with mental illness and 31.8% reported willingness to maintain a friendship with a person who had mental illness.

Attitudes towards individuals with mental illness

The attitude of the participants towards mental illness varied across the 4 CAMI subscales. For the Authoritarian subscale, 75% agreed that individuals with mental illness should be controlled like young children, 68.2% agreed that there is something about persons with mental illness that makes them easily identifiable from normal people, 63.3% agreed that a person should be hospitalized as soon as signs of mental illness are noted (see Table 2). The results indicated strong benevolence attitude (Table 2). In the Restrictiveness subscale, 52.3% disagreed with the statement regarding women who were once patients in mental hospital being trusted as babysitters and 45.5% indicated that they would not want to live next door to someone who had had mental illness. The Community Mental Health Ideology subscale showed elevated negative attitude in four items. Sixty-eight percent of the participants agreed that having individuals with mental illness living in a residential area might be good therapy, but the risks are too great, 52.2% stated that mental health centres should be kept out of residential areas, 45.5% agreed that local residents have good reasons to resist the location of a mental hospital in their area and 43.2% agreed that it is frightening to think of people with mental problems living in residential neighbourhoods.

There were other questions included in the survey that were derived from the themes of *Rethink: Combating Stigma* DVD covering issues of employability, impact of mental health on physical health, housing and violence. These questions revealed conflicting attitudes. For example, 74.4% of the participants agreed that employment can help persons with mental health to stabilize but only 40% indicated that they would be likely to employ individuals who have had mental illness and 68.2% reported that they would fire the employee if they learn about his/her current mental illness. In terms of housing, 76.7% agreed that stable housing could help persons with mental illness but only 18.2% reported that they would rent their houses/apartments to individuals with mental illness. Regarding violence, 79.5% reported

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that individuals with mental illness are more likely to be victims of violence and 61.4% indicated that they likely to be perpetrators of violence.

Treatment of mental illness

The exploration of the types of treatments that are given to persons with mental illness indicated that 81.8% of the participants endorsed psychotherapy, 29.5% medicine, 25% spiritual exorcism and 22.7% other types of treatment. Participants were asked to explain other types of treatment and they wrote spiritual rehabilitation, praying to God, being close to the person with mental illness, mentoring, and making persons with mental illness happy. There were questions on treatment targeted towards participants who had mental illness included in the survey but due to low number of respondents with mental illness, these items were not analysed.

Discussion

The findings regarding causes and attitude to mental illness were consistent with those from Gureje et al. (2005), Kabir, Iliyasu, Abubakar, & Aliyu (2004) and Ukpong and Abasiubong (2010) studies. The results indicated that participants believed in a variety of causes of mental illness with use of drugs being the most commonly reported cause. The findings also suggested that participants hold negative view of mental health. It is surprising that these results were obtained despite the educational level of the respondents. With the exception of one participant, all others had received at least three years of university education.

Causes of Mental Illness

The most commonly reported cause of mental illness, use of drugs, supports the idea of inadequate knowledge of mental illness which could be linked to negative attitude towards persons with mental illness. Although the belief in use of drugs causing mental illness may be perceived by some individuals as a deterring factor in the use of drugs, this general belief may enhance the stigmatization of mental illness as a problem that people bring upon themselves for which they should suffer. This is because use of drug is perceived as a failure in morality and the norms of the society. Thus, if mental illness is considered as occurring primarily due to use of drugs, the society may display condemnatory attitude towards individuals with mental illness and fail to empathize and support the advancement of understanding and treatment of mental illness (Weiner, Perry, & Magnusson, 1988). The most frequently reported drug was marijuana (canabis) and its use is considered criminal in Nigeria. Participants' report of cannabis as a primary drug of abuse related to emergence of mental illness may be portraying a commonly held view in Nigeria suggesting that most people with mental illness use cannabis or that those who use cannabis develop mental illness (Gureje et al., 2005). This type of view may be associated with linking criminality to mental health. This researcher received a list of inmates at the Enugu prisons and was surprised to find that the reason cited for a majority of the inmates was insanity and this shows the way the society treats persons with mental illness.

