Attitude of Parents to Childhood Psychiatric Disorders in Nigeria

Zaharaddeen Garba Habib[1,2]

[1]Department of Psychiatry, Faculty of Clinical Sciences, College of Health Sciences, Bayero University, Kano, Nigeria
[2]Aminu Kano Teaching Hospital, Kano, Nigeria
Email: zghabib@yahoo.com

Abstract

Background: Many community and hospital based studies have found high prevalence of childhood psychiatric morbidity in the community and hospital. However, it has been noticed that few children are presented to hospital by parents with complaints related to psychological or emotional disturbances. This may be due to stigma and discrimination attached to mental illness including those of children. **Aim:** This part of the study set out to assess the attitudes of parents to childhood psychiatric disorders. It also set out to reveal what factors were associated with attitude and predictors of positive or negative attitude. **Methodology**: A cross-sectional study was carried out where parents were interviewed and the sociodemographic features of the child, parents and family were elicited. The study was carried out at Murtala Muhammad Specialist, hospital, Kano, Nigeria within a three months period. The child was assessed for psychological disorder with the Reporting Questionnaire for children. Parent's attitude was assessed with a modified community attitude towards the mentally ill scale, (CAMI). **Result**: A total of two hundred and three subjects (203) were involved in the study. Most (78.3%) parents had negative attitude to childhood psychiatric disorders while only (13.8%) had positive attitude. Parents who classified a child as having a psychological component to their illness were more likely to exhibit positive than negative attitude (83.3% vs. 16.7%, X^2 = 22.75, d.f = 1, p = 0.0002). Those with positive attitude were more likely to be mothers than fathers (71.4% vs. 28.6%; X^2 = 4.78, d.f = 1, p = 0.04). Those with a family history of psychiatric illness were more likely to exhibit positive than negative attitude. (58.3% vs 41.7%; X^2 = 18.94, d.f = 1, p = 0.0003). A child's father being of lower social class predicted positive attitude. No variable predicted negative attitude. **Conclusion**: Most parents had negative attitude to psychiatric disorders in children. The study advocated health education and enlightenment programmes to enhance mental health literacy for parents so that they could de-

velop a more positive attitude to psychiatric disorders including childhood psychiatric disorders which will lead to reduction in childhood psychiatric disorders and later adversities.

Keywords

Attitude, Childhood Psychiatric Disorders, Parents, Nigeria

1. Introduction

Illness is seen by some as a "social deviance". Jones and Jones [1] stated that the diagnoses of medical conditions are not "biological acts" peculiar to mice and monkeys but "social acts" peculiar to humans. Illness, they stated, may be biological in origin but the idea of illness is social and so also is the way human beings respond to it .Thus, "biological deviance" or "disease" is defined socially and is surrounded by social acts that condition it. Jones and Jones [1] stated that deviant behaviour is any behaviour that fails to meet some specified standard that is locally or culturally expected by a society, social group or system. They also highlighted four perspectives to explain illness deviance, social pathology, social disorganization, value conflict and labelling theory. Scheff [2] applied the labelling theory to mental illness as a theory of mental disorder in which utilized symptoms are considered labelled violations of social norms and stable "mental illness" to be a social role. The theory suggests that different cultures may have different stereotypes of mental illness. This is because others within those cultures react toward the potential patient in a uniform way which leads the patient to act in the expected role and thus tends to validate the original stereotype.

Multiple studies in Nigeria have found prevalence of childhood psychiatric disorders to be between 10% - 37% [3]-[10] in community studies. However, hospital based studies has found that most of the children brought to hospital for treatment consist of those with brain damage, severe mental retardation, epilepsy, psychosis and conduct disorder [11] [12]. Childhood psychiatric disorders have been shown to be associated with impairments and 7.1% were functionally impaired. Amongst children, those with psychiatric disorders were more functionally impaired than those without. This highlights the importance of this disorders not only in children but there subsequent impact on adult life [13].

The World Health Organization (WHO) has described stigma as a mark of shame, disgrace or disapproval that results in an individual being shunned or rejected by others [14]. The World Health Organization states that stigma and discrimination associated with mental illness has been strongly associated with suffering, disability and poverty. It lowers access of sufferers to resources and opportunities such as housing and employment and leads to diminished self-esteem and greater isolation and hopeless life and also has implication for helping seeking behaviour [15]. A review article of attitude toward mental illness [16] opined that throughout history mental illness and treatment of the mentally

ill have evoked a lot of emotions. The attitude to the mentally ill has reflected the prevailing situation at the time. Bhugra [16] showed that a lot of people in Europe and America had a lot of rejecting attitudes toward the mentally ill and tendency to restrict social interactions with the mentally ill. Binitie, [17] in Nigeria showed that educated Nigerians felt the mentally ills were worthless, dirty, dangerous, cold and unpredictable. He also showed that as relationship became more intimate they were less willing to interact with the mentally ill. Judgements were based mostly on behavioural observations. A study [18] showed that primary health care workers were poorly enlightened about mental health problems and many held negative attitude towards the mentally ill. It has been shown that knowledge may play a significant role in shaping attitudes which in turn could determine responses to particular situations or circumstances. [19] Literacy was found to be significantly associated with positive attitude towards the mentally sick. However, the relationship between stigmatizing opinions and lack of knowledge of mental illness is not direct, even among mental health service providers [19] [20] [21].

