KNOWLEDGE AND ATTITUDE OF URBAN AND RURAL DWELLERS TOWARD VAGRANT SUFFERERS OF *SCHIZOPHRENIA* IN DELTA STATE, NIGERIA

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ABSTRACT

This study aimed at assessing knowledge of schizophrenia and attitude towards vagrant sufferers in urban and rural areas of the state. The sample of 583 and 120 respondents from urban and rural areas respectively were drawn using the multi-stage sampling technique. Data generated were statistically analyzed using the SPSS version 11 of Fishers test (ANOVA). The significant finding among others shows that knowledge is most potent factor to determine attitude towards vagrant sufferers of schizophrenia. Conclusively, it was recommended that government legislate against mass media organizations negative depictions of sufferers of mental illness. Also, goverment should make as one of the health policies, free treatment of patients living with schizophrenia after diagnosis.

Keywords: Schizophrenia, Vagrant sufferers, knowledge, attitude, location.

INTRODUCTION

Sights of 'mad' people or mentally ill individuals are common on the streets, markets, public places in Delta state.This is an embarrassment to the government. It is against this backdrop that the State Ministry of Social Development has moved to evacuate these 'mad' people from streets and public places to designated centres of 'care'. Numerous large-scale surveys of the prevalence of mental health disorders in adults in the general population have been concluded (Binitie, 1970; Awaritefe and Ebie, 1975; Erinosho and Ayorinde, 1978; W.H.O, 2001; Gureje, Lasebikan, Ephraim, Oluwanuga, 2005). The improvement of people's knowledge of mental illness, particularly Schizophrenia, and their attitudes towards this disease is important for the sufferers' holistic rehabilitation to family and society.

Mental disorder or mental illness is used to refer to a psychological or physiological pattern that occurs in an individual and is usually associated with distress or disability that is not expected as part of normal development or culture. The recognition and understanding of mental disorders, particularly schizophrenia has changed overtime.

While newly infected patients in most cases can be very hostile and violent, full blown patients on the other hand are less violent and hostile. There is this truism that a mad man after carefully observing a drunk displayed at a function instructed that "he (the drunk) be called to order because his (the mad person) equally started in like manner". Consequently, if a normal person suddenly begins to act abnormally, there are every indication that something is wrong somewhere and appropriate action must be taken immediately. Early detection of this sickness can better be handled by knowing the proximate causes. In Delta State mental illness is easily recognized only when the sufferer roam the streets or seen unkempt in a public place. They are referred to as 'mad' or locally as 'Kolo'. The expert

knowledge of schizophrenia is understood only by a few educated mostly living in urban communities of the state. In rural areas, the 'Mad' or 'Kolo' individual is a person who behaves abnormally and does so in public places like the village and market squares.

The attitude of people living in urban and rural areas are said to be different. It is assumed that, due to urbanization the communal social structure where everyone was responsible for everyone else has been destroyed due to individuation of families in a culture when mental illness was often seen as a curse or possession by the devil and can only be cured by traditional healers or shamans.However, some of the causes of this sickness include among others: old age, drugs, diabolical means of making money/protection, and nature.

When the causes are detected at the earliest possible time, measures towards helping the victim should be taken immediately. However, it must be noted that some are not curable.This is against the backdrop of the fact that, urban areas are inhabited by educated people who are elites in the state. On the other hand, the uneducated, low socio-economic people remain in their villages (the rural areas) believed to be the source or 'warehouse' of witchcraft the perceived cause of schizophrenia (Mohammed, et. al, 2004).

