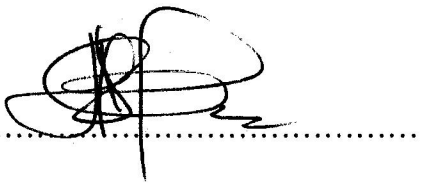
CERTIFICATION

This is to certify that this project was carried out by Olumilua Oluwafumbi Precious with Matric Number SOC/13/1302 of the faculty of social sciences, Sociology department, Federal University Oye Ekiti, Ekiti State. In partial fulfillment of Bachelor of Science Degree in Sociology.



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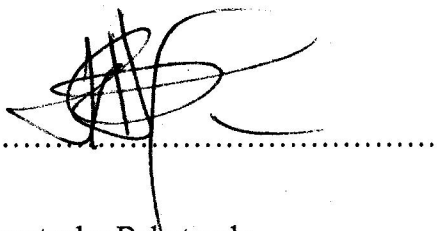
Dr. Omotosho Babatunde DATE

(Project Supervisor)



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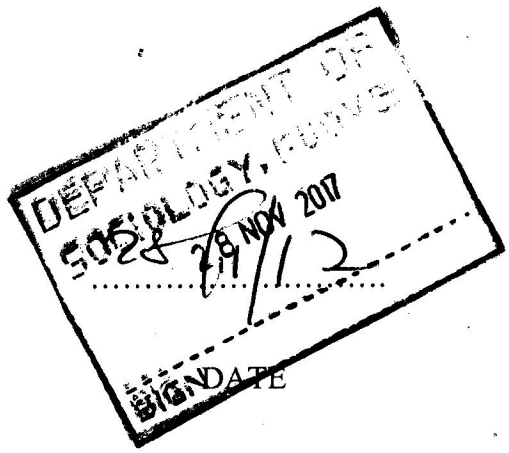

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External Examiner DATE

DEDICATION

To God, to whom I return all the Glory and Honor; to MR and MRS Olumilua and my mother Agboola abosede Tina.

ACKNOWLEDGEMENT

For God so good, since the course of this work, I got peoples help, encouragement and advice, which has been the source of my strength, usually, the number is large and I cannot possibly write out all names, However, I must as much as possible, acknowledge the contributions of those so material. I bless my God, my creator, my essence, my lifter, without God I can do nothing (John 15:5). I appreciate him for keeping, guiding, sustaining and giving wisdom, also blessing me with the gift of life to complete this research work successfully. He has been helping me to overcome challenges life including those that want to hinder this work. To him I say 'All Glory and Adorations, Thank you father'.

I express my most sincere appreciation to my parents MR and MRS Olumilua and my mother Agboola Abosede Tina for their support financially, morally, spiritually and for the love they have shown me, towards the successful complication of my first degree programme. I really appreciate my loving, caring father, my backbone, my supporter, I cannot love you less, may God continue to bless you and bless all your generations (Amen).

I must not forget my project supervisor, Dr Omotosho Babatunde, whose direction, efforts and encouragement aided the outcome of this study and can never be forgotten, he was there for me just like a father would be for his daughter, I really appreciate all the corrections, new insights that our interaction brought into the work, I cannot thank you enough, I am so grateful and honored to have you as my project supervisor, thank you sir, may God continue to bless the work of your hand [Amen]. Likewise I also want to thank my level coordinator, Reverend [Dr] Adebayo for his fatherly advice and guidance, my regards and thanks also goes to all my lecturers the likes of professor O. Fasoranti, professor Adewole Atere, Dr Babatunde Omotosho, Dr Abrifor, Dr Kola Taiwo, Dr Abimbola, Reverend [Dr] Adebayo, Mr fasoranti, MS Adeoye, Mrs Oriola. I cannot leave out the effort of my non-teaching staffs.

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ABSTRACT

There has been much outcry of international organizations about the state of mental illness and how it affects a person's ability to perform the tasks necessary for daily living. Depression in particular causes an adjustment from the psychological well-being of an individual which is indicated by his emotional and behavioral disposition. This study investigated the attitudes of the society to the mentally ill using depression a case.

The population constituted all the adults in Ado and Oye-Ekiti from which sample of two hundred (200) respondents were selected based on purposive sampling. The study focused on public perception; level of stigma, health workers attitude, family care and the possible solution to depression. Descriptive analysis and inferential analysis such as chi-square analysis was used to analyze the effect of public attitude on the mentally ill persons using Statistical Package for Social Sciences (SPSS) version 20.

The findings from the research work evidence for the researcher's to conclude that there is statistically significant relationship between public attitudes; societal stigmatization, health practitioner attitude, and family care and the depression recovery.

The study recommended the need for government intervention through provision of medical care; public sensitization; and adequate family care.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Mental health is an important component of the overall health of any individual. This was long recognized in ancient India, where in addition to the medical dimension, philosophical, religious, moral and ethical dimensions shaped and provided the ground for normal mental health and contributed to an integrated healing and welfare system for mental illness. Conceived as the absence of conformity to social norms and values, mental illness is on the rise in the United States and other parts of the world (Mecahnic, 2008 in Bessa 2012). Each year more and more people are being diagnosed with mental problems like depression (Mirowsky & Ross, 2003; Scheff, 1999).

Depression has been understood within a scientific and clinical context within the twentieth century even though it has been recognized since classical times (Gilbert, 1984; Jackson, 1986) and explained from within philosophical perspectives as a problem of individual understanding. Understandings of depression can be seen as the product of socio-political factors.

Depression is prevalent worldwide and is among the leading causes of disability that contribute to the global burden of disease (Churchill, 2010). Depression can be detrimental to the well-being of an individual, and impairs functioning in daily living in areas including social, academic, and occupational, and increases risk of suicide. Features may involve changes in weight and sleep, agitation, loss of energy, feelings of worthlessness, inability to sustain concentration and thoughts of suicide. Such symptoms impact and impair an individual's ability to function in important areas of their life (i.e. occupational, social, and academic). Depression haunts the lives of many, especially our young people, this is

becoming more and more apparent in Western countries. Depression is a common mental disorder characterized by sadness, loss of interest in activities and by decreased energy (Barnes, 2003).

Following the threat of depression, the difference in the vulnerability of the genders becomes an interesting area of discuss. According to Bates (1999), one remarkably consistent finding in studies across different continents has been that women are about twice as likely to experience depression as men. There are many explanations for this, including increasing role strain for women, fragmentation of the community, changing expectations and feelings of needing to compete with others to prove ones' self-worthy, knowledgeable and able. There is need to confirm or annul the finding. More so, the few studies on depression literacy among adolescents found inadequate knowledge of depression and appropriate source of help seeking. However, depression is amenable to treatment, and early intervention is associated with a more favourable outcome.

People's beliefs and attitudes toward mental illness set the stage for how they interact with, provide opportunities for, and help support a person with mental illness. 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. About one in four U.S. adults (26.2%) age 18 and older, in any given year, has a mental disorder (e.g., depression, mood disorder, anxiety disorder, impulse control disorder, or substance abuse disorder) (Kessler, Chiu, Demler, & Walters, 2005), meaning that 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—further complicating self-management of these disorders and adversely affecting quality of life (Chapman et al., 2005; El-Gabalawy et al.,

2010; IOM, 2012). WHO in Barnes, (2003) argues that the lack of attention to the mental health of young people may lead to health problems with long consequences. This is why although the extent of the association of depression and suicide remains open to confirmation on a general population basis it is nevertheless an important issue for the whole of society.

Depressive disorder is a common cause of distress and impairment in physical, social, occupational and other important aspect of life especially among women in the Niger Delta region of Nigeria has been poorly explored. A study was designed to determine the prevalence of depression among women attending the Mental Health Clinic at the Federal Medical Center, Yenagoa, Bayelsa State. Data was collected from case files from January 2009-December 2012 of women diagnosed with depression. Result shows that prevalence of depression among women ranged from 21(24.1%) in 2009, 17(19.5%) in 2010, 16(18.4%) in 2011 and 33(37.9%) in 2012, with a mean prevalence of 21% per year. In addition, 57.5% of the women had severe depression, 17.2% had moderate and 25.3% with mild depression. The results show a highest prevalence of depression (39.1%) within ages 20–30".

There are few studies conducted in Nigeria to assess the prevalence of depression. Former Governor of Lagos State and the national leader of the All Progressives Congress, APC Asiwaju Ahmed Tinubu said that about 400 million people are currently suffering from depression as a global problem out of which 12 percent (48 million) are Nigerians. Tinubu gave the statistics in Lagos at the public presentation of a book Shadows in the Mirror: the Many Faces of Depression, written by Dr. Vivian Ikem (DailyTrust, 2017). This indicates an epidemic and calls for an uprising.

Yusuf and Adeoye (2011) reported on prevalence of depression among civil servants in Osun State and showed a high prevalent among women. Also, in another study by Amoran et al (2007), of prevalence among adults in Oyo State, reported an overall prevalence of 5.2%, and that depression was prevalent among women than men (5.7% vs 4.8%), and more in rural population. This apparent difference in depression per gender has further motivated the researcher to conduct a study on the vulnerability of male and females to depression in Ado and Oye Ekiti. Obi et al (2015) reported a high prevalence of depression among health workers in Enugu, South East Nigeria. However, lack of studies on depression in Nigeria makes it difficult to produce empirical and statistical evidence to emphasize the magnitude of this problem locally. This study therefore attempts to add to this minimal body of empirical literature and to examine the perception of the society to the mentally ill especially the depressed as understanding more about depression vulnerability can pave the way for tailored intervention and preventative strategies in the hope of reducing its high prevalence.

1.2 Statement of the Problem

Depression is one of the most commonly encountered emotional distresses in both the general public and in various types of clinical populations. While options for effective treatments are widely available, this disorder is often under-diagnosed and undertreated. Many a people who suffer from depression are not even aware of its severity and its apparent impact on their productivity and social life in general. As a matter of fact, many are in the dark on the best possible medical and non-medical response to the threat of depression and mental illness in its entirety.

Depression is a common serious mental illness with major health, economic, and social consequences. The World Health Organization (WHO) defines depression as a disorder

characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disordered sleep or appetite, decreased energy and poor concentration (Dinas 2011 in Barret, 2012). Depressive feelings and symptoms can be acute or chronic, often recurrent and can considerably impair an individual's ability to carry out activities of daily living. In its most extreme cases, depression can lead to suicide, accounting for approximately 850,000 fatalities each year (WHO, 2011 in Barret, 2012).

Over the past four decades, there have been many studies on the public's attitude toward people with mental illness. Stigma has been discovered to be a widely propagator of negative outcomes from those suffering from depression. The attitude of the public as pointed out by Rabkin in Rahav, Struening & Andrews, (1984), affects the patients' pursuit of friends, a job, and a place to live and even schooling. There is no argument that stigma is now a major issue and a growing concern for health experts. Negative connotations and false assumptions connected with mental illness may be as harmful as the disease itself and could force the depressed or mentally ill to dangerousness like suicide, bitterness, starvation and unthinkable social disorders and anti-social behaviour. Some places have even synonymized mental illness with witchcraft (Dr. J. A. Oluwole, 1976). This research endeavor seeks to evaluate the level of stigma in Ado and Oye-Ekiti as it affects people with depression.

In the same light, the internal perception of one's family becomes highly imperative to supply the intrinsic energy and will to live through and plays an important role in the lives of people with experience of mental illness. People with experience of mental illness often rely on family members as part of their support mechanisms. However, there is a large number of stereotypes about families of people with experience of mental illness including their being dysfunctional, incompetent, burdened or brave (Banks 2003). The lack of

family care and support may negatively affect the liveliness of the depressed. Angermeyer, Shulze et al. (2003) stated succinctly that family members of people with experience of mental illness are characterized by 'responsibility'. That is "they act as the major caretaker, and have a special emotional closeness" (Angermeyer, Shulze et al. 2003). There is therefore need to investigate how the level of care shown by families in Ado and Oye-Ekiti affects the population of people suffering from depression. Moreover, the availability, accessibility, acceptability and quality treatment are the core obligations and elements of the right to health. Health practitioners owe the society a responsibility to be available, accessible, and acceptable and give quality treatment to the depressed. Although, there have been indications and untested opinions of academics and individuals on the attitude shown by these medical practitioners to the depressed, much light is yet to be seen in the seeming effect on the depressed.

This study will therefore examine the perception of the society in relation to the mentally ill and the apparent differences in attitude and perception of one's family and the health practitioners to coping with the wide-ranging issue of depression in our society today.

1.3 Research Questions

This research is carried out to answer the following questions:

1. How frequently do people suffer from depression as perceived by residents of Ado and Oye-Ekiti?
2. What is the perception of the society to the level of stigma associated with people coping with depression?
3. How does the society perceive the attitude of health practitioners to people with mental illness?

4. What is the perception of the society to the effect of family care to those with mental illness?
5. What is the perception of residents of Ado and Oye-Ekiti on the best possible solution to depression?

1.4 Objectives of the Study

Generally, the purpose of the study was to investigate the perspective of the society towards the mentally ill. The specific objectives were to:

1. Understand the perception of the society to the frequency to which residents of Ado and Oye-Ekiti suffer from depression
2. Investigate the perception of the society to the level of stigma associated with people with depression
3. Identify the perception of the society to the attitude of health practitioners to people with mental illness
4. Identify the perception of the society to the effect of family care to those with mental illness.
5. Find out the perception of residents of Ado and Oye-Ekiti on the best possible solution to depression

1.5 Research Hypotheses

To achieve the objective of this study, the following hypotheses are formulated.

Hypothesis 1

H0 – stigmatization as a societal factor does not significantly affect the depressed

Hypothesis 2

H0 – medical practitioner attitude does not significantly affect the depressed

Hypothesis 3

H0 – family care for mentally ill relatives does not significantly affect the depressed

1.6 Significance of the Study

Although various research works has been carried out regarding mental illness and depression, but due to the dynamism surrounding this concept, there is need for frequent and regular investigation on the perspective of the society towards the mentally ill as this research work will add to the existing volume of literature on the area especially as bulk of the research work has been in foreign countries. The government and or its agencies will find this study useful as it will supply information on the level of frequency with which depression captures it's citizenry as recommendations will be provided as a guide to ways of managing the mentally ill in the society. The society will awaken to consciousness on the dangers of the lethal force of depression on their lives through the exposure from this study.

This study will also serve as a launching pad for further educative researches into the incidences and gravity of other mental illnesses that affects us.

1.7 Scope of the Study

The concept of mental illness is broad and cannot be exhausted in a single study. This is why the researcher restricted the study to depression and its attendant effect on the populous and societal development. The study is also delimited to all the adults in Ado and Oye-Ekiti.

1.8 Definition of Terms

Mental illness: a psychiatric illness which symptoms are mostly characterized by behavioral or psychological impairment of functioning

Mental health: mental health refers to our cognitive, and/or emotional wellbeing.

Depression: a state of low mood and aversion to activity

Society: Humanly created organization or system of interrelationships that connects individuals in a common culture.

Social problem: A social problem exists when a significant number of people in a society believe that a certain condition is in fact a problem.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents the related literature and studies after the thorough and in-depth search done by the researchers. The chapter also present the scholarly definition of mental health; Scholarly definition of mental illness; Sociological Perspectives to mental illness; Types of mental illness; Sociological perspective of depression; Types of depression; Causes of depression; Effect of depression on the society; Treatment of the mentally ill and depressed; and Theoretical framework

2.1 Scholarly definition of mental health

The concept of mental health has been described in a number of ways by different researchers. According to WHO (2007), mental health refers to our cognitive, and/or emotional wellbeing. It is all about how we think, feel and behave. WHO further defines mental health as a concept as a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community (WHO, 2007). Individually, mental health affects our expressive, cognitive, perspective, relational, and coping abilities, undergirding our general health and wellbeing and capacity to integrate into and become productive members of society (Dwivedi & Harper, 2004).

Furthermore, according to the Health Education Authority, (1997), mental health is defined as the emotional and spiritual resistance that helps us to survive pains, disappointment and sadness. It is an elementary belief in our own and others self-worth, esteem and dignity. Mental health can also be described as a level of psychological well-being, or an absence of mental illness. It is the psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment. From the perspective of positive

psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience.

2.2 Concept of Mental illness

The concepts about mental illness can be subjective, and it can be difficult to define. One of the general definitions for mental illness is "mentally disordered, mad, or crazy". However, during the middle ages, people with mental illness were considered to be living examples of the weakness of humankind. The common belief was that mental illness was a result of being unable to remain morally strong. People with mental illnesses were jailed as criminals and, on some occasions, put to death (Corrigan, 2002). Mental illness has been conceived to mean the absence of conformity to social norms and values (Mecahnic, 2008). A broader and more current definition of mental illness refers to the spectrum of cognitions, emotions, and behaviors that interfere with interpersonal relationships as well as functions required for work, at home, and in school (Johnstone, 2001). This definition takes into account a myriad of different functions and how they affect a person's ability to perform the tasks necessary for daily living. Most of the diagnostic categories take into consideration the degree to which the symptoms of a mental illness impede a person's daily functioning when identifying the severity of the diagnosis. With this definition as a criterion, statistics shows that 30% of all general practitioner consultations involved a mental illness. They also reported that one in four people has a mental illness at some time in her or his life.

Furthermore, mental illness is one of the leading causes of morbidity in the world, resulting in high socioeconomic costs for medication and treatment on the society at large. Hence, estimating the economic cost of mental illness is a key factor in gaining greater insight into the scale of this health problem, as well as in the allocation of human and material health

care resources aimed at mitigating the unwanted effects of chronic mental illness for patients, the health care system, and for society as a whole. In Nigeria, research has shown high levels of ignorance about mental illness and negative attitudes towards individuals with mental disorders (Omigbodun, Adedokun, Dogra, Bella, Ronzoni & Adesokan, 2012). Traditional healers and religious leaders are usually the first point of consultation for mental illness, with consequent prolongation of the pathway to appropriate care.

Mental illnesses are among the most stigmatizing conditions worldwide. The reasons for this are obvious. A common stereotype is that people with serious mental illness might behave peculiar and sometimes even frightening. The majority of persons suffering from mental disorders, however, do not behave in a conspicuous way. Instead, people with depression, anxiety disorders, and most persons suffering from psychotic disorders, are silent and withdrawn. This and other stereotypes depend, in part, on the cultural context; what is perceived as a mental disorder, what is known, and what is believed about the background and the nature of different expressions of mental distress. People who have a mental disorder tend to be discriminated against in several ways. They often withdraw from their family and society and they avoid asking for help. This increases the burden of illness both for the person with the disorder, but also for their families and friends. The costs for the society are enormous and at least partly a result of the stigma attached to mental disorders. There is a considerable amount of research on the nature of stigma because of mental illness and its consequences.

Most of these studies have been performed in western industrialized countries with more or less developed services for mentally ill (Roberts, 2005). However, mental disorders are also prevalent in low and middle income countries, many with traditional cultures, and the level of stigma is also high in this millennium (Barney, Griffiths, Christensen, & Jorm,

2009). Much less is about the attitudes towards people with a mental illness in other cultures. For example, there are a limited number of studies from Islamic countries even though Islam is the second largest of the religious belief systems in the world. An interesting element in Islamic teaching is the idea that mental illness as well as other ailments might be an effect of the will of God and not necessarily a punishment for sins (Reavley & Jorm, 2011). This could imply that persons suffering from mental disorders might be less stigmatized because their way of life and behavior might not be viewed as the result of personal defaults.

2.3 Sociological Perspectives to mental illness

Society's attitudes toward mental illness and the mentally ill play an important role in every domain of the life of those who are labeled 'mentally ill'. They affect the pursuit of friends, a job, and a place to live and schooling (Rabkin in Rahav, Struening & Andrews, 1984). Attitudes affect the actual behavior of the mentally ill, the success of various treatment programs and the treatment rates. People with mental disorders are one of the most vulnerable populations in society. They are often isolated, stigmatized (as shown above), discriminated, humiliated and marginalized. They often end up in unhygienic and inhumane living conditions either in the community or in the mental hospitals with increased likelihood of human rights violation.

People suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society (Johnstone, 2001). Negative connotations and false assumptions connected with mental illness may be as harmful as the disease itself. Schizophrenia may evoke visions of violence and inability to care for oneself. Depression may conjure thoughts of

laziness and substance abuse. Societal stigma significantly limits opportunities that are available for people with serious mental illnesses (Johnstone, 2001).

Specifically as a culture, it is normative behavior to perceive people with mental illness as dangerous and violent. There are many areas in which this cultural norm for prejudicial behavior results in prejudice against people with mental illness.

The following areas are examples of the way in which stigma has an impact on people with mental illness:

i. Lack of employment opportunities;
ii. Limitations on finding adequate shelter;
iii. Barriers to obtaining treatment services,
iv. Negative attitudes of mental health professionals and
v. The role of the media in perpetuating the negative image of people with mental illness.

Mental health professionals' attitudes toward someone with a mental illness can both perpetuate stigma and create new barriers to receiving treatment. Stigma can originate from the very people in the mental health field who are expected to offer help to persons with a mental illness. Most well-trained professionals in the mental health disciplines subscribe to the same stereotypes about mental illness as the general public (Corrigan, 2002). However, in some primitive areas of Nigeria, Schizophrenia is recognized as witchcraft. According to Dr. J. A. Oluwole (1976) in contextualizing schizophrenia, he concluded that witchcraft is an imaginary word used to explain away schizophrenia and all forms of mental and natural abnormalities''. From his research, women who are suffering from schizophrenia are generally regarded to be witches. Women are always the victims even if men also suffer from the same illness and in most cases these women could lose

their lives. This perspective of the society allows for maltreating and absolute disregard and segregation of the mentally ill.

The mentally ill, lack mental health legislation acts as a protection of their rights and privileges as citizens and members of the society. Such legislation provides a legal framework for addressing issues such as admission, treatment, care in institutions and discharge; civil, political, economic, social and cultural rights; and implementation of mental health policy and programmes. Ultimately, objectives of all mental health legislations are to ensure equal access to mental health services, protection of human rights and reintegration of person with mental disorders into the mainstream of society.

2.4 Types of mental illness

The following are popular types of mental illness.

i. Depression
ii. Anxiety
iii. Obsessive-compulsive disorder(OCD)
iv. Phobias
v. Eating problems
vi. Bipolar disorder
vii. Schizophrenia
viii. Personality disorder.

2.4.1 Depression

When a person has depression, it interferes with daily life and normal functioning. It can cause pain for both the person with depression and those who care about him or her. Doctors call this condition "depressive disorder," or "clinical depression." It is a real illness. Most people who experience depression need treatment to get better. There have

been some other various accounts of depression as a mental illness such as the genetic, biochemical and the psychological theories. Clinical psychologist view depression form the angle of unipolar disorder and bipolar disorder.

Depression is known to be a feeling of heaviness that lasts for a long time and affects one's everyday life. Depression therefore, is a change in a person's mood, with feelings of sadness and misery. These feelings can go on over some period of time It can make one feel hopeless, despairing, guilty, worthless, unmotivated and exhausted. It can affect one's self-esteem, sleep, appetite, sex drive and, sometimes, one's physical health. In its mildest form, depression doesn't stop one leading a normal life, but it makes everything harder to do and seem less worthwhile. Sometime, one cannot even leave one's bed at the dawn of a new day. They find it rather difficult to cope with the activities of their daily living. At its most severe, depression can make one feel suicidal, and be life-threatening.

Many factors may play a role in depression, including genetics, brain biology and chemistry, and life events such as trauma, loss of a loved one, a difficult relationship, an early childhood experience, or any stressful situation (National Institute of Mental Health, 2015). Depression can happen at any age, but often begins in the teens or early 20s or 30s. Most chronic mood and anxiety disorders in adults begin as high levels of anxiety in children. In fact, high levels of anxiety as a child could mean a higher risk of depression as an adult.

Depression can co-occur with other serious medical illnesses such as diabetes, cancer, heart disease, and Parkinson's disease. Depression can make these conditions worse and vice versa. Sometimes medications taken for these illnesses may cause side effects that contribute to depression. A doctor experienced in treating these complicated illnesses can help work out the best treatment strategy.

There are also some common specific forms of depression, such as:

i. Major depression:

ii. Persistent depressive disorder:

Some forms of depression are slightly different, or they may develop under unique circumstances. They include:

i. Psychotic depression

ii. Postpartum depression

iii. Seasonal affective disorder

iv. Bipolar disorder

2.4.2 Anxiety

Anxiety refers to strong feelings of unease, worry and fear. Because occasional anxiety is a normal human experience, it's sometimes hard to know when it's becoming a mental health problem, but if your feelings of anxiety are very strong, or last for a long time, they can be overwhelming. Anxiety is something we all experience from time to time. Most people can relate to feeling tense, uncertain and, perhaps, fearful at the thought of sitting an exam, going into hospital, attending an interview or starting a new job. One may worry about feeling uncomfortable, appearing foolish or how successful one will be. In turn, these worries can affect one's sleep, appetite and ability to concentrate. If everything goes well, the anxiety will go away (Hatloy, 2012).

2.4.3 Obsessive-compulsive disorder (OCD)

OCD is a type of anxiety disorder. The reality of this disorder is a lot more complex and serious. OCD has two main parts:

i. Obsessions – intrusive thoughts, ideas or urges that repeatedly appear in one's mind. For example, thinking that one have been contaminated by dirt and germs, or worrying that one might hurt someone.

ii. Compulsions – repetitive activities that one feel one have to do. This could be something like repeatedly washing something to make sure it's clean or repeating a specific phrase in one's head to prevent harm from coming to a loved one.

The aim of a compulsion is to relieve the intense anxiety caused by obsessive thoughts. However, the process of repeating these compulsions is often distressing in itself, and any relief one feel is often short-lived.

2.4.4 Phobias

A phobia is an extreme form of fear or anxiety triggered by a particular situation (such as going outside) or object (such as spiders), even when there is no danger. A fear becomes a phobia if it lasts for more than six months, and has a significant impact on how one live one's day-to-day life. For example, one may begin to organize one's life around avoiding the thing that one fear. The impact of a phobia on one's life depends on how easy it is to avoid the feared object, place, or situation (Anxiety Disorder Association of America, ADAA, 2008). Since individuals do whatever they can to avoid the uncomfortable and often terrifying feelings of phobic anxiety, phobias can disrupt daily routines, limit work efficiency, reduce self-esteem, and place a strain on relationships. Specific phobias are the most common type of anxiety disorder, affecting 19 million American adults (ADAA, 2008). Most phobias seem to come out of the blue, usually arising in childhood or early adulthood. Scientists believe that phobias can be traced to a combination of genetic tendencies, brain chemistry and other biological, psychological, and environmental factors.

2.4.5 Eating problems

Eating problems aren't just about food. They can be about difficult things in one's life and painful feelings, which one may be finding hard to express, face or resolve. Focusing on food can be a way of disguising these problems. The most common eating problems are:

i. Anorexia – not allowing oneself to eat enough food to get the energy and nutrition one need to stay physically healthy. Sometime people assume that anorexia is about slimming and dieting, but it is often connected to very low self-esteem, negative self-image and feelings of intense distress.

ii. bulimia – finding that one eat large amounts of food all in one go, often because one is feeling upset or worried (this is called bingeing); then feeling deeply guilty or ashamed, and taking steps to get rid of the food one have eaten (this is called purging).

iii. Binge eating disorder – feeling that one can't stop one's self from eating, even when one want to. This is sometimes described as having a food addiction or compulsive eating.

iv. Eating disorder not otherwise specified (EDNOS) – this diagnosis means one meet some of the criteria for one of the above disorders, but not all of them.

2.4.6 Bipolar disorder

Bipolar disorder (previously called manic depression) mainly affects one's mood. With this diagnosis one are likely to have times when one experience:

i. Manic or hypomanic episodes (feeling high)

ii. Depressive episodes (feeling low)

iii. Potentially some psychotic symptoms during manic or depressed episodes

Everyone has variations in their mood, but in bipolar disorder these changes can be very distressing and have a big impact on one's life. One may feel that one's high and low moods are extreme, and that swings in one's mood are overwhelming. In between, one might have stable times where one experience fewer symptoms.

2.4.7 Schizophrenia

One may receive a diagnosis of schizophrenia if one have symptoms such as:

i. Psychotic experiences, for example hallucinations or delusions

ii. Disorganized thinking

iii. A lack of interest in things

iv. Feeling disconnected from one's feelings

v. Wanting to avoid people

This diagnosis can be controversial as not all people who experience such things agree that they have a mental health problem, or that the term 'schizophrenia' is the best way to describe their experiences.

2.4.8 Personality disorders

Personality disorders are a type of mental health problem where one's attitudes, beliefs and behaviors cause one longstanding problems in one's life. There are several different types of personality disorder, but the two most commonly diagnosed ones are:

i. Borderline personality disorder (BPD) – one might be given this diagnosis if one experience things like intense, changeable moods, an overwhelming fear of abandonment, an unstable sense of identity and impulsive, risky behavior. Some people prefer the term 'emotionally unstable personality disorder' (EUPD) to BPD, as they feel it's a more accurate description of the symptoms.

ii. antisocial personality disorder (ASPD) – one might be given this diagnosis if one experience things like disregard for the feelings and needs of others, manipulating others for one's own gain, difficulty maintaining relationships, feeling little guilt for one's actions and feeling easily bored

2.5 Sociological perspective of depression

The World Health Organization (WHO) defines depression as a disorder characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disordered sleep or appetite, decreased energy and poor concentration (WHO, 2011). Depression is a leading cause of disability and is projected to become the 2nd most burdensome disease by the year 2020 (WHO, 2012). Depression can be said to be a subtle weapon that has predated into lives without the host even knowing it. Depression interferes with normal functioning and frequently causes problems with work, social and family adjustment. Serious depression can destroy the family life and the life of the depressed person. Research also has it that there is also a clear association between depression in youth and suicide (Rao et al., 1993 & Harrington, 2001). Depression impacts upon the lives of individuals, and can pose a significant risk of suicide, with over 10 million suicide attempts occurring per year worldwide (Churchill, 2010). In Australia alone, according to the Australian Bureau of Statistics between 2001 and 2010 a total of 22,526 suicide deaths were registered.

The society understands depression to be a condition that generally comes and goes that is more likely at certain stages of the life cycle and with some types driven by genetic, biological factors and other types being more a response to major life events. The depressed persons may easily become so apathetic, lethargic and uncaring about personal hygiene, eating, activity etc., that the patients require an increased amount of staff time to execute their daily chores (Stice, 2001). Many depressed people are easily mistaken for personality

disorders and illnesses. The depressed person may become psychotic, hearing voices or believing things that aren't real leading staff to think them as schizophrenic (Migliore, 1994). Agitated depression with increased irritability, brooding, pacing, and worry can create many problems for the staff and other residents. The person may become either verbally or physically threatening. The common attitude of the society is simply to keep off, to stigmatize the depressed which according to health experts only worsens the situation.

"People with serious mental illness are not ill in isolation. Their families, extended, and significant others, whatever they think about the illness, cannot escape being affected by it. The lives of people with serious mental illness are inextricably involved with the lives of those they love and care for, and the lives of those who love and care about them" (Mental Health Commission 1998).

The perception of families may play an important role in the lives of people with experience of mental illness. People with experience of mental illness often rely on family members as part of their support mechanisms. The relationships with family members may be the closest relationships that we have. A recent survey of discrimination against people with experience of mental illness in New Zealand (Peterson, Pere et al. 2004), however, showed that more people reported discrimination occurring from their friends and family than from any other source. This means that while families are an important feature in our lives, their attitudes and behaviors, whether they intend them or not, are not always effective in supporting people with experience of mental illness. It is important to note that the congregation of families consist the society at large. There is a large number of stereotypes about families of people with experience of mental illness including their being dysfunctional, incompetent, burdened or brave (Banks 2003). The British Columbia

Minister of Health's Advisory Council on Mental Health (2002) reports that these stereotypes have an impact on people with experience of mental illness have strained relationships with others, and experience fear, violence, anxiety, conflict, lowered self-esteem and guilt. While mental health services have changed in the last ten years or so, the 'burden' placed on family members has not lessened (Ostman, Hansson et al. 2000). Angermeyer, Shulze et al. (2003) state succinctly that family members of people with experience of mental illness are characterized by 'responsibility'. That is "they act as the major caretaker, and have a special emotional closeness" (Angermeyer, Shulze et al. 2003). When deciding on what they believe to be the causes of mental illness, family members tend to think specifically about their own situation and that of their relative taking an individual approach rather than the causes of mental illness in general (Magliano, Fiorillo et al. 2004). There are differing views as to how families perceive the causes of mental illness. Some researchers believe that families are strong proponents of a medical model of mental illness (Jones 2002) that mental illness is caused by a brain disease. Other researchers state that families more frequently adhere to a psychological model of mental illness (Magliano, Guarneri et al. 2001; Magliano, Fiorillo et al. 2004). Marshall, Solomon et al. (2003) report that family members hold both biological and family causations beliefs about mental illness simultaneously, with families tending to blame themselves in the early stages of the recovery of their relative. Scheurich (2002) comments that family members tend to believe in the 'power of positive thinking' as a way of dealing with mental illness, implying that people are able to control their symptoms and behaviour.

2.6 Types of Depression

2.6.1 Major Depression: Major depression is a serious illness that affects a person's family personal relationships, work or school life, sleeping eating habits and general health. It's

impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes. These observable changes occur nearly every day over at least a two week period of time and represent a change from the person's previous level of functioning. A Major Depressive Disorder (MDD) is characterized by episodes of more persistent and pervasive disturbances in mood and accompanying features. It is formally diagnosed by the presence of at least five out of the nine symptoms including depressed mood and loss of interest. Over time, the person may also withdraw from social contact and show impairment in performing usual social roles. MDD is generally categorized into bipolar and unipolar subtypes. A distinction is made based on the different courses of the disorders and indicating different approaches to treatment [John, 2006].

2.6.2 Minor Depression: It is also called as "subclinical" or "subsyndromal" depression because it does not meet the full criteria for major depression. For example, the person has 4 of 5 symptoms. Like major depression, minor depression is associated with disability, reduced quality of life and responds well to the same treatments that are used with major depression.

2.6.3 Dysthymic Disorder: It is a chronic but less severe form of depression that includes depressed mood and at least two additional symptoms that persist for at least two years. People with dysthymia may also develop major depression.

2.6.4 Bipolar Disorder: Bipolar disorder is characterized by episodes of depression which may alternate with mania, which is indicated by elevated mood or irritability and other symptoms. Bipolar disorder requires different treatments from major depression; professional diagnosis and treatment is essential.

2.6.5 Unipolar disorders: Unipolar disorders represents a larger residual group of disorders where an individual experiences depressive episodes only.

2.6.6 Melancholic or endogenous depression: It is associated with specific clinical features, particularly disturbance of psychomotor function. Although melancholic depression is rare in the community, it is an important condition in specialist treatment settings as it responds best to chemo-physical treatments such as antidepressant drugs and electroconvulsive therapy.

2.6.7 Postnatal depression: It describes the expression of depression associated with childbirth and post-partum mood disorder. These include brief episodes of depressed mood, MDD and post-partum psychosis in which psychotic symptoms are also present.

2.6.8 Adjustment Disorder with Depressed Mood: It has signs and symptoms of depression that occur in response to a significant psychosocial stressor but do not meet the full criteria for major depression. Symptoms occur within 3 months of the stressor and subside within six months after the stressor or its consequences have resolved.

2.6.9 Bereavement: It is signs and symptoms of depression that occur following the loss of a loved one. It is considered as bereavement unless the patients "persist for more than two months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation."

2.7 Causes of Depression

2.7.1 Stress and Loss Associated with Ageing: Physical illness or disability decreased sensory capacities, changes in social status and responsibilities to others. It decreased self-esteem due to role loss or change, loss of friends and family, relocation, loss of financial resources, social isolation and diminished capacity to adapt to change.

2.7.2 Biological Depression: Comes "out of nowhere", tends to be more severe than the "reactive" type and person more likely to have other episodes earlier in life.

2.7.3 Physical Illness: Physical illness can directly cause the symptoms of depression, physical illness can cause a reaction of depression by causing chronic pain, or fear of pain, disability, loss of function, loss of self-esteem, increased dependence, fear of death, depressed elderly may present with physical complaints and medications can cause the symptoms of depression. The environment in which physical illnesses are treated may contribute to isolation, sensory deprivation and enforced dependency.

2.8 Effect of Depression on the society

Research has identified a link between anti-social behavior and depression. Researchers speculate that depression exists as a precursor to anti-social behavior and influences anti-social tendencies by altering the subject's perception of consequences as well as their personal safety (Obeidallah & Earls, 1999). Depressive symptoms, such as limited interests, low self-esteem, and social withdrawal may result in rejection by pro-social peers, and subsequent withdrawal from pro-social institutions and community activities (Obeidallah & Earls, 1999).

From a sociological perspective, social problems are created by the failure to close the gap between the way people want things to be and the way things really are (Coleman, 1999). Certain social conditions are detrimental in any situation (Eitzen, Smith & Baca-Zinn, 2009). These conditions prevent members of a society from developing and using their full potential. Those conditions like poverty, racism, unequal opportunity are, therefore, social problems in any social setting.

In the account of Osaat (1999), the present Nigeria generation has been a generation of youth restiveness and moral decadence, sporadic ethnic and religious violence, insurgent tribal youth militias, and labour unrest among adult workers, and a generation where youths grow with criminal tendencies, with growing interests in cultic activities, and examination

malpractice as the dominant means of achieving success in educational institutions. Deviance, disturbances, crises, issues, violence, unrest and all anti-social behaviours, all of which have been categorized as social problems are prevalent in every sector of the Nigerian nation. These deviances are linked to the growing rate of mental illness and related mental health challenges such as depression. Therefore, if untamed, depression can regress into a social problem, affecting individuals and the society at large. The educational sector in Nigeria for instance, is suffocated with poor performance and high rate of students' indiscipline and disregard for teachers and parents. Mental illness cannot be disassociated from this menace and the urgent need for the most suitable treatment for mental illnesses becomes a core objective.

2.9 Treatment of the mentally ill and depressed

Availability, accessibility, acceptability and quality are the core obligations and elements of the right to health. A mentally ill person is in need of special care and attention both at home and in the hospital for the simple reason that he/she is unable to fend for himself/herself. The best ways to treat a mental illness like depression is either pharmacologically or non-pharmacologically. In most cases, therapies are used which includes; anti-depressant therapies and psychotherapy. The responsibility for special care and attention also lies with the care givers and includes the following:

i. Treating the mentally ill person with dignity, decency, kindness and compassion;
ii. Not suppressing the information that someone at home has been affected by mental illness;
iii. Recognizing that time is of the essence, and taking the ill person to a mental health facility for evaluation and admission, if considered necessary by the treating mental health professional

iv. Furnishing accurate postal address of the admitted individual to the hospital authorities at the time of admission;

v. Not suppressing any information about relationship with the individual and about the nature of ailment;

vi. Volunteering to stay with the admitted relative in the family ward/open ward, as the case may be;

vii. If it is not convenient to stay with the person for personal and family reasons, interacting with him/her at the hospital at frequent intervals as necessary;

viii. Ensuring that after the person has been effectively treated and fit for discharge, he/she is taken home, treated kindly and given the best care and attention, ensuring strict and timely compliance with the medicines prescribed;

ix. Taking the person to the hospital for follow-up as advised;

x. Infusing hope, faith and confidence in the mind of the recovering person all the time that he/she can be effectively treated, cured and can resume a normal life like in any other illness;

xi. Extending cooperation to the psychiatric social worker during follow-up home visits.

2.10 Theoretical framework

Labeling Theory

One of the most promising approaches to development in mental health and depression has been the labeling approach. Coming into prominence in the 1960s, it inspired an incredible amount of debate and research endeavor. It has lost in recent years much of its early luster but so much of what it has given to theoretical sociology remains as truisms.

The intellectual heritage of labelling is directly traceable to the symbolic interactionist school of thought as expressed by W. I. Thomas, G.H. Mead, Dewey, etc. Second, Lindesmith's study of opiate use demonstrated how persons became aware of their addiction. In essence it is not the drug that makes the person an addict, rather addiction is a social definition. When a significant other (another user) labels him/herself as an addict, the person comes to define him/herself as an addict. This also applies for depression, when individuals labels themselves as depressed, their entity responds to that definition.

Labelling theory has been credited as sociology of the underdog. As Becker expressed it in his presidential address to the Society for the Study of Social Problems, we have to proclaim whose side we are on. The persons who are considered depressed are actually victims "more sinned against than sinning". The social audience could be the community in general or particular agents of social control, e.g. the police (or teachers). In other words behavior is not inherently deviant or normal but is defined and labeled that way by people in charge of defining and labelling. The key component of the process is the social audience, regardless of how social audience comes to be defined.

Writing from a sociological perspective, Link and Phelan put more stress on the societal aspects of labeling theory. A precondition of stigma differences between persons has to be noticed, to be regarded as relevant and to be labeled accordingly. This labeling process is at the core of Link's modified labeling theory (Link et al.,1989). Phelan and colleagues have recently investigated the possible intersection of conceptual models of stigma and prejudice, and concluded that the two approaches have much in common with most differences being a matter of emphasis and focus. They argue that stigma and prejudice have three functions: exploitation and domination (keeping people down); disease

avoidance (keeping people away) and norm enforcement (keeping people in) (Phelan et al., 2008).

In Nigeria today, the sigma and rejection given to people with mental illness is rather unfortunate. As a matter of fact, more people die from the rejection associated with their mental illness than the illness itself. More so, many people are labeled as mentally ill and depressed from the interaction with their immediate society. The views of members of the society on those with mental illness need to be evaluated as they society determines what is an accepted norm or behavior and what is not. This organization of the society allows rewarding individuals who conform and punishing those who do not. One way to punish individual rule-breakers is to label or stigmatize them. The stigmatization, segregation, and criticism of the society to the depressed and mentally ill in general are imperative to the management of depression. The stereotype of the public poses negative belief about a group such as incompetence, character weakness and dangerousness.

Scheff (1999) considers mental illness as deviant behavior and consequently defines it as rule-breaking. The society believes that members with depression and mental illness are non-conformed to the residual rules. These residual rules are norms that are not explicitly classified as either prescribed or proscribed. The definition of the social problem (depression) is actually within the context of the social forces that determine it. This is the onus behind this study in responding to the perception of the society to the mentally ill in an attempt to ease the suppression and the stigmatization on the depressed for their eventual liberation.

Criticism of Labeling Theory

Labeling theory posit that people come to identify and behave in ways that reflect how others label them. It has the following criticisms

1. It faces the problem of definitions and values. Beckers' definition ignores the characteristics of depression. In favor of the position that social interaction is a universal process.
2. It ignores certain problem areas of mental illness such as violent crime, physical handicap or sexual activity. But these are still believed subsequently by abstract agencies and in ways that involve social reaction and self-reaction
3. Labeling theory lacks solid empirical validity and does not explain what actually causes depression and deviances

CHAPTER THREE

METHODOLOGY

To avert a haphazard approach to this study, the researcher has chosen a research methodology that would be suitable for this study. However, it is pertinent to state that every research procedure is determined by the nature of its problems and objectives. However, this chapter defines the methodological aspects which the researcher used to collect, analyze and interpret data. This chapter includes the research design, the survey population, sample size, sampling methods and techniques, data collection sources and method data analysis.

3.1 Research design

In this study: **"societal perception of mental illness attitude",** the most reliable research procedure capable of eliciting responses from respondents is survey research method. The study therefore employed survey research design. The survey approach is based on examination of some specific areas of concern by providing answers to certain relevant research questions. In the process of achieving the objective, the structured questionnaire and interview were employed. However, selecting the choice of research method to be used for the purpose of acquisition, analysis and interpretation of data, the researcher put in mind the nature of the study, the problem at hand and the desire objectives set to be achieved.

3.2 Study area

The study area selected for the study includes Ado-Ekiti and Oye-Ekiti in Ekiti state. Ado Ekiti is a city in southwest Nigeria, the state capital and headquarters of Ekiti State. The population in 2006 was 308,621. This area covers a land area of 293 square kilometers. The people of Ado Ekiti are mainly of the Ekiti sub-ethnic group of the Yoruba. Various commercial enterprises operate in Ado Ekiti. The city is the trade centre for a farming

region where yams, cassava, grain, and tobacco are grown. Cotton is also grown for weaving. Ado-Ekiti is situated is a land that has been continuously inhabited/occupied by human communities from time immemorial. Available research shows that human societies of unknown antiquity occupied this neighbourhood about eleven thousand (11,000) years ago. These ancient inhabitants were probably the same or progenitors/ancestors of Igbon near Ogotun, Erijiyan, Ijero, Ulesun and Asin (near Ikole) who were probably autochthones because available traditions shows that they had lived in and near their abodes from time immemorial.

Oye-Ekiti on the other hand, Oye is a town and headquarter of Oye Local Government Area in Ekiti State, Nigeria. Oye Local Government Area was carved out from the defunct Ekiti North Local Government on 17 May 1989. There are 134,210 people in Oye-Ekiti area as its Local Government is bounded by Ilejemeje Local Government to the North, Irepodun/Ifelodun to the South, Ikole local Government to the East and Ido/Osi Local Government to the West. There are no distinctive ethnic groups in the Local Government as a greater percentage of the people resident is of the Yoruba Language race. Nearly all the people speak Yoruba Language with negligible dialectical variations.

3.3 Population of the study

A population is made up of all conceivable elements, subjects, or observations relating to a particular phenomenon of interest to the researcher. The population of the study describes the overall people where the sample for a research work can be drawn. The population describes the entire number of people which a researcher can select the number of sample to be used for the research work. A population is a term used in more general sense which includes all members or elements of a well-defined group.

Therefore, the population of the study constitutes all adults, (members of the society) in Ado-Ekiti and Oye-Ekiti in Ekiti state.

3.4 Sample size and sampling technique

Sample size is the particular proportion of the defined population estimated by the use of certain method or procedure. Sampling involves systematically choosing a limited number of units to represent a total population.

Considering the fact that it is not possible to absorb the entire population in this study due to time constraint and lack of resources, the researcher adopted a non-probability sampling technique to select a sample that will truly represent the whole population. The non-probability sampling used is purposive sampling to obtain information from specific target groups. The sampling is confined to specific adults from Ado and Oye-Ekiti who are old enough and well-learned to answer questions on depression. In this regard, the researcher limits the sample to 200 respondents for both Ado and Oye-Ekiti to represent the whole population.

More so, in a bid to collect adequate information, an interview was arranged with 10 purposively sampled adults (5 each from Ado and Oye Ekiti) because of their roles in the society. These sampled individuals were:

1.Two local chieftain

2.Two medical practitioner

3.Two sociologist

4.Four nominal professionals

3.5 Research instrument

The research instrument adopted for this study is a questionnaire and an interview guide. The questionnaire is titled Societal Perception of Mental Illness Attitude Scale (SPMIAS).

This questionnaire is made up of four sections. Section A is concerned with personal, section B, C and D are made up of items on the attitude of the citizens to depression and mental illness in general. The interview guide comprised questions suitable to elicit information from the selected categories of people. A sound recorder was used to relay information after which it was noted in paper.

3.6 Validity of the instrument

All items contained in the assessment scale were related to the core objectives of the study. The research instrument was first exposed to professionals in the field of Sociology for necessary corrections, modifications and validation of the instrument. The instrument was standardized by the research supervisor. The interview guide was also submitted to the research supervisor who ensured that the questions were properly framed and tangent to the objective of the study.

3.7 Reliability of instrument

The instruments employed in this study were found consistent in measuring what they ought to measure after undergoing some statistical guidelines. The instruments were subjected to test-retest as a measure of stability to check the reliability of the instruments. A study area apart from the selected sample ones was selected and each of the same instruments was administered to the same group of individuals over a space of two weeks.

3.8 Method of data collection

The ultimate aim of every research is to find solutions to identified problems of the subject of study. This can only be achieved through the collection of reliable data. Therefore data were collected for analysis through the use of structured questionnaire and interview. The questionnaire is designed as a self-administered process whereby respondents read the

questions and record their responses without the help of the interviewer while the interview procedure allowed respondents to express themselves in their own words.

3.9 Method of data analysis

In this research, both descriptive and inferential statistics is used for the analysis. Descriptive statistics summarizes the characteristics of data obtained from the administered questionnaire, presents in tables, frequency, percentage, and analyzed descriptively. Also, inferential analysis through a non-parametric statistical testing tool chi-square is conducted on the data obtained for the purpose of testing the hypotheses formulated. The analysis is carried out using the statistical package for social science (SPSS version 20) software to ensure accurate presentation and interpretation.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

In this chapter, the researcher presents the results of the analysis of primary data gathered through questionnaire administered to various respondents in tables showing frequencies and percentages and also the result of the interview conducted. The result and interpretation of the research hypotheses earlier stated in chapter one of the research work were also presented. A total of two hundred (200) questionnaires were distributed and all were duly completed and returned. Thus, response rate of this study is 100.0%. However, the study used all the data collected for the purpose of the analysis.

4.1 Data Presentation

This section contains the presentation and analysis of responses to the questionnaire administered.

Table 4.1: Demographic distribution of the respondents

VARIABLES		FREQUENCY	PERCENTAGE
Age	Below 25	27	13.5
	26-35	34	17.0
	36-45	71	35.5
	46-55	49	24.5
	56 and above	19	9.5
	Total	200	100.0
Sex	Male	93	46.5
	Female	107	53.5
	Total	200	100.0
Occupation	Civil servant	65	32.5
	Artisan	75	37.5
	Student	14	7.0
	Professional	41	20.5
	Others	5	2.5
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.1 presents the demographic distribution of the respondents. The age distribution shows that 27(13.5%) of the respondents are below 25 years of age, 34(17%) are within

age range of 26-35 years, 71(35.5%) are within age 36-45 years, 49(24.5%) have age range between 46-55 years while the remaining 19(9.5%) are 56 years and above. This result implies that majority of the respondents are within the age range 36-45 years.

The table also shows the gender distribution of the respondents. It is revealed that 93(46.5%) respondents are males while the remaining 107(53.5%) are females.

The occupation distribution of the respondents is presented in the table 4.1. The result depicts that 65 which account for 32.5% of the total respondents are civil servants, 75(37.5%) are artisans, 14(7%) are students, 41(20.5%) are professionals while 5(2.5%) have other occupation.

Table 4.2: Respondents' marital status and religion affiliation distribution

VARIABLES		FREQUENCY	PERCENTAGE
Marital status	Single	61	30.5
	Married	85	42.5
	Divorced	27	13.5
	Widowed	27	13.5
	Total	200	100.0
Religion	Christianity	104	52.0
	Islam	88	44.0
	Others	8	4.0
	Total	200	100.0
Academic Qualification	No formal education/SSCE	35	17.5
	NCE/HND	74	37.0
	B.Ed./BSc	58	29.0
	MSc/Med	27	13.5
	Others	6	3.0
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.2 presents the marital status of the respondents. Result reveals that 61 respondents are single, 85(42.5%) are married, 27(13.5%) are divorced and widowed respectively.

The table also depicts the religious affiliation of the respondents. The result shows that 104(52.0%) respondents are Christians, 88(44%) practice Islam while 8 belong to other

religious group. It is also depicted that 35 respondents have no formal education or SSCE, 74(37%) have NCE/HND, 58(29%) have B.Ed./BSc, 27(13.5%) have either MSc/Med while 6 respondents have other qualifications.

Table 4.3: Distribution showing whether people suffer from depression

VARIABLES		FREQUENCY	PERCENTAGE
Do you think people easily suffer from depression?	Frequently	133	66.5
	Rarely	61	30.5
	Never	6	3.0
	Total	200	100.0
Do you think everybody suffer from depression?	Yes	140	70.0
	No	60	30.0
	Total	200	100.0
Can you say people in your community easily get depressed?	Yes	113	56.5
	No	52	26.0
	Unsure	35	17.5
	Total	200	100.0
Have you personally suffered from depression?	Yes	84	42.0
	No	116	58.0
	Total	200	100.0
If Yes, how frequently?	Always	77	91.7
	Not frequent	7	8.3
	Total	84	100.0

Source: Researcher's Survey, 2017.

Table 4.3 presents the view of the respondents on the manner in which people suffer from depression. Result shows that 133(66.5%) respondents affirm that people frequently suffer from depression, 61(30.5%) confirm that it rare for people to suffer from depression while 6(3%) respondents are of the opinion that never suffer depression. This implies that people easily and frequently suffer from depression. The interviewed respondents confirmed it that the frequency of depression is high among people in Ado and Oye-Ekiti. According to a respondent, "*people suffered from depression as a result of economic meltdown, rejection from loved ones, loss of properties and loved ones, and unemployment*" (IDI, Ado-Ekiti).

Another respondent:

"People suffered from depression because they do not have the ability and money to cater for their basic necessities, also things (business activities) are not moving as supposed to, therefore, people (businessmen) suffer from depression" (IDI, Oye-Ekiti).

The table also presents the perception of the respondents on people suffering depression. It is depicted that 140(70%) of the respondents agree that everybody suffer from depression while 60(30%) reject this. The implication is that everybody in one way or the other suffers from depression. The result of the respondents' opinion on whether people in their community easily get depressed is also presented in the table 4.3. 113(56.5%) of the respondents affirm that their community people easily get depressed, 52(26%) reject this while 35(17.5%) are unsure about this.

Table 4.3 also present the result on if the respondents have personally suffered depression. The result shows that 84(42%) of the total respondents agreed to have personally suffered from depression while 116(58%) have not. Also, the result shows that out of the 84 respondents who have personally experienced depression, 77(91.7%) frequently suffers depression while 7 rarely suffer depression.

Also two of the interviewed persons affirmed that they have personally suffered from depression. **First respondent:**

"I suffered depression when I lost my father. I had series of sleepless night; I lost appetite for food and social activities" (IDI, Oye-Ekiti).

Another respondent:

"I suffered depression when I lost my job. I could no longer carry out my expected responsibilities at home. Then it seemed as if that was the end of life. I felt unequal with my peers due to this loss of job" (IDI, Ado-Ekiti).

Table 4.4: Distribution showing the level of societal stigmatization on people coping with depression

VARIABLES		FREQUENCY	PERCENTAGE
Do you think residents of Ado-Ekiti and Oye-Ekiti feel irritated living with the mentally ill?	Yes	158	79.0
	No	42	21.0
	Total	200	100.0
Can people stay around people suffering from depression?	True	152	76.0
	False	45	24.0
	Total	200	100.0
I perceive my community resists the depressed	Yes	142	71.0
	No	58	29.0
	Total	200	100.0
Do you think the level of stigma associated with the mentally ill is high	Yes	157	78.5
	No	43	21.5
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.4 presents the level of societal stigmatization on people coping with depression. The table shows that 158(79%) of the respondents affirm that the residents of Ado and Oye-Ekiti feel irritated living with mentally ill while 42(42%) reject this.

The table also depicts the respondents' opinion on whether people stay around the depressed. The result shows that 152(76%) respondents gave their confirmation that people can stay around people suffering from depression while 45 which account for 24% reject this view.

Also the table 4.4 reveals the respondents perception on the resistance of the depressed by the community. Result shows that 142(71%) respondents agree that their community resists the depressed while 58 reject this.

The table also depicted the level of stigma associated with the mentally ill. The result shows that 157(78.5%) of the respondents affirm that the level of stigma associated with the mentally ill is high while 43(21.5%) reject. To support this assertion, the interviewed persons affirmed that: *"the level at which the depressed are being stigmatized is on the high level, most times they are being neglected and avoided in almost all aspect of life"* (IDI, Ado-Ekiti).

Another respondent:

"The depressed are being segregated and discriminated, most especially when it comes to decision making that has to do with public matters – such as politics, social activities" (IDI, Oye-Ekiti).

4.5: Distribution showing the society believes the depressed are associated with spiritual problems

VARIABLE		FREQUENCY	PERCENTAGE
The society believes the depressed are associated with spiritual problems	True	155	77.5
	False	45	22.5
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.13 shows that 155(77.5%) respondents affirm that society believes the depressed are associated with spiritual problem while 45 reject this.

Table 4.6: Distribution of health practitioners' attitude to people with mental illness

VARIABLES		FREQUENCY	PERCENTAGE
I think health workers are afraid of the mentally ill and try to avoid them	Yes	153	76.5
	No	47	23.5
	Total	200	100.0
I believe most health workers avoid touching the mentally ill	Yes	143	71.5
	No	57	28.5
	Total	200	100.0
Would you say health workers care for the mentally ill	Yes	112	56.0
	No	88	44.0
	Total	200	100.0
	Yes	139	69.5

Would you say health workers in Ado-Ekiti and Oye-Ekiti stigmatized the mentally ill	No	61	30.5
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.6 shows the respondents view on health workers avoid mentally ill because of fear. The result shows that 153(76.5%) respondents agree that health workers are afraid of the mentally ill and avoid them while 47 do not agree. Also the table depicts that 143 respondents believed that most health workers avoid touching the mentally ill while 57(28.5%) do not agree.

Respondents view on the health workers care for mentally ill is presented in the table 4.6. Result shows that 112(56%) of the respondents agree that health workers care for the mentally ill while 88(44%) do not agree.

Also, the stigmatization from medical workers is also presented in the table above. The result shows that 139(69.5%) respondents agree that health workers in Ado and Oye-Ekiti stigmatized the mentally ill while 61 reject. This implies health practitioners in both Ado and Oye-Ekiti neglect those that are mentally ill. The interview result does not support this assertion that medical practitioners stigmatized the mentally ill. Majority (80%) of the interviewed persons affirmed that medical workers give proper attention and care to people suffering from depression while the remaining 20% support the assertion that medical practitioners behaved irrational.

First respondent:

"*Medical practitioners are well trained to the extent that they attend to the mentally ill with high urgency*" (IDI,Ado-Ekiti).

Another respondent:

"In Ekiti state generally, government has invested a whole lot on medical care for the citizens. You can see that the level of mental illness is low in Ekiti" (IDI,Ado-Ekiti).

Another respondent:

"Medical workers often neglect the depressed. They do not give adequate care to the mentally ill persons".

The implication of this interview result is that medical practitioners do give attention to mentally ill; this is not in accordance with the quantitative analysis result.

Table 4.7: Distribution of the effect of family care on those that are mentally ill

VARIABLES		FREQUENCY	PERCENTAGE
I can say that mental illness usually originates from dysfunctional families	True	136	68.0
	False	64	32.0
	Total	200	100.0
I think mental illness is aggravated when one's family do not show enough care and support	True	167	83.5
	False	33	16.5
	Total	200	100.0
In Ado and Oye-Ekiti, I think the families of the mentally ill do not care for their mentally ill relatives	Yes	165	82.5
	No	35	17.5
	Total	200	100.0
Which of the support service do you prefer to be better against depression?	Medical care	110	55.0
	Family care	90	45.0
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.7 presents the distribution of the effect of family care on those that are mentally ill as perceived by the respondents. The table shows the respondents confirmation on whether mental illness originates from dysfunctional family. Result shows that 136(68.0%) respondents confirm it to be true that mental illness is from dysfunctional families while 64 reject.

It is also depicted that 167(83.5%) of the respondents affirm that mental illness is aggravated when family members of the mentally ill person do not show enough care and support while 33 reject. The table presents the perceived family care for the depressed. The result shows that 165(82.5%) of the respondents affirm that families of the mentally ill do not care for their mentally ill relatives while 35(17.5%) reject.

Finally on the table 4.7, the respondent preference on care for the depressed is presented. The result shows that 110(55%) of the respondents prefer medical care as the support service to combat against depression while 90(45%) prefer family care. In support of the quantitative analysis, the interviewed persons also prefer family care to medical care. A respondent said: *"family care forms a basis for any other care"* (IDI, Ado-Ekiti).

Table 4.8 Distribution showing the best way to combat depression

VARIABLE		FREQUENCY	PERCENTAGE
How best do you think depression should be combated?	Family care	136	68.0
	Medical care	49	24.5
	Prayers and Traditional believe	15	7.5
	Total	200	100.0

Source: Researcher's Survey, 2017.

Table 4.8 presents the respondents perceived measures to combat depression. The result shows that 136(68%) of the respondents believed that family care will combat depression, 49(24.5%) agreed medical care while 15(7.5%) believed that prayers and traditional care will combat depression. To support the result of the quantitative analysis, the interviewed persons also suggested possible solution to depression. Three 3(30%) of the interviewed person suggested family care as best solution, 5(50%) suggested medical care while 2(20%) agreed on both.

A respondent who agreed on family care said that "*care to mental illness care start from the family because family is the basic unit of the society*" (IDI, Oye-Ekiti).

Another respondent:

"Medical care is the best care that can be given to a mentally ill person because medical practitioner will handle the depressed case with high level of expertise" (IDI, Oye-Ekiti).

Another respondent:

"Solution come from both family and medical, the solution first come from the family because the family members shows love to the depressed thereafter seek medical care for the depressed relatives"(IDI, Ado-Ekiti). The implication is that medical care as suggested by the interviewed persons does not agree with the assertion that family care is the best solution for mental illness as derived from the quantitative analysis.

4.2 Test of Hypotheses

In this section, the hypothesis earlier formulated by the researcher in chapter one is tested to enable an opinion and inference to be drawn. The inferential statistics chi-square was used to test the Hypothesis at 5% significance level. The analysis considered relevant questions as they relate to the hypothesis.

Decision rule:

Reject the H0 if the p-value is less than (<) 5% level of significance. Accept the H0 if the p-value is greater than (>) 5% level of significance.

Hypothesis 1

H0 – stigmatization as a societal factor does not significantly affect the depressed

Table 4.9: Test statistics of the relationship between stigmatization and the depressed

stigmatization as a societal factor does not significantly affect the depressed	Chi-Square	390.245
	Df	2
	Asymp. Sig.	.000

Source: Researcher's Survey, 2017.

Table 4.9 present the result of the chi square statistics conducted to find out if stigmatization; a societal factor significantly affects the depressed. The table shows a chi

square value of 390.245, degree of freedom 2 with p-value of 0.000 which is significant at 5% level of significance. That is $X^2(2) = 390.245$, $p = 0.000$. The result implies that there is existence of significant relationship between societal factor and state of depression at 95% confidence level. Since the p-value (sig. 2-tailed) is 0.000 which is less than 5% level of significance, ($0.000 < 0.05$), the study therefore reject the null hypothesis (H0) which states that stigmatization as a societal factor does not significantly affect the depressed.

Hypothesis 2

H0 – health practitioner attitude does not significantly affect the depressed

Table 4.10: Test statistics of the relationship between health practitioner attitude and the depressed

health practitioner attitude does not significantly affect the depressed	Chi-Square	692.350
	Df	4
	Asymp. Sig.	.000

Source: Researcher's Survey, 2017.

Table 4.10 presents the summary of chi-square result of the relationship between health practitioner attitude and the state of depression. From the table, the result indicates a chi-square value of 692.350, degree of freedom of 4 and p-value of 0.000, that is $X^2(4) = 692.350$, $p = 0.000$. This implies that there exist a strong and significant relationship between health practitioner attitude and state o depression at 5% level of significance.

From the foregoing, it is evident that the Prob. of t-statistics (0.000) is less than 5% level of significance; the study reject the null hypothesis (H0) which states that health practitioner attitude does not significantly affect the depressed.

Hypothesis 3

H0 – family care for mentally ill relatives does not significantly affect the depressed

Table 4.11: Test statistics of the relationship between family care and the depressed

family care for mentally ill relatives does not significantly affect the depressed	Chi-Square	84.500
	Df	1
	Asymp. Sig.	.000

Source: Researcher's Survey, 2017.

Table 4.11 present the result of the chi square statistics summary on the family care for mentally ill relatives and the state of depression. The table shows a chi square value of 84.500, degree of freedom 1 with p-value of 0.000 which is significant at 5% level of significance. That is $X^2(2) = 84.500$, $p = 0.000$. This indicates that there is existence of significant relationship between family care and state of depression at 5% significant level. Since the p-value 0.000 is less than 5% level of significance, ($0.000 < 0.05$), the study reject the null hypothesis (H0) which states that family care for mentally ill relatives does not significantly affect the depressed is accepted.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

The main aim of this study is to investigate the perspective of the society towards the mentally ill. However, this project has been classified into five (5) chapters. The first chapter deals with the introduction of the research topic. The second chapter deals with the definition of concepts, theoretical and empirical framework. The literatures related to this research were thoroughly reviewed and a clean surplus sociological theory which underpins the study was identified. The third chapter deals with the research methodology, data sources, and estimation procedure used to analyze the result of the research work.

The fourth chapter presented the results of the analysis of primary data gathered through questionnaire administration and interview. The result and interpretation of the research hypothesis were also presented. Finally, the fifth chapter presents the summary of the study, conclusions, and recommendation. Also this chapter also deals with the discussion of research findings as they relate to the objectives of the study and providing answers to the research questions formulated in this study.

5.1 Discussion of the findings

This section of this chapter provides the discussion of research findings as they relate to the objectives of the study and answers to the research questions. These results of the above are discussed below;

5.1.1 Society and the state of depression

From the result of the analysis in the previous chapter, it can be deduced that rate at which people get depressed is of high increase. Table 4.3 shows that majority of the respondents consented that the people do frequently get depressed. This could be as a result of environmental or economic issues like joblessness, poverty etc. Also the study found that

society often resists the depressed which affect their rate of recovery from depression. In addition to the descriptive analysis, inferential analysis using chi-square revealed that stigmatization as a societal significantly affects the depressed. The implication is that the societal stigmatization slow down the rate at which they recover.

5.1.2 Health practitioner attitude and the state of depression

Result confirms that health worker often get afraid of the depressed and therefore avoid touching them. Analysis of the respondents view depicts that majority of the respondents perceived that health workers medically avoid the depressed. Inferential analysis also reveals that there is significant relationship between health practitioner attitude and the state of depression. The result implies that health practitioner attitude like avoidance worsen people's state of depression.

5.1.3 Family care and the state of depression

Care from the family members for the mentally ill relatives might increase or reduce the suffering of the depressed but reverse is the case. The result in the table 4.7 confirms that families of the mentally ill do not give adequate attention and care for their mentally ill relatives. In support of this, chi-square result also confirms it that family care does significantly affect the depressed.

5.2 Conclusion

From the result of the empirical findings in the chapter four of this study, the researcher concludes therefore that:

People are frequently subjected to depression;

Society stigmatization affects the depressed level of recovery; the rate at which the depressed are stigmatized by their societies is alarming;

Health workers attitude of avoidance and fear significantly affect the depressed;

Family support to the depressed is insufficient to aid recovery from depression;

Adequate medical and family serve the best way of combating depression.

On the overall, the study concludes that public attitude towards the mentally ill especially the depressed significantly affect the rate of recovery from depression.

5.3 Recommendations

Based on the results of the findings, the following recommendations were made:-

i. The families of the mentally ill should take proper care of their mentally ill relatives

ii. Government support should be given to the mentally ill persons through the provision of modernized medical care centres equipped with cut-edge technologies and well-trained medical personnel.

iii. The society should embrace the depressed and help their level of recovery from depression. The public should be sensitized on how best to cope with the depressed and to show care during period of depression encounter.

iv. Government extension programs can be carried out to help depressed individuals cope with their illness. These programs can be carried out in forms of rural extension projects on mental illness and the importance of sound mental health.

v. Counseling outreaches should be set up in schools and organizations to help people with psychotherapy and guidance services in schools and organizations to help people suffering from depression.

5.4 Limitations of the Study

In the process of this study, researcher encountered some difficulties in obtaining data on depression. The selection of the participants from only two towns in Ekiti state may limit

generalization of the results and may affect the perception of the public sampled. Also the study inability to obtain data from a very large sample of the population tends to impair the generalization of the findings to a certain extent.

Another limitation of this study is that it did not assess the potential factors that may have a relationship with depression such as the academic performance, life style and socioeconomic factors. These factors could also be potential confounders that might have masked the association between depression and gender.

5.5 Suggestions for further Studies

The researcher recommendation for future studies is to extend the analysis to all other forms of mental illness. Future researchers can extend their study to other states. More so, future researchers should identify other specific strategies for coping with mental illness cases.

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APPENDIX
DEPARTMENT OF SOCIOLOGY
FACULTY OF SOCIAL SCIENCES
FEDERAL UNIVERSITY, OYE EKITI

"Societal Perception of Mental Illness Attitude Scale (SPMIAS)"

Dear Respondent,

This questionnaire is designed to gather information on the perception of the public towards the mentally ill especially the depressed. Please note that this questionnaire is strictly for research and academic purpose and you are requested to complete the appropriate columns of this questionnaire. This is not a test, and as such there is no right or wrong answers. You are also assured of total confidentiality and anonymity of all information provided.

Thank you.

Olumilua

Precious

SECTION A: BACKGROUND INFORMATION

Respondents will be required to fill the space with the necessary information or by ticking the boxes where applicable

1. Age: Below 25 ( ); 26-35 ( ); 36-45 ( ); 46-55 ( ); 56 and above ( )
2. Sex: Male ( ); Female ( )
3. Occupation: Civil servant ( ); Artisan ( ); Student ( ); Professional ( ); Others please specify .....
4. Marital status: Single ( ); Married ( ); Divorced ( ); Widowed ( );
5. Religion: Christianity ( ); Islam ( ); Others please specify .....
6. Academic Qualification: No formal education SSCE ( ); NCE/HND ( ); B.Ed, B.Sc, B.A ( ); MSc, MEd ( ) Others please specify .....

SECTION B: FREQUENCY OF SUFFERING FROM DEPRESSION

Please tick √ on the option that suits your opinion.

1. Do you think people easily suffer from depression? Frequently ☐ Rarely ☐ Never ☐
2. Do you think everybody suffer from depression? Yes ☐; No ☐
3. Can you say people in your community easily get depressed? Yes ☐; No ☐; ☐ Unsure
4. Have you personally suffered from depression before? Yes ☐; No ☐
5. If yes, how frequently? .....

SECTION C: LEVEL OF STIGMA ASSOCIATED WITH PEOPLE COPING WITH DEPRESSION

1. Do you think residents of Ado and Oye-Ekiti feel irritated living with the mentally ☐ Yes ☐ No
2. Can you stay around people suffering from depression? True ☐; False ☐
3. The society believes the depressed are associated with spiritual problems. ☐ True ☐ False
4. I perceive my community resists the depressed. Yes ☐; No ☐
5. Do you think the level of stigma associated with the mentally ill is high? .....

SECTION D: ATTITUDE OF HEALTH PRACTITIONERS TO PEOPLE WITH MENTAL ILLNESS

1. I think health workers are afraid of the mentally ill and try to avoid them. Yes ☐ ; No ☐
2. I believe most health workers avoid touching the mentally ill. Yes ☐ No ☐
3. Would you say health workers care for the mentally ill. Yes ☐ ; No ☐
4. Would you say health workers in Ado and Oye-Ekiti stigmatized the men ☐ ill Ye ☐ ; No

SECTION E: EFFECT OF FAMILY CARE TO THOSE WITH MENTAL ILLNESS

1. I can say that mental illness usually originates from dysfunctional families. ☐

True ; False ☐

2. I think mental illness is aggravated when one's family do not show enough care and support

   True ☐; False ☐

3. In Ado and Oye-Ekiti, I think the families of the mentally ill do not care for their mentally ill relatives.

   Yes ☐; No ☐

4. Which of the support service do you prefer to be better against depression?

   Medi☐are ; Fan☐are

SECTION D: PERCEPTION OF RESIDENTS OF ADO AND OYE-EKITI ON THE BEST POSSIBLE SOLUTION TO DEPRESSION

How best do you think depression should be combated?

.....

.....

.....

.....

Thank you

DEPARTMENT OF SOCIOLOGY

FACULTY OF SOCIAL SCIENCES

FEDERAL UNIVERSITY, OYE EKITI

"Interview guide on Societal Perception of Mental Illness"

Introduction

This interview is drawn only to provide additional information to the perception of the society to the mentally ill. The respondents will consist of any of the following:

5.Local chieftain

6.Medical practitioner

7.Sociologist

8.Nominal professionals

The interviewer performs the following proceedings

1. Welcome
    - Introduces herself
    - Explains the purpose of the session
    - Inform the interviewee of what will be done with the information
    - Explain why the interviewee was asked to participate
2. Appreciates the interviewee for deciding to participate in the interview process and ensures that the interviewee is comfortable and calm
3. Assures the interviewee of complete confidentiality
4. Notify the interviewee of the use of a recording device

The interviewer proceeds with the process and ask the following questions, giving enough time to the interviewee to think before answering and to express him/herself.

Questions

1. Can you please introduce yourself?
2. What do you understand by mental illness?
3. What in your perception is depression?
4. Have you ever suffered from depression? Give details (when last, cause etc)

5. How frequent, in your perception, do residents of Ado and Oye-Ekiti suffer from depression?
6. What is the level of stigma associated with people coping with depression in Ado and Oye-Ekiti?
7. How do medical/health practitioners behave to people with mental illness?
8. How do you see family care as a treatment to people suffering from mental illness?
9. What are the best possible solutions to depression

Thank you.

Olumilua Precious