A study [22] near the locality where this study was carried out amongst 250 adults found that almost half of the respondents harboured negative feelings towards the mentally ill. Literate respondents were seven times more likely to exhibit positive feelings towards the mentally ill as compared to non-literate subjects. A study carried out in Kano, Nigeria [23] amongst relatives of patients on admission with mental illness found nearly 35% of the interviewed relatives agreed that mentally ill person should not be allowed to make decisions, even those concerning routine events. Males significantly agreed more than females (p = 0.013), over 65% of the relatives agreed that they could maintain a friendship with mentally ill person. Out of the interviewees, 27.1% agreed that they could marry someone with a mental illness. Nearly 30% of the respondents held the idea that they would not want people to know if they are diagnosed with mental illness. Less educated strongly agreed that they will hide their diagnosis of mental illness compared to highly educated ones (p = 0.001). However, more than 35% of the respondents stated that they will be ashamed if one of their family members is diagnosed with mental illness. A most recent survey in Nigeria [24] found poor perception about mental health persists, majority of the respondents (69%) said they would not engage in any relationship with someone who has a mental health disorder.

A study in north central Nigeria [25], on health workers attitude towards children and adolescents with mental illness in a teaching hospital found Some of the responses suggest significant negative attitudes towards children and adolescents with mental illness as 42% of the participants did not think that children and adolescent affected by mental illness should be allowed to play with other children, 30% did not believe affected children and adolescents can be friendly, or eventually get married. Thirty-eight per cent would feel ashamed if people knew a child in their family had mental illness, 41% would be concerned if their child invited a child or adolescent with mental illness to their birthday party, and

a similar proportion would be concerned if their child sat next to a child with mental illness in the class, or did homework together with an affected child or adolescent. Furthermore, 27% indicated they would be afraid to have a conversation with an affected child or adolescent. Mann–Whitney tests indicated that female health workers had significantly higher stigmatising attitudes towards them than males.

1.1. Objective

The study was carried out with a two part objective of assessing the knowledge and attitude of parents to childhood psychiatric disorders. This article reports on the Attitude aspect.

1.2. Aims

1) To determine the attitude of parents to child hood psychiatric disorders.

2) To determine the factors associated with attitude to childhood psychiatric disorders.

3) To determine the factors that predict attitude to childhood psychiatric disorders.

2. Methodology

The study was a cross sectional descriptive study conducted in Kano city, northern Nigeria. Kano had a population of 2,958,000 based on 2006 census while it has an estimated population of 3,906,000 in 2019 [26] [27]. It is a major cosmopolitan city in West Africa and a major centre of commerce. A large part of its population consists of the Hausa ethnic group with a significant population of other ethnic groups. The study was carried out at the Murtala Muhammad Specialist hospital which is a tertiary hospital owned by the state government and has been in existence for about a hundred years. It has a fully functional paediatrics department and the paediatrics clinic where the study was carried holds daily. Average attendance was 200 - 250 patients per day.

Sample Size:

Sample size required was calculated using the formula; [28] [29]

$$S = Z^2 P(1-P) / D^2$$

S = Sample size required at 95% confidence level

P = Prevalence of factor

(Self-referrals to institution, in this case 5%); [30]

D = Allowable error (3%)

$$S = 1.96^2 \times 0.05(1-0.05) / 0.03^2$$

$$S = 203$$

A set of criteria's were used in the study for selecting the subjects to be enrolled in the study, the following inclusion and exclusion criteria were adopted.

Inclusion Criteria:

1) All children brought by their parents to the paediatric outpatient department.

Exclusion:

1) All those children whom were too ill to participate in the study.

2) Those whose parents refused consent.

3) Those children accompanied by a caregiver not a parent who does not know the required information.

4) Those whom were accompanied by a care giver whom is also young.

2.1. Instruments/Questionnaire Used in the Study

1) Author designed questionnaire to gather information on reason for consultation and socio demographic features of the index child and his family.

2) The Community Attitude towards the Mentally Ill (CAMI) scale [31] is a 40-item a self-report inventory for measuring public attitudes towards the mentally ill. The CAMI includes four subscales (authoritarianism (AUTH), benevolence (BNVL), social restrictiveness (SRST) and community mental health ideology (CMHI)). Alpha coefficients were 0.63, 0.67, 0.64 and 0.60 for the AUTH, BNVL, SRST and CMHI subscales, respectively. Alpha coefficients for all 4 scales were above 0.60, indicating satisfactory though modest levels of reliability. The CAMI is an integration and adaptation of two validated scales. The opinion about Mental Illness scale (OMI) and The Community Mental Health Ideology (CMHI) Scale. The scale has been used in Nigeria [32] [33] [34].

3) Reporting questionnaire for children (RQC): It is a ten item questionnaire developed by the World Health Organization (WHO) where it identifies children with probable psychiatric morbidity. The response to each question is a "Yes" or "No". A minimum score of one identifies those with probable psychiatric disorder. The RQC has been found to have a sensitivity of between 73% - 97% and a specificity of between 61% - 81% [4] [5] [9].