Judging from the above, it is believed that the sickness is prevalent in the rural areas mostly in young persons, but after a while they migrate to the urban areas where they make public places like the market square their home. It is believed that the families of persons with schizophrenia play a significant role in their care (Leff, 1976; Jegede, 1981; Ewhrudjakpor, 2008a; 2009b, 2009c). In Delta state of Nigeria this care used to take place in the structure of African communal –individualism that is the extended family system where kins help each other in every human endeavour. The communal – individualism acts the economic, medical and social units where strong members lend support to the weak (Onwuejeogwu, 1986). Contrary to this today, some families instead of taking care of their schizophrenai patients, they help them move to the urban areas where

they cannot easily trace their way back, or even be identified with their relations.

In the perception, attitude and general management of schizophrenia in Delta State, the African philosophy of communal – individualism is put literally in 'reverse gear'. Traditional beliefs about schizophrenia as leading to care in the community decrease. Traditional beliefs in schizophrenia as possession of witchcraft now worsen the stigma attached to patients and their families. Family members report they are hostile towards their ill relatives. There is a high degree of expressed emotion, particularly distressing to patients with schizophrenia (Oshisada, 2006; Ewhrudjakpor, 2009c). Often they leave home and roam the streets. The question is why?

The knowledge and attitude towards roaming or vagrant sufferer of schizophrenia shall be situated in the labeling theory, a variant of interactionism perspective (Mead, 1934; Goffman, 1968). The labeling theory explains deviation from norm in society as not characteristic of behaviour qua behaviour, but it is simply a product of interaction process. Becker (1963: 9) posits that:

> *Social groups create deviance by making the rules whose infraction constitutes deviance and by applying those rules to particular people and labeling them as outsiders, are not a quality of the act the person commits, but rather consequences of the application by others of the rules and sanctions to an "offender". The deviant is one to whom the label has successfully been applied; deviant behaviour is behaviour that people so label.*

Backer (1963) suggests above that there is no such thing as deviant act. An act only becomes deviant when significant others (the family, community and other agents of socialization) perceive and define it as such. The act of rebuffing sufferers of schizophrenia in Delta State provides a good illustration for interactions.

This study therefore, is aimed at assessing in comparative terms, knowledge and attitude of people in urban and rural communities towards vagrant sufferers of schizophrenia. The result

of this study will enhance policy on changing attitude towards vagrant sufferers of schizophrenia. Also, it is designed to: assess the reversal of communal care for sufferers of schizophrenia in the rural areas and to profile the reason(s) for knowledge and attitudinal differences between urban and rural dwellers towards schizophrenia and its sufferers.

METHODOLOGY

Delta state as officially delimited by the Federal Government of Nigeria extends over about 16,475 square kilometers land space. The state is bounded on the North by Edo state, on the East and North-East by Anambra and Kogi states respectively, while it lies to the South by the Atlantic Ocean. The population of the state according to the 2006 census figure is put at 4,098,391 out of Nigeria's census figure of 140,003,542 (Federal Republic of Nigeria official Gazette, 2007).

The state is inhabited by five main indigenous ethnic groups (Urhobo, Isoko, Itsekiri, Izon, Igbo/Ukwuani) with identical customs, beliefs and cultures. These ethnic groups inhabits three politically designated senatorial zones, namely; Delta Central inhabited by the Urhobo people; Delta South occupied indigenously by Isoko, Itsekiri, Izon and some Urhobo people; and Delta North by Ibo and Ukwuani people. The family structure is patriarchal and polygynous in the South and Central senatorial zones and mainly patriarchal and monogamous in the Delta North senatorial zone. The people of the state are farmers, fishermen, traders and also engage in some white collar jobs particularly in urban areas, where most educated indigenes resides. In Delta State, there are 44 government owned hospitals (Inside Delta state, 2000) and numerous private medical clinics. Out of these 44 hospitals, only five have miniature psychiatric presence. Most of these government hospitals are located in urban areas, leaving the rural areas with primary health centres (PHCs)

that has no medical doctor or in-patient facility.

