AWARENESS OF MENTAL HEALTH CHALLENGES AMONG PATIENTS - DOCTORS' PERSPECTIVE IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL, BENIN CITY, EDO STATE.

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DEDICATION

This project is dedicated to God Almighty, the source of all knowledge, for bringing me this far. I would not have made it without His divine help and guidance. I also dedicate this project to my beloved parents for their unwavering support throughout the course of this program.

I extend this dedication to my supervisor, Professor Obehi Okojie, whose guidance have proved invaluable to this study.

Finally, I dedicate this project to every medical student whose input was important to the completion of this study.

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To my lovely parents-, Mr. and Mrs. Onyekwelu, I am deeply grateful for your unconditional love and support—emotionally, financially, and spiritually in the place of prayer. To my Guardians, Mr. and Mrs. Falodun, I am sincerely grateful for all your support and sacrifice. You have all been a source of inspiration up to this point of my journey, and I couldn't have wished for better parents.

I would not fail to express how deeply grateful I am to my beloved siblings, Chinyelu, Chukwuemeka, Chimnonso, Peace and Adaeze. I would not have made it this far without your unwavering support. You have all been a reliable pillar in the completion of this journey, and I am blessed to have you as my slibings.

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Finally, to everyone else who supported me in various ways, your support has not gone unnoticed. I am grateful. This project is as much yours as it is mine.

DECLARATION

I hereby declare that this research project titled "AWARENESS OF MENTAL HEALTH CHALLENGES AMONG PATIENTS - DOCTORS' PERSPECTIVE IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL, BENIN CITY, EDO STATE" will be conducted under supervision and has not been submitted in part or in full for any purpose.

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CERTIFICATION

This is to certify that this research study titled "**AWARENESS OF MENTAL HEALTH CHALLENGES AMONG PATIENTS - DOCTORS' PERSPECTIVE IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL, BENIN CITY, EDO STATE"** will be conducted by ONYEKWELU PRINCE SOMTOCHUKWU with matriculation number MED1705939 under the supervision of **Prof. Obehi Okojie** in the Department of Public Health and Community Medicine, College of Medical Sciences, University of Benin as part of the requirements for the award of Bachelor of Medicine, Bachelor of Surgery (MBBS) degree.

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LIST OF ABBREVIATIONS

1. **AOR:** Adjusted Odds Ratio
2. **API:** Africa Polling Institute
3. **CI:** Confidence Interval
4. **DSM-IV-TR:** Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
5. **NNMHS:** Nigeria National Mental Health Survey
6. **SPSS:** Statistical Package for the Social Sciences
7. **UBTH:** University of Benin Teaching Hospital
8. **WHO:** World Health Organization

DEFINITION OF TERMS

Awareness:

zThe knowledge or understanding individuals have about a specific subject, in this case, mental health challenges, and their implications.

Barriers:

Factors or obstacles, such as stigma, cultural beliefs, or lack of resources, that hinder patients' understanding and acknowledgment of mental health issues.

Doctors:

Professionals involved in delivering healthcare services, including doctors, nurses, pharmacists, and laboratory scientists, working directly with patients.

Educational Awareness Programs:

Initiatives or campaigns aimed at informing and educating individuals, especially patients, about mental health issues to improve understanding and reduce stigma.

Knowledge:

The information or understanding doctors possess about mental health challenges and how they relate to patients' awareness.

Mental Health Challenges:

Psychological, emotional, or behavioral conditions that significantly affect an individual's thoughts, feelings, or behaviors, including conditions such as depression, anxiety, and schizophrenia.

Perception:

The way doctors interpret, understand, or form opinions about patients' awareness of mental health challenges based on their professional experience.

Stigma:

A negative perception or discrimination directed toward individuals due to their association with mental health issues, often leading to societal rejection or exclusion.

Strategies:

Planned actions or approaches proposed by doctors to improve patients' awareness and understanding of mental health challenges.

Tertiary Healthcare Facility:

A hospital or medical center that provides specialized care, such as the University of Benin Teaching Hospital, which serves as the study location.

ABSTRACT

Background: Mental health challenges remain a major global public health concern, yet awareness among patients is often limited, particularly in low- and middle-income countries. In Nigeria, many individuals misattribute psychiatric symptoms to stress, spiritual causes, or ordinary life difficulties, resulting in delayed presentation, poor treatment adherence, and worsened outcomes. Doctors' perspectives are vital in assessing the extent of patients' awareness and identifying barriers to care.

Objective: This study assessed doctors' perspectives on the level of patients' awareness of mental health challenges at the University of Benin Teaching Hospital (UBTH), Benin City, Nigeria, and explored perceived barriers, consequences, and strategies for improvement.

Methods: A descriptive cross-sectional study was conducted among doctors at UBTH using a structured, self-administered questionnaire. Data collected included socio-demographics, perceptions of patients' awareness, barriers, and suggested interventions. Data were analyzed using SPSS version 25.0, with results presented in prose, tables, and charts.

Results: Most doctors perceived patients' awareness of mental health challenges to be low to moderate, with only a small proportion demonstrating good awareness of common conditions such as depression and anxiety. Patients often misattributed symptoms to stress or spiritual problems, delaying diagnosis and treatment. Stigma (reported by over two-thirds of respondents), cultural and religious beliefs, low literacy, and weak health system capacity were identified as major barriers. Doctors noted that poor awareness contributed to late presentation, misdiagnosis, treatment non-adherence, and frequent relapses. Suggested strategies included integrating mental health education into routine consultations, strengthening community outreach, collaborating with religious and cultural leaders, expanding training for healthcare providers, and implementing hospital-based and national awareness campaigns.

Conclusion: Doctors at UBTH perceive patients' awareness of mental health challenges as inadequate, with significant consequences for timely diagnosis, treatment adherence, and clinical outcomes. Stigma and sociocultural misconceptions remain key barriers. Targeted interventions—including patient education, anti-stigma programs, and community engagement—are urgently needed to improve awareness and enhance mental health care delivery.

Keywords: Mental health, awareness, patients, doctors' perspective, barriers, University of Benin Teaching Hospital, Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Mental health is a vital part of our overall well-being, yet it is often overlooked and stigmatized. In many cases, mental health challenges are masked under various physical health problems the patient tends to be more concerned about. This they do ignorantly. “Patient’s awareness of mental health challenges significantly influences their willingness to seek help, adhere to treatment, and engage in preventive measures.[1] Therefore, the need to increase mental health awareness. Doctors who take the lead in healthcare delivery, possess adequate insight into the degree of mental health awareness among their patients. Hence, their perspective is pertinent in identifying the lapses in mental health education and proposing more efficient ways to improve patient mental health and health awareness.

Mental health disorders are part of the leading cause of health issues. According to the World Health Organization (WHO), about 450 million people are currently living with one or more mental health conditions.[2] This makes it one of the major world public health concerns. Common conditions like depression, schizophrenia and anxiety affect a large percentage of the world, impacting these individuals both personally and economically. Despite this high prevalence, mental health challenges are largely overlooked, underreported and stigmatized.

In Nigeria and most parts of Africa, where mental health illness is barely acknowledged as a health issue, this becomes an even bigger problem. An average Nigerian will only visit the hospital if he has “real diseases” like malaria, typhoid; HIV etc.[3] To this group of people, mental health is nonexistent. In cases where mental health challenges are acknowledged, they are usually attributed to evil spirit possession. So the victims will most likely end up in a spiritual house rather than a health facility.

For this reason, doctors and other healthcare workers play a crucial role in enlightening the public on mental health issues. Leveraging their daily interaction with patients who visit the hospital for the treatment of “real disease”, they can interact with them and explain to them the concept of mental health disorders, their symptoms and treatment. In so doing their perspective as healthcare workers can bring to light how well patients know their mental health conditions and the possible barriers they face while seeking help.

A survey by the American Psychological Association (APA) revealed that only 56% of primary care physicians felt that their patients had a good understanding of mental health issues.[4]This figure gets much smaller in a low-income country like Nigeria with over 30% illiteracy level.

This poor level of mental health awareness results in delayed diagnoses, late intervention, and poorer prognosis. In addition to this is the fear of being stigmatized by peers and loved ones, ultimately discouraging them from seeking help from mental health professionals.

Improving mental health literacy among patients is essential for fostering a proactive approach to mental health care. Doctors' insights into patients' awareness can inform the development of targeted educational initiatives and public health campaigns aimed at increasing knowledge and reducing stigma. By enhancing mental health literacy, patients can better recognize symptoms, understand the importance of seeking timely help, and adhere to treatment plans more effectively.

In summary, the perspective of the doctors on the awareness of mental health challenges is an important aspect of medical practice. Their insight into their patients’ understanding of mental health issues and help-seeking habits will reveal a lot about the existing knowledge gap and ultimately help bridge this gap through educational and enlightenment programs.

1.2 Statement of Problem

Across the world, 8 million people die every year due to mental health disorders and the lifespan of people with severe mental health conditions is reduced by 10 to 20 years according to the World Health Organization (WHO). The WHO also estimates that worldwide, 450 million people have a mental disorder and 25% of the population will suffer from mental illness at some time in their lives. These figures establish mental health challenges as an important aspect of health, hence the need for more people to be aware of it.[2]

According to the survey conducted in 2019 by a collaboration between Africa Polling Institute (API) and EpiAFRIC which adopted the stratified quota sampling technique, via Face-to-Face interviews in all the 36 States and the Federal Capital Territory (FCT), an estimated 20% - 30% of the Nigerian population are believed to suffer from mental disorders (this translates to 1 in every 4 Nigerians) and about 50% will suffer from it in their lifetime, this finding mirrors the 2006 WHO-AIMS report that claims that about 20 million Nigerians suffer from mental illness of which a good number of them go without professional assistance.

The American Psychological Association (APA) went further to conduct a study among their patients, revealing that over 40% of primary care physicians felt that their patients had a poor understanding of mental health issues. It is pertinent to note that this study was conducted in a supposed "developed country" where awareness is expected to be at its peak. Imagine how far this figure drops when the same study is done in an African country where the term "mental health" is barely known.[4]

The 2019 survey by Africa Polling Institute (API) and EpiAFRIC went ahead to show how awareness of mental health is low in Nigeria, with most respondents being unaware of having mental health disorders. In cases where people were aware, the majority of them attributed it to possession by evil spirits and sickness of the brain and the majority of the patients ended up being taken to a prayer house for spiritual interventions. This study reveals a sad but true fact; many Nigerians are unaware of mental health challenges but when they do, they do so poorly. This culminates in the association of mental health issues with spiritual problems. The implication of this is that these people will most likely end up in spiritual houses rather than in the hospital. In addition, these sets of people have a very high risk of being stigmatized. This further reduces the chances of them seeking professional help. Due to all these factors, people with mental health challenges will prefer to suffer in silence than be stigmatized or termed "demon-possessed".

Contributing to the low awareness of mental health challenges is the absence of qualified medical professionals to carry out mental health awareness programs. Nigeria with over 200 million population, has fewer than 300 psychiatrists accounting for a ratio of about 700,000 of the population per psychiatrist (1:700,000), most of whom are urban-based, and in view of poor knowledge of mental disorders at the primary health-care level, caring for people with mental illness is typically left to family members. Furthermore, nine out of every ten doctors in Nigeria are seeking to leave the country and only eight neuropsychiatric hospitals are available in the entire country responsible for the professional training of psychiatric doctors as well as managing patients with psychiatric disorders.

1.3 Justification

Mental health disorders are problems that have plagued the health of many people around the world including Nigeria as revealed by the WHO. Yet, it is grossly overlooked especially in developing countries where a large percentage of their populace are ignorant of the term “Mental Health”. To them, the real forms of illness are malaria, HIV/AIDS, tuberculosis etc. So, they only visit the hospital for these diseases and never for mental health problems. Their visit to the hospital as a patient provides a good opportunity for them to be accessed on their mental health awareness and educated accordingly. This is one of the reasons for this study. Another reason for this to assess doctors ’ perspective on the level of awareness of mental health challenges among their patients, the impact of patients' awareness (or lack thereof) on the diagnosis and management of mental health conditions, identify the barriers that prevent patients from being aware of their mental health challenges, estimate mental health problems in their patients and identify doctors suggested strategies to improve mental health awareness among patients in their practice settings. Very importantly, is the existence of few researches on this topic conducted among patients and much fewer ones conducted from doctors’ perspective.

Hence, this study, therefore, aims to assess the knowledge, factors, challenges and influence of educational awareness of mental awareness among patients to harness doctors ' perspective in improving the awareness of mental health challenges among patients. It will also enable policymakers to formulate policies that will help optimize the awareness of mental health challenges.

1.4 Research Questions

1. What are the perceptions of doctors regarding the level of awareness of mental health challenges among their patients?

2. How do doctors perceive the impact of patients' awareness (or lack thereof) on the diagnosis and management of mental health conditions?

3. What barriers do doctors perceive that prevent patients from being aware of their mental health challenges?

4. What is the doctors' perception of mental health burden among their patients?

5. What strategies do doctors suggest to improve mental health awareness among patients in their practice settings?

1.5 AIMS AND OBJECTIVES

1.5.1 General Objective

To explore doctors' perspectives on the awareness of mental health challenges among patients and to identify strategies to enhance patients' understanding and management of mental health issues.

1.5.2 Specific Objectives

1. To assess the perceptions of doctors regarding the current level of awareness of mental health challenges among their patients.

2. To determine the perceived impact of patients' awareness (or lack thereof) on the diagnosis, treatment, and management of mental health conditions from the perspective of doctors.

3. To identify common barriers perceived by doctors to hinder patients' awareness and help-seeking behaviour regarding mental health challenges.

4. To assess the doctors’ perception of mental health burden among their patients.

5. To determine doctors’ recommendations to improve mental health awareness among their patients

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Mental health challenges remain of public health importance due to the recognition of its influence on the general well-being of an individual. However, this recognition is lesser in developing countries like Nigeria where the awareness of mental health is grossly limited. Hence, the consequence of lack of its importance is evident in delayed diagnosis, poor management and increased stigmatization of patients with mental health challenges who they perceive to be demon-possessed. For this reason, doctors ’ input is highly necessary because they are the first point of contact of these patients and play a vital role in identifying and assessing patients’ knowledge of mental health. Hence, their perception of their patients’ mental health awareness level is pertinent to devising strategies and workable interventions.

This chapter provides a comprehensive review of existing surveys on the awareness of mental health challenges among patients.

2.2 PERCEPTION OF HEALTH WORKERS AWARENESS OF MENTAL HEALTH CHALLENGES AMONG THEIR PATIENTS

A cross-sectional study was conducted in 2021 among 400 patients with type 2 diabetes mellitus (T2DM) in Iran to measure depression literacy (D-Lit) as well as mental health literacy (MHL).

In addition, to find out their relationship with psychological status and quality of life. Samples were selected using proportional stratified sampling. Findings from this study reveal that 10.25% of participants ($n = 41$) had severe depression, while 36.75% ($n = 147$) experienced severe anxiety. The mean (standard deviation) of MHL was 80.92 (9.16) out of 130 points. Only 1.7% ($n = 7$) of participants did not answer any questions correctly on the D-Lit scale, while only 5.8% ($n = 23$) answered 15 or more questions correctly. Mental health awareness had a significant negative correlation with depression ($r = -0.236$), anxiety ($r = -0.243$), and stress ($r = -0.155$) ($P < 0.001$). There was a positive and significant correlation between MHL and D-Lit ($r = 0.186$) ($P < 0.001$). Depression literacy also had a significant negative correlation with depression ($r = -0.192$), anxiety ($r = -0.238$), and stress ($r = -0.156$) ($P < 0.001$). Furthermore, there was a positive and significant correlation between the ability to recognize disorders ($r = 0.163$), knowledge of self-treatment ($r = 0.154$), and DQOL ($P < 0.001$). Depression ($r = -0.251$), anxiety ($r = -0.257$), and stress ($r = -0.203$) had a significant negative correlation with DQOL ($P < 0.001$).[5]

An institutional-based cross-sectional study was conducted at Black Lion Specialized Hospital; Addis Ababa, Ethiopia involving a total of 396 participants (230 men and 160 women) diagnosed with cancer revealed that about 70.3% of the participants had common mental disorders (CMD) like anxiety and depression. Among the participants, 73.5% of women and 67.8% of men reported CMD in the last 4 weeks. Factors significantly associated with CMD included being female (AOR = 1.74; 95% CI: 1.00, 3.02), being unemployed (AOR = 3.035; 95% CI: 1.37, 6.72), having an average monthly income of less than 1600 Ethiopian Birr (AOR = 2.838; 95% CI: 1.58, 5.08), undergoing cancer treatment for more than 5 years (AOR = 2.653; 95% CI: 1.39, 5.03), having poor social support (AOR = 3.618; 95% CI: 1.33, 9.80), and current use of substances (AOR = 6.852; 95% CI: 2.038, 23.034). The study concluded that a significant proportion of cancer patients experienced mental health challenges, with higher rates among women. Addressing these associated factors is pertinent for improving the mental health and overall well-being of cancer patients.[6]

A cross-sectional descriptive survey carried out among University of Nigeria students in 2018 to assess their mental health knowledge and help-seeking behaviour, a total of 400 questionnaires were distributed, 389 were completed and returned (97.3% response rate). Respondents were mainly female (64.9%, n=252) and were between the ages of 18 and 24 years (75.8%, n=294). One in eight respondents (12.1%, n=47) correctly identified and labelled the schizophrenia vignette. Hallucination was the most identified symptom of distress for schizophrenia (47.9%, n=186). The most common alternative label for schizophrenia was 'mental illness' (24.7%, n=96). Schizophrenia was also mislabelled as depression (11.6%, n=45). More than a 10th of the respondents used stigmatising labels such as 'crazy' and 'mad' (11.1%, n=43). Psychiatrists were the most recommended source of help for the vignette character (36.3%, n=141). There was a strong association between the faculty of study and the ability to correctly identify and label the schizophrenia vignette (χ^2=44.557, p<0.001). The study concluded that only 12.1% of all the participants were aware of mental health challenges.

A cross-sectional study was carried out in Epe Local Government Area (LGA), one of the four LGAs in Lagos State, a total of 253 questionnaires were adequately filled and analysed, and this was above the minimum calculated sample size of 246. About half of the respondents were less than 35 years of age (52.18%), with a mean age of 37.11 years and an s.d. of ± 13.84 years. Married respondents, Muslims, those belonging to the Yoruba tribe and respondents with at least a secondary school certificate constituted about 65.61, 50.59, 67.98 and 69.96%, respectively.

About two-fifths of respondents did not know the meaning of mental illness (41.90%), and the majority could identify the causes of mental illness (90.90%), of which 60.87% identified personal factors such as stress, worry, loss of a loved one and substance abuse as causes. The majority of respondents knew the symptoms of mental illnesses (93.66%), of which 78.90% mostly knew unusual behaviour. Most of the respondents (65.61%) agreed that 'mental health is important'; 39.13% admitted that they would not relate with an MIP, whilst almost half of the respondents (47.82%) reported that they would keep their distance from such a person. Most respondents (63.24%) believed that evil spirits could cause mental illnesses; 60.87% believed that curses from supernatural beings (gods) could lead to mental illnesses, whilst 41.91% believed that the influence of one's ancestors, regarding past sins, could lead to mental health problems. However, 46.64% of the respondents disagreed that the head of the household should be the one making decisions concerning mental health for the rest of the household. More than one-third of the respondents (36.50%) believed that persons suffering from mental illness should be hidden. About 45.00% believed that the 'traditional' way is in fact the first path that should be explored in the treatment of people with mental illness, whilst about one-third agreed that traditionalists were better than western doctors in the treatment of mental illness. Similarly, 34.47% of participants agreed with the statement that 'traditional medicine is more effective for treating mental illness than modern medicine'. More than one-third (35.79%) reported that they shouldn't be associating with mentally ill people. Almost half (47.31%) felt that there was no need for collaboration between medical doctors and traditionalists with regard to mental health.[8]

2.3 PERCEIVED IMPACT OF PATIENTS' AWARENESS AND MANAGEMENT OF MENTAL HEALTH CONDITIONS FROM THE PERSPECTIVE OF DOCTORS.

This cross-sectional study investigated depression literacy (DL) among community-based adults aged 40 to 64 years in five South Korean provinces. Convenience sampling was used to select participants. The study found that the average percentage of correct answers on the D-Lit questionnaire was 58.6%. The domain with the highest DL level was incidence and prognosis, with an accuracy rate of 87.2%. The item with the highest percentage of correct answers in this domain was "Many famous people have suffered from depression" (91.1%). Conversely, the domain with the lowest DL level was non-pharmacological effectiveness, with an accuracy rate of 30.7%. The item with the lowest percentage of correct answers in this domain was "Counseling is as effective as CBT for depression" (3.3%). The second-lowest DL level was found in the domain of differential symptoms (41.9%), with the item "Having several distinct personalities may be a sign of depression" scoring 27.6%. The third-lowest DL level was in the domain of pharmacological knowledge (51.6%), with the item "Antidepressants are addictive" scoring 29.3%. Regarding the participants' general characteristics, 70.5% were women. The majority were in their 40s (50.5%), followed by those in their 50s (40.6%), and those in their 60s (8.9%). Around 60% of the participants had a college or university degree, and 29.9% had a master's degree or higher. In terms of employment, 77.1% were employed, and half lived in the capital areas of Seoul and Gyeonggi. Additionally, approximately 50% of the participants had a normal BMI, 19.0% reported heavy drinking, and 54.2% exercised regularly. This study highlights varying levels of depression literacy among adults in South Korea, indicating a need for targeted education to improve understanding of non-pharmacological treatments and differential symptoms of depression.[9]

An institution-based cross-sectional study A cross-sectional study was conducted among 627 patients in two public hospitals and selected health centers in Addis Ababa, using a systematic random sampling technique from inpatient and outpatient departments (OPD) was conducted to evaluate adult patients' awareness of their diagnosis, treatment plan, and prognosis. The study took place at St. Paul Hospitals Millennium Medical College (SPHMMC), St. Peter Specialized Hospital, and their associated health centers between July 20th and August 30th, 2019. The findings revealed that 61.9% of participants were aware of their correct diagnosis, and 52.8% were familiar with their treatment plan. Additionally, 68.4% reported knowing the prognosis of their illness. However, only 3.6% (21) of the patient medical records contained information on prognosis. Awareness of diagnosis and treatment plans was significantly lower among gynecologic patients compared to those from general outpatient departments. Emergency patients also had significantly lower awareness of their treatment plan (OR = 0.27; 95% CI: 0.11, 0.68) and prognosis (OR = 0.21; 95% CI: 0.09, 0.50) than new outpatient department (OPD) patients. Interestingly, patients who reported having a positive experience during their clinical assessment were found to have significantly lower awareness of their prognosis (OR = 0.25; 95% CI: 0.08, 0.81).[10]

A descriptive (cross sectional) survey design strategy was adopted for this study. Three hundred and eighty-five youths selected based on convenience sampling approach participated in this cross-sectional survey. Participants were between the ages 18 and 24 years old. This selection was done among youths selected from several locations within the inner city of Uyo using a multistage sampling approach, while 174 or 45.2% of participants were males, 211 (54.8%) were females Participants' demographic profiles are presented. The result shows that 51.9% of the respondents are in the age bracket of 18 – 21, 48.1 percent are between 22 – 24years. The age group of interest to this study is 18 – 24 years, the researcher merely want to give options to the respondents, yet making sure that they fall within the selected age band especially for those who may not want to disclose their age. Further, the Table also indicates that 45.2% are males, while 54.8% are females. This shows that more females took part in the study than males while 54.8% are females. This shows that more females took part in the study than males. Results on the demographic profile are as presented in table 1. Respondents are largely Christians with 88.8% of the total respondents. As regards the income level of the respondents' background, 47.3% has lower level income status, 37.7% has middle level income status while those of the upper level income status are 15.1%. This is an indication that the majority of the respondents have a lower income background. We explored the association of the predictor variables with attitude towards seeking professional mental health. Results indicated that only delay factors ($r = -0.18$; $p < .01$) and mental health literacy were significantly related to ATSMH ($r = -0.16$; $p < .01$). These imply that the less delay factors (perceived barriers to mental health), the more favorable ATSMH, and surprisingly, the more mental health literacy, the less favourable ATSMH. Age ($r = -0.03$; $p > .05$), sex ($r = -0.06$; $p > .05$), and income ($r = 0.04$; $p > .05$) were not significantly associated with ATSMH.[11]

A survey was conducted with 5,484 respondents, of which 5,315 completed interviews. These respondents were 18 years and older, and the interviews took place from September 2nd to September 28th, 2019, using Face-to-Face Household Interviews and a stratified quota sampling technique. The interviews were conducted in English, Pidgin English, Yoruba, Hausa, and Igbo. The survey findings indicated that 70% of Nigerian Patients associate mental health disease with behaviors like "running around naked," 63% with "talking to oneself," 55% with self-harm, 54% with harming others, and 25% with social withdrawal. Notably, 80% of respondents from the South-West believed mental illness involves running around naked, while 43% from the North-East associated it with social withdrawal. This poor and in some cases wrong perception of mental health made diagnosis difficult. When it comes to causes, 84% of respondents identified "Drug Abuse" as the leading cause of mental illness, followed by "Sickness of the mind" (60%), "Possession by evil spirits" (54%), heredity (32%), and "God's punishment" (23%). Gender and location influenced perceptions, with more women (25%) than men (20%) viewing mental illness as divine punishment, and rural respondents (55%) more likely than urban ones (53%) to attribute it to evil spirits. In response to how Nigerians would react to someone with a mental illness, 65% would take the person to the hospital, 18% to a prayer house, and 8% to a traditional healer. Some would use forceful measures, with 4% opting to lock up the person and 2% to physically discipline them. The South-East showed the lowest willingness to seek hospital treatment (46%) and the highest for turning to prayer houses (28%), traditional healers (14%), or confinement (8%). Regarding relationships with individuals with mental disorders, 69% of respondents would avoid any relationship, while 29% were open to friendship (26%), business (2%), or marriage (1%). Those who would not engage cited concerns for personal safety (58%), doubts about the individual's judgment (17%), societal perceptions (15%), fears of transmission (5%), and potential heartbreak (4%). The study also revealed that 8% of respondents believe mental health disorders are untreatable. This belief was more common in the South-East (13%) and slightly more prevalent in rural areas (8%) than urban ones (7%). Those who believe mental illness is treatable cited hospitals (38%) and knowing recovered individuals (30%) as reasons, with others mentioning divine healing (21%), traditional medicine (6%), or likening it to other diseases (4%). In contrast, those who believe it is incurable pointed to the visible presence of mentally ill people (31%), possession by evil spirits (26%), divine curses (17%), punishment for wrongdoing (13%), and the perceived seriousness of the condition (12%). This poor awareness resulted in reduced help-seeking behaviour and adversely affected diagnosis, treatment and management of these patients.[12]

2.4 BARRIERS THAT DOCTORS PERCEIVE HINDER PATIENTS FROM BECOMING AWARE OF THEIR MENTAL HEALTH CHALLENGES AND SEEKING PROPER CARE.

A cross-sectional survey was conducted among populations in three different cities in the United Arab Emirates (UAE): Abu Dhabi, Dubai, and Sharjah. Out of 377 distributed questionnaires, 341 were returned, yielding a high response rate of 90.5%. The sample was nearly evenly split between males (n = 170, 49.9%) and females (n = 171, 50.1%). The majority of participants were in the age groups of 18–30 years (n = 112, 32.8%) and 31–40 years (n = 125, 36.7%). Arabs constituted the largest ethnic group (n = 196, 57.5%), and most participants were living with their families (n = 236, 69.0%). Additionally, a significant portion of respondents did not have a medical background (n = 238, 69.8%) and were graduates with a bachelor's or diploma degree (n = 257, 75.4%). The study identified several barriers to seeking help from health professionals for mental health issues. A substantial proportion of participants believed that the disease would resolve on its own without treatment (n = 205, 60.1%) and felt embarrassed or ashamed (n = 201, 58.9%), which were the most common obstacles. Fewer participants cited fear of disapproval from family members (n = 114, 33.4%) and being too unwell to ask for assistance (n = 116, 34.0%) as significant barriers. The study also explored the potential effects of untreated mental health disorders, with 69.2% of participants reporting social problems with friends and family, 56.3% reporting suicidal thoughts, 51.0% facing financial problems, 50.4% discontinuing from university or work, and 49.0% experiencing a reduction in academic performance. Regarding the outcomes of seeking professional help, over 70% of participants noted improvements in confidence (78.9%), relationships with family and friends (73.0%), and social skills (70.7%) with professional assistance. Additionally, 61.6% reported an improvement in academic or work performance, and 50% experienced physical improvement. Financial issues (15.5%) or no improvement in outcomes at all were the least common outcomes reported.[13]

A cross-sectional study was conducted in 25 primary health care centers in Jordan in 2015, involving 482 clients who attended these centers. The participants' ages ranged from 18 to 74 years (M = 34.75, SD = 11.755), with 52.9% being female (n = 254) and 47.1% being male (n = 226). The educational levels varied, with 27.7% (n = 133) having a high school education or less, 67.6% (n = 325) holding a diploma or bachelor's degree, and 4.8% (n = 23) possessing a master's or doctoral degree. Regarding marital status, 59.8% (n = 288) were married, 34.6% (n = 167) were single, and 5.6% (n = 27) were either divorced or widowed. Only 8.1% (n = 39) of participants had sought mental health services (MHS) in the past three years, while the majority (91.9%, n = 443) had never visited any. When it came to help-seeking preferences for mental health problems, 66% (n = 319) of participants tended to seek informal resources as their first choice, only 16% (n = 77) preferred formal mental health professionals, and 17.7% (n = 85) opted for no help. Among the informal resources, 38.7% (n = 186) preferred seeking help from close friends. Participants expressed less favorable attitudes towards seeking formal MHS (M = 39.19, SD = 5.073, Range = 15–60), reported high adherence to cultural beliefs about mental health problems (M = 30.32, SD = 4.401, Range = 11–44), and indicated a significant feeling of stigma towards seeking formal MHS (M = 12.40, SD = 2.931, Range = 5–20).[14]

A descriptive, quantitative cross-sectional survey was conducted among congregants of the Assemblies of God, a Pentecostal Christian charismatic church in KwaZulu-Natal, South Africa. A total of 300 respondents met the criteria and completed the questionnaires, with 61.7% of the respondents being female (n = 185) and 38.3% being male (n = 115). The largest group of respondents were between 18 and 20 years old (n = 108, 36%), while only 10% were over the age of 50 years. Most of the participants (n = 163, 54%) had completed high school, and only one participant had no formal education. More than half of the respondents had been attending their current church for five years or less. High knowledge scores on the Mental Health Knowledge Schedule were recorded for 47% (n = 141) of participants, while 37% (n = 110) scored in the moderate knowledge range. Low-level mental health knowledge was found in 16% (n = 49) of participants. A high level of agreement was observed that schizophrenia (76.3%) and bipolar disorder (71.7%) are types of mental illness, but depression (61%) and drug addiction (58%) were less often recognized as mental illnesses. The Community Attitudes Towards Mentally Illness (CAMI) scale showed medium levels of public stigma towards mental illness, with 46.8% (n = 141) of respondents scoring medium and 31.6% (n = 96) scoring high, indicating more favorable attitudes. Among male respondents, 50% (n = 58) scored in and above the 75th percentile, indicating favorable attitudes, while 52% (n = 96) of female respondents had a medium attitude response. Across ethnic groups, most scores were in the 50th percentile, reflecting intermediate attitudes. The Reported and Intended Behaviour Scale revealed that 46% (n = 139) of respondents scored medium and 31.6% (n = 95) scored high, indicating fairly high community exposure to the mentally ill. A majority (51.3%, n = 154) reported either currently living with or previously having lived with someone with a mental health problem. However, 63% (n = 189) had not worked with someone with a mental illness, and 62% (n = 186) reported no history of having neighbors with mental health problems. The mean score on Subscale B, reflecting positive attitudes toward individuals with mental illness, was 12.47 with a standard deviation of 5.78. Less than 25% of participants reported a lack of willingness to interact with those experiencing mental illness. Bivariate analysis indicated that males had higher Mental Health Knowledge Schedule scores compared with females (45.78 vs 42.53, $p < 0.001$). The highest mean scores were in the 31–40-year age group, while the lowest scores were found in the 50+ age group (43.41 vs 40.64, $p < 0.001$). Education level was significantly associated with knowledge, with higher knowledge scores linked to secondary school completion ($r = 0.36$, $p < 0.005$). Participants with tertiary education had the highest knowledge scores, while those with only primary school education had the lowest. Bivariate analysis of CAMI scores showed that males had higher scores and more favorable attitudes than females (92.0 vs 80.7). Stigma was lowest in the 31–40 and 41–50-year age groups and highest in the 18–20 age group (75.9 vs 95.98). A higher level of education predicted more favorable attitudes toward mental illness ($r = 0.015$, $p < 0.005$). Males also exhibited more favorable behavior than females (14.63 vs 11.15), with favorable intended behavior higher in older age groups and the lowest scores in the adolescent group. Primary education was associated with less favorable behaviors compared with tertiary education (8.33 vs 14.35). A positive community attitude correlated with favorable intended behavior ($r = 0.594$, $p < 0.05$). Logistic regression analysis revealed that the number of years as a Christian was not predictive of mental illness knowledge or attitude, but education level was significantly predictive of greater knowledge ($p < 0.005$, $r = 0.361$).[15]

A cross-sectional study was conducted in Epe Local Government Area (LGA), Lagos State, where 253 adequately filled questionnaires were analyzed, exceeding the minimum sample size of 246. The study population was predominantly young, with 52.18% of respondents under 35 years of age, and a mean age of 37.11 years (SD = 13.84). The majority of participants were married (65.61%), Muslim (50.59%), Yoruba (67.98%), and had at least a secondary school certificate (69.96%). The study found that about 41.90% of respondents lacked knowledge of the meaning of mental illness, though the majority (90.90%) could identify its causes, with 60.87% citing personal factors like stress, worry, loss of a loved one, and substance abuse. Most participants (93.66%) recognized symptoms of mental illness, with 78.90% identifying unusual behavior as a key symptom. However, negative attitudes were prevalent; 39.13% admitted they would avoid someone with mental illness, and 47.82% stated they would keep their distance. Cultural beliefs were significant, as 63.24% believed that evil spirits could cause mental illness, 60.87% thought curses from gods could be a cause, and 41.91% believed that ancestral influence could lead to mental health problems. Traditional views on treatment were also common, with 45.00% believing that the traditional method should be the first approach in treating mental illness, and 34.47% agreeing that traditional medicine is more effective than modern medicine. Furthermore, 35.79% reported that mentally ill individuals should not be associated with, and 47.31% saw no need for collaboration between medical doctors and traditionalists regarding mental health.[8]

2.5 DOCTORS' PERCEPTION OF MENTAL HEALTH BURDEN AMONG THEIR PATIENTS

A cross-sectional telephonic study was conducted in 2020 in Tehran, Iran, involving 602 recovered COVID-19 patients, both with and without a history of hospitalization. The participants had a mean age of 53.2 years (SD = 14.7). The study found that 5.8% of respondents experienced anxiety (95% CI: 4.2–7.8%), 5.0% reported depression (95% CI: 3.5–7.0%), and 3.8% had PTSD symptoms (95% CI: 2.3–5.3%). The likelihood of reporting anxiety and depression was significantly higher among participants younger than 50 years ($p < 0.01$ for anxiety; $p < 0.001$ for depression) and among females ($p < 0.01$ for anxiety; $p < 0.02$ for depression). The study concluded that a significant portion of recovered COVID-19 patients exhibited symptoms of anxiety and depression.[16]

A cross-sectional study was conducted in 25 primary health care centers in Jordan in 2015, involving 482 patients who attended these centers. The participants' ages ranged from 18 to 74 years (M = 34.75, SD = 11.755), with 52.9% being female (n = 254) and 47.1% being male (n = 226). The educational levels varied, with 27.7% (n = 133) having a high school education or less, 67.6% (n = 325) holding a diploma or bachelor's degree, and 4.8% (n = 23) possessing a master's or doctoral degree. Regarding marital status, 59.8% (n = 288) were married, 34.6% (n = 167) were single, and 5.6% (n = 27) were either divorced or widowed. Only 8.1% (n = 39) of participants had sought mental health services (MHS) in the past three years, while the majority (91.9%, n = 443) had never visited any. When it came to help-seeking preferences for mental health problems, 66% (n = 319) of participants tended to seek informal resources as their first choice, only 16% (n = 77) preferred formal mental health professionals, and 17.7% (n = 85) opted for no help. Among the informal resources, 38.7% (n = 186) preferred seeking help from close friends. Participants expressed less favorable attitudes towards seeking formal MHS (M = 39.19, SD = 5.073, Range = 15–60), reported high adherence to cultural beliefs about mental health problems (M = 30.32, SD = 4.401, Range = 11–44), and indicated a significant feeling of stigma towards seeking formal MHS (M = 12.40, SD = 2.931, Range = 5–20).[17]

An institutional-based cross-sectional study was conducted at Black Lion Specialized Hospital, Addis Ababa, Ethiopia involving a total of 396 participants (230 men and 160 women) revealed that about 70.3% of the participants had common mental disorders (CMD) like anxiety and depression. Among the participants, 73.5% of women and 67.8% of men reported CMD in the last 4 weeks. Factors significantly associated with CMD included being female (AOR = 1.74;

95% CI: 1.00, 3.02), being unemployed (AOR = 3.035; 95% CI: 1.37, 6.72), having an average monthly income of less than 1600 Ethiopian Birr (AOR = 2.838; 95% CI: 1.58, 5.08), undergoing cancer treatment for more than 5 years (AOR = 2.653; 95% CI: 1.39, 5.03), having poor social support (AOR = 3.618; 95% CI: 1.33, 9.80), and current use of substances (AOR = 6.852; 95% CI: 2.038, 23.034). The study concluded that a significant proportion of cancer patients experienced mental health challenges, with higher rates among women. Addressing these associated factors is crucial for improving the mental health and overall well-being of cancer patients.[6]

A cross-sectional study was conducted among 245 outpatients patients aged 20 years and above attending the General Outpatient Clinic of the University of Uyo Teaching Hospital with the objective of finding out the percentage of their patients with anxiety and depression co-occurring with medical conditions. The participants were randomly assessed for anxiety and depression using the Hospital Anxiety and Depression Scale (HADS), with a score of 8 and above indicating a level of caseness for these mental health disorders. The study found that 36.7% of the patients scored above the cutoff for anxiety, while 24.5% scored above the cutoff for depression. Regarding the severity of anxiety, 24.1% (n = 59) had mild anxiety (HADS score of 8–10), 11.0% (n = 27) had moderate anxiety (HADS score of 11–14), and 1.6% (n = 4) had severe anxiety (HADS score of 15–21). For depression, 15.9% (n = 39) had mild depression (HADS score of 8–10), 7.8% (n = 19) had moderate depression (HADS score of 11–14), and 0.8% (n = 2) had severe depression (HADS score of 15–21). The study also explored the associations between mental health disorders and medical conditions. It was found that hypertension was present in 22.04% (n = 54) of respondents with anxiety (p = 0.016) and depression (p = 0.025). Additionally, HIV/AIDS was present in 4.08% (n = 10) of respondents with depression (p =

0.006). The study concluded that patients attending general outpatient clinics may suffer from mental disorders such as anxiety and depression, which can co-exist with conditions like hypertension and HIV/AIDS. A careful assessment of patients in these clinics could lead to the detection and treatment of these mental disorders, potentially improving the patients' overall physical health.[18]

2.6 SUGGESTIONS TO IMPROVE MENTAL HEALTH AWARENESS AMONG PATIENTS

A descriptive cross-sectional study was conducted in Sri Lanka in 2017 using a pretested questionnaire on 1002 adolescent patients aged between 13 and 16 to assess mental health literacy and improvement strategies. The assessment utilized four case vignettes representing depression with suicidal ideation, social phobia, psychosis, and diabetes, with the latter included for comparison. The results showed that the recognition rates of the vignettes as mental health problems were 82.2% (n = 824) for depression, 68.7% (n = 689) for psychosis, and 62.3% (n = 623) for social phobia. "Talking to the person" was identified as a helpful intervention by 49.9% (n = 500) for depression, 49.8% (n = 499) for social phobia, 39.5% (n = 396) for psychosis, and 19.5% (n = 195) for diabetes. Exercise was considered helpful by 25% (n = 251) for diabetes, 21% (n = 210) for social phobia, 18.7% (n = 187) for psychosis, and 18.4% (n = 184) for depression. Additionally, 70.2% (n = 704) of respondents believed there would be benefit in seeing a doctor for diabetes, compared to 48.5% (n = 486) for psychosis, and 48.2% (n = 483) for both depression and social phobia. The belief that the conditions in the vignettes would improve with treatment was highest for diabetes at 81.4% (n = 816), followed by depression at 79.5% (n = 797), psychosis at 75.6% (n = 758), and social phobia at 63.4% (n = 636). A statistically significant association was found between family income level and the appropriate recognition of mental health problems across all three mental health-related vignettes. The study concluded that education is a key factor to improve mental health literacy having observed that the ability to recognize mental health problems is directly proportional to the patient's educational level.[19]

A cross-sectional study was conducted among 240 Twitter users who self-identified as having a mental illness, inviting them to participate in an online survey. The survey, conducted in English, gathered information about the participants' mental health conditions, their use of social media for mental health purposes, and their interest in accessing mental health programs delivered via social media. A total of 135 respondents from 10 countries completed the survey, with the majority being from the United States (54%), Canada (22%), and the United Kingdom (17%). The respondents reported psychiatric diagnoses including schizophrenia spectrum disorder (27%), bipolar disorder (25%), major depressive disorder (16%), and depression (20%). The study found that younger adults aged 35 and below (46%) were significantly more likely to use Instagram ($p=0.002$), Snapchat ($p<0.001$), and their mobile phones for accessing social media ($p<0.001$) compared to adults aged 36 and older (53%). Additionally, 85% of participants expressed interest in mental health programs delivered through social media, particularly those aimed at promoting overall health and well-being (72%) and helping them cope with mental health symptoms (90%).[20]

This systematic review focused on identifying key strategies to improve mental health literacy (MHL) among adolescent patients. The review highlighted five primary themes: strengthening adolescents' resilience, the use of the internet and books, social support, school-based MHL programs, and community awareness campaigns. A comprehensive search identified 328 studies from four databases available through the North-West University website, specifically African Journals, Google Scholar, Science Direct, and Sabinet Online. After removing duplicates, 294 studies remained, of which 237 were excluded after screening. Ultimately, 57 full-text articles were assessed for eligibility, and 46 were excluded, leaving 11 studies that met the inclusion criteria. Strengthening adolescents' resilience emerged as a key theme, with three studies identifying it as a crucial strategy for improving MHL. Resilience, defined as positive adaptation and the ability to overcome hardships, is considered a protective factor against mental illness. Mental health knowledge was found to help adolescents build resilience and better understand their own mental health challenges, as well as those of their family and friends. The review suggested that teaching adolescents skills like positive self-talk, goal setting, emotional regulation, and problem-solving can further enhance their resilience. The use of the internet and books was identified as another effective strategy. Three studies supported the idea that these resources can play a significant role in improving MHL among adolescents. The internet, in particular, offers a cost-effective way to reach a large number of adolescents, and web-based interventions targeting MHL can be successful if they include active ingredients. Adolescents were also found to be more inclined than older age groups to use books as a helpful resource, and self-help strategies provided through these mediums were seen as potentially more effective than professional interventions. Social support was also recognized as a critical factor in enhancing MHL. Three studies emphasized that adolescents need appropriate social support, which includes trusted individuals who are knowledgeable in providing first aid and ongoing mental health support. Targeting parents and other trusted adults in MHL interventions was suggested as a way to improve adolescents' mental health and help-seeking behaviors. School-based MHL programs were the most frequently mentioned strategy, with six studies advocating for their effectiveness. Schools were identified as ideal settings for embedding MHL at both individual and population levels, as they reach a wide audience and provide familiar environments for educational activities. The review highlighted that these programs could reduce mental illness and improves self-efficacy for seeking mental health support. However, it was also noted that the impact of such programs on help-seeking behaviors among adolescents is not yet conclusively demonstrated. Finally, community awareness campaigns were identified as an important strategy, though only two studies supported their effectiveness. These campaigns were suggested to include a variety of activities such as distributing pamphlets, using websites, and utilizing media advertising to spread MHL information. It was also recommended that community awareness efforts be sustained and embedded within the community, potentially through school curricula, rather than relying solely on standalone events.[21]

In a two-armed, randomized controlled study, adolescents and young adults aged 14 years and older were recruited. After an initial baseline assessment, participants will be randomly assigned to either the intervention group (IG, n = 75), which will receive a mental health intervention through the application "Mental Health Guide" (co-developed by lived experience experts), or the waiting list control group (CG, n = 75). Both groups will be followed up after 3 and 6 months post-assessment. The study hypothesizes an increase in mental health literacy in the IG compared to the CG at post-assessment and follow-up, measured by the Mental Health Literacy Scale (primary outcome). Additionally, improvements in mental health and psychological well-being, better emotion regulation, reduced psychological distress, and positive ratings in usability and acceptance of the "Mental Health Guide" are expected in the IG. Multiple simulations of potential outcome scenarios were performed to generate realistic datasets and obtain accurate estimates of statistical power.[22]

CHAPTER THREE

METHODOLOGY

3.1 STUDY AREA

The study was conducted at the University of Benin Teaching Hospital (UBTH), Benin City, a tertiary healthcare facility in Edo State. Edo State is one of the 36 states in Nigeria located in the South-South geopolitical zone. It has an approximate population of 5 million.[23] It is bounded by the states of Kogi to the northeast and east, Anambra to the east, Delta to the southeast and south, and Ondo to the west and northwest; Benin City is the state capital and largest urban center. The main ethnic groups in Edo State are Edos, Afemais, Esans, Owans and Akoko Edos. The Bini speaking people who occupy seven out of the 18 Local Government Areas of the state constitute

57.54% while others Esan (17.14%) Afemai comprising Etsako (12.19%), Owan (7.43%), and Akoko Edo (5.70%).[24]

UBTH was taken over by the Federal Government on April 1st, 1975 as the fifth teaching hospital coming after Ibadan Teaching Hospital and Lagos Teaching Hospital. With an initial bed capacity of 360 when it was officially opened on May 12th, 1973, the UBTH of today boasts of a bed capacity of over 900 as at August 2019 and still increasing with a multiplicity of departments offering a wide range of services.[25] It consists of many doctors among which the research will be carried out.

3.2 STUDY DESIGN

A descriptive cross sectional study design was used for this study.

3.3 STUDY DURATION

This study was conducted between 2024 and 2025, with the following activities scheduled: Writing of Chapters 1 to 3 – May to December 2024, Corrections of chapters 1 to 3 – January to July 2025, Ethical approval and questionnaire pretesting – July 2025, Data collection – July to August 2025, Data analysis and interpretation – August 2025, Completion of Chapters 4 and corrections - August, 2025, Completion of chapter 5, Correction and final submission – August 2025.

3.4 STUDY POPULATION

The study was carried out among doctors at the University of Benin Teaching Hospital (UBTH), Benin City.

3.5 SELECTION CRITERIA

3.5.1 Inclusion Criteria

Doctors who have practiced for a minimum of 6 months who gave consent to participate in this study.

3.5.2 Exclusion Criteria

Doctors in strictly administrative or non-clinical roles (e.g. full-time researchers or hospital administrators without regular patient interaction).

3.6 SAMPLE SIZE DETERMINATION

The minimum sample size (n) was calculated using the Cochran formula for a cross-sectional study.[26]

$$n = \frac{Z^2 pq}{d^2}$$

Where,

n = minimum sample size

nr = non-response rate

nf = final minimum sample size

Z = standard normal deviation set at 1.96 (at 95% confidence interval)

d = degree of precision set at 0.05

p = prevalence rate of a particular characteristics of the target population (a prevalence rate of 12.1% will be used. This is the percentage of patients who were aware of mental health conditions according to the study done in among university of Nigeria).[7]

Therefore,

p = 12.1%

$= \frac{12.1}{100}$

= 0.121

q = 1 – 0.121

$= 0.879$

Hence:

$$\frac{(1.96)^2 \times 0.879 \times 0.121}{(0.05)^2}$$

n=

$n \approx 163$

$nr = 10\% = 0.10$

$nf \approx 180$

3.7 SAMPLING TECHNIQUE

Sampling Technique

A multi-stage sampling technique was employed to recruit participants for this study among medical doctors at the University of Benin Teaching Hospital (UBTH), Benin City.

In the first stage, stratification was carried out by cadre (consultants, residents, and house officers) and by clinical department to ensure broad representation across the hospital workforce.

In the second stage, proportional allocation was applied so that the number of participants selected from each cadre and department reflected their relative distribution within UBTH.

In the final stage, simple random sampling was used within each stratum to select individual doctors. This approach ensured that the sample was both representative and adequately balanced across cadres and specialties.

3.8 DATA MANAGEMENT

3.8.1 Tools for Data Collection

A pretested structured questionnaire served as the primary tool for data collection. The questionnaire is informed by the World Health Organization's validated Mental Health Gap Action Programme (mhGAP) Intervention Guide[27], which addresses mental health service delivery, awareness, and barriers to care. The questionnaire is divided into six sections, corresponding to the study objectives:

Section A: Socio-demographic characteristics of respondents, including age, sex, profession, years of experience, and department/unit.

Section B: Perceptions of patients' awareness of mental health challenges.

Section C: Impact of patients' awareness (or lack thereof) on diagnosis and management.

Section D: Barriers preventing patients from being aware of mental health challenges.

Section E: Estimates of patients presenting with mental health challenges.

Section F: Strategies suggested by doctors to improve mental health awareness

3.8.2 Method of Data Collection

Data were collected using a structured, self-administered questionnaire designed to capture doctors' perspectives on patients' awareness of mental health challenges. The questionnaires were distributed to healthcare workers at the University of Benin Teaching Hospital.

3.8.3 PRETESTING

The questionnaire was pretested at Edo Specialist Hospital to determine comprehensibility, validity, sensitivity, and reliability. Nineteen doctors, representing 10% of the minimum sample size, were used for pretesting, and observed errors were corrected before deployment in the main study.

Measurement of Variables and Scoring

1. Perception of Patients' Awareness

This domain included items using Likert-type and categorical responses to assess perceptions. Responses on a 5-point Likert scale (e.g., "Very low" to "Very high", "Strongly disagree" to "Strongly agree") were scored from 1 to 5. Items using ordinal categories (e.g., percentages or frequencies) were numerically coded from 1 to 5 in increasing order of severity or frequency. Perceptions were classified as below, based on a similar study conducted by Naidoo & Bhengu to assess awareness of patient safety[28]:

Perception Score (%) = (Total Obtained Score ÷ Maximum Possible Score) × 100

- **Positive perception**: ≥ 60%
- **Negative perception**: < 60%

2. Impact on Diagnosis and Management

Items in this domain were described using frequencies, proportions, and prose summaries. Responses were rated on a 5-point Likert scale ranging from 'Strongly disagree' to 'Strongly agree,' and scored from 1 to 5. Items that allowed multiple answers (such as perceived benefits of awareness) were analyzed by reporting the frequency and percentage of each selected option.

3. Barriers to Mental Health Awareness

This section included Yes/No and Likert-scale responses. Each barrier was rated on a 3-point Likert scale: Low (1), Medium (2), and High (3).

For each barrier, the mean score was calculated and classified as:

- Low: Mean < 1.5
- Medium: Mean 1.5–2.4
- High: Mean ≥ 2.5

Yes/No responses were summarized as the percentage of respondents that mentioned each barrier.

4. Estimated Burden of Mental Health Issues

Items in this section were analyzed according to their type. Ordinal responses (such as estimated patient proportions or referrals) were summarized descriptively. Binary Yes/No items (e.g., whether most cases went undiagnosed) were reported as proportions. Likert-scale responses (e.g., agreement that undiagnosed conditions worsen outcomes) were scored from 1 to 5 but presented in collapsed categories (e.g., agree vs. disagree) for clearer interpretation.

5. Strategies and System Improvements

This section included multiple-response, binary, and Likert-scale items. Multiple-response options (e.g., strategies to improve awareness or access) were analyzed by reporting the frequency and percentage of selections. Binary Yes/No items were summarized as proportions. Likert-scale responses were grouped into categories (e.g., agree vs. disagree), and presented in prose and descriptive narratives.

3.8.4 STATISTICAL ANALYSIS

The data collected were screened for completeness and accuracy before being serially entered into IBM Statistical Package for the Social Sciences (SPSS), version 27.0, for analysis. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarize respondents' socio-demographic characteristics and other study variables.

Associations between categorical variables (e.g., department and perception of awareness) were assessed using the chi-square test, while independent t-tests compared the means of continuous variables across groups. Variables in bivariate analysis were included in a multivariate logistic regression model to identify predictors of mental health awareness. Findings were reported as Adjusted Odds Ratios (AORs) with 95% Confidence Intervals (CIs).

All statistical tests were two-tailed, and a p-value < 0.05 was considered statistically significant. Results were presented in tables and figures (including bar charts and pie charts), supported by narrative summaries.

3.9 ETHICAL CONSIDERATIONS

Ethical approval and permission to carry out the study was obtained from the Health Research Ethics Committee of the University of Benin Teaching Hospital with the Ethical Registratuion Number: NHREC/24/01/202.

Informed consent was taken from the respondents before administering the questionnaires. The respondents were informed of their right to withdraw from the study at any time and that the withdrawal poses no harm or loss.

3.10 LIMITATIONS

The findings of this study may have been influenced by recall bias, as data collection relied on self-reported responses. To reduce this risk, the questionnaire was designed with clear, simple, and specific questions to aid accurate recall and minimize misinterpretation. Social desirability bias may also have occurred, as respondents might have provided answers they perceived to be professionally acceptable rather than their actual opinions. To minimize social desirability bias, respondents were assured of strict confidentiality and informed that their responses would be used solely for research purposes. The questionnaire was anonymous, with no collection of names or identifying details.

CHAPTER FOUR

A total of 180 respondents participated in the study. The results are presented in the following sections in line with the specific objectives.

SECTION A: Sociodemographic characteristics of the respondents

SECTION B: Perception of patients' awareness

SECTION C: Impact of awareness on diagnosis and management

SECTION D: Barriers to awareness

SECTION E: Estimated burden of mental health issues

SECTION A

SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Table 1: Sociodemographic characteristics of respondents

Variable	Frequency (n = 180)	Percent (%)
Age group (years)		
<30	8	4.4
30 – 39	50	27.8
40 – 49	79	43.9
50 – 59	32	17.8
≥60	11	6.1
Mean ± SD	**43.80 ± 9.0**	
Sex		
Male	110	61.1
Female	70	38.9
Marital status		
Married	118	65.6
Single	39	21.7
Widowed	14	7.8
Divorced/Separated	9	5.0
Religion		
Christianity	174	96.7
Islam	6	3.3
Ethnicity		
Benin	71	39.4
Esan	35	19.4
Yoruba	30	16.7
Igbo	24	13.3
Hausa	13	7.2
Others*	7	3.9
Years of practice		
< 1	13	7.3
1 – 5	52	28.9
6 – 10	47	26.1
>10	68	37.8

Others; Etsako, Ibibio, Idoma, Igbanke, Isoko, Itsekiri, Urhobo

The study included 180 respondents with a mean age of 43.80 ± 9.0 years. The largest age group was 40–49 years, 79 (43.9%), followed by 30–39 years, 50 (27.8%), 50–59 years, 32 (17.8%), ≥ 60 years, 11 (6.1%), and the smallest group was those < 30 years, 8 (4.4%). Males accounted for

110 (61.1%), while females were 70 (38.9%). Most participants were married, 118 (65.6%), with single 39 (21.7%), widowed 14 (7.8%), and divorced/separated 9 (5.0%).

Christianity was the predominant religion, 174 (96.7%), with 6 (3.3%) practicing Islam.

Ethnically, the largest groups were Benin, 71 (39.4%), and Esan, 35 (19.4%), followed by Yoruba, 30 (16.7%), Igbo, 24 (13.3%), and Hausa, 13 (7.2%). Other ethnicities (Etsako, Ibibio, Idoma, Igbanke, Isoko, Itsekiri, and Urhobo) together accounted for 7 (3.9%).

With respect to years of practice, 68 (37.8%) had practiced for > 10 years, 52 (28.9%) for 1–5 years, 47 (26.1%) for 6–10 years, and 13 (7.3%) for < 1 year.

Table 2: Professional Characteristics and Training of Participants

Variable	Frequency (n = 180)	Percent (%)
Cadre		
Consultant	70	38.9
Resident	92	51.1
House officer	18	10.0
Department		
Surgery	36	20.0
Internal medicine	22	12.2
Obstetrics and Gynaecology	19	10.6
Pediatrics	18	10.0
Dentistry	17	9.4
Pathology	13	7.2
Anesthesiology	13	7.2
Family medicine	11	6.1
Radiology	11	6.1
Ophthalmology	6	3.3
Public health and community medicine	6	3.3
Psychiatry	5	2.8
Emergency medicine	3	1.7
Radio-oncology	2	1.1
Received formal training on mental health		
Yes	128	71.1
No	52	28.9
Daily patient interaction		
Yes	142	78.9
No	38	21.1

Among the 180 participants, residents were the largest cadre, 92 (51.1%), followed by consultants 70 (38.9%), and house officers 18 (10.0%). Regarding department, the highest representation was from surgery, 36 (20.0%), followed by internal medicine, 22 (12.2%), obstetrics and gynaecology, 19 (10.6%), and pediatrics, 18 (10.0%). Most participants had received formal training on mental health, 128 (71.1%), while 52 (28.9%) had not. Daily patient interaction was reported by 142 (78.9%) participants, compared with 38 (21.1%) who did not interact with patients daily.

SECTION B

PERCEPTION OF PATIENTS' AWARENESS

Table 3: Doctors' Perceptions of Patients' Mental Health Awareness and Behaviour

Variable	Frequency (n = 180)	Percent (%)
Patients' awareness of mental health conditions		
Very high	5	2.8
High	45	25.0
Moderate	85	47.2
Low	39	21.7
Very low	6	3.3
Patients' knowledge affects health-seeking behaviour		
Strongly agree	7	3.9
Agree	71	39.4
Neutral	88	48.9
Disagree	11	6.1
Strongly disagree	3	1.7
Estimated proportion of patients with combined physical and mental health issues (%)		
≤20	81	45.0
21 – 40	74	41.1
41 – 60	9	5.0
61 – 80	11	6.1
>80	5	2.8
Patient frequency of discussing mental health during consultations		
Frequently	32	17.8
Occasionally	72	40.0
Rarely	64	35.6
Never	12	6.7
Patient mental health awareness has improved in recent years		
Yes	91	50.6
No	89	49.4

Doctors reported that patients' awareness of mental health was mostly moderate, 85 (47.2%), followed by high, 45 (25.0%), low, 39 (21.7%), very low, 6 (3.3%), and very high, 5 (2.8%). Regarding the effect of patients' knowledge on health-seeking behaviour, 88 (48.9%) were neutral, 71 (39.4%) agreed, 7 (3.9%) strongly agreed, 11 (6.1%) disagreed, and 3 (1.7%) strongly disagreed.

Doctors estimated that most patients had ≤20% combined physical and mental health issues, 81 (45.0%), or 21 – 40%, 74 (41.1%), with smaller proportions in higher categories. Patient discussions on mental health during consultations occurred occasionally, 72 (40.0%), rarely, 64 (35.6%), frequently, 32 (17.8%), or never, 12 (6.7%). About half of the doctors, 91 (50.6%), perceived that patient mental health awareness has improved in recent years, while 89 (49.4%) disagreed.

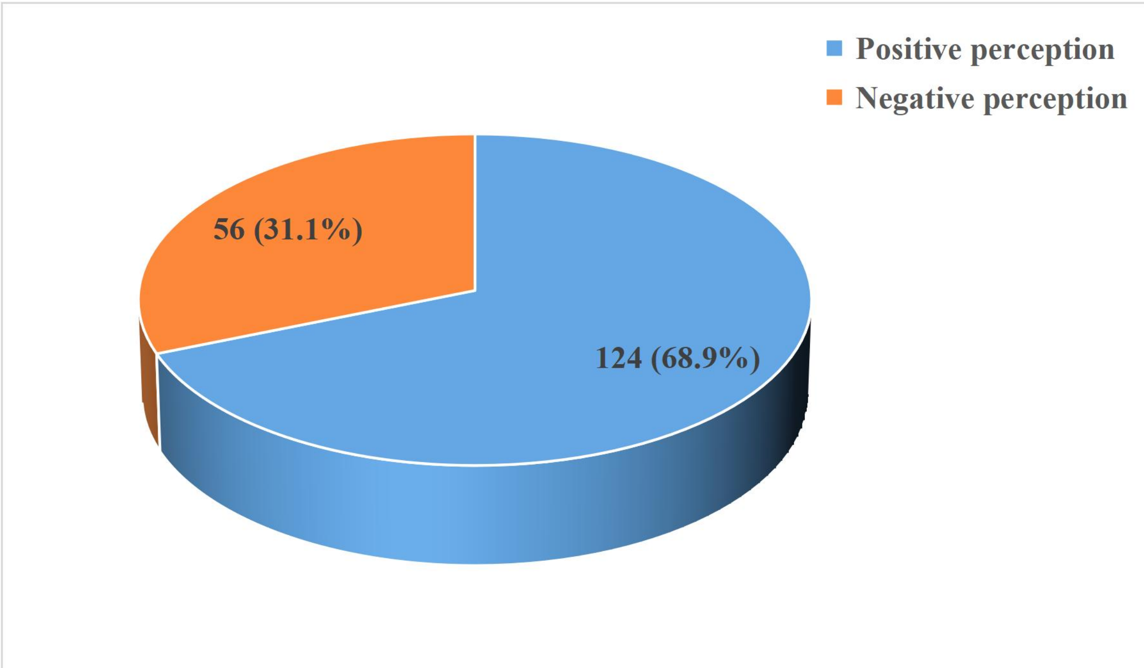

Figure 1: Perception of patient awareness of mental health challenges

Among the doctors surveyed, 124 (68.9%) perceived patients' awareness of mental health as positive, while 56 (31.1%) perceived it as low or negative

Table 4: Association Between Sociodemographics and Doctors' Perception of Patients' Awareness of Mental Health

Sociodemographic variables	Perception of patient awareness	
	Positive (n = 124) n (%)	**Low (n = 56) n (%)**
Age group (years)		
<30	4 (50.0)	4 (50.0)
30 – 39	37 (74.0)	13 (26.0)
40 – 49	56 (70.9)	23 (29.1)
50 – 59	19 (59.4)	13 (40.6)
≥60	8 (72.7)	3 (27.3)
	Fischer's exact = 3.515	p = 0.469
Sex		
Male	75 (68.2)	35 (31.8)
Female	49 (70.0)	21 (30.0)
	$\chi^2 = 0.066$	$p < 0.869$
Marital status		
Married	**86 (72.9)**	**32 (27.1)**
Single	28 (71.8)	11 (28.2)
Widowed	7 (50.0)	7 (50.0)
Divorced/Separated	3 (33.3)	6 (66.7)
	Fischer's exact = 8.174	**p = 0.038***
Religion		
Christianity	119 (68.4)	55 (31.6)
Islam	5 (83.3)	1 (16.7)
	$\chi^2 = 0.604$	p = 0.667
Years of practice		
< 1	9 (69.2)	4 (30.8)
1 – 5	37 (71.2)	15 (28.8)
6 – 10	29 (61.7)	18 (38.3)
>10	49 (72.1)	19 (27.9)
	$\chi^2 = 1.500$	p = 0.683
Cadre		
Consultant	45 (64.3)	25 (35.7)
Resident	65 (70.7)	27 (29.3)
House officer	14 (77.8)	4 (22.2)
	$\chi^2 = 1.489$	p = 0.499
Received formal training on mental health		
Yes	97 (75.8)	31 (24.2)
No	27 (51.9)	25 (48.1)
	$\chi^2 = 9.821$	**p = 0.002***
Daily patient interaction		
Yes	100 (70.4)	42 (29.6)
No	24 (63.2)	14 (36.8)
	$\chi^2 = 0.738$	**p = 0.390**
Department		
Medical	46 (74.2)	16 (25.8)
Surgical	63 (68.5)	29 (31.5)
Diagnostic and Laboratory	15 (57.7)	11 (42.3)
	$\chi^2 = 2.342$	**p = 0.293**

Statistically significant

Positive perception of patients' awareness of mental health was highest among doctors aged 30–39 years, 37 (74.0%), and lowest among those aged <30 years, 4 (50.0%), but the association was not statistically significant (Fischer's exact = 3.515, $p = 0.469$).

Male doctors 75 (68.2%) had a slightly lower positive perception than female doctors 49 (70.0%), but this was not statistically significant, p = 0.869.

Positive perception was significantly higher among married doctors 86 (72.9%) and single doctors 28 (71.8%) compared with widowed 7 (50.0%) and divorced or separated 3 (33.3%), p = 0.038.

For years of practice, positive perception ranged from 9 (69.2%) among those with <1 year of experience, 37 (71.2%) for 1–5 years, 29 (61.7%) for 6–10 years, and 49 (72.1%) for >10 years. The differences were not statistically significant ($\chi^2 = 1.500$, $p = 0.683$).

Doctors with formal mental health training had higher positive perception 97 (75.8%) compared with those without 27 (51.9%), and this was statistically significant, p = 0.002.

Positive perception by cadre ranged from 45 (64.3%) among consultants to 65 (70.7%) among residents and 14 (77.8%) among house officers, but this was not statistically significant, p = 0.499.

Daily patient interaction showed 100 (70.4%) positive perception among those with daily contact versus 24 (63.2%) among those without, but this was not statistically significant, p = 0.390.

By religion, 119 (68.4%) of Christians and 5 (83.3%) of Muslims had positive perception, but this was not statistically significant, p = 0.667.

Across departments, positive perception was highest among medical specialties 46 (74.2%), followed by surgical specialties 63 (68.5%), and lowest among diagnostic and laboratory specialties 15 (57.7%), but this was not statistically significant ($\chi^2 = 2.342$, $p = 0.293$).

SECTION C

IMPACT OF AWARENESS ON DIAGNOSIS AND MANAGEMENT

Table 5: Doctors' Perceptions of the Impact of Patient Awareness on Management

Variable	Frequency (n = 180)	Percent (%)
Patient awareness influences accurate diagnosis and treatment		
Yes	130	72.2
No	50	27.8
Ways patient awareness helps* (n=130)		
Treatment adherence	86	66.2
Early diagnosis	68	52.3
Stigma reduction	22	16.9
Improved family support	12	11.6
Experienced delayed diagnosis due to poor awareness		
Yes	102	56.7
No	78	43.3
Aware patients seek care earlier		
Yes	123	68.3
No	57	31.7
Patient awareness improves prognosis		
Strongly agree	9	5.0
Agree	64	35.6
Neutral	106	58.9
Disagree	1	0.5

Multiple response question

Most doctors, 130 (72.2%), reported that patient awareness influences accurate diagnosis and treatment, while 50 (27.8%) did not. Among the 130 who agreed, patient awareness was reported to improve treatment adherence by 86 (66.2%), facilitate early diagnosis by 68 (52.3%), reduce stigma by 22 (16.9%), and enhance family support by 12 (11.6%).

Over half of the doctors, 102 (56.7%), had experienced delayed diagnosis due to poor patient awareness, while 78 (43.3%) had not. A majority, 123 (68.3%), believed that aware patients seek care earlier. Regarding prognosis, 9 (5.0%) strongly agreed, 64 (35.6%) agreed, 106 (58.9%) were neutral, and 1 (0.5%) disagreed that patient awareness improves prognosis.

SECTION D

PERCEIVED BARRIERS TO AWARENESS OF MENTAL HEALTH ISSUES

Table 6: Doctors' Perceptions of Barriers to Patient Awareness

Variable	Frequency (n = 180)	Percent (%)
Quality of mental health education on your facility		
Excellent	5	2.8
Good	46	25.6
Average	121	67.2
Poor	6	3.3
Very poor	2	1.1
Barriers to awareness in patients*		
Limited resources	98	54.4
Culture and religious beliefs	95	52.8
Lack of insight	91	47.9
Denial of symptoms	90	47.4
Lack of education	86	47.8
Stigma	77	42.8

***Multiple response question**

Most doctors rated the quality of mental health education in their facility as average, 121 (67.2%), followed by good, 46 (25.6%), excellent, 5 (2.8%), poor, 6 (3.3%), and very poor, 2 (1.1%).

In terms of barriers to patient awareness, the most frequently reported obstacle was limited resources, identified by 98 (54.4%) doctors. This was followed closely by cultural and religious beliefs, 95 (52.8%), lack of insight, 91 (47.9%), and denial of symptoms, 90 (47.4%). Other commonly cited barriers included lack of education, 86 (47.8%), and stigma, 77 (42.8%).

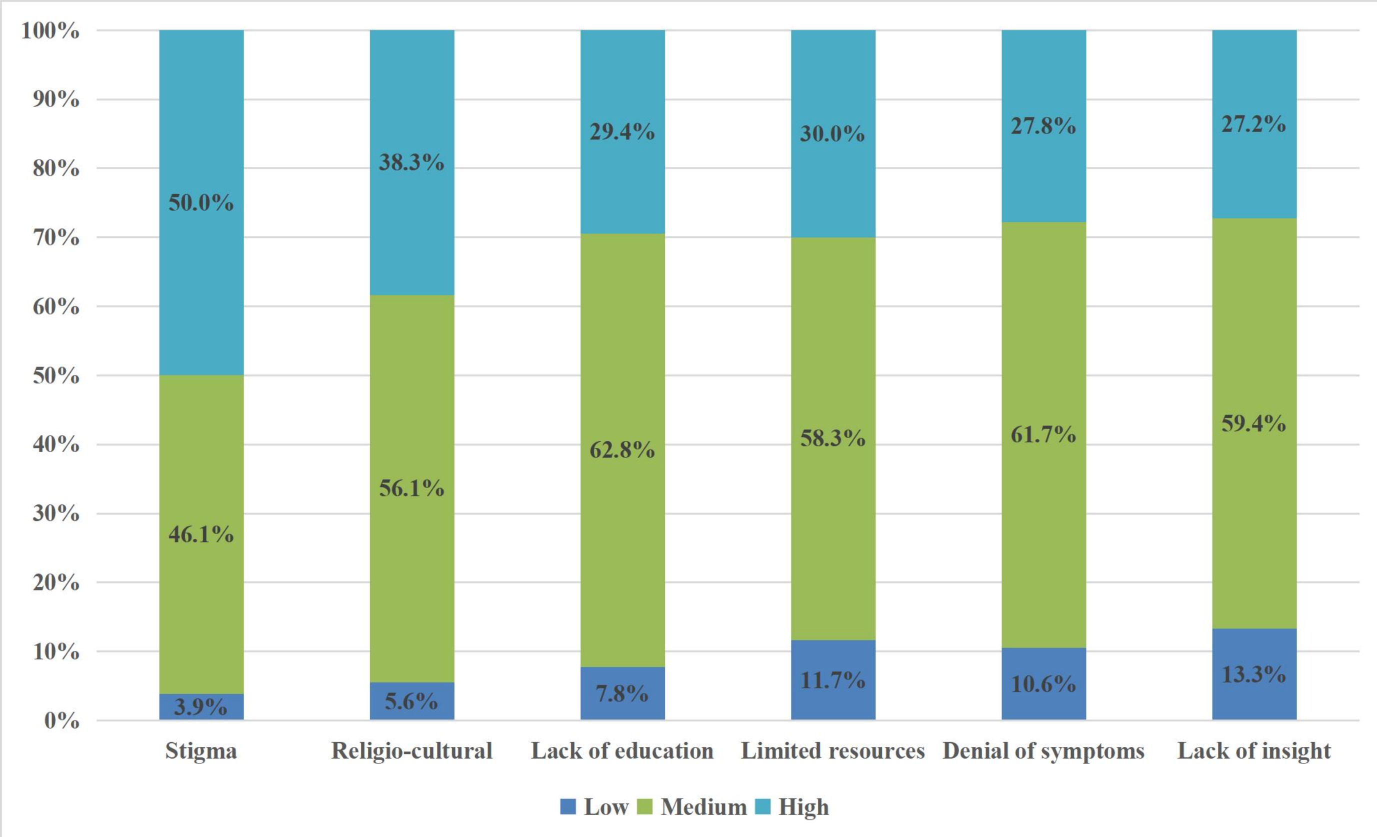

Figure 2: Perceived severity of each barrier

Table 7: Overall Perceived Severity of Barriers to Patient Awareness

Variable	Mean ± S.D	Overall rating
Lack of insight	1.86 ± 0.6	Medium
Denial of symptoms	1.83 ± 0.6	Medium
Limited resources	1.81 ± 0.7	Medium
Lack of education	1.78 ± 0.6	Medium
Cultural beliefs	1.67 ± 0.6	Medium
Stigma	1.54 ± 0.6	Medium

Doctors rated lack of insight highest with a mean score of 1.86 ± 0.6, followed by denial of symptoms 1.83 ± 0.6, limited resources 1.81 ± 0.7, lack of education 1.78 ± 0.6, cultural beliefs 1.67 ± 0.6, and stigma 1.54 ± 0.6. All barriers were rated medium in overall severity.

SECTION E

ESTIMATED BURDEN OF MENTAL HEALTH ISSUES

Table 8: Doctors' Reports on Burden of Mental Health Cases

Variable	Frequency (n = 180)	Percent (%)
Proportion of patients with diagnosed or suspected mental health issues in past month		
None	56	31.2
1 – 10%	110	61.1
11 – 30%	8	4.4
31 – 50%	2	1.1
>50%	4	2.2
Most cases go undiagnosed		
Yes	73	40.6
No	107	59.4
Undiagnosed mental health conditions worsen other health outcomes		
Strongly agree	11	6.1
Agree	64	35.6
Neutral	104	57.8
Disagree	1	0.6
Number of mental health cases referred in last month		
None	65	36.1
1 – 5	101	56.1
6 – 10	13	7.2
>10	1	0.6

Most doctors, 110 (61.1%), reported that 1–10% of their patients had diagnosed or suspected mental health issues in the past month, while 56 (31.2%) reported none, 8 (4.4%) reported 11–30%, 2 (1.1%) reported 31–50%, and 4 (2.2%) reported more than 50%.

A total of 73 (40.6%) doctors believed that most cases go undiagnosed, while 107 (59.4%) did not. Regarding the impact of undiagnosed mental health conditions on other health outcomes, 11 (6.1%) strongly agreed, 64 (35.6%) agreed, 104 (57.8%) were neutral, and 1 (0.6%) disagreed.

In terms of referrals, 101 (56.1%) doctors referred 1–5 mental health cases in the past month, 65 (36.1%) referred none, 13 (7.2%) referred 6–10 cases, and 1 (0.6%) referred more than 10 cases.

Table 9: Doctors' Perceptions of Strategies and Programs to Improve Patient Awareness of Mental Health

Variable	Frequency (n = 180)	Percent (%)
Strategies to improve awareness*		
Community outreach	131	72.8
Posters and leaflets	104	57.8
Collaboration with religious leaders	71	39.4
Re-training of doctors	44	24.4
Media campaigns	20	11.1
Mental health should be part of routine care		
Strongly agree	16	8.9
Agree	48	26.7
Neutral	111	61.7
Disagree	3	1.7
Strongly disagree	2	1.1
Awareness programs are available in facility		
Yes	29	16.1
No	151	83.9
Effectiveness of available programs (n = 29)		
Effective	7	24.1
Ineffective	22	75.9
Awareness programs should be held at the following frequency		
Annually	3	1.7
Quarterly	31	17.2
Monthly	144	80.0
Not necessary	2	1.1
Government should prioritize mental health education		
Strongly agree	38	21.1
Agree	101	56.1
Neutral	41	22.8
Healthcare workers are adequately trained for screening		
Yes	46	25.6
No	128	71.1
Not sure	6	3.3
Mobile mental health services can reduce barriers to access		
Yes	138	76.7
No	42	23.3

Multiple response question

Among the doctors, community outreach was identified by 131 (72.8%) as a strategy to improve awareness, followed by posters and leaflets 104 (57.8%), collaboration with religious leaders 71 (39.4%), re-training of doctors 44 (24.4%), and media campaigns 20 (11.1%).

Regarding the inclusion of mental health in routine care, 16 (8.9%) strongly agreed, 48 (26.7%) agreed, 111 (61.7%) were neutral, 3 (1.7%) disagreed, and 2 (1.1%) strongly disagreed. Awareness programs were available in only 29 (16.1%) facilities, while 151 (83.9%) reported no programs. Of the 29 available programs, 7 (24.1%) were considered effective and 22 (75.9%) ineffective.

Doctors suggested that awareness programs should be held monthly 144 (80.0%), quarterly 31 (17.2%), annually 3 (1.7%), and 2 (1.1%) considered them unnecessary. Government prioritization of mental health education was supported by 38 (21.1%) who strongly agreed, 101 (56.1%) who agreed, and 41 (22.8%) who were neutral.

Only 46 (25.6%) doctors felt healthcare workers were adequately trained for mental health screening, 128 (71.1%) said they were not, and 6 (3.3%) were not sure. A majority, 138 (76.7%), believed that mobile mental health services could reduce barriers to access, while 42 (23.3%) did not.

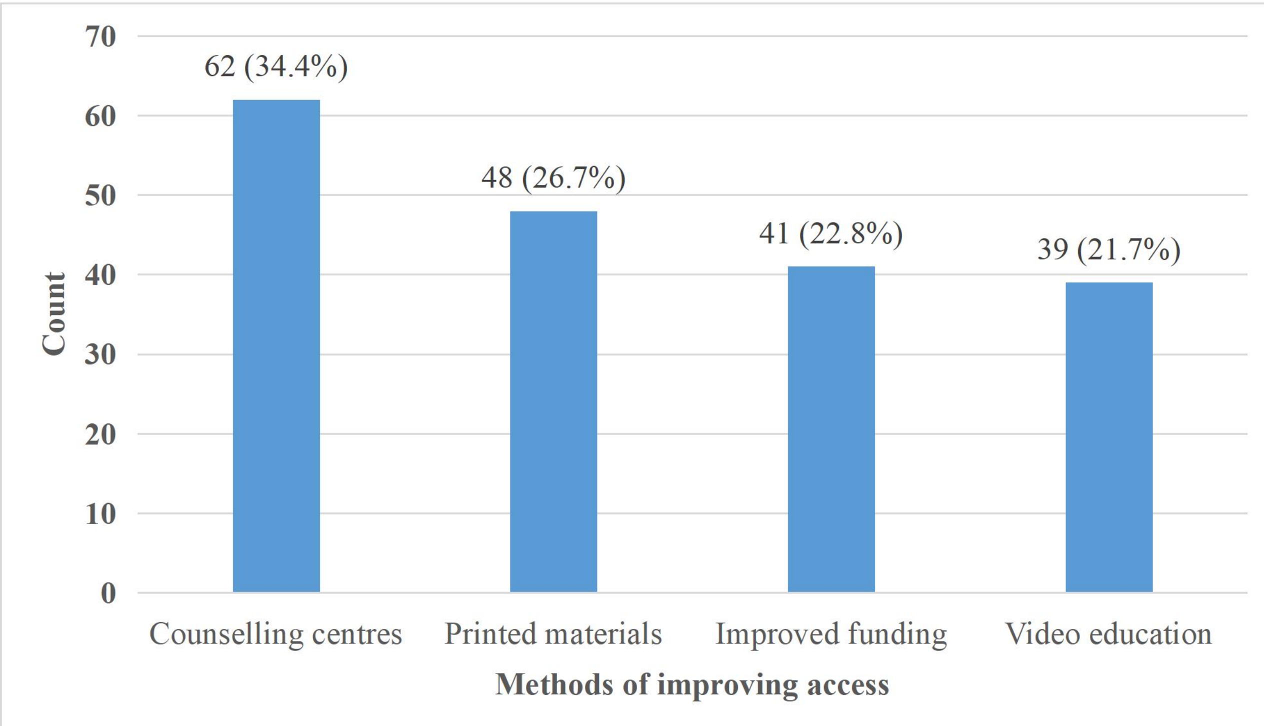

Figure 3: Perceived methods of improving access to mental health support

Among the doctors, counselling centres were the most commonly suggested method, 62 (34.4%), followed by printed materials 48 (26.7%), improved funding 41 (22.8%), and video education 39 (21.7%).

CHAPTER FIVE

DISCUSSION

This study found that the majority of doctors at the University of Benin Teaching Hospital (UBTH) perceived patients' awareness of mental health challenges to be mostly moderate. Only a small proportion believed that patients demonstrated good awareness of common mental health conditions. Respondents observed that patients often failed to associate their symptoms with mental health and instead attributed them to stress, spiritual problems, or ordinary life difficulties. For instance, symptoms such as persistent sadness, loss of interest in activities, difficulty sleeping, fatigue, or unexplained bodily pain were frequently interpreted as "stress" or "normal life issues," rather than as possible indicators of depression or anxiety.

This perception among doctors is in line with findings from the Nigeria National Mental Health Survey (NNMHS), which revealed that less than 20% of Nigerians with diagnosable mental health conditions recognized the need for professional help.[29] Similarly, the study conducted by Gureje reported that only 12% of individuals with depressive symptoms were able to correctly identify their condition as a mental disorder.[30] These statistics reflect the large knowledge gap that exists in the general population regarding mental health.

One explanation for this low level of awareness may lie in Nigeria's sociocultural framing of mental illness. In many communities, mental illness is understood in very narrow terms—often associated only with severe psychiatric symptoms such as wandering, incoherence, or aggression. Consequently, milder disorders such as anxiety, phobias, or mild depression are not viewed as medical conditions requiring professional attention. This observation is consistent with the Adewuya and Makanjuola study, which noted that Nigerians often equate mental illness with "madness," a belief that hinders recognition of less overt psychiatric symptoms.[31] Such cultural perceptions reinforce the stigma around mental illness and contribute to denial or misattribution of symptoms.

International comparisons provide further perspective. In high-income countries such as the United States, surveys by the American Psychological Association indicated that although misattribution of symptoms occurs, over 50% of respondents were able to recognize common psychiatric conditions such as anxiety and depression.[32] In contrast, sub-Saharan Africa presents a more concerning picture. For example, a study conducted in Kenya found that only 15% of individuals correctly recognized depression symptoms as a medical issue.[33] The trend suggests that limited health literacy and cultural stigma are not unique to Nigeria but represent a broader regional challenge.

The implications of these findings are significant. When patients lack awareness of their mental health, they are less likely to recognize when to seek professional help, leading to delayed presentation, underdiagnosis, and chronic progression of illness. Doctors at UBTH, therefore, encounter patients whose conditions may have worsened by the time they present for care, complicating both diagnosis and management. Furthermore, low awareness can negatively affect treatment adherence, since patients who do not accept their illness as medical may resist pharmacological treatment, psychotherapy, or follow-up visits.

This study highlights that poor patient awareness of mental health conditions is not an isolated phenomenon in UBTH but reflects a wider national and regional trend. The convergence of evidence suggests that unless awareness is addressed at the community level, doctors will continue to face challenges in identifying and managing mental health conditions effectively. Thus, the perceptions reported by doctors in this study underscore the urgent need for targeted mental health literacy campaigns, designed to fit Nigeria's sociocultural context, including collaboration with community leaders, religious organizations, and the media. Improving public knowledge of mental health has the potential to reduce stigma, promote earlier help-seeking, and ultimately improve clinical outcomes.

Doctors in this study overwhelmingly agreed that patient awareness plays a central role in the diagnosis, treatment, and overall management of mental health conditions. The consensus among respondents was that patients who lack awareness are more likely to present late to the hospital, misreport or minimize their symptoms, and resist psychiatric referrals when suggested. In practice, this often leads to delayed initiation of treatment, progression of illness, and increased risk of complications. Doctors also highlighted that such patients tend to default from treatment once initiated, resulting in frequent relapses, chronicity of illness, and ultimately poor prognosis. These findings suggest that awareness is not merely a background factor but a key determinant in the clinical trajectory of mental health disorders.

This observation is consistent with previous research in Nigeria. In a study conducted in 2019 among physicians in Lagos, reported that 64% of doctors considered poor patient awareness to be the single most important barrier to accurate diagnosis and adherence in mental health treatment.[34] Similarly, lack of insight was one of the strongest predictors of treatment non-adherence among psychiatric patients in a study conducted in Ilorin.[35] Taken together, these studies reinforce the conclusion of the present research that improving patient awareness is essential for successful outcomes in mental health care.

From a diagnostic standpoint, this study confirms a well-documented pattern in the literature: patients with poor awareness of mental health often present with somatic complaints such as chest pain, headaches, gastrointestinal disturbances, or generalized weakness, while concealing or misunderstanding psychological distress. This phenomenon, sometimes termed "somatization," has been described by Adewuya and Makanjuola in their 2016 study,[31] who noted that Nigerian patients with depressive or anxiety disorders frequently reported only bodily complaints, leaving the underlying psychiatric component unrecognized. Doctors at UBTH corroborated this by reporting that patients often undergo multiple and sometimes unnecessary laboratory investigations before mental illness is considered. This results not only in avoidable financial strain for patients and families but also in resource wastage within the health system, prolonging the time before correct diagnosis and treatment are made.

International evidence mirrors these challenges. A study by Kohn estimated that in low- and middle-income countries (LMICs), between 76% and 85% of individuals with severe mental disorders receive no treatment, primarily due to lack of awareness and delayed help-seeking.[36] In contrast, high-income countries, while not immune to the problem, demonstrate better outcomes because of higher mental health literacy and earlier engagement with services. For instance, a study conducted in the United States found that individuals who recognized early signs of mental illness were significantly more likely to access care within six months of symptom onset, compared to those who attributed their symptoms to stress or spiritual causes.[37] This underscores the critical role that awareness plays in shaping the patient pathway from illness recognition to care engagement.

The effect of poor awareness also extends to treatment adherence. A patient who does not believe they have a mental illness is unlikely to comply with long-term medication, engage with psychotherapy, or attend follow-up appointments. Doctors in this study frequently reported that patients abandoned treatment once they felt "better" or after receiving alternative advice from non-medical sources such as traditional healers, religious leaders, or family members. This finding aligns with evidence from a study done by Abiodun,[35] who demonstrated that lack of insight and low awareness were among the strongest predictors of non-adherence in psychiatric clinics in Nigeria. Furthermore, Saraceno in his study emphasized that globally, stigma and lack of awareness contribute not only to non-adherence but also to poor reintegration into society, exacerbating the cycle of disability and relapse.[38]

The broader implication of these findings is that patient awareness directly influences clinical outcomes, health system efficiency, and long-term quality of life for patients. Awareness is not an abstract concept but a practical determinant that shapes whether patients seek care, whether diagnoses are made correctly and on time, and whether treatment plans are adhered to consistently. Without adequate awareness, even the most advanced medical interventions may fail to achieve desired outcomes.

Therefore, this study underscores the need for structured patient education programs within hospitals, alongside broader community-based mental health literacy campaigns. Such initiatives should go beyond general information and be tailored to Nigeria’s cultural context, addressing common misconceptions such as the belief that mental illness only refers to “madness” or that it is purely spiritual. Doctors themselves could play a key role in integrating awareness-building into routine consultations, while partnerships with community leaders, schools, religious institutions, and the media could extend the reach of such interventions. In this way, improved awareness could translate into earlier diagnosis, better treatment adherence, and improved long-term prognosis for patients with mental health challenges.

Respondents in this study identified several barriers that limit patients' recognition of mental health conditions and their willingness to seek appropriate care. The most frequently mentioned barriers were stigma, cultural and religious beliefs, low literacy levels, and weak health system structures. These findings suggest that patients' struggles with awareness are not only cognitive but also deeply rooted in broader sociocultural and institutional contexts.

Stigma emerged as the single most consistent and pervasive barrier. More than two-thirds of the doctors in this study reported that many patients, even when they recognize their symptoms, avoid hospital care due to fear of being labeled "mad" or associated with insanity. This reflects the widespread belief in Nigeria that mental illness equates to severe psychiatric disturbance, leading to social exclusion, family shame, and diminished marriage or employment prospects. The Nigeria National Mental Health Survey in 2018 similarly cited stigma as the most important barrier to accessing care,[29] with individuals often preferring to remain untreated than risk public knowledge of their diagnosis. Another study further demonstrated this in a national survey where up to 70% of respondents admitted they would fear social rejection if diagnosed with a mental illness.[30]

Beyond stigma, cultural and religious beliefs play a significant role in shaping health-seeking behavior. Doctors in this study observed that many patients first turn to traditional healers, prayer houses, or religious leaders before seeking medical attention. This aligns with findings from Abiodun in Ilorin,[35] where more than half of psychiatric patients reported using spiritual remedies prior to hospital presentation. While such avenues may provide psychosocial support, they frequently delay timely medical care and reinforce misconceptions about the causes of mental illness, including witchcraft, spiritual attacks, or ancestral curses. In a broader African context, A study by Ae-Ngibise reported similar patterns in Ghana, where over 60% of caregivers of mentally ill patients first sought traditional or spiritual care.[39]

Educational and literacy levels further intersect with these cultural beliefs. Respondents emphasized that low health literacy contributes to misunderstanding symptoms and accepting non-medical explanations. Patients with limited education may lack the vocabulary or conceptual framework to recognize psychological distress, instead interpreting conditions such as depression or anxiety in purely physical terms. Adewuya and Makanjuola, in their study observed that somatization is more common among patients with low literacy, complicating recognition and timely intervention.[31]

The issue is compounded by systemic health system barriers. Nigeria has fewer than 300 psychiatrists serving a population of over 200 million people,[40] resulting in an enormous treatment gap. Doctors at UBTH reported that even when patients eventually present to hospitals, referral bottlenecks, high out-of-pocket treatment costs, and overcrowded psychiatric clinics limit continuity of care. In some cases, patients abandon treatment midway due to long waiting times or financial constraints. The study conducted by Saraceno highlighted similar issues globally,[38] noting that in low- and middle-income countries, resource limitations and health system inefficiencies significantly widen the treatment gap.

Another barrier raised was the role of misinformation within communities. Doctors noted that patients are often discouraged by peers or family members who propagate myths about psychiatric treatment, such as fears of addiction to medication, permanent institutionalization, or loss of social standing. This form of social pressure, when combined with stigma and cultural misconceptions, often dissuades patients from pursuing professional care even when they have initial awareness. This aligns with findings by the Sheikh study in Kenya, where misinformation and negative community attitudes significantly limited mental health service utilization despite increased awareness campaigns.[33]

The convergence of these factors—stigma, cultural and religious frameworks, low literacy, misinformation, and systemic health barriers—illustrates why improving awareness alone is insufficient. Even when individuals recognize their mental health challenges, these external constraints may still prevent them from accessing care. Consequently, interventions must be comprehensive and multi-dimensional. Doctors in this study suggested the need for anti-stigma campaigns, community-based education programs, and partnerships with religious and cultural leaders to reshape beliefs around mental illness. At the same time, health system strengthening is necessary to ensure that patients who do present can access affordable, timely, and continuous care.

The barriers identified by doctors at UBTH mirror both national and regional challenges in mental health care. They highlight that effective strategies must move beyond patient education to address deep-seated societal attitudes and structural weaknesses in the health system. Unless these barriers are tackled simultaneously, the cycle of poor awareness, delayed care-seeking, and inadequate treatment outcomes will persist.

In this study, doctors at the University of Benin Teaching Hospital (UBTH) estimated that less than half of their patients present with mental health problems. Importantly, many of these cases were described as being masked by physical complaints, such as headaches, chest pain, gastrointestinal disturbances, or fatigue. This observation highlights the challenge of somatization, a phenomenon where psychological distress is expressed through physical symptoms, making detection of mental health issues in general practice more complex.

These estimates are consistent with the World Health Organization report, which states that one in four patients in primary care settings has a diagnosable mental health disorder.[40] This global figure reinforces the idea that mental health problems are not rare but rather ubiquitous across healthcare systems, including low- and middle-income countries.

When compared to Nigerian studies, the prevalence estimates reported by UBTH doctors appear somewhat higher. For instance, Adewuya and Makanjuola reported a 14.3% prevalence of depression among primary care patients in Nigeria,[31] while Abiodun (2017) found a 7% prevalence of psychiatric morbidity in Ilorin general outpatients.[35] The higher estimates in this study may be attributable to the tertiary nature of UBTH, which serves as a referral center.

International comparisons provide further context. In high-income countries, large-scale epidemiological studies also reveal significant mental health burdens. For example, the National Comorbidity Survey in the United States reported that about 26% of adults meet the criteria for a mental disorder in any given year.[41] Similarly, data from the European Study of the Epidemiology of Mental Disorders showed that approximately 27% of adults in Europe experience a mental disorder annually,[42] with depression and anxiety being the most common.

One possible explanation for the higher perception among UBTH doctors is the hidden nature of many mental health problems in Nigeria. Studies such as the one conducted by Gureje have shown that patients often present to health facilities multiple times with physical complaints before a psychiatric diagnosis is even considered.[30]

The implication of these findings is profound. If doctors across different specialties estimate that up to 40% of their patients may have mental health problems, it suggests that psychiatric issues are integral to everyday clinical practice rather than being the exclusive domain of psychiatrists. This has implications for training, practice, and health system planning. Doctors in specialties such as internal medicine, surgery, pediatrics, and obstetrics must therefore be equipped with the skills to identify, screen, and refer patients with mental health concerns.

To bridge this gap, there is a need to integrate mental health modules into continuing medical education (CME) and undergraduate medical training. Early exposure to psychiatry and mental health concepts can enhance doctors' ability to differentiate between somatic and psychiatric presentations, thereby reducing misdiagnosis. Moreover, task-shifting approaches—where general practitioners and non-psychiatrist specialists are trained in basic mental health assessment and management—could help address the severe shortage of psychiatrists in Nigeria, fwhich is fewer than 300 nationwide for over 200 million people.[40]

Finally, these findings underscore the urgency of policy-level interventions. Routine screening for depression and anxiety in general medical consultations could be adopted, similar to practices in high-income countries. Incorporating simple tools like the Patient Health Questionnaire (PHQ-9) for depression or the Generalized Anxiety Disorder scale (GAD-7) could empower doctors in non-psychiatric specialties to identify at-risk patients early.

The perception among UBTH doctors that less than half of patients present with mental health problems is not only consistent with global estimates but also highlights the everyday relevance of psychiatry in general medical care. Strengthening doctors' capacity to recognize and manage these conditions through education, screening protocols, and system reforms is essential for improving outcomes in Nigeria's mental health landscape.

Doctors in this study proposed a variety of strategies for improving patient awareness of mental health challenges, reflecting their daily encounters with the consequences of poor literacy and delayed care-seeking. The most prominent recommendations included: public enlightenment campaigns using mass media and community leaders; integration of mental health education into routine hospital consultations; collaboration with religious and cultural institutions; and the development of community-based outreach programs, particularly in rural areas.

Respondents emphasized that mass media and social media platforms are essential for spreading accurate knowledge about mental health. Television, radio, and social media networks such as Facebook, Twitter, and WhatsApp were identified as powerful channels for reaching wide audiences, including young people and semi-literate populations. This is consistent with findings from the Oladipo study, which reported that Nigerian health workers strongly endorsed hospital-based and media-driven awareness campaigns as effective in countering stigma and misinformation.[43]

The WHO Mental Health Action Plan also highlights public advocacy and awareness-raising as a cornerstone of effective national strategies.[44] By aligning with these recommendations, the doctors' proposals reflect a recognition that patient awareness cannot be improved through clinical interactions alone; it requires societal-level messaging that reshapes how mental illness is understood in Nigerian culture.

Another recurring suggestion was the integration of mental health education into routine medical consultations. Doctors argued that opportunities exist in outpatient departments (OPD) and inpatient settings to provide brief, structured counseling on mental health. This is especially relevant given the high prevalence of somatic presentations of psychiatric illness observed in UBTH, where many patients present with headaches, fatigue, or abdominal pain that may mask underlying depression or anxiety. By incorporating mental health screening tools and brief awareness messages during these encounters, doctors can normalize discussions about mental wellbeing in the same way they educate patients about hypertension or diabetes.

This approach echoes the principle of task-sharing in mental health care promoted by WHO[44] and supported by Nigerian studies such as the Gureje study, which showed that training non-psychiatrist physicians to screen for depression significantly improved case detection rates in primary care.[30]

The role of religious and cultural leaders was highlighted as indispensable. Doctors observed that many patients first seek help in prayer houses or traditional healing centers, where misconceptions about mental illness are reinforced. By collaborating with churches, mosques, and traditional leaders, accurate information about mental health could be disseminated in trusted community settings. This aligns with the Abiodun study,[35] which noted that more than half of psychiatric patients in Ilorin had used spiritual remedies before presenting to the hospital. Engagement with these institutions is therefore not about replacing medical care but about leveraging existing community trust to shift perceptions.

International experiences also provide support for this strategy. For example, in Kenya, the Sheikh study reported that collaboration with local chiefs and faith-based leaders significantly improved acceptance of mental health programs.[33] In Nigeria, similar partnerships could be adapted to incorporate local languages and cultural practices, making messages about depression, anxiety, and substance use disorders more relatable to the general population.

Finally, doctors emphasized the importance of community-level outreach programs, especially in rural areas where misconceptions about mental illness are deeply entrenched. They recommended the use of mobile clinics, town hall meetings, and school-based programs to bring mental health education closer to underserved populations. This recommendation is consistent with the National Mental Health Policy of Nigeria,[45] which advocates for decentralized, community-oriented mental health care as a way to bridge treatment gaps.

Global initiatives further validate these approaches. In the United Kingdom, the "Time to Change" anti-stigma campaign achieved measurable improvements in public attitudes and increased help-seeking behavior.[46] In the United States, the National Alliance on Mental Illness (NAMI) awareness campaigns have been particularly effective in reducing stigma among young people, encouraging early recognition and treatment.[47]

For Nigeria, these models suggest that multi-layered, context-specific campaigns—using local radio, television dramas, social media, and religious gatherings—can be tailored to the sociocultural landscape.

The implication of these findings is that awareness campaigns must be multi-pronged and contextually relevant. Doctors, given their societal respect, can serve as advocates and educators both inside and outside hospital walls. Partnerships between government, health professionals, media outlets, and community institutions are essential for creating a supportive environment where patients feel safe to acknowledge symptoms and seek care.

The strategies proposed by doctors at UBTH are not only feasible but also consistent with both global best practices and local evidence. Implementing these approaches could substantially improve mental health literacy, reduce stigma, and enhance timely care-seeking, thereby addressing one of the most significant barriers identified in this study.

Conclusion

This study found that doctors at the University of Benin Teaching Hospital perceived patients' awareness of mental health challenges to be low, with many patients misattributing psychiatric symptoms to stress, spiritual causes, or ordinary life difficulties. Such limited awareness was seen to delay presentation, complicate diagnosis, and negatively affect adherence to treatment and long-term outcomes.

Several barriers were identified as contributing to this problem, including stigma, cultural and religious beliefs, misinformation, low health literacy, and systemic weaknesses such as limited mental health personnel and poor access to care. These barriers not only discouraged help-seeking but also reinforced misconceptions, reliance on non-medical explanations, and premature abandonment of treatment.

The findings align with national and regional studies that similarly highlight poor awareness and stigma as central challenges in Nigeria and other African countries. Comparisons with high-income countries revealed that although misattribution of symptoms occurs globally, greater mental health literacy in those settings supports earlier diagnosis, improved treatment adherence, and better clinical outcomes.

To address these challenges, doctors proposed strategies such as strengthening patient education during routine consultations, implementing public awareness campaigns through mass and social media, engaging religious and cultural leaders in mental health promotion, and expanding community outreach services. These strategies, which reflect both local needs and global best practices, hold strong potential for improving awareness and reducing stigma.

Recommendations

To UBTH Policymakers and Authorities

1. Implement Public Awareness Campaigns: Multi-channel campaigns using radio, television, social media, and community leaders should be prioritized to improve public understanding of mental health. Campaigns should address common misconceptions, emphasize that mental illness is treatable, and normalize help-seeking behavior.
2. Improve Health System Capacity: Prioritize increased investment in mental health infrastructure, including recruitment of psychiatrists, psychologists, and psychiatric nurses, and ensure that treatment remains affordable.

To UBTH Healthcare Facilities and Providers

1. Integrate Mental Health Education into Routine Consultations: Doctors across specialties should incorporate basic mental health education into patient interactions, especially when primary or secondary complaints may mask psychiatric conditions.
2. Strengthen Anti-Stigma Interventions: Hospitals should collaborate with advocacy groups and professional associations to organize anti-stigma programs within healthcare facilities and surrounding communities.

3. Expand Training for Doctors Across Specialties: Continuing medical education programs should include mental health modules, equipping non-psychiatric doctors to recognize early symptoms and make timely referrals.

To Community and Cultural Institutions

1. Engage Cultural and Religious Institutions: Collaborate with traditional leaders, religious organizations, and local influencers to reshape beliefs about mental illness and encourage early help-seeking.

2. Promote Community-Based Interventions: Develop outreach programs in rural and semi-urban areas to bridge the gap between traditional/religious healers and formal medical care.

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APPENDIX I

INFORMED CONSENT FORM

TITLE OF STUDY: AWARENESS OF MENTAL HEALTH CHALLENGES AMONG PATIENTS - DOCTORS' PERSPECTIVE IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL, BENIN CITY, EDO STATE

INVESTIGATOR: ONYEKWELU PRINCE SOMTOCHUKWU

SUPERVISOR: PROF. OBEHI OKOJIE

FINANCIAL SPONSORSHIP: This research project is self-sponsored.

PURPOSE OF THE RESEARCH: The purpose of this study is to assess the awareness of mental health challenges among patients in the perspective of doctors at University of Benin Teaching Hospital, Benin City, Edo State.

PROCEDURES AND PROTOCOL INVOLVED IN THE STUDY

You are kindly requested to complete a questionnaire designed to assess the awareness of mental health challenges among patients in the perspective of doctors at University of Benin Teaching Hospital, Benin City, Edo State. This questionnaire is for research purposes only.

COMPENSATION

There will be no financial compensation for participating in this study.

VOLUNTARY PARTICIPATION

Your participation in this research is completely voluntary. There will be no discrimination against you if you choose not to participate. You are free to change your mind and withdraw from the study at any time, even if you initially agreed to take part.

SIDE EFFECTS

There is no anticipated adverse effect associated with participating in this study.

BENEFIT

The benefit of this study includes the provision of useful local data for the improvement of mental awareness among patients.

CONFIDENTIALITY

All information and data obtained during this study will be kept confidential. Participant names will not be recorded on the questionnaires, and all collected information will be securely stored in a password-protected file on my personal computer. Any physical copies will be stored in a locked personal document cabinet.

CONTACT INFORMATION

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Ethics and Research Committee

University of Benin Teaching Hospital

Benin City.

Phone Number: 07063331337

CERTIFICATE OF CONSENT

I have read the above information (or it has been read to me). I had the opportunity to ask questions about it and the questions were answered to my satisfaction.

(A) I consent voluntarily to take part as a participant in this study

(B) I do not consent to participate in this study.

Name of Participant: ---

Signature of participant: ---

Date:--

APPENDIX II

MULTI-STAGE SAMPLING

Stage 1: Stratification by Cadre

The total population of doctors in UBTH is 696, distributed as follows:

- **House Officers: 70**
- **Residents: 354**
- **Consultants: 272**

Stage 2: Proportional Allocation by Cadre

Using the total sample size of 180, samples will be allocated proportionally across cadres using the formula:

$\mathbf{n_i = (N_i / N) \times n}$

Where:

- **n_i = sample size for each cadre**

- **N_i = population of each cadre**

- **N = total population (696)**

- **n = total sample size (180)**

Cadre	**Population (N_i)**	**Proportion (%)**	**Sample Size (n_i)**
House Officers	**70**	**10.06%**	**≈ 18**
Residents	**354**	**50.86%**	**≈ 92**
Consultants	**272**	**39.08%**	**≈ 70**
Total	**696**	**100%**	**180**

Stage 3: Departmental Distribution

Sample sizes within each cadre will be proportionally distributed across departments based on the known departmental population.

Consultants (Total = 70)

Department	Total No.	% of Consultants	Sample Size
Internal Medicine	33	12.13%	8
Emergency Medicine	3	1.10%	1
Surgery	55	20.22%	14
Obstetrics & Gynecology	20	7.35%	5
Pediatrics	25	9.19%	6
Ophthalmology	13	4.78%	3
Pathology	28	10.29%	7
Public Health & Community Medicine	13	4.78%	3
Psychiatry	10	3.68%	3
Anesthesiology	18	6.62%	5
Family Medicine	7	2.57%	2
Radiology	10	3.68%	3
Dentistry	33	12.13%	8

Radiation & Clinical Oncology	**4**	**1.47%**	**1**

Residents (Total = 92)

Department	**Total No.**	**% of Residents**	**Sample Size**
Surgery	**57**	**16.10%**	**15**
Radiology	**29**	**8.19%**	**8**
Radiation & Clinical Oncology	**3**	**0.85%**	**1**
Psychiatry	**6**	**1.69%**	**2**
Pediatrics	**32**	**9.04%**	**8**
Ophthalmology	**12**	**3.39%**	**3**
Obstetrics & Gynecology	**37**	**10.45%**	**10**
Internal Medicine	**25**	**7.06%**	**6**
Family Medicine	**34**	**9.60%**	**9**
Emergency Medicine	**7**	**1.98%**	**2**
Anesthesiology	**30**	**8.47%**	**8**

Dentistry	**35**	**9.89%**	**9**
Pathology	**25**	**7.06%**	**6**
Community Health & Public Medicine	**10**	**2.82%**	**3**

House Officers (Total = 18)

Department	Total No.	% of House Officers	Sample Size
Internal Medicine	**24**	**34.29%**	**6**
Obstetrics & Gynecology	**20**	**28.57%**	**5**
Surgery	**15**	**21.43%**	**4**
Pediatrics	**11**	**15.71%**	**3**

Note: All sample sizes are rounded to the nearest whole number while maintaining the total per cadre.

Stage 4: Selection of Respondents

Systematic sampling will be used within each department-cadre subgroup. Steps:

1. Calculate sampling interval k = Total in department / Sample size

2. Use simple random sampling to select the first respondent.

3. Select every k-th individual from the department list until the quota is met.

QUESTIONNAIRE TITLE:

Awareness of Mental Health Challenges Among Patients – Doctors' Perspective in the University of Benin Teaching Hospital (UBTH), Benin City.

This questionnaire was developed based on the WHO mhGAP framework to assess doctors' perspectives on patients' mental health awareness, access, and attitudes. Kindly complete honestly. All responses are confidential. Thank you.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age (in years): _______

2. Sex: ☐ Male ☐ Female

3. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

4. Religion: ☐ Christianity ☐ Islam ☐ Traditional ☐ Other (specify): _______

5. Ethnic Group: ☐ Igbo ☐ Hausa ☐ Yoruba ☐ Benin ☐ Esan ☐ Others (specify): _______

6. Years of Practice: ☐ <6 months ☐ 6 months -1 year ☐ 1–5 years ☐ >5 years

7. Current Position: ☐ House Officer ☐ Medical Officer ☐ Registrar ☐ Senior Registrar ☐ Consultant

8. Department: ☐ GOPD ☐ Psychiatry ☐ Internal Medicine ☐ Surgery ☐ O&G ☐ Pediatrics ☐ Others (specify): ________

9. Have you received formal training on mental health? ☐ Yes ☐ No

10. Do you have direct patient contact daily? ☐ Yes ☐ No

SECTION B: PERCEPTIONS OF PATIENT AWARENESS

11. How would you rate your patients' awareness of mental health conditions?

☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very low

12. Does patient knowledge affect their help-seeking behavior?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

13. In your estimate, what proportion of patients present with mental health issues alongside physical symptoms?

☐ <20% ☐ 21–40% ☐ 41–60% ☐ 61–80% ☐ >80%

14. How often do patients discuss mental health during consultations?

☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

15. Has patient awareness improved in recent years? ☐ Yes ☐ No

SECTION C: IMPACT OF AWARENESS ON DIAGNOSIS AND MANAGEMENT

16. Does awareness influence accurate diagnosis and treatment? ☐ Yes ☐ No

17. In what ways does awareness help (tick all that apply)?

☐ Early diagnosis ☐ Treatment adherence ☐ Reduces stigma ☐ Other (specify): ________

18. Have you experienced delayed diagnoses due to low awareness? ☐ Yes ☐ No

19. Do you believe awareness influences prognosis?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

20. Do more aware patients seek care earlier? ☐ Yes ☐ No

SECTION D: BARRIERS TO AWARENESS

Which barriers exist among your patients? (Tick Yes/No for each)

21	Stigma	☐ Yes	☐ No
22	Cultural beliefs	☐ Yes	☐ No
23	Lack of education	☐ Yes	☐ No
24	Limited services	☐ Yes	☐ No

25. Do you consider religious/cultural beliefs major barriers?

☐ Yes ☐ No ☐ Not sure

26. Rate the availability of mental health education in your facility:

☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Very poor

27. Do you believe stigma prevents help-seeking?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

28–31. Rate extent of each barrier:

28. Stigma: ☐ Low ☐ Medium ☐ High

29. Cultural/religious beliefs: ☐ Low ☐ Medium ☐ High

30. Lack of education: ☐ Low ☐ Medium ☐ High

31. Inadequate resources: ☐ Low ☐ Medium ☐ High

SECTION E: ESTIMATED BURDEN OF MENