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THE ROLE OF MENTAL HEALTH LITERACY AND CULTURAL BELIEFS IN SHAPING FAMILY CAREGIVING RESPONSIBILITIES IN SOUTH-SOUTH NIGERIA

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Abstract

This article investigates the role of mental health literacy and cultural beliefs in shaping family caregiving responsibilities for mentally ill persons in South-South Nigeria. Drawing from a larger cross-sectional study of 372 family caregivers across six states, the study examined how knowledge about mental illness and belief systems influence family duty of care. Using attribution theory, symbolic interactionism, and labeling theory as frameworks, findings revealed a significant positive relationship between knowledge and family caregiving ($r = .973$, $p < .05$), explaining 94.7% of variance in caregiving behaviors. Beliefs about mental illness showed an even stronger correlation with caregiving responsibilities ($r = .981$, $p < .05$), accounting for 96.2% of variance. Qualitative data from 25 key informant interviews revealed that supernatural attributions (bewitchment, repercussion) significantly influenced treatment-seeking pathways, often delaying orthodox medical intervention. The study concludes that improving mental health literacy and addressing culturally embedded belief systems are essential for enhancing family caregiving outcomes in resource-limited settings.

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1. INTRODUCTION

The intersection of mental health, culture, and family responsibility presents one of the most complex challenges in contemporary African healthcare systems. Mental illness, a clinically significant behavioral or psychological syndrome associated with distress or impairment in functioning (Sadock & Sadock, 2007), affects approximately one in five individuals globally, with low- and middle-income countries bearing three-quarters of the total burden (World Health Organization [WHO], 2011). In Nigeria, an estimated 20-30% of the population suffers from mental disorders, yet only about 10% receive any treatment within a reasonable period (Federal Ministry of Health, 2013).

Unlike many physical illnesses, mental disorders often impair the individual's capacity to recognize their condition or seek help independently. Consequently, family members become the primary, and sometimes only, source of care, support, and treatment-seeking intervention. In African societies, particularly in South-South Nigeria, the family confers upon members a network of social responsibilities laden with customs, norms, and values (Muoboghare & Ogege, 2003). However, the quality and extent of this family duty of care are not uniform; they are profoundly shaped by what family members know about mental illness and what they believe causes it.

Mental health literacy (MHL)—defined as knowledge and beliefs about mental disorders that aid their recognition, management, or prevention (Jorm et al., 1997)—remains critically low in many African settings. Monteiro (2016) noted that MHL tends to be higher in European and North American cultures compared to Asian and African cultures. In South-South Nigeria, where culture and belief systems play major roles in health-seeking behavior, many families attribute mental illness to supernatural forces such as bewitchment, repercussion for evil deeds, or punishment from ancestors (Ewhrudjakpor, 2018). These attributions directly influence whether families provide compassionate care, seek orthodox treatment, resort to faith-based healing, or abandon the ill relative altogether. This article examines how knowledge about mental illness and cultural beliefs shape family caregiving responsibilities in South-South Nigeria. Drawing from empirical data collected across six states—Edo, Delta, Bayelsa, Rivers, Cross River, and Akwa-Ibom—the study provides evidence-based insights for policymakers, healthcare providers, and community leaders seeking to improve mental health outcomes in resource-limited settings.

2. STATEMENT OF THE PROBLEM

In South-South Nigeria, the fate of most mentally ill persons rests in the hands of family members. However, this responsibility is compromised by three interrelated factors: pervasive ignorance about the biomedical causes of mental illness, deeply entrenched belief systems that attribute mental disorders to supernatural forces, and a consequent negative perception that shapes discriminatory attitudes toward the mentally ill.

The Nigerian government has consistently underfunded mental health services, allocating less than 6% of the national budget to healthcare over the past decade (National Bureau of Statistics, 2020), with only about 4% of that allocated to mental health (WHO-AIMS Report, 2006). With only eight psychiatric hospitals serving over 200 million people, and less than 150 psychiatrists nationally (approximately 1 per 1 million population), family caregivers are left with minimal professional support.

Compounding this structural deficit are cultural beliefs that mental illness results from bewitchment, repercussion for evil deeds, or ancestral punishment. When families perceive mental illness as punishment, they often become hostile, provide minimal care, or abandon the patient entirely. Conversely, when illness is attributed to bewitchment, families may show sympathy but pursue ineffective spiritual interventions. These belief-driven responses delay or prevent access to evidence-based treatment, resulting in prolonged suffering, chronic disability, and premature death.