This study used descriptive ex-post facto type of research with respondents' location and knowledge factors of schizophrenia as the independent variables and Attitude towards vagrant sufferers of schizophrenia as the dependent variable. The study involves two populations namely; urban dwellers and rural dwellers. The sample size was 583 urban and 120 rural residents of Delta state. They had varied socio-demographics (see table 1). A multi-stage sampling technique was adopted. In the first phase two communities each was selected from urban and rural areas of each of the three senatorial districts of Central, South and North. After that, two towns each were selected from the urban and rural areas representing five ethnic groups in the state.

The instruments to gather information in this study were drawn from a pilot study. 40 questions generated from stakeholders: health workers and the general public were hinged on two topical themes: knowledge about mental illness; and attitude towards sufferers of schizophrenia.which are central to this study. The 34 questions generated were pre-tested and yielded test retest reliability of r = 0.91. Twenty-two questions were put in a structured questionnaire format to construct the attitude scale. The questions included positive and negative aspects of schizophrenia vis-à-vis our community. Finally, the structured questionnaire consisted of three sections, namely; section 'A': Socio-demographics of respondents, section 'B' knowledge of schizophrenia, and section 'C': Attitude towards sufferers of schizophrenia.

The researcher selected twelve postgraduate students of Sociology/Psychology that comes from the designated six cities and six villages. These students were debriefed by the researcher on the essence of the study and techniques to distribute and retrieve the 600 questionnaires from the six cities. And to conduct interviews using the structured questionnaire on the respondents in the villages who cannot write or speak English language. The interview was

augmented by a Micro-cassette recorder. At the end of the exercise, 583 or 97.17% questionnaires were returned completely filled-out, and 120 or 100% of the questionnaires used for interviews were recovered and returned completely filled-out. These questionnaires were subjected to statistical analysis to justify the objectives of this study.

RESULTS AND DISCUSSION

The Study revealed that respondents in urban locations have better knowledge of schizophrenia than respondents in rural areas; respondents in urban locations have negative attitudes towards vagrant sufferers of schizophrenia; respondents in rural locations have ambivalent attitudes towards vagrant sufferers of schizophrenia; and respondents' attitudes towards vagrant schizophrenia are generally determined by knowledge of schizophrenia.

Despite the Delta state government policy of evaluating vagrant sufferers of schizophrenia from public view to homes of traditional medicine practitioners (Ewhrudjakpor 2008a) there still exist many more vagrants on the streets and market places (Oshisade, 2006). It is against this background, that this study was embarked upon, specifically to assess in comparative quantification knowledge and attitude of urban and rural dwellers towards vagrant sufferers of schizophrenia.

Table 1: Socio-Demographics and Attitude Scores of Urban and Rural Respondents about vagrant sufferers of Schizophrenia (N = 703).

Socio-demographic Characteristics	Urban (583)							Rural (120)				
	Males No 286	49.06% 30.96%	Attitude Score 30.96%	Females No. 297		Attitude Score No		Males 63.33% No	Attitude Score	Females 50.94%		Attitude Score No
Age *												
20 < 30	84	29.37	1680	101	34.01	1886	10	13.16	2366	04	9.09	3242
30 < 40	66	23.08	2230	93	31.31	2001	07	9.21	3456	03	6.82	2989
40 < 50	89	31.12	1470	86	28.96	2969	07	9.21	3109	11	25.00	3200
50 < 60	38	13.29	1320	17	5.72	1849	21	27.63	4707	15	34.09	3414
60+	09	03.14	970	00	0.00	000	31	40.79	3365	11	25.00	2689
Ethnic group												
Urhobo	66	23.08	1440	71	23.90	1318	08	10.53	3144	07	15.91	2864
Isoko	52	18.18	1321	45	15.15	1244	07	9.21	3642	09	20.45	3100
Izon	51	17.83	2102	37	12.46	1680	23	30.26	2864	11	25.00	2366
Itsekiri	71	24.83	1904	86	28.96	890	16	21.05	3887	07	15.91	3008
Igbo/Ukwuani	46	16.08	811	58	19.53	880	22	28.95	2679	10	2273	2655
Educational Status												
PrimarySch. Cert.	60	20.98	814	141	47.47	640	43	56.58	3984	35	79.55	3614
Sec.Sch.Cert	108	37.76	1092	103	34.68	901	30	39.47	3641	09	20.45	3266
Tertiary Inst.Cert	118	41.26	4096	53	17.85	3003	03	03.95	2642	00	0.00	00
Family Type												
Monogamy	86	30.07	4192	86	28.96	3606	09	11.84	3141	09	2045	3007
Polygamy	123	43.01	868	152	51.18	1006	56	73.58	896	32	72.73	1009
Others	77	26.92	1099	59	19.86	909	11	14.47	921	03	6.82	1091
Economic Status												
N5,000 <N40,000	128	44.75	599	156	52.52	861	59	77.63	1002	39	88.64	1062
N40,000<N75,000	97	33.92	1335	128	43.10	1092	17	22.37	896	05	11.36	1035
N75,000 +	61	21.33	2989	13	4.38	3066	00	0.00	00	00	0.00	00
*Mean Age	36.63				31.78		48.82		52.65			

Source: Field work 2008

Table 2: Percentage Distribution of Respondents by knowledge of Schizophrenia.

Knowledge Factors	Urban (n= 583)			Rural (n=120)		
	Yes (%)	No(%)	N.S(%)	Yes(%)	No(%)	N.S(%)
Source(s) of Information						
Mass Media	41.62	36.10	22.28	22.19	68.14	09.67
Town crier	00.00	96.85	3.15	86.14	13.86	00.00
Know a sufferer	68.86	31.14	00.00	67.49	23.18	09.33
Health centre	21.06	78.14	00.00	02.39	86.16	11.45
Reading Books	31.04	68.96	00.00	00.00	89.14	10.86
Causes						
Germs	56.10	36.29	7.61	06.19	61.55	32.26
Hereditary	3.09	29.41	67.50	18.78	64.14	17.08
Curse/Punishment	7.86	61.09	31.05	63.15	03.06	33.79
Witchcraft	9.33	39.99	50.68	62.91	06.14	30.95
Drugs	23.62	46.17	30.21	19.48	65.16	15.36
Signs/Symptoms						
Delusion	51.06	11.04	37.90	63.16	6.14	30.70
Hallucination	58.66	06.07	35.27	62.14	3.09	34.77
Destructiveness	61.72	110.6	27.22	59.86	8.18	31.96
Wandering	62.84	09.09	28.07	61.11	2.08	36.81
Loquaciousness	70.25	11.02	18.73	59.14	11.16	29.70
Eccentric acts	41.09	06.10	47.19	63.15	13.14	23.71
Consequences						
Social exclusion	75.64	04.02	20.34	68.14	0313	28.73
Deformities	17.14	39.86	43.00	11.16	81.16	7.68
Stigma	64.81	02.04	33.15	76.19	02.14	21.67
No effect	00.00	86.60	13.40	00.00	81.64	18.36
Curability						
Curable	86.92	09.10	3.98	06.81	81.47	11.72
Incurable	3.63	92.41	3.96	86.11	02.14	11.75
Ethnic Beliefs						
Outcast	49.64	06.04	44.32	67.14	01.09	31.77
Witch/wizard	51.04	02.10	46.86	61.33	02.14	36.53
Evil doer	55.04	08.09	36.87	69.16	16.13	14.17
Taboo	56.66	06.10	37.24	65.17	19.30	15.53

Source: Field work 2008

SPSS output Fisher's Test (ANOVA). Summary: Cell means and 2x2 ANOVA
NS = NOT SURE

Table 3: Showing the influence of Location and knowledge of schizophrenia towards attitude of urban and rural respondents.