Although the world has moved largely to an understanding of the etiology of mental health that could be explained by biopsychosocial model, some of the respondents have continued to believe in a supernatural model (Odejide, Oyewunmi, & Ohaeri, 1989) which was the first model for the explanation of mental illness. This belief in supernatural causes is made visible by the participants' endorsement of spiritual attack, possession by the evil spirit and God's punishment as causes of mental illness. This type of mindset suggest that some Nigeria may approach the treatment of mental illness from spiritual strategies that are purely religiously-based (Gureje et al., 2005). The endorsement of spiritual exorcism for the treatment of mental illness supports this notion.

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Contact and social isolation

The results indicating that the participants prefer social distance to persons with mental illness noted in both the RIBS and the Community Mental Health Ideology subscale of the CAMI shows that many people are not comfortable with socializing with those who have mental illness. As noted by Gureje et al. (2005), the closer the intimacy or contact required for communication, the more individuals would seek for social distance. Only 6% indicated that they would be willing to live with persons who have mental illness. The findings of high level of unwillingness to offer employment or rent accommodation space to individuals with mental illness also indicate an attitude of seeking social distance from persons who have mental illness. This type of attitude is apt to produce a lack of adequate knowledge of persons with mental illness. It has been noted that interaction is one way of reducing prejudice, stereotype and stigma. The continual social distance towards persons with mental illness will serve to prolong the lack of adequate knowledge of mental illness and its stigmatization.

Attitude to people with mental illness

The elevated negative attitude towards mental health noted in this study indicates the level of tolerance individuals might have for persons with mental illness. Beliefs such as people with mental illness need the same kind of control as young children, may undermine the rights of person with mental illness if they are given this type of treatment. Also disagreeing with the notion that mental illness is an illness like any other could heighten differential treatment of persons with mental illness. For example when someone is diagnosed with a physical illness like malaria, they may not suffer employment or housing adverse effect but as noted in this study a diagnosis of mental illness is more likely to lead to a loss of employment and stable housing. Thus, it is apparent that individuals with mental illness carry the additional burden of stigmatization. This finding is consistent with results from studies done in other parts of the country and the world (Gureje et al., 2005; Shibre et al., 2001; Thara & Srinivasan, 2000; Ukpong & Abasiubong, 2010).

Limitations

The results of this study should be interpreted with caution as it represents the views of southeastern Nigeria. Ayorinda, Gureje, & Lawal (2004) had noted the diverse nature of Nigeria and varying levels of access to mental health in different areas of Nigeria. In addition, because of the small sample size, certain variables that could have been examined were not explored. It is suggested that subsequent studies should endeavour to use a large sample size and include persons who have had or are currently having mental illness. Other studies conducted in other parts of the country produced similar results and therefore suggest that findings indicating poor knowledge of mental health and negative attitude towards persons with mental illness may not be circumscribed to the southeastern region of Nigeria.

Conclusion

This study found that poor knowledge of mental health is still prevalent in Nigeria. Most commonly reported cause of mental illness was use of drugs. Negative or conflicting attitude has continued to impact mental illness. It is very surprising that the respondents recognized the need for employment and stable housing for individuals with mental health and yet were unwilling to employ or rent house/apartment to them. This shows that benevolent attitude may not translate to positive action to advance the cause of mental illness in Nigeria. This calls for continual education of the public on the etiology, treatment, prognosis and nature of mental illness. The stigmatizing attitude towards mental health poses greater illness burden on persons with mental illness and suggests a need for advancement of anti-stigma projects in Nigeria. There is also a great need to develop a mental health policy in Nigeria to guide work in this

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area.

