

AWARENESS AND ATTITUDE TOWARDS MENTAL ILLNESS AMONG RESIDENTS OF BINJI COMMUNITY, BINJI LOCAL GOVERNMENT AREA, SOKOTO STATE, NIGERIA

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ABSTRACT

Mental illness is a major public health concern and is often associated with stigma, discrimination, fear and social exclusion, which may hinder care-seeking and community reintegration. Globally, nearly one in seven people were living with a mental disorder in 2021, underscoring the need for community-level evidence and mental health education. This study assessed awareness and attitudes towards people living with mental illness among residents of Binji Community, Binji Local Government Area, Sokoto State, Nigeria. A descriptive cross-sectional survey was conducted among 407 adults aged 18 years and above who were residents of Binji Community and gave informed consent. Non-consenting individuals and residents outside the selected ward were excluded. Respondents were selected through multistage sampling, followed by accidental sampling within selected districts. Data were collected using a researcher-administered structured questionnaire adapted from a previous community mental health study. Data were analysed using Microsoft Excel and presented as frequencies, percentages and 95% confidence intervals. Administrative permission was obtained, informed consent was secured, and confidentiality was maintained throughout the study. The mean age of respondents was 28.1 ± 7.14 years; 71.7% were male, 28.3% were female, 96.3% practised Islam and 3.7% practised Christianity. All respondents had heard of mental illness, although only 36.1% correctly defined it, and 47.2% had high awareness. Negative attitudes and social distance persisted: 86.0% avoided going near people living with mental illness, 73.7% were afraid of them and 89.7% would not eat with them. However, 49.2% reported that they would interact freely with people living with mental illness, suggesting mixed or ambivalent attitudes. Major perceived influences on attitude were fear (86.0%), gender (84.8%), previous encounter (77.6%), age (76.4%), severity of illness (76.4%) and social factors (72.0%). Awareness of mental illness was relatively high, but negative attitudes, fear and social avoidance remained common. Community mental health education, anti-stigma campaigns, public enlightenment and healthcare provider-led community engagement are recommended to improve acceptance and interaction with people living with mental illness.

Keywords: Awareness; Attitude; Community mental health; Mental illness; Stigma; People living with mental illness.

INTRODUCTION

Mental health is an essential component of health and well-being. It influences how individuals think, feel, relate with others, make decisions and cope with ordinary stresses of life. Mental illness, on the other hand, may affect cognition, emotional regulation and behaviour, and can lead to distress, impaired functioning and social disadvantage when effective care and support are not available (World Health Organization [WHO], 2025).

The global burden of mental illness is substantial. WHO reported that in 2021 nearly one in seven people worldwide, approximately 1.1 billion people, were living with a mental disorder, with anxiety and depressive disorders being the most common (WHO, 2025). The same report emphasized that many people with mental disorders do not have access to effective care and that stigma, discrimination and human rights violations remain major barriers to care. This global evidence strengthens the need for studies that examine community awareness, attitudes and factors that shape social responses to people living with mental illness.

Stigma remains one of the most persistent challenges in mental health care. It affects people living with mental illness, their families, caregivers and healthcare professionals, and may reduce help-seeking, treatment continuation and social reintegration. Javed et al. (2021) argued that mental health stigma requires coordinated action through culturally appropriate awareness programmes, workforce capacity building, inclusive policies and improved access to services, particularly in low- and middle-income countries.

In Nigeria, mental health has gained increasing policy attention. The 2021 National Mental Health Act received presidential assent in December 2022, and the country has strengthened mental health policy, public health programming and the contextualization of WHO mhGAP 3.0. However, WHO Regional Office for Africa noted that stigma and discrimination remain key barriers to mental health care in Nigeria, despite improving public conversation around mental health (WHO Regional Office for Africa, 2025).

Community beliefs are especially important because people living with mental illness often first experience judgement, fear, social exclusion or support within their immediate environment. Across African settings, mental illness may still be attributed to supernatural causes, spiritual punishment, substance use, brain disease or other perceived factors, and these interpretations may affect willingness to interact with, support or seek appropriate care for affected persons (Labinjo et al., 2020; Okafor et al., 2022).

Previous Nigerian and African studies have reported that awareness of mental illness does not always translate into accepting attitudes. For example, Effiong et al. (2019) found poor knowledge and stigmatizing attitudes towards mental illness in a community in Akwa Ibom State, while a recent community-based study in Tanzania reported that stigmatizing attitudes such as unwillingness to visit, marry or share a room with people living with mental illness persisted despite adequate knowledge among many participants (Oguma et al., 2025).

This study was anchored on Attribution Theory, which explains how individuals interpret the causes of other people's behaviour and how those interpretations shape reactions towards them. Applied to mental illness, the theory helps to explain how community members may attribute unusual behaviour to controllable or

uncontrollable causes, such as personal choice, supernatural influence, stress, biology, environment or illness. These attributions may influence whether people respond with fear, blame, avoidance, sympathy or support. In the context of this study, Attribution Theory provides a useful framework for understanding how awareness and perceived causes of mental illness may shape attitudes towards people living with mental illness.

In Sokoto State, there is still limited community-level evidence from rural local government areas such as Binji. Understanding residents' awareness, attitudes and perceived factors influencing attitudes is important for designing culturally appropriate mental health education, anti-stigma interventions and community-based mental health nursing activities. This study therefore assessed awareness and attitude towards people living with mental illness among residents of Binji Community, Binji Local Government Area, Sokoto State, Nigeria.

Research Questions

1. What is the level of awareness of mental illness among residents of Binji Community?
2. What attitudes do residents of Binji Community have towards people living with mental illness, including their willingness to interact with and support them?
3. What social, cultural, demographic and experiential factors are perceived to influence residents' attitudes towards people living with mental illness?

Research Objectives

The broad objective of this study was to assess awareness and attitudes towards people living with mental illness among residents of Binji Community, Binji Local Government Area, Sokoto State, Nigeria. The specific objectives were to:

1. assess the level of awareness of mental illness among residents of Binji Community;
2. determine the attitudes of residents of Binji Community towards people living with mental illness; and
3. identify perceived social, cultural, demographic and experiential factors influencing residents' attitudes towards people living with mental illness.

METHODS

Research Design

A descriptive cross-sectional survey design was adopted to assess awareness, attitudes and factors influencing attitudes towards people living with mental illness among residents of Binji Community. The design allowed data to be collected from respondents at a single point in time without manipulating study variables.

Study Setting

The study was conducted in Binji Community, Binji Local Government Area of Sokoto State, Nigeria. Binji Local Government Area is located within the Sokoto North Senatorial District and comprises ten wards. The residents are predominantly Hausa and Fulani, with Islam as the dominant religion. Common occupations in the area include agriculture, trade, cattle rearing, pottery and other local economic activities.

Study Population and Eligibility Criteria

The study population comprised adult male and female residents of Binji Community. Eligible participants were residents aged 18 years and above who were available during data collection and gave informed consent to participate. Non-consenting

individuals, residents below 18 years and persons who were not residents of the selected ward were excluded from the study.

Sample Size and Sampling Technique

A total of 407 respondents participated in the study. A multistage sampling technique was used to select the study area and respondents. Sokoto State's local government areas were first listed and Binji Local Government Area was selected. Wards and districts within the selected area were then identified, after which respondents were recruited within selected districts using accidental sampling until the required number of participants was reached.

Instrument for Data Collection

Data were collected using a researcher-administered structured questionnaire adapted from Effiong et al. (2019). The questionnaire consisted of sections on socio-demographic characteristics, awareness of mental illness, attitudes towards people living with mental illness, and perceived factors influencing attitudes. The instrument was reviewed for face and content validity by the research supervisor and colleagues, and corrections were incorporated before administration.

Data Collection Procedure

The researcher and trained assistants administered the questionnaire to eligible and consenting respondents. The purpose of the study was explained to respondents before data collection. Questionnaires were checked for completeness and no personal identifiers were collected.

Data Analysis

Data were coded, entered into Microsoft Excel, checked for completeness and analysed using descriptive statistics. Frequencies and percentages were used to summarize demographic characteristics, awareness items, attitude items and perceived factors influencing attitudes. A 95% confidence interval was computed for selected proportions to indicate the precision of the estimates. Awareness scores were categorized as low, moderate and high based on the scoring guide used for the questionnaire. Attitude items were reported individually to show the pattern of social acceptance, fear and avoidance. No causal inference was made because of the descriptive cross-sectional design.

Ethical Considerations

An introductory letter was obtained from the Department of Nursing Sciences, ethical approval was sort from the Sokoto State Health Research Ethics Committee (SKHREC/118/2021) and administrative permission was obtained from relevant community authorities before data collection. Informed consent was obtained from respondents after explaining the purpose of the study, voluntary participation and the right to withdraw. Confidentiality and anonymity were maintained by excluding names and other personal identifiers from the questionnaire.

RESULTS

A total of 407 respondents participated in the study. Results on socio-demographic characteristics, awareness of mental illness, attitudes towards people living with mental illness and perceived factors influencing attitudes are presented below.

Table 1: Socio-demographic characteristics of respondents (N = 407)

Variable	Frequency	Percentage
Age		
18-22 years	119	29.2
23-27 years	81	19.9
28-32 years	86	21.1
33-37 years	67	16.5
38-42 years	30	7.4
Above 42 years	24	5.9
Sex		
Male	292	71.7
Female	115	28.3
Religion		
Islam	392	96.3
Christianity	15	3.7
Ethnicity		
Hausa	255	62.7
Fulani	90	22.1
Others	62	15.2
Education		
Tertiary	126	31.0
Secondary	139	34.1
Islamic	76	18.8
Primary	38	9.3
None	28	6.8
Occupation		
Self-employed	145	35.6
Civil servant	116	28.5
Unemployed	57	14.0
Trading	44	11.0
Farming	41	10.0

Table 1 shows that the largest age group was 18-22 years (29.2%), while the mean age of respondents was 28.1 ± 7.14 years. Most respondents were male (71.7%), Muslim (96.3%), Hausa (62.7%), had secondary education (34.1%) and were self-

employed (35.6%). The relatively small proportions of female respondents (28.3%) and Christian respondents (3.7%) should be considered when interpreting subgroup-related findings.

Table 2: Awareness of mental illness among respondents (N = 407)

Variable	Category	Frequency	(%)	95% CI (%)
Ever heard of mental illness	Yes	407	100.0	99.1-100.0
Source of information	Mass media	170	41.8	37.1-46.6
Source of information	Peer group	141	34.6	30.2-39.4
Source of information	School	51	12.5	9.7-16.1
Source of information	Hospital	42	10.3	7.7-13.7
Correctly stated meaning of mental illness	Yes	147	36.1	31.6-40.9
Identified brain problems as most common cause	Yes	390	95.8	93.4-97.4
Believed an individual can be born with mental illness	Yes	292	71.7	67.2-75.9
Correctly identified hospital as place of treatment	Yes	264	64.9	60.1-69.3
Level of awareness	Low	72	17.7	14.3-21.7
Level of awareness	Moderate	143`	35.1	30.7-39.9
Level of awareness	High	192	47.2	42.4-52.0

Note: CI = confidence interval for the reported proportion.

Table 2 shows that all respondents had heard of mental illness, with mass media as the leading source of information (41.8%; 95% CI: 37.1-46.6). Although 36.1% correctly defined mental illness, most respondents identified brain problems as a common cause (95.8%; 95% CI: 93.4-97.4) and hospital as a place of treatment (64.9%; 95% CI: 60.1-69.3). Overall, 47.2% had high awareness, 35.1% had moderate awareness and 17.7% had low awareness.

Table 3: Attitudes towards people living with mental illness (N = 407)

Attitude item	Response	Frequency	(%)	95% CI (%)
People living with mental illness present in community	Yes	407	100.0	99.1-100.0
Avoids going near people living with mental illness	Yes	350	86.0	82.3-89.0
Afraid of people living with mental illness	Yes	300	73.7	69.2-77.8
Interacts freely with people living with mental illness	Yes	201	49.4	44.6-54.2
Would not work with a person living with mental illness	Yes	240	59.0	54.1-63.6
Would not eat with a person living with mental illness	Yes	365	89.7	86.3-92.3
Would interact freely once the person is cured	Yes	393	96.6	94.3-97.9
Would consider marrying a cured person	Yes	107	26.3	22.2-30.8

Note: Items were analysed descriptively and independently; therefore, item-level percentages should not be interpreted as mutually exclusive responses.

Table 3 shows that negative attitudes and social distance were common. Most respondents avoided going near people living with mental illness (86.0%; 95% CI: 82.3-89.0), were afraid of them (73.7%; 95% CI: 69.2-77.8), would not work with them (59.0%; 95% CI: 54.1-63.6) and would not eat with them (89.7%; 95% CI: 86.3-92.3). However, 49.2% reported that they would interact freely with people living with mental illness, and 96.6% reported willingness to interact freely once the person was cured. This pattern suggests ambivalent attitudes, where some willingness to interact may coexist with fear and avoidance.

Table 4: Perceived factors influencing attitudes towards mental illness (N = 407)

Factor	Response	Frequency	(%)	95% CI (%)
Fear	Yes	350	86.0	82.3-89.0
Gender	Yes	345	84.8	81.0-87.9
Previous encounter with a person living with mental illness	Yes	316	77.6	73.3-81.4
Age	Yes	311	76.4	72.1-80.3
Severity of mental illness	Yes	311	76.4	72.1-80.3
Social factors	Yes	293	72.0	67.4-76.1
Cultural factors	Yes	109	26.8	22.7-31.3
Religious factors	Yes	93	22.9	19.0-27.2

Note: Respondents could identify more than one factor; therefore, percentages do not sum to 100%.

Table 4 shows that the leading perceived influences on attitudes were fear (86.0%; 95% CI: 82.3-89.0), gender (84.8%; 95% CI: 81.0-87.9), previous encounter with a person living with mental illness (77.6%; 95% CI: 73.3-81.4), age (76.4%; 95% CI: 72.1-80.3), severity of illness (76.4%; 95% CI: 72.1-80.3) and social factors (72.0%; 95% CI: 67.4-76.1). Cultural factors (26.8%) and religious factors (22.9%) were less frequently reported but remained relevant influences.

DISCUSSION

This study assessed awareness and attitudes towards people living with mental illness among residents of Binji Community. The socio-demographic profile showed that respondents were predominantly young, male, Muslim and Hausa. The gender and religious distribution is important for interpretation because female respondents constituted only 28.3% and Christian respondents 3.7%. Consequently, the findings should be interpreted as reflecting the dominant socio-demographic composition of the sampled community, and caution is required when applying the

results to minority groups within the area. The study found that all respondents had heard of mental illness, and nearly half were categorized as having high awareness. Mass media was the leading source of information, suggesting that radio, television and other media channels may be useful platforms for mental health education in the community. However, only 36.1% of respondents correctly defined mental illness. This indicates that general familiarity with the term "mental illness" does not necessarily mean accurate understanding of its meaning, causes or appropriate management.

The finding that awareness was relatively high but precise understanding remained limited is consistent with the broader literature showing that communities may recognize mental illness while still holding misconceptions about its nature, causes and treatment. Effiong et al. (2019), in a community study in Akwa Ibom State, reported that poor knowledge and stigmatizing attitudes were common, while Oguma et al. (2025) similarly found that community knowledge may coexist with stigmatizing attitudes and social distance.

Negative attitudes were evident in this study. A large proportion of respondents avoided going near people living with mental illness, were afraid of them, would not work with them and would not eat with them. These attitudes reflect fear and social distance, which may contribute to exclusion, delayed care-seeking and poor reintegration of affected persons. This finding supports the position of Javed et al. (2021), who emphasized that stigma remains a major barrier to access, uptake of services and social participation among people living with mental illness, particularly in low- and middle-income countries.