Table 3a: Case processing summary *

Cases					
Included		**Excluded**		**Total**	
N	Percent	N	Percent	N	Percent
703	100.0%	0	0.00%	703	100.0%

Table 3b Cell Means * *

*Urban, Rural by knowledge, Attitude

Location Variables

	Knowledge		**Attitudes**	
Urban	Mean	N	Mean	N
Good	361.2414	482	288.1142	482
Poor	96.8133	88	63.6885	88
Unsure	24.3456	13	11.3211	13
Total	107.6842	583	102.6891	583
Rural				
Good	76.5680	21	64.4990	21
Poor	131.2164	96	66.3810	96
Unsure	11.9610	03	67.2120	03
Total	95.8781	120	57.4891	120
Total Good	141.2116	503	76.8383	503
Poor	68.6452	184	23.6619	184
Unsure	23.1429	16	10.9291	19
Total	71.4648	**703**	69.1817	**703**

*Grand Total

** Urban, Rural by Knowledge, Attitude

Table 3c Calculation of the F –ratio

	Sum of squares	d.f	Mean	F	Sig
Urban mean					
(Combined)	36499.141	2	18249.57	314.012	.000
Effort knowledge	396.614	1	396.614	13.341	.000
Attitude	684.091	1	684.091	8.266	.020
2- way Interactions Knowledge					
Attitude	149.682	1	149.682	7.612	0.19
Model	31412.610	3	10470.87	434.120	.000
Residual	9120.414	599	13.047		
Total	40533.024	702	57.739		
Rural main					
(Combined)	1142.614	2	571.307	16.349	.000
Effort knowledge	642.112	1	642.112	19.233	.000
Attitude	513.334	1	513.334	15.142	.000
2-way Interactions knowledge					
Attitude	67.131	1	67.131	1.234	.028
Model	2396.4413	3	798.813	38.212	.000
Residual	984.319	116	8.48		
Total	3380.76	119	28.409		

Knowledge, Attitude by Urban, Rural Location

It was expected that good knowledge of the disease will encourage family members to care in a familial way, for their sick kin. In that way, the government will not be bothered with her over stretched budget to forcibly evacuate these sufferers of schizophrenia from public places. The reason for this, is that in the olden days, Africans do traditionally live out communal individualism (Onwuejeogwu, 1986), that every member of a family, is every body's keeper'. This tradition it seems has been put in 'reverse gear' by presence of sufferers of schizophrenia roaming and littering public places. A confirmation of this fact and reasons for the seemingly reversal of this 'communal individualism' is provided in findings of this study anchored on the 2 x 2 Analysis of variance interaction of variables of knowledge of schizophrenia, location of respondents and positive or negative attitudes towards sufferers of the disease.

The table one is socio-demographics and corresponding sub-total attitudinal scores of respondents in urban and rural locations. The mean age of respondents in urban areas for males and females respectively depicts rural–urban drift as respondents grow old, in order to retire. Table two is the percentage distribution of respondents by location in respect of knowledge of schizophrenia. At a glance, urban respondents have better or good knowledge of the disease of schizophrenia than rural respondents. Also, urban and rural respondents said that schizophrenia is curable. Both urban and rural respondents were unanimous in their ethnic beliefs and consequences that sufferers of schizophrenia are witches and wizards and should be tabooed and socially excluded from groupings. Again, both urban and rural respondents agreed that sufferers of schizophrenia wanders, destructive and are loquacious.

In table three the statistical package of social sciences (SPSS) version 11 using the technique of 2 x 2 Analysis of Variance (ANOVA) was applied. Table 3a shows the case processing summary

revealing 703 respondents (cases) and no case was excluded from the subsequent analysis, which means 100% case profiling. Table 3b shows the cell means of the independent and dependent variables, that is for knowledge and attitude respectively. The mean scores for good, poor and unsure responses to knowledge and attitude were also given here. For instance urban respondents who had good knowledge of schizophrenia mean score is greater than the mean score of rural respondents. Their attitude mean scores were related, that is in favour of urban and rural respondents respectively.

Table 3c contains result of the ANOVA given under the headings: sum of squares, degree of freedom (d.f), mean square, F–ratio and significance or alpha level.To determine the influence of location on knowledge, look at the row of knowledge, we will see that $P<0.05$ and reach significant level (that is the value under the significance column is less than 0.05. This indicates that respondents in urban areas plus knowledge of schizophrenia significantly determine attitudes towards schizophrenia. This result supports studies (Erinosho and Ayorinde, 1978; Gureje, et.al, 2005; Ewhrudjakpor 2009b).

Knowledge as an independent factor also has a significant influence on attitude towards vagrant schizophrenia. This result means that respondents' knowledge of schizophrenia determine good attitude towards vagrant sufferers of schizophrenia. Again location treated as an independent factor also affects attitudes towards schizophrenia. That is urban respondents have negative attitudes than respondents in rural areas. The findings corroborate earlier studies of Binitie (1970); Awaritefe and Ebie (1975); Jegede (1981); Mohammed et.al (2004). In fact rural areas respondents attitude can said to be ambivalent considering slight differences in cell means in table 3b, for good (positive), poor (negative) and unsure (neutral) attitudinal responses.

There was also an interaction effect between knowledge and attitude of urban and rural dwellers towards vagrant sufferers of schizophrenia. The results of this interaction effect show the moderating influence of the independent variables of knowledge and attitude towards sufferers of schizophrenia. But it requires a post hoc or multiple comparison tests which will confirm and show the level or degree of the interaction by the two independent variables.

Finally, the effect of location on a combination of interaction between knowledge and attitude is shown on the third row in terms of model $p<0.05$. This further goes to confirm the separate knowledge scores in table two and attitude scores in table one relating to urban and rural locations of respondents as determinants towards schizophrenia and its vagrant sufferers. It also situates explanatorily in the theory postulated about labeling sufferers of schizophrenia (Mead, 1934; Becker, 1963; Goffman, 1968). The findings also corroborated earlier studies about environment, family location and social support for sufferers of schizophrenia.

CONCLUSION

This study was designed to empirically compare knowledge of schizophrenia and attitude towards vagrant sufferers in urban and rural locations. The study was based on the daily newspapers and academic studies reporting the seemingly helpless situation these sufferers are found as a result of weakened traditional values in the practice of communal individualism.

A structured questionnaire consisting of three sections about socio-demographics, knowledge of schizophrenia, and attitude towards vagrant sufferers of schizophrenia was used to gather data from respondents (583 and 120 from urban and rural locations respectively. These respondents were selected through the multi-stage sampling technique procedures. The data were analyzed using simple percentages and the SPSS version 11 Fisher's test or ANOVA.

The findings among others show that knowledge is the most significant variable that determines attitude towards vagrant sufferers of schizophrenia. Respondents' attitudes in rural locations were ambivalent, unlike the negative attitudes shown by respondents in urban locations. These results were corroborated by earlier studies in the literature nationally, internationally and situated in the Becker's (1963) theory of labeling, a variant of symbolic interactionism (Mead, 1934).

Knowledge like information is 'power', the power to reconstruct peoples negative attitudes towards vagrant sufferers of schizophrenia is squarely premised on education, enlightenment and reconstruction of peoples perceptions, thoughts and minds. The findings of this study has shown empirically that any location one lives, urban or rural may be insignificant if people have good knowledge about the disease of schizophrenia.

In order to impact good knowledge the government and non governmental organizations should be encouraged to legislate against negative depictions of schizophrenia on television and in daily newspapers or magazines. The mass media and organs of information and communication technology should be pushed by law to facilitate education, information and enlightenment of the citizenry about non communicable diseases such as schizophrenia, in order to positively change attitude and be empathetic, which of course is the first step to holistic treatment and rehabilitation of people living with schizophrenia.

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