References

Adewuya, A.O., & Makanjuola, R.O. (2008). Social distance towards people with mental illness in southwestern Nigeria. *Australian and New Zealand Journal of Psychiatry, 42*(5), 389-395. DOI: 10.1080/00048670801961115

Ayonrinde, O., Gureje, O., & Lawal, R. (2004). Psychiatry research in Nigeria: bridging tradition and modernisation. *British Journal of Psychiatry, 184*, 536-538. DOI: 10.1192/bjp.184.6.536

Berzins, K.M., Petch, A., & Atkinson, J.M. (2003). Prevalence and experience of harassment of people with mental health problems living in the community. *British Journal of Psychiatry, 183*, 526-533. DOI: 10.1192/bjp.183.6.526

Bhugra, D. (1989). Attitudes toward mental illness: A review of the literature. *Acta Psychiatrica Scandinavica, 80*, 1-12. DOI: 10.1111/j.1600-0447.1989.tb01293.x

Brockington, I.F., Hall, P., Levings, I., & Murray, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry, 162*, 93-99. DOI: 10.1192/bjp.162.1.93

Corrigan, P.W., & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*, 16-20. DOI: 10.1016/j.psychres.2011.05.024

Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I., & Rowlands, O.J. (2000). Stigmatization of people with mental illness. *British Journal of Psychiatry, 177*, 4-7.

Evans-Lacko, S., Little, K., Meltzer H., Rose, D., Rhydderch, D., Henderson, C., & Thornicroft, G. (2010). Development and psychometric properties of the Mental Health Knowledge Schedule (MAKS). *Canadian Journal of Psychiatry, 55*, 440-448.

Evans-Lacko, S., Rose, D., Little, K., Rhydderch, D., Henderson, C., Thornicroft, G., (in press). Development and psychometric properties of the Reported and Intended Behaviour Scale (RIBS), *Epidemiology and Psychiatric Sciences*. DOI:10.1017/s2045796011000308

Gureje, O., Lasebikan, V., Ephraim-Oluwanuga, O., Olley, B.O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *British Journal of Psychiatry, 186*, 436-441. DOI:10.1192/bjp.186.5.436

Gureje, O., Odejide, O.A., & Acha, R.A. (1995). Pathways to psychiatric care in Ibadan, Nigeria. *Tropical and Geographical Medicine, 47*, 125-129.

Kabir, M., Iliyasu, Z., Abubakar, I.S., & Aliyu, M.H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights, 4*, 11-15. DOI: 10.1186/1472-698x-4-3

Kelly, L., & Mckenna, H. (1997). Victimization of people with enduring mental illness in the community. *Journal of Psychiatric and Mental Health Nursing, 3*, 185-191. DOI:10.1046/j.1365-2850.1997.00054.x

Odejide, O.A., Oyewumi, K.L., & Ohaeri, J.U. (1989). Psychiatry in Africa: An overview. *American Journal of Psychiatry, 146*, 708-716.

Sevigny, R., Yang Wenying, Zhang Peiyan, Marleau, J.D., Yang Zhouyun, Su Lin, … Wang Haijun (1999). Attitudes toward the mentally ill in a sample of professionals working in a psychiatric hospital in Beijing (China). *International Journal of Social Psychiatry*, *45*(1), 41-55. DOI: 10.1177/002076409904500106

Shibre, T., Negash, A., Kullgren, G., Kebede, D., Alem, A., Fekadu, A., … Jacobsson, L. (2001). Perception of stigma among the family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. *Social Psychiatry and Psychiatric Epidemiology, 36*, 229-303. DOI: 10.1007/s001270170048

Taylor, S.M., & Dear, M.J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7*, 225-240. DOI: 10.1093/schbul/7.2.225

Thara, R., & Srinivasan, T.N. (2000). How stigmatizing is schizophrenia in India? *International Journal of Social Psychiatry, 46*, 135-141. DOI: 10.1177/002076400004600206

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

Weiner, B., Perry, R.P., & Magnussan, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55*, 738-748. DOI: 10.1037/0022-3514.55.5.738

Table 1. Participants' Reported Causes of Mental Illness

Reported Cause	No	%
Use of Hard Drugs	32	72.7
Traumatic Events	21	47.7
Use of Alcohol	19	43.2
Stress	18	40.9
Genetic Inheritance	18	40.9
Spiritual Attack	10	22.7
Physical Illness	10	22.7
Physical Abuse	10	22.7
Possession by Evil Spirit	9	20.5
Poverty	6	13.6
Other Causes	6	13.6
Witches	4	9.1
God's Punishment	3	6.8

*** Participants endorsed multiple causes.

Table 2. Attitude Towards the People with Mental Illness

Community Attitude Toward Mental Illness (CAMI) Items	N	%
CAMI Authoritarian Subscale		
	21	47.7
Large mental hospitals are an outdated means of treating the mentally ill	30	68.2
(strongly disagree/disagree)	14	31.8
There is something about the mentally ill that makes it easy to tell them from normal	33	75
people (strongly agree/agree)	28	63.6
Less emphasis should be placed on protecting the public from the mentally ill	25	56.8
(strongly disagree/disagree)	15	34.1
Mental patients need the same kind of control as young children (strongly agree/agree)	12	27.3
A person should be hospitalised once he shows signs of mental illness (strongly	5	11.3
agree/agree)	6	13.6
Mental illness is an illness like any other (strongly disagree/disagree)		
Lack of self-discipline and willpower is one of the main causes of mental illness (strongly agree/agree)		
Keeping them behind locked doors is one of the best ways to handle the mentally ill (strongly agree/agree)		
Virtually any one can become mentally ill (strongly disagree/disagree)		

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The mentally ill should not be treated as outcasts from society (strongly disagree/disagree)		
CAMI Benevolence Subscale		
The mentally ill are a burden on society (strongly agree/agree)	13	29.5
	9	20.5
It is best to avoid anyone who has mental problems (strongly agree/agree)	4	9.1
	3	6.8
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for (strongly disagree/disagree)	4	9.1
	11	25.0
More tax money should be spent on the care and treatment of the mentally ill (strongly disagree/disagree)	0	0
	0	0
The mentally ill do not deserve our sympathy (strongly agree/agree)	1	2.3
	8	18.2
The mentally ill have for too long been the subject of ridicule (strongly disagree/disagree)		
We have a responsibility to provide the best care for the mentally ill (strongly disagree/disagree)		
We need to adopt a more tolerant attitude towards the mentally ill in our society (strongly disagree/disagree)		
Increased spending on mental health services is a waste of tax money (strongly agree/agree)		
There are sufficient existing mental health services in Nigeria (strongly agree/agree)		
CAMI Social Restrictiveness Subscale		
The mentally ill should be denied their individual rights (strongly agree/agree)	3	6.8
	23	52.3
Women who were once patients in a mental hospital can be trusted as babysitters (strongly disagree/disagree)	14	31.8
	14	31.8
The mentally ill should not be given any responsibility (strongly agree/agree)	10	22.7
	20	45.5
Anyone with a history of mental illness should be excluded from taking public office (strongly agree/agree)	3	6.8
	9	20.5
The mentally ill are far less of a danger than most people suppose (strongly disagree/disagree)	3	6.8
	3	6.8
I would not want to live next door to someone who has been mentally ill (strongly agree/agree)		
The mentally ill should be isolated from the rest of the community (strongly agree/agree)		
No one has the right to exclude the mentally ill from their neighborhood (strongly disagree/disagree)		
Mentally ill patients should be encouraged to assume the responsibility of normal life (strongly disagree/disagree)		
A woman would be foolish to marry a man who has suffered from mental illness, though he seems fully recovered (strongly agree/agree)		
CAMI Community Mental Health Ideology Subscale		

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Having mental patients living in a residential area might be good therapy, but the risks are too great (strongly agree/agree)	30 19	68.2 43.2
It is frightening to think of people with mental problems living in residential neighbourhoods (strongly agree/agree)	23 16	52.3 36.4
Mental health centres should be kept out of residential areas (strongly agree/agree)	20	45.5
Locating mental health services in residential neighbourhoods does not endanger local residents (strongly disagree/disagree)	9 10	20.5 22.7
Local residents have good reasons to resist the location of a mental hospital in their area (strongly agree/agree)	5 9	11.4 20.5
Residents have nothing to fear from people coming into their area to receive mental health treatment (strongly disagree/disagree)	7	15.9
The best therapy for many mental health problems is to be part of a normal community (strongly disagree/disagree)		
As far as possible, mental health services should be provided through community-based facilities (strongly disagree/disagree)		
Locating mental health facilities in residential areas downgrades the neighbourhood (strongly agree/agree)		
Residents should accept location of mental health facilities in their neighbourhood to serve the needs of the local community(strongly disagree/disagree)		

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