An important observation in Table 3 is the apparent coexistence of fear and willingness to interact. While 73.7% of respondents reported fear of people living

with mental illness, 49.2% also reported that they would interact freely with them. This should not be interpreted simply as contradiction. Rather, it may suggest ambivalent attitudes, where some respondents express a general willingness to interact but still maintain emotional fear or practical avoidance. It is also possible that respondents understood "interaction" differently, ranging from brief public contact to close personal relationship. Because the analysis was based on item-by-item descriptive statistics and not cross-tabulation of individual responses, the study cannot determine exactly how many respondents were both afraid and willing to interact. This finding indicates the need for future studies to examine attitude patterns more deeply using cross-tabulation, inferential analysis and qualitative exploration.

The very high proportion of respondents willing to interact freely once a person is cured suggests that stigma may be linked more to active illness than to the person's identity. This is an important implication for community education. Health education should emphasize that many mental disorders are treatable, people living with mental illness can recover or improve with appropriate care, and affected persons deserve dignity, support and inclusion before, during and after treatment.

Fear was the most commonly reported factor influencing attitude, followed by gender, previous encounter, age, perceived severity of illness and social factors. These findings suggest that attitudes are shaped by a combination of personal experience, demographic characteristics and community-level beliefs. Although cultural and religious factors were less frequently reported than fear and social factors, they should not be ignored in northern Nigerian communities where religious and traditional leaders often influence health beliefs and care-seeking

behaviour. This supports the need for culturally sensitive mental health education involving healthcare providers, community leaders and faith leaders.

The findings have important implications for community-based mental health nursing practice. Nurses can play an active role in public enlightenment, early identification of mental health problems, referral, family education, stigma reduction and follow-up support. By engaging community members through health talks, outreach, schools, religious gatherings and local media, nurses can help transform awareness into acceptance and supportive behaviour towards people living with mental illness.

Limitations of the Study

This study has some limitations. First, it used a descriptive cross-sectional design, so causal relationships between awareness, perceived factors and attitudes cannot be established. Second, accidental sampling was used at the final stage of recruitment, which may introduce selection bias. Third, the sample was predominantly male and Muslim; therefore, the perspectives of women and religious minorities may not have been fully represented. Fourth, responses were self-reported and may have been affected by social desirability bias. Finally, the attitude items were analysed descriptively and independently, without cross-tabulation or regression analysis; therefore, the study could not determine whether specific demographic or experiential factors were statistically associated with positive or negative attitudes.

IMPLICATIONS FOR NURSING

The study has implications for nursing practice, nursing education and nursing research. In nursing practice, the findings highlight the need for nurses to provide

respectful, non-stigmatizing and community-oriented mental health education. Nurses working in primary healthcare and community settings can help identify misconceptions, counsel families and encourage timely care-seeking. In nursing education, the findings support the inclusion of mental health literacy, stigma reduction and community engagement in teaching and clinical learning. In nursing research, the study provides baseline evidence for future analytical or intervention studies on mental health stigma and community-based nursing interventions in Sokoto State.

CONCLUSION

This study found that awareness of mental illness among residents of Binji Community was relatively high, but negative attitudes, fear and social distancing towards people living with mental illness persisted. Although all respondents had heard of mental illness, fewer respondents could correctly define it, showing a gap between awareness and accurate knowledge. Fear, gender, previous encounter, age, severity of illness and social factors were the leading perceived influences on attitudes. These findings show the need to move beyond general awareness towards targeted mental health education that corrects misconceptions, reduces fear and promotes respectful interaction with people living with mental illness.

RECOMMENDATIONS

Based on the findings, the following recommendations are made:

1. Community-based mental health education should be strengthened in Binji Community to improve accurate understanding of mental illness, its causes, treatment options and recovery possibilities.

2. Healthcare providers, especially nurses and community health workers, should lead public enlightenment activities that encourage respectful interaction with people living with mental illness.
3. Anti-stigma campaigns should be developed in collaboration with government, mass media, community leaders and religious leaders to reduce fear, misconceptions and social exclusion.
4. Mental health education should be integrated into primary healthcare outreach activities, schools, religious gatherings and community meetings to reach diverse groups within the community.
5. Future studies should use analytical designs, cross-tabulation, inferential statistics and qualitative methods to better understand the relationship between awareness, demographic characteristics, personal experiences and attitudes towards people living with mental illness.

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