An assessment of parent's knowledge/perception to childhood psychiatric disorders was made (Reported elsewhere).

2.2. Data Collection

The Research questionnaires were translated into Hausa language which is the local language. The Hausa questionnaire was back translated to English and a consensus of translation arrived at. The questionnaire was administered in Hausa to those parents whom could not understand English. Three other trained assistants were used in data collection. Statistical analysis was done using the statistical product and service solutions (IBM SPSS version 25) [35].

2.3. Pilot Study

A pilot study was carried out to determine the validity and reliability of the English and Hausa translated questionnaire. It involved two groups of 30 respon-

dents in each group; Psychiatric Nurses fluent in Hausa and English and parents matched for years of education with the nurses whom were also bilingual and have presented their children to the clinic. A test retest, inter-rater and split-half reliabilities were variously found to be 0.88, 0.97 and 0.71. The Psychiatric nurses had an Attitude score of 2.9 while the non-nurses had a score of 1.8. A statistical test of significance between the two scores found a p = 0.0001.

3. Results

A total of two hundred and three (203) children and their parents took part in the study.

3.1. Socio-Demographic Features of Index Children

There were two hundred and three children aged between 5 - 12 years. Mean 7.1 ± S.D 1.8 yrs. About 108 (53.2%) were in orthodox education, mean years of education 2.6 ± 1.5 yrs. 79 (38.9%) were in Islamic schools and 16 (7.9%) were not in any form of education. This is as reflected in Table 1.

Table 1. Socio-demographic features of index cases.

Total N = 203		
Variables		n (%)
Age (years)		
5 - 8		148 (72.9)
9 - 12		55 (27.1)
Educational level (years of Schooling)		
0		16 (7.9)
1 - 2		65 (32.0)
3 - 4		29 (14.3)
5 - 6		12 (5.9)
7 - 8		2 (1.0)
Islamic Only		79 (38.9)
Siblings		
Full	0 - 4	123 (60.6)
	5 - 8	63 (31.0)
	9 - 12	11 (5.4)
	12+	6 (3.0)
Half	0 - 4	141 (69.5)
	5 - 8	42 (20.7)
	9 - 12	16 (7.9)
	12+	4 (1.9)

3.2. Socio-Demographic Features of Parents and Families

Most of the parents were young, mean of 39.9 years and 33.3 years for fathers and mothers respectively. Most of the parents were Hausa/Fulani from the study area. Most of the parents were from the lower social class. More than 54.2% of the parents had some form of orthodox education as highlighted in Table 2. Half of the fathers were monogamous. Mean years of parenting was 9.3 years while over half had their children less than ten years. Only 6% of the children had a family history of psychiatric illness. This is reflected in Table 3.

Table 2. Socio-demographic features of parents.

N = 203			
		Fathers	Mothers
Variables		n (%)	n (%)
Age (Years)			
11 - 20		2 (1.0)	14 (6.9)
21 - 30		43 (21.2)	65 (32.0)
31 - 40		62 (30.6)	78 (38.4)
41 - 50		53 (26.1)	36 (17.7)
51 - 60		34 (16.7)	8 (4.0)
60+		9 (4.4)	2 (1.0)
Ethnicity			
Hausa/Fulani/northern		183 (90.1)	176 (86.7)
Others		19 (9.4)	27 (13.3)
Social Class			
Skilled/Class I		0 (0.0)	0 (0.0)
Intermediate/Class II		9 (4.4)	3 (1.5)
Semi-Skilled/Class III		108 (53.2)	37 (18.2)
Unskilled/ Class IV		67 (33.0)	140 (69.0)
Unemployed/Class V		17 (8.3)	23 (11.3)
Educational Level			
No Schooling		0 (0.0)	2 (1.0)
Primary School:	Not Completed	15 (7.4)	11 (5.4)
	Completed	25 (12.3)	51 (25.1)
Secondary School:	Not Completed	34 (16.7)	15 (7.4)
	Completed	24 (11.8)	17 (8.4)
Tertiary Education		12 (6.0)	0 0.0)
Islamic Only		93 (45.8)	107 (52.7)

Table 3. Socio demographic characteristics of families.

N = 203	
Variables	n (%)
Number of fathers wives	
0	4 (2.0)
1	113 (55.7)
2 - 4	86 (42.3)
Age of parents eldest living child (years)	
0 - 5	58 (28.6)
6 - 10	54 (26.6)
11 - 15	49 (24.1)
15+	42 (20.7)
Family history of psychiatric illness	
None	191 (94.0)
First degree relative	4 (2.0)
Second degree relative	4 (2.0)
Third degree relative	4 (2.0)

3.3. Characteristics of Illness and Hospital Consultation

Most (85.7%) of the children were accompanied by their mothers. Only 2(1%) of the children were perceived as having a psychological problems by the parent, 5 (2.4%) were perceived as having a combination of physical and psychological illness. The rest were perceived as having only physical illness as reflected in Table 4.

3.4. RQC Scores

The number of those with probable psychiatric cases was 39 (19.2%) based on their RQC score of one and above while the rest were non probable psychiatric cases as presented in Table 5.

3.5. Parents Attitude

Most (78.3%) parents had negative attitude to mental illness while only (13.8%) had positive attitude as presented in Table 6.

The positive attitude exhibited by parents of about 14% was mostly accounted for by five items parents positively evaluated to a varying degree. This is as presented in the barchart below, the items the parents held positive attitude to is as shown in Figure 1.

3.6. Further Analysis

1) Logistic regression analysis on variables that predicted positive attitude to mental illness: A child's father being of lower social class predicted positive
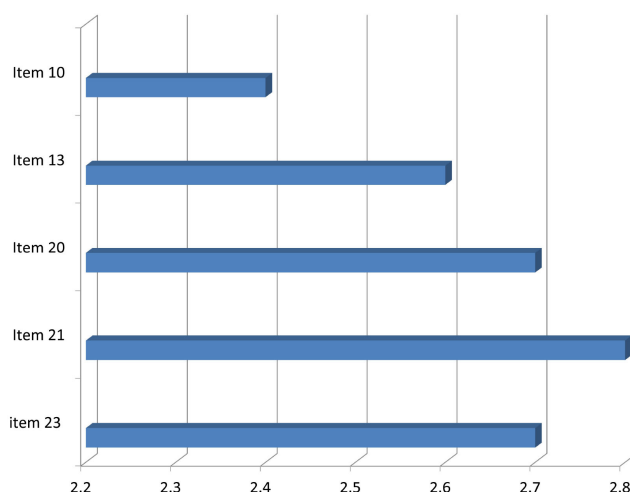
Figure 1. Statements parents' expressed positive attitude. Legend: Vertical axis: Item; horizontal axis: Mean scores of the items; Key: Parents expressed positive attitude by disagreeing with the statements. Item 10: Epilepsy may be transmitted by coming into contact with the saliva of an epileptic. Item 13: There is no hope that a mentally ill person roaming the street can ever be cured. Item 20: Mental illness in children is as a result of irresponsibility in the child. Item 21: Mental illness in children is best controlled by punishment. Item 23: Mental illness in children persists into adulthood.

Table 4. Characteristics of illness and hospital consultation.

Total N = 203	
Variables	n (%)
Gender of Accompanying Parent	
Mother	174 (85.7)
Father	29 (14.3)
Reason for Hospital Consultation	
Fever	63 (31.0)
Diarrhoea/vomiting/Stomach ache/Poor appetite	30 (14.8)
Malnutrition	16 (7.9)
Cough/Catarrh/respiratory problems	49 (24.1)
Rashes	15 (7.4)
Combination/other Complaints	30 (14.8)
Parent's Classification of Child's Illness.	
Psychological Only	2 (1.0)
Psychological and Physical	5 (2.4)
Physical Only	196 (96.6)

Table 5. Index children scores on the reporting questionnaire for children.

N = 203	
Variable	n (%)
RQC Scores:	
Non Probable Cases	164 (80.8)
Probable Cases	39 (19.2)
TOTAL	203 (100.00)

Table 6. Parents attitude to mental illness.

	N = 203	
Variable	n	%
Attitude to Mental Illness.		
Negative	159	78.3
Positive	28	13.8
Not Sure	16	7.9
TOTAL	203	100.00

attitude (r = 0.701, P = 0.040807). Good knowledge about factors contributory to the development of childhood psychiatric disorders also predicted positive attitude (r = 0.647, P = 0.0001) No variable predicted negative attitude as presented in Table 7.

2) Attitude to mental illness versus some variables: Parents who classified children as having a psychological component to his illness were more likely to exhibit positive than negative attitude (83.3% vs 16.7%, X^2 = 22.75, d.f = 1, P = 0.0002). Those with positive attitude were more likely to be mothers than fathers (71.4% vs 28.6%; X^2 = 4.78, d.f = 1, P = 0.04). Those with a family history of psychiatric illness were more likely to exhibit positive than negative attitude. (58.3% vs 41.7%; X^2 = 18.94, d.f = 1, P = 0.0003) as presented in Table 8.

3) Parents' knowledge versus Attitude to mental illness: Parents with poor knowledge were more likely to exhibit negative than positive attitude (84.2% vs 9.2%, X^2 = 22.45, d.f = 4, P = 0.00003) while parents with good knowledge were more likely to exhibit positive than negative attitude (75.0% vs 25.0%, X^2 = 22.45, d.f = 4; P = 0.00003) as presented in Table 9.

4. Discussion

1) Index child and families socio-demographic features: About half the children came from homes with a large family size *i.e.* having more than four sibling/half-siblings and this is usually what obtains in the study area [26] [27]. Many of the children were brought in by their mothers, this is usually due to the nurturing role of mothers and also the care of children including hospital presentations is left to mothers as observed in previous studies [36] [37] [38]. Most of the parents were young below 40 years; this is similar to Kano population profile. The education level of the parents was low, similar to the population profile probably due to the low acceptance of orthodox education. Mean years of parenting was 9.3 years.

2) Characteristics of hospital Consultation: Only few (3.4%) of the children were classified by the parents as having a psychological component to their illness. This classification by the parents may be due poor knowledge about childhood psychiatric disorders or as hypothesised by Ebrahimi *et al.* due to denial by parents in order to avoid labelling the child as having a psychiatric disorder because of social stigma attached to mental illness in the society [38]. Most of the

Table 7. Logistic regression analysis on variables that predicted positive attitude to mental illness.

Variable	Coefficient	std Error	T-Ratio	P value
Positive Attitude	−8.41557	1.68071	−5.00714	0.0000
Fathers class (Low social Class)	0.92849	0.32964	2.81669	0.0487
Knowledge of cont factors (Good knowledge)	1.87162	0.37873	4.94180	0.0001
Gender of accompanying parent (mother)	0.71458	0.58387	1.22388	0.22098

$X^2 = 39.5357$; df = 3.

Table 8. Attitude to mental illness versus some variables.

No. (Col. %) (Row. %)	Attitude		X^2	P value	FET
Variable	Negative	Positive			
Parent's classification of child's illness.					
Physical Only	158 (99.3) (87.3)	23 (82.1) (12.7)	22.75	0.0000018	0.0002922
Psychological	1 (0.7) (16.7)	5 (17.9) (83.3)			
Gender of accompanying parent.					
Mother	139 (87.4) (87.4)	20 (71.4) (12.6)	4.78	0.0287437	0.0419521
Father	20 (12.6) (71.4)	8 (28.6) (28.6)			
Family history of psychiatric illness					
None	154 (96.8) (88.0)	21 (75.0) (12.0)	18.94	0.0000135	0.0197314
Yes	5 (3.2) (41.7)	7 (25.0) (58.3)			

Table 9. Parents' knowledge versus attitude to mental illness.

No. (Row) (Col)	Knowledge			TOTAL
Variable	Poor	Not Sure	Good	
Attitude				
Negative	154 (84.2) (96.9)	2 (25.0) (1.3)	3 (25.0) (1.8)	159 (100.00) (87.19)
Not Sure	12 (6.6) (75.0)	4 (50.0) (25.0)		16 (100.00) (12.81)
Positive	17 (9.2) (60.7)	2 (25.0) (7.2)	9 (75.0) (32.1)	28
			12 (5.91)	203 (100.00)
TOTAL	183 (90.0)	8 (4.0)	12 (6.0)	203 (100.0)

$X^2 = 38.45$, d.f = 3, P = 0.000003311.

children were accompanied by their parent and help seeking behaviours of parents showed that mothers visited the medical centres more than fathers to get help for their children similar to what was found in other studies [37] [38]. The Reporting Questionnaire for Children (RQC) identified 19.2% of the children as those with probable psychiatric disorder the level of morbidity elicited by the RQC is comparable to what has been found in other community studies with rates between 10% - 22% [3]-[9] [11] [12] [13] [14] [30] [36] [37].

3) Parents Attitude to Mental illness and Predictor Variables: Majority of the parents expressed a negative attitude to childhood psychiatric disorders. This was similar to findings of other workers where a negative attitude to mental illness was found to be very high in the community [16] [17] [18] [39] [40]. This negative attitude might be due to lack of knowledge as observed by Wolff *et al.* [41]. Binitie [17] has shown that those with low level of education express a more negative attitude than those whom are educated. A study in Ethiopia found in that there was an increasing trend of positive attitudes with increased educational level among 9th, 10th, and 11th graders (*p*-trend < 0.0001) and with an increase in the educational level of the students father (*p*-trend = 0.028) [42]. They concluded that progress in educational level can inculcate a positive attitude and perception towards mental illness [42]. This was further collaborated by a study in Iran where, a significant relationship was observed between the education level of fathers and parents' attitudes toward method of treatment and the causes of mental disorders, so that 89% of fathers who had higher levels of education had better attitudes than the fathers who had lower levels of education. Indeed in Iran, it was found that 93.7% of parents had a good attitude toward mental illness of their children [38]. An almost similar study [43] in Egypt found that higher education predicted good knowledge of parents and it correlated positively with their attitude toward childhood mental disorders. In the present study as noted earlier most of the parents had low level of education which might have accounted for the negative attitude. In this study, there was no significant association between the genders of parents with the fields related to their attitudes toward mental illness. The positive evaluation of epilepsy might be due to the various health education programmes undertaken about epilepsy in the media. Most (75%) parents agreed that a mentally ill person roaming the street can be cured and also a lot (79%) of parents opined that mental illness in children does not persist into adulthood, this may be due to a social desirability response. Most parents (83%) felt mental illness is not due to irresponsibility in the child. This suggest the parents considered childhood psychiatric disorders to be due to external factors this was further supported when a large (87%) proportion of the parents disagreed with the phrase that mental illness is best controlled by punishment. Low social class in a father was predictive of positive attitude, this could be a spurious finding as not all classes were adequately represented and there was an over representation of the lower social classes. Most other studies [11] [40] have found low social class to be associated with negative attitude. The mother being the respondent showed a trend towards predicting positive at-

titude but this did not reach statistical significance. Some studies have found that being a female as the respondent predicted positive attitude [38] [39]. Parents with good knowledge were more likely to exhibit positive attitude, even though good knowledge did not predict positive attitude. This is similar to the finding of Wolff *et al.* [41] The finding in the present study may be because there are other confounding factors which mediate the relationship between knowledge and attitude as Wolff *et al.* [41] found that parents of children with psychiatric disorders may be knowledgeable about mental illness but express a negative attitude due to an accentuated weariness of the mentally ill because of their children's vulnerability. Those with a positive family history of psychiatric illness were more likely to exhibit positive than negative attitude. This was similar to findings in other studies [32], this is probably because the respondent has interacted with a relative who has a psychiatric illness and has acquired a more tolerant attitude towards the mentally ill. Indeed knowing somebody with a mental illness has been associated with more tolerance towards the mentally ill [31] [41]. The findings of this study are not surprising as even among health workers it has been shown that a negative attitude towards child and adolescent mental illness is predicted by poor knowledge and being from a non- medically professional group [25].

5. Limitations

1) The sample was skewed towards the lower social class. This limits generalisation of the findings.

2) The possibility of responses being influenced by social desirability response set especially on the Attitude responses.

6. Conclusion

Cultural and social growth and development of human resources depends on the health of society, and mental health is a key element of communities' health. Since children are the future builders of every society, the health of human societies is dependent on children's health. Mental disorders are among the most important risks threatening health of children; hence, on time recognition and appropriate actions by families to remedy the harmful effects of these disorder scan decrease the harms [38]. The study showed that most parents had negative attitude towards mental illness in children. A parent classifying his child as having a psychological illness, being a mother and a positive family history of psychiatric illness were more likely to be associated with positive attitude.

7. Recommendations

The evidence from the study presents the need for mental health literacy at all levels of education. A better understanding of mental illness would significantly improve knowledge and attitude towards mentally ill persons including childhood psychiatric disorders. There is an urgent necessity, to improve the health-

care system in Nigeria, by developing strategies that would improve mental health literacy, and change stigmatizing attitude at both institutional and community levels. This will in the long run improve the quality of the societal attitude towards mental illness and the socio-economy of the mentally ill [39]. Indeed, a Meta analytic study found evidence for the effectiveness of help-seeking interventions in terms of improving attitudes, intentions and behaviours to seek formal help for mental health problems among adults [44]. Mental health literacy programme should enlighten parents about mental illness in general and about childhood psychiatric disorders in particular, so that parents could be taught on how mental illness is no different from other illnesses and how like many other illnesses it can be managed. This may improve the knowledge, attitude and help seeking behaviour of parents for children with perceived psychiatric symptoms.

Acknowledgements

Conflicts of Interest

None.

References

[1] Jones, R.K. and Jones, P.A. (1975) Sociology in Medicine. English University Press, London, England.

[2] Scheff, T.J. (1974) The Labelling Theory of Mental Illness. *American Sociological Reviews*, **39**, 442-452. https://doi.org/10.2307/2094300

[3] Ohaeri, J., Odejide, O.A., Gureje, O. and Olatawura, M.O. (1991) Psychiatric Morbidity among Children Attending Facilities for Primary Health Care in a Rural Nigerian Community. Federal Ministry of Health, Abuja, Nigeria

[4] Abiodun, O.A. (1993) Emotional Illness in a Paediatric Population in Nigeria. *Journal of Tropical Paediatrics*, **39**, 49-51. https://doi.org/10.1093/tropej/39.1.49

[5] Omigbodun, O.O. (1991) Screening Children for Psychiatric Morbidity in Primary Care: Selecting an Appropriate Instrument. Dissertation to the West African Postgraduate Medical College for the Part II Examination of the Fellowship of the Medical College.

[6] Chukwujekwu, D.C. (2019) Patterns of Childhood and Adolescent Disorders at the University of Port Harcourt Teaching Hospital: A 3 Year Review. *Journal of Psychiatry and Psychiatric Disorders*, **3**, 23-30.

[7] Abubakar-Abdullateef, A., Adedokun, B. and Omigbodun, O. (2017) A Comparative Study of the Prevalence and Correlates of Psychiatric Disorders in *Almajiris* and Public Primary School Pupils in Zaria, Northwest Nigeria. *Child and Adolescent Psychiatry and Mental Health*, **11**, 29. https://doi.org/10.1186/s13034-017-0166-3

[8] Abiodun, O.A., Tunde-Ayinmode, M.F., Adegunloye, O.A., Ayinmode, B.A., Suly-

man, D., Unaogu, N.N., Saliu, R.O., Sajo, S., Salami, R.A., Jimba, M.K. and Agba-biaka, T. (2011) Psychiatric Morbidity in Paediatric Primary Care Clinic in Ilorin. *Journal of Tropical Paediatrics*, **57**, 173-178.
https://doi.org/10.1093/tropej/fmq072

[9]   Tunde-Ayinmode, M.F., Ayinmode, B.A., Adegunloye, O.A. and Abiodun, O.A. (2012) A Comparison of Two Screening Instruments in Detecting Psychiatric Morbidity in a Nigerian Paediatric Primary Care Service: Assessing Clinical Suitability and Applicability. *Annals of African Medicine*, **11**, 203-211.
https://doi.org/10.4103/1596-3519.102849

[10] Abdulmalik, J.O. and Sale, S. (2012) Pathways to Psychiatric Care for Children and Adolescents at a Tertiary Facility in Northern Nigeria. *Journal of Public Health in Africa*, **3**, e4. https://doi.org/10.4081/jphia.2012.e4

[11] Olatawura, M.O. and Odejide, O.A. (1976) Child Psychiatric Disorders in Ibadan, Nigeria. *Nigerian Journal of Paediatrics*, **3**, 9-14.

[12] Ringo, E.G. (1987) Childhood Psychiatric Disorders at Neuropsychiatric Hospital. Dissertation of the National Postgraduate Medical College of Nigeria for the Part II Examination of the Fellowship of the College, Aro, Abeokuta.

[13] Ogboghodo, E.O., Omuemu, V.O., Obarisiagbon, O.E., Olaniyi, K., Francis, I.B. and Michael, I.O. (2018) Pattern of Psychiatric Disorders among Young Persons' Attending Psychiatric Clinics in Benin City: Implications for Health.
https://www.ijcmph.com/index.php/ijcmph/article/view/2425
https://doi.org/10.18203/2394-6040.ijcmph20180225

[14] WHO (2001) The World Health Report. Mental Health: New Understanding; New Hope. Geneva, WHO. http://www.who.int/whr2001/2001/

[15] Corrigan, P.W. and Watson, A.C. (2002) Understanding the Impact of Stigma on People with Mental Illness. *World Psychiatry*, **1**, 16-20.

[16] Bhugra, D. (1989) Attitudes towards Metal Illness. A Review of the Literature. *Acta Psychiatrica Scandinavia*, **80**, 1-12.
https://doi.org/10.1111/j.1600-0447.1989.tb01293.x

[17] Binitie, A.O. (1970) Attitude of Educated Nigerians to Psychiatric Illness. *Acta Psychiatrica Scandinavia*, **46**, 391-398.
https://doi.org/10.1111/j.1600-0447.1970.tb02128.x

[18] Ogunlesi, A.O. and Adelekan, M.L. (1988) Nigerian Primary Health Care Workers: A Pilot Survey on Attitude to Mental Health. *Psychological Bulletin*, **12**, 441-443.
https://doi.org/10.1192/pb.12.10.441

[19] Madianos, M.G., Priami, M., Alevisopoulos, G., Koukia, E. and Rogaku, E. (2005) Nursing Students' Attitude Change towards Mental Illness and Psychiatric Case Recognition after a Clerkship in Psychiatry. *Mental Health Nursing*, **26**, 169-183.
https://doi.org/10.1080/01612840590901635

[20] Kingdon, D., Sharma, T. and Hart, D. (2004) The Schizophrenia Subgroup of the Royal College of Psychiatrists' Changing Minds Campaign. What Attitudes Do Psychiatrists Hold towards People with Mental Illness? *Psychiatric Bulletin*, **28**, 401-406. https://doi.org/10.1192/pb.28.11.401

[21] Mukherjee, R., Fialho, A., Wijetunge, A., Checinski, K. and Surgenor, T. (2002) The Stigmatization of Psychiatric Illness: The Attitudes of Medical Students and Doctors in a London Teaching Hospital. *Psychiatric Bulletin*, **26**, 178-181.
https://doi.org/10.1192/pb.26.5.178

[22] Kabir, M., Iliyasu, Z., Abubakar, I.S. and Aliyu, M.H. (2004) Perception and Beliefs

about Mental Illness among Adults in Karfi Village, Northern Nigeria. *BMC International Health and Human Rights*, **4**, 3. https://doi.org/10.1186/1472-698X-4-3

[23] Yar Zever, I.S. (2017) Assessment of Relatives Beliefs and Attitude on Mental Illness and Treatment in Kano, Nigeria. *Annals of Medical and Health Science Research*, **7**, 110-111.

[24] Epi AFRIC and the Africa Polling Institute (API) (2020) Mental Health in Nigeria Survey Report 2020. Abuja, Nigeria.
https://www.thenigerianvoice.com/news/284340/mental-health-in-nigeria-survey-report-2020.html

[25] Tungchama, F.P., Omigbodun, O. and Ani, C. (2019) Health Workers' Attitude towards Children and Adolescents with Mental Illness in a Teaching Hospital in North-Central Nigeria. *Journal of Child & Adolescent Mental Health*, **31**, 125-137. https://doi.org/10.2989/17280583.2019.1663742

[26] National Population Commission (1994) Legal Notice and Publication of Details of the Breakdown of the National and State Provisional Totals of 2006 Census. Census 91: Summary Results. Government Official Gazette No. 24, Volume 94. Lukulu Street, Abuja, Nigeria.

[27] https://www.macrotrends.net/cities/22005/kano/population

[28] Centre for Disease Control (2019) Epi Info: Version, 7.2.3.1. Epidemiology Programme Office, Atlanta, GA.

[29] Lemeshow, S., Hosmer Jr., D.W., Klar, J. and Lwanga, S.K. (1990) Adequacy of Sample Size in Health Studies. World Health Organization, 1-5.

[30] Cortina, M.A., Sodha, A., Fazel, M. and Ramchandani, P.G. (2012) Prevalence of Child Mental Health Problems in Sub-Saharan Africa. A Systematic Review. *Archives of Pediatrics & Adolescent Medicine*, **166**, 276-281. https://doi.org/10.1001/archpediatrics.2011.592

[31] Taylor, M.S. and Dear, M.J. (1981) Scaling Community Attitudes toward the Mentally Ill. *Schizophrenia Bulletin*, **7**, 225-240. https://doi.org/10.1093/schbul/7.2.225

[32] Ukpong, D.I. and Abasiubong, F. (2010) Stigmatising Attitudes towards the Mentally Ill: A Survey in a Nigerian University Teaching Hospital. *South African Journal of Psychiatry*, **16**, 56-60. https://doi.org/10.4102/sajpsychiatry.v16i2.238

[33] Abasiubong, F., Ekott, J.U. and 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**, 345-351.

[34] Theddeus, I., Daniel, K., Chinenye, O.E., Alice, A.O., Amaka, G.O., Anulika, I., Dina, P., Elina, S., Robert, R., Michael, O. and Echezona, E.E. (2016) Attitudes and Beliefs about Mental Illness among Church-Based Lay Health Workers: Experience from a Prevention of Mother-to-Child HIV Transmission Trial in Nigeria. *International Journal of Culture and Mental Health*, **9**, 1-13. https://doi.org/10.1080/17542863.2015.1074260

[35] IBM (2019) Statistical Product and Service Solutions (IBM SPSS Version, 25). IBM Corp., Armonk, NY. http://www.ibm.com/products/spss-statistics

[36] Giel, R., De Arango, M.V., Clement, C.E., Harding, T.W., Ibrahim, H.A., Ladrido-Ignacio, L., Srinivasa, R., Salazar, M.C., Wig, N. and Younis, Y.O.A. (1981) Childhood Mental Disorders in Primary Health Care: Results of Observations in Four Developing Countries. *Paediatrics*, **68**, 677-683.

[37] Ohaeri, J., Odejide, O.A., Gureje, O. and Olatawura, M.O. (1991) Psychiatric Morbidity among Children Attending Facilities for Primary Health Care in a Rural Ni-

gerian Community. Federal Ministry of Health, Abuja, Nigeria.

[38] Ebrahimi, H., Movaghari, R.M., Bazghaleh, M., Abbasi, A. and Ohammadpourhodki, R.M. (2019) Assessment of Attitude of Parents toward Children's Mental Disorder and Its Relation with Parents Helps Seeking Behaviours. *Journal of Community & Public Health Nursing*, **5**, 225. https://doi.org/10.1515/jcim-2018-0244

[39] Okpalauwaekwe, U., Mela, M. and Oji, C. (2017) Knowledge of and Attitude to Mental Illnesses in Nigeria: A Scoping Review. *Integrative Journal of Global Health*, **1**, 5. http://www.imedpub.com/integrative-journal-of-global-health/

[40] Wolff, G., Pathare, S., Craig, T. and Leff, J. (1996) Community Attitude to Mental Illness. *British Journal of Psychiatry*, **168**, 183-190. https://doi.org/10.1192/bjp.168.2.183

[41] Wolff, G., Pathare, S., Craig, T. and Leff, J. (1996) Community Knowledge of Mental Illness and Reaction to Mentally Ill People. *British Journal of Psychiatry*, **168**, 191-198. https://doi.org/10.1192/bjp.168.2.191

[42] Medhane, M.T., Amos, Y.T., Dawit, H.H., Eyob, A.A., Eyob, B.G. and Nebay, A.T. (2018) Attitude towards Mental Illness among Secondary School Students in Asmara, Eritrea: A Cross-Sectional Study. *Psychiatry Journal*, **2018**, Article ID: 4578721. https://doi.org/10.1155/2018/4578721

[43] Arafa, A., Magdi, M., Mayar, M., Elsharkawy, H. and Saleh, L. (2019) Knowledge and Attitude of Egyptian Parents toward Childhood Mental Disorders. *International Journal of Adolescent Medicine and Health*. https://doi.org/10.1515/ijamh-2019-0044

[44] Xu, Z., Huang, F., Kösters, M., Staiger, T., Becker, T., Thornicroft, G. and Rüsch, N. (2018) Effectiveness of Interventions to Promote Help-Seeking for Mental Health Problems: Systematic Review and Meta-Analysis. *Psychological Medicine*, **48**, 2658-2667. https://doi.org/10.1017/S0033291718001265

Appendix I: Questionnaire on Attitude of Parents to Childhood Psychiatric Disorders

Dear respondent,

The following is a questionnaire designed for a clinical research project to provide information on the attitude of parents to childhood psychiatric disorders. You can choose to participate in the study or not, it will not affect the care of your child in any way. The Questionnaire is confidential and does not record any names.

I solicit for your cooperation. There are no wrong or right answers.

I hope you will respond according to your convictions.

I sincerely thank you for your co-operation.

SOCIO-DEMOGRAPHIC FEATURES:

I: Features of Index Child:

1) Age of child,

2) Literacy level (Total number of education years spent at school), Islamic education only

3) Reason/complains for hospital consultation

4) Parents' classification of index child's illness; psychological only, psychological & physical, physical only.

II: Features of Family:

1) Gender of accompanying parent

2) Number of fathers wives

3) Number of index child's siblings

4) Number of index child's half siblings

5) Age of parents eldest living child

6) Family history of psychiatric illness

7) Ages of parents

8) Parents social class

9) Parents literacy level

III: Reporting Questionnaire for Children (RQC)

IV: The Community Attitude towards the Mentally Ill Scale (CAMI)