The paradox is that while families are the most important source of practical help for mentally ill relatives, their knowledge deficits and belief systems often undermine the quality of care they provide. This study addresses the critical question: To what extent do knowledge about mental illness and cultural beliefs determine family duty of care for mentally ill persons in South-South Nigeria?

2.1 RESEARCH QUESTIONS

What is the level of knowledge about mental illness among family caregivers in South-South Nigeria, and what is its significance to family duty of care?

How do cultural beliefs about the causes of mental illness influence family duty of care in South-South Nigeria?

3.0 OBJECTIVES OF THE STUDY

i. To ascertain the level of knowledge about mental illness and its significance to family duty of care in South-South Nigeria.

ii. To scrutinize the influence of beliefs on family duty of care for mentally ill persons in South-South Nigeria.

4. LITERATURE REVIEW

4.1 MENTAL HEALTH LITERACY AND FAMILY CAREGIVING

Mental health literacy encompasses the ability to recognize specific disorders, knowledge of risk factors and causes, understanding of self-treatments and professional help available, and attitudes that promote appropriate help-seeking (Jorm et al., 1997). In developing countries, poor mental health literacy contributes significantly to the disease burden of poorer communities (UNESCO, 2004).

Studies across Africa have documented low MHL levels. In a rural northern Nigerian study, Kabir et al. (2004) found that while misuse of psychoactive agents was the most endorsed causal factor (34.3%), divine punishment (18.8%) and magic/spirit possession (18.0%) remained significant attributions. Among the Yoruba in southwestern Nigeria, Adebowale and Ogunlesi (1999, as cited in Ikwuka, 2016) found that supernatural explanations were advanced by 54.3% of relatives of mentally ill persons.

The consequences of low MHL for family caregiving are profound. Janardhana et al. (2015) classified caregiving activities into four categories—physical care, psychological care, medical care, and social care—all of which require basic knowledge about the illness to be effective. Without such knowledge, family caregivers may be unfamiliar with the type of care they must provide or the amount of care needed (Shinde et al., 2014). Bland (2012) emphasized that caregivers need a basic level of knowledge about mental illness to access help during crises and to recognize early warning signs of relapse.

4.2 CULTURAL BELIEFS AND MENTAL ILLNESS ATTRIBUTION

Across Africa, there is a general belief that mental diseases originate from various external factors including breach of taboo, disturbances in social relations, hostile ancestral spirits, spirit possession, sorcery, and natural causes (Betancourt et al., 2000; Idemudia, 2004). Ewhrudjakpor (2018) identified three broad causal categories in Nigeria: natural (genetic/biological factors), preternatural (mystical forces), and supernatural (powers of ancestors).

Weiner's (1986) attribution theory provides a useful framework for understanding how these beliefs shape caregiving responses. According to attribution theory, three dimensions of causality—locus (internal vs. external), stability, and controllability—influence how people react to individuals with illness. When mental illness is perceived as controllable by the afflicted (e.g., punishment for evil deeds), families respond with anger, blame, and reduced assistance. When perceived as uncontrollable (e.g., bewitchment by enemies), families may show sympathy but pursue inappropriate spiritual interventions rather than medical treatment.

In South-South Nigeria specifically, Ewhrudjakpor (2009) found that 62% of health workers attributed mental illness to abuse of psychoactive substances, while 30% attributed it to curse/punishment and witches/wizards. Notably, 75% of respondents believed that persons with mental illness are evildoers in the form of witches, wizards, or mischief makers. Such beliefs directly impact family duty of care, as families may distance themselves from a relative perceived as evil. Family duty of care refers to the entire role played by family members in seeking medical solutions for mentally ill relatives, including emotional care, financial obligations, physical commitment (bathing, feeding, clothing, administration of prescriptions), and spiritual intervention (Edeta, 2021). Rakesh (2014) noted that family caregivers bear with behavioral disturbances, curtail social and leisure activities, take leave from jobs, and meet financial needs including treatment costs. The caregiver burden has two dimensions: objective (disrupted family routines, constraints on social activities, financial costs) and subjective (feelings of loss, guilt, shame, anger) (Rakesh, 2014). In South-South Nigeria, where mental health facilities are concentrated in urban centers and medication costs are often borne entirely by families, this burden is particularly severe.

5. THEORETICAL FRAMEWORK

This study is anchored on three complementary theories. Attribution theory (Weiner, 1986) explains how causal attributions (internal/external, controllable/uncontrollable) shape emotional responses and helping behaviors toward mentally ill persons. Symbolic interactionism (Mead, 1934; Blumer, 1969) illuminates how meanings attached to mental illness through cultural symbols and language determine family responses. Labeling theory (Becker, 1963; Scheff, 1966) explains how the label of "mentally ill" creates stigma, discrimination, and reduced caregiving commitment. Together, these theories provide a comprehensive framework for understanding the knowledge-belief-caregiving pathway.

6. METHODOLOGY

Study Design and Area: This study employed a cross-sectional design with mixed methods (quantitative and qualitative). The research was conducted in South-South Nigeria, comprising six states: Edo, Delta, Bayelsa, Rivers, Cross River, and Akwa-Ibom. The region hosts three major federal psychiatric hospitals (Benin, Calabar, Port Harcourt) and several psychiatric units in teaching hospitals.

Population and Sample: The target population consisted of family caregivers of mentally ill persons receiving treatment in mental health facilities across the six states. Using Taro Yamane's formula with a 5% error margin, a sample size of 385 was calculated. A total of 372 valid questionnaires were analyzed (97% response rate). Purposive sampling was used to select participants who were adult family members (≥18 years) currently

providing care for a mentally ill relative.

Instruments: A 40-item structured questionnaire assessed: (a) sociodemographic characteristics, (b) knowledge about mental illness (10 items), (c) perception of mental illness (10 items), (d) beliefs about mental illness (10 items), and (e) family duty of care (10 items). Responses were measured on a 5-point Likert scale (Strongly Agree to Strongly Disagree). The instrument was validated through expert review and pre-tested using test-retest reliability (Pearson correlation r = 0.87). Qualitative data were collected through 25 key informant interviews (7 psychiatrists, 8 social workers, 5 traditional healers, 5 caregivers) and in-depth interviews.

Data Analysis: Quantitative data were analyzed using descriptive statistics (frequencies, means, standard deviations), Pearson correlation, and multiple regression analysis (stepwise method) at $p \leq 0.05$ significance level using SPSS. Qualitative data were analyzed thematically.

Ethical Considerations: Ethical approval was obtained from relevant institutional review boards. Informed consent was obtained from all participants, and confidentiality was maintained through anonymization.

7. RESULTS

7.1 SOCIODEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

TABLE 1:
SOCIODEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS (N=372)

Characteristic	Category	Frequency	Percent
Sex	Male	157	42.2
	Female	215	57.8
Education	Primary	60	16.1
	Secondary	121	32.5
	First degree	103	27.7
	Postgraduate	88	23.7
Socioeconomic Status	Poor	184	50.7
	Average	124	34.2
	Rich	55	15.2
Mental Health Facility Availability	Same city	84	22.6
	Same state	196	52.7
	Not in state	92	24.7

Table 1 presents the sociodemographic profile of the 372 respondents. Females constituted 57.8% of caregivers, reflecting the gendered nature of family caregiving. The majority (75.8%) were Christians, followed by African Traditional Religion (14.5%). Educational levels varied: 32.5% had secondary education, 27.7% had first degrees, 23.7% had postgraduate qualifications, and 16.1% had only primary education. Regarding socioeconomic status, 50.7% classified themselves as poor, 34.2% as average, and 15.2% as rich. Notably, 52.7% reported that mental health facilities were available only within their state (not locally), and 60.7% were struggling to pay for mental health medications.

7.2 OBJECTIVE 1: LEVEL OF KNOWLEDGE AND ITS SIGNIFICANCE TO FAMILY DUTY OF CARE

TABLE 2:
MEAN AND STANDARD DEVIATION OF KNOWLEDGE ABOUT MENTAL ILLNESS

Item	Mean	SD
Ignorance about mental illness is a major cause of societal stigma	4.09	1.09
Family duty of care is determined by knowledge about mental illness	3.13	1.36
Drug abuse is the major cause of mental illness	1.91	0.92
Involvement in money rituals causes mental illness among youths	3.15	1.39
Mental disorder is associated with old age	4.19	0.71
Mental illness can occur from brain damage in an accident	3.22	1.46
Family response is determined by economic status	3.35	1.34
Once a mentally ill person eats in the marketplace, they become incurable	3.95	0.91
Mental illness is associated with talking nonsense	3.03	1.44
Mental disorder is associated with loss of memory	2.71	1.65

Average Mean	3.27	1.22

Table 2 presents the mean scores for knowledge items. The average mean score for knowledge about mental illness was 3.27 (SD = 1.22), indicating moderate knowledge levels. Items with highest endorsement included "Mental disorder is associated with old age" (M = 4.19, SD = 0.71) and "Ignorance about mental illness is a major cause of societal stigma" (M = 4.09, SD = 1.09). However, misconceptions persisted: "Once a mentally ill person eats and stays in the marketplace, they become incurable" received moderate agreement (M = 3.95, SD = 0.91).

Hypothesis 1 Testing: A linear regression analysis tested the relationship between knowledge about mental illness and family duty of care. As shown in Table 3, the computed r value was .973, indicating a strong positive linear relationship. Knowledge explained 94.7% of the variance in family duty of care (R^2 = .947). The F-ratio was significant, $F(1,370) = 6651.121$, $p < .05$. Therefore, the null hypothesis was rejected, concluding that knowledge about mental illness has a significant positive relationship with family duty of care.

TABLE 3:
LINEAR REGRESSION OF KNOWLEDGE ON FAMILY DUTY OF CARE

Variable	B	SE B	β	t	p	R	R^2
(Constant)	-.278	.034		-8.156	.000	.973	.947
Knowledge	1.199	.015	.973	81.554	.000		

7.3 OBJECTIVE 2: INFLUENCE OF BELIEFS ON FAMILY DUTY OF CARE

TABLE 4:
MEAN AND STANDARD DEVIATION OF BELIEFS ABOUT MENTAL ILLNESS

Item	Mean	SD
Traditional belief system determines family choice of care	**3.29**	**1.38**
Culture and belief system affect health-seeking behavior	**3.27**	**1.37**
Mental illness is best treated through spiritual intervention	**3.61**	**1.24**
It is the faith of family members that stands in the gap during prayers	**3.15**	**1.41**
Mental illness cannot be cured if it is punishment for evil deeds	**3.53**	**1.36**
Mentally ill persons are not capable of true friendships	**3.58**	**1.26**
Mentally ill people should be prevented from walking freely in public	**3.48**	**1.29**
The mentally ill should not be allowed to make decisions	**3.44**	**1.33**
Entering a mental hospital is a sign of personal failure	**3.64**	**1.29**
Cultural belief holds that mental illness can happen at any time	**3.62**	**1.25**
Average Mean	**3.46**	**1.32**

Table 4 presents mean scores for beliefs about mental illness. The average mean was 3.46 (SD = 1.32), indicating relatively strong endorsement of traditional beliefs. Highest endorsement was for "Most people believe that entering a mental hospital is a sign of personal failure" (M = 3.64, SD = 1.29), "Most cultural belief holds that mental illness can happen at any time" (M = 3.62, SD = 1.25), and "Mental illness is best treated through spiritual intervention" (M = 3.61, SD = 1.24).

Hypothesis 2 Testing: Regression analysis revealed an even stronger relationship between beliefs and family duty of care (r = .981, R^2 = .962), indicating that beliefs explained 96.2% of the variance in caregiving responsibilities (Table 5). The F-ratio was significant, $F(1,370) = 9433.75$, $p < .05$, leading to rejection of the null hypothesis.

TABLE 5

LINEAR REGRESSION OF BELIEFS ON FAMILY DUTY OF CARE

Variable	B	SE B	β	t	p	R	R^2
(Constant)	-.095	.027		-3.536	.000	.981	.962
Beliefs	1.131	.012	.981	97.128	.000		

7.4 JOINT EFFECT OF KNOWLEDGE, BELIEFS, AND PERCEPTION

Hypothesis 5 Testing: Multiple regression analysis examined the joint effect of knowledge, beliefs, and perception on family duty of care (Table 6). The model produced R = .982, R^2 = .965 (adjusted R^2 = .965), indicating that the three independent variables jointly explained 96.5% of the variance in family duty of care. The F-ratio was significant, $F(3,368) = 3386.511$, $p < .05$.

TABLE 6
MULTIPLE REGRESSION OF KNOWLEDGE, BELIEFS, AND PERCEPTION ON FAMILY DUTY OF CARE

Variable	B	SE B	β	t	p	Tolerance	VIF
(Constant)	-.189	.032		-5.945	.000		
Beliefs	1.127	.085	.977	13.230	.000	.017	57.37
Knowledge	.420	.087	.341	4.847	.000	.019	52.08
Perception	-.393	.088	-.336	-4.461	.000	.017	59.74

Perception emerged as a mediator, with a negative beta weight (β = -.336, $p < .05$), indicating that negative perceptions reduce family caregiving even when knowledge and beliefs are considered.

8. DISCUSSION OF FINDINGS

8.1 KNOWLEDGE AND FAMILY DUTY OF CARE

The finding that knowledge about mental illness has a strong positive relationship with family duty of care (r = .973, R^2 = .947) aligns with previous research. Janardhana et al. (2015) similarly found that inadequate knowledge and caregiving skills leave family caregivers unfamiliar with the type or amount of care needed. Sin and Norman (2013) emphasized that a basic level of knowledge facilitates partnership with health professionals. However, the persistence of misconceptions—such as the belief that eating in the marketplace causes incurable mental illness—indicates that knowledge alone is insufficient; the quality and accuracy of knowledge matter significantly.

The moderate average knowledge score (M = 3.27) suggests that while basic awareness exists, specific biomedical understanding remains limited. This finding supports Monteiro's (2016) observation that mental health literacy is lower in African cultures compared to European and North American contexts.

8.2 BELIEFS AND FAMILY DUTY OF CARE

The stronger relationship between beliefs and caregiving (r = .981, R^2 = .962) underscores the primacy of cultural explanatory models in shaping health behaviors. The endorsement of spiritual intervention as the best treatment (M = 3.61) and the belief that entering a mental hospital signals personal failure (M = 3.64) reflect deep-seated cultural frameworks that directly conflict with biomedical approaches.

From an attribution theory perspective (Weiner, 1986), when families believe mental illness results from controllable causes (punishment for evil deeds), they respond with reduced care and increased blame. This was evident in qualitative reports of families hiding ill relatives or refusing to seek treatment. Conversely, when bewitchment is perceived as the cause (external but controllable through spiritual means), families invest significant resources in faith healing—often delaying effective medical treatment for months or years.

9.0 CONCLUSION

This study conclusively demonstrates that knowledge about mental illness and cultural beliefs are powerful determinants of family duty of care for mentally ill persons in South-South Nigeria. Knowledge explains 94.7% of the variance in caregiving behaviors, while beliefs explain 96.2%. Together with perception, they explain 96.5% of caregiving outcomes. Education and poverty mediate

these relationships, indicating that structural interventions are as necessary as educational ones.

The persistence of supernatural attributions—bewitchment, repercussion, ancestral punishment—continues to divert families from evidence-based treatment toward spiritual and traditional healing. While these cultural frameworks are not inherently harmful, their effect of delaying or preventing biomedical intervention has documented negative consequences for patient outcomes.

Addressing this situation requires a dual strategy: improving mental health literacy through culturally sensitive community education, and expanding access to affordable, mental health services. Without both components, families will continue to struggle with the impossible choice between culturally congruent but ineffective care and effective but inaccessible or unaffordable biomedical treatment.

10. RECOMMENDATIONS

Based on the findings, the following recommendations are made:

Government: Increase mental health funding to at least 15% of the health budget as pledged in the Abuja Declaration (2001), establish psychiatric units in all general hospitals, and subsidize psychotropic medications to reduce out-of-pocket expenses for families.

Health Ministries: Integrate mental health literacy into primary school curricula and community health programs, using culturally appropriate messaging that respects traditional beliefs while providing accurate biomedical information.

Healthcare Providers: Develop family psychoeducation programs that address both knowledge deficits and belief systems, recognizing that changing caregiving behavior requires addressing cultural explanatory models, not merely providing facts.

Traditional and Faith Healers: Establish referral partnerships between orthodox providers and traditional/faith healers, enabling patients to receive spiritual care without delaying biomedical treatment when indicated.

Non-Governmental Organizations: Implement community-based anti-stigma campaigns targeting the specific beliefs identified in this study (e.g., that mental hospital admission signals personal failure, that mentally ill persons cannot form friendships).

Researchers: Conduct longitudinal studies to track how changes in knowledge and beliefs over time affect caregiving outcomes, and develop and test culturally adapted family interventions for South-South Nigeria.

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