

Influence of Socio-Demographic Characteristics on Attitude of People towards Mental Health Disorders at Abuja Municipal Area Council

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ABSTRACT

Mental health disorders represent a growing global public health burden, with Low- and Middle-Income Countries bearing a disproportionate share. In Nigeria, an estimated 20–30% of the population live with some form of mental health disorder. The study aims to determine the influence of sociodemographic characteristics on attitude of people towards mental health disorders at AMC. A community-based descriptive cross-sectional design was employed among 640 adult residents of AMAC aged ≥ 18 years, recruited through multistage sampling. A structured, pre-tested, self-administered questionnaire covering mental health awareness, cultural and religious beliefs, attitudes, stigma, and help-seeking intentions was administered. Data were analysed using SPSS with descriptive and inferential statistics; significance was set at $p < 0.05$. The mean age of respondents was 51.1 years (SD = 19.1), with a slight female majority (51.6%) and 52.6% having tertiary education. Based on the result, the scores in gender (female: 6.00; male: 5.95) as well as the education levels (primary: 6.15; secondary: 6.00; tertiary: 5.92) and ages showed no statistically significant differences (gender: $\chi^2 = 0.10$, $p = 0.75$; education: $\chi^2 = 1.98$, $p = 0.37$; age: $F = 0.26$, $p = 0.91$). In a similar fashion, the scores of attitudes did not differ significantly among all demographic groups, with values that were closed around 0.16 and 0.00. These findings underscore the urgent need for culturally sensitive mental health literacy programmes, strategic engagement with religious leaders, and structural interventions to reduce the financial cost of formal mental health services in AMAC.

Keywords: Influence, Socio-Demographic Characteristics, Mental Health Attitudes, AMAC, Nigeria

INTRODUCTION

Mental health disorders are a huge and increasing public health problem all over the world and they make a big contribution to the global disease burden (Fan *et al.*, 2025). In low- and middle-income countries, this burden is intensified by weak health systems, a shortage of trained personnel, and deep-rooted stigma. The World Health Organization (WHO) estimates that about one in four people will be affected by mental or neurological disorders at some point in their lives. In Nigeria, the situation is getting worse. Recent data shows that about 20% to 30% of Nigerians are suffering from different types of mental health disorders which means about 50 million people (Africa Polling Institute, 2020; Afolabi, 2025a).

Even with such a high rate, mental health issues are still neglected in the Nigerian public health system. Nigeria has a very serious "treatment gap." Almost 85% of those with severe needs for mental healthcare cannot get it (Healthnika, 2025). This gap is not only because there are fewer than 300 psychiatrists for over 200 million people but also heavily influenced by how the community sees and views things culturally (Afolabi, 2025a). In many Nigerian communities, mental illness is usually seen through the lens of spiritualism; it is often attributed to witchcraft, curses, or "spiritual attacks" rather than biomedical causes (Jidong *et al.*, 2021).

Abuja Municipal Area Council (AMAC) as Nigeria's Federal Capital Territory FCT cosmopolitan center has unique demographic mixing rapid urbanization with diverse cultural backgrounds; even though urbanization brings better access to health facilities it also introduces stressors like economic pressure overcrowding social fragmentation which

can worsen mental health issues understanding specific nuances on this diverse community perception regarding mental health is very important for the implementation of provisions recently signed National Mental Health Act (Adewuya *et al.*, 2025).

The central issue that this study seeks to address is the fact that stigmatization and lack of understanding about mental health disorders are both prevalent in the Abuja Municipal Area Council, serving as a significant obstacle to the delivery of effective mental healthcare. Some tertiary psychiatric facilities exist in the FCT, but service uptake is not optimal. Studies have shown that pervasive myths continue to exist. For example, mental disorders are often referred to as "madness" or equated with immorality, resulting in the rejection of such persons and their families (APA, 2026). This stigmatization is both social and clinical: the fear of being branded "mentally unstable" makes one avoid or delay treatment until it becomes impossible to cope with (Afolabi, 2025a). In addition, while there are studies on particular subgroups such as adolescents in AMAC (Idoko *et al.*, 2023). Empirically determining the influence of sociodemographic characteristics on the attitudes of community members toward mental health disorders within AMAC as this affect the treatment seeking and also will guide intervention and prevention of stigma. Therefore, the study seeks to determine whether sociodemographic characteristics have significant influence on attitude of people toward mental health disorders or not

MATERIALS AND METHODS

Research Design

Community-based descriptive cross-sectional design to assess perception and attitude toward mental health disorders among adult residents (≥ 18 years) in Abuja Municipal Area Council (AMAC), Federal Capital Territory (FCT), Nigeria was done. This design is suitable for estimating the distribution of knowledge, beliefs, attitudes (including stigma/social distance), and help-seeking intentions at one point in time and also for testing associations as specified in the study hypotheses.

Participant selection and Setting

640 respondents were selected using multistage sampling technique. A predetermined number of wards (4–6 wards) were selected from the twelve AMAC wards using simple random sampling. Systematic sampling was applied to select households using a calculated sampling interval $k = \frac{\text{total households}}{\text{households required}}$. The first household was selected randomly between 1 and k , then every k^{th} household thereafter. In each selected household, one eligible adult was selected using a simple random method (balloting among eligible adults). Where only one eligible adult is present, that person was selected. Sample allocation across wards/communities was proportionate to estimated population size where population figures are available; otherwise, equal allocation was used and clearly justified.

The sample population comprised of adult men and women aged 18 years and above who have been residing in the Abuja Municipal Area Council (AMAC) for at least six months before the data collection exercise.

AMAC is a very urbanized and fast-growing local government area with an estimated population of about 1.7–1.9 million people; approximately two-thirds of this population are within the age bracket of 15–64 years (Sabi, 2024). This constitutes the economically active largely adult population from whom respondents was drawn. The residents spread over 12 political/administrative wards comprising City Centre, Garki, Wuse, Gwarinpa, Nyanya, Karu, Karshi, Orozo, Kabusa, Gwagwa, Jiwa and Gui these are all high-density urban neighbourhoods as well as peri-urban communities (Sabi, 2024).

In terms of job nature, the adult people comprise a diverse group of civil servants, formal private-sector workers, traders and market vendors, artisans (mechanics, electricians, carpenters), transport workers' security personnel plus a large informal sector involved in small to medium businesses and services. Also present is a large student and youth population due to the concentration of tertiary institutions alongside unemployed and underemployed adults who occasionally engage in casual labour as well as informal economic activities. This diversity in numbers occupational profiles spatial distributions is hence very ideal for getting broad cross-sections regarding adult residents' awareness beliefs attitudes toward mental health issues within AMAC.

Instrument for Data Collection

The instrument used for data collection was a structured interviewer-administered questionnaire (paper-based or electronic using ODK/Kobo Collect). The instrument was

adapted from validated scales and relevant literature, aligned with the study objectives and research questions.

Validity and Reliability of Instrument

The drafted questionnaire prepared by the researchers after review of relevant literatures was presented to the supervisor for face & content validity and also a team of three (3) experts in public health, psychiatry/clinical psychology and epidemiology/biostatistics psychiatry.

Internal consistency reliability was assessed for multi-item scales (MAKS, CAMI subscales, RIBS, GHSQ) using Cronbach's alpha ($\alpha \geq 0.70$ considered acceptable for established scales, with context-based interpretation). For items requiring reverse scoring, coding was verified prior to reliability computation.

Data Collection

Permission was sought from AMAC authorities and community gatekeepers in selected wards and communities. Written informed consent was obtained from each participant prior to the commencement of any interview procedures. Fieldworkers received structured training on the study objectives, principles of ethical conduct in human subjects' research, appropriate consent administration procedures, interviewing techniques, protection of participants' privacy, and strategies for recognizing and appropriately responding to distress. Interviews were conducted in a private and comfortable setting within or around the respondent's household, in order to minimize social desirability bias and to safeguard participant confidentiality. Any participant who exhibits signs of distress or explicitly requests assistance during the interview was provided with information on accessible mental health service delivery points and referral options within the Federal Capital Territory (FCT).

Data Analysis

Quantitative data was analyzed using statistical package for social sciences (SPSS) version 22. Both descriptive and inferential statistics were performed to manage the data. Chi-square was used as an avenue to reject or fail to reject the null hypothesis. The confidence interval was set at 95% and alpha of 0.05.

Ethics Approval

Ethical approval was obtained from a recognized Health Research Ethics Committee (HREC) of the FCT Ministry of Health in accordance with the National Code for Health Research Ethics.

RESULTS AND DISCUSSION

Based on the table below, slightly more than half of the respondents were female (51.6%), the approximate mean age being 51.1 years with a standard deviation of about 19.1 years. In terms of educational level, a significant majority (52.6%) had tertiary education. 46.0% were married or cohabiting, 56.0% reported having had contact with mental illness. A significant majority (62.0%) had received formal mental health information.

Age: mean = 51.1 years, SD = 19.1 years

Table 1: Socio-demographic Characteristics of Respondents

Variable	Category	Count	Percentage (%)
Gender	Female	329	51.6
	Male	308	48.4
Marital Status	Married/Cohabiting	293	46.0

Variable	Category	Count	Percentage (%)
Education	Single (Never Married)	264	41.4
	Divorced/Separated	53	8.3
	Widowed	27	4.2
	Tertiary Education (OND, HND, B.Sc., M.Sc.)	335	52.6
	Secondary School	208	32.7
	Primary School	94	14.8
Religion	Christianity	336	52.7
	Islam	291	45.7
	Other	7	1.1
	Traditional Religion	3	0.5
Personal Contact with Mental Illness	Yes	357	56.0
	No	280	44.0
Received Formal Mental Health Info	Yes	395	62.0
	No	242	38.0

The table below shows the influence of gender, education, and age group on perception of mental health disorders, measured by the mean awareness score. Females showed a slightly higher mean awareness score (6.00) compared to males (5.95). Regarding education, respondents with primary education showed the highest mean score (6.15). The youth

within age groups 26–35 and 18–25 have the highest mean awareness scores combined (6.13), suggesting younger respondents tend to demonstrate relatively higher awareness of mental health disorders.

N = 640

Table 2: Influence of Gender, Education, and Age Group on Perception

Demographic	Category	Mean Awareness Score	Std Dev	Count
Gender	Male	5.95	1.57	308
Gender	Female	6.00	1.53	329
Education	Secondary School	6.00	1.52	208
Education	Tertiary Education (OND, HND, B.Sc., M.Sc.)	5.92	1.56	335
Education	Primary School	6.15	1.61	94
Age Group	18–25	6.03	1.56	76
Age Group	26–35	6.13	1.54	87
Age Group	36–45	5.89	1.61	103
Age Group	46–55	6.11	1.56	93
Age Group	56–65	5.93	1.68	102
Age Group	65+	5.90	1.45	176

Table 3 shows the influence of gender, education, and age group on overall attitude scores towards mental health disorders. Males recorded a slightly higher mean attitude score (-0.07) while respondents with tertiary education recorded the lowest score (-0.12), suggesting a relatively uniform attitude across educational backgrounds. The 18–25 age group recorded the highest mean attitude score (0.00),

with scores declining progressively across older age groups, reaching the lowest among respondents aged 65 and above (-0.16), suggesting that younger respondents tend to hold comparatively more positive attitudes towards people with mental health disorders, though the overall variation across all age groups remains relatively modest.

Table 3: Influence of Gender, Education, and Age Group on Attitudes N = 640

Demographic	Category	Mean Attitude Score	Std Dev	Count
Gender	Male	-0.07	1.10	308
Gender	Female	-0.12	1.01	329
Education	Secondary School	-0.08	1.06	208
Education	Tertiary Education (OND, HND, B.Sc., M.Sc.)	-0.12	1.04	335
Education	Primary School	-0.07	1.12	94
Age Group	18–25	0.00	0.92	76
Age Group	26–35	-0.03	1.08	87
Age Group	36–45	-0.05	1.07	103
Age Group	46–55	-0.12	1.12	93
Age Group	56–65	-0.14	0.94	102
Age Group	65+	-0.16	1.13	176

From Table below, the test fails to reject H_0 . There is no significant relationship between socio-demographic

characteristics (age, gender, education) and awareness levels ($p > 0.05$ for all variables).

Table 4: Hypothesis 1: Socio-demographic Characteristics and Awareness

Variable	Test Statistic	Degrees of Freedom	P-value
Age	F = 0.2577	4	0.9050
Gender	$\chi^2 = 0.1003$	1	0.7515
Education	$\chi^2 = 1.9752$	2	0.3725

Discussion

Socio Demographic Characteristics of Respondents

The mean age (SD = 19.1) of the respondents was 51.1 years with a ratio somewhat favored by the females (51.6) with majority being tertiary education (52.6) and almost equal between Christians (52.7) and Muslims (45.7). It was interesting to note that 56.0% of them were personally affected by mental illness and 62.0% had received formal mental health information before. This profile is an indication of a mature, educated and religiously diverse urban population, which typifies the Federal Capital Territory. This population structure can be compared to the one described by Pederson *et al.* (2023), investigated the topic of mental health stigma among Nigerian medical students and discovered that participants who lived in urban areas and were educated showed more moderate yet equally ambivalent attitudes. Concerning the background of the study, the relatively high percentage of respondents that had prior mental health information (62.0) is a significant aspect of the study that puts into perspective the relative sufficiency of the awareness levels that were noted under the various objectives that have been set.

Influence of Socio Demographic Characteristics on Awareness and Attitudes

The scores in gender (female: 6.00; male: 5.95) as well as the education levels (primary: 6.15; secondary: 6.00; tertiary: 5.92) and ages showed no statistically significant differences (gender: $\chi^2 = 0.10$, $p = 0.75$; education: $\chi^2 = 1.98$, $p = 0.37$; age: $F = 0.26$, $p = 0.91$). In a similar fashion, the scores of attitudes did not differ significantly among all demographic groups, with values that were closed around 0.16 and 0.00. These are in line with findings by Komu *et al.* (2025) found reports across sub Saharan African studies that individual socio demographic factors are always weak predictors of mental health literacy because awareness is better determined by community exposure and personal experience of having an ill than through formal education and age. Thornicroft *et al.* (2022) also agreed that stigma is a societal and cultural phenomenon, and not exactly a demographic stratified phenomenon, which supports the importance of population wide instead of demographic specific anti stigma efforts in AMAC.

CONCLUSION

The study determined the influence of sociodemographic characteristics on attitude of people towards mental health disorders. The study has limited generalizability to rural area because of its different cultural and socioeconomic profile with the setting. Therefore, concludes that gender as well as the education levels and ages showed no statistically significant differences. In a similar fashion, the scores of attitudes did not differ significantly among all demographic groups, with values that were closed around 0.16 and 0.00. This implies that gender, age and educational level share related influences when it comes to the attitude of people toward mental health disorders. Therefore, the researchers recommend giving equal attention and emphasis in providing culturally sensitive mental health literacy programmes, and structural interventions to improve the attitudes of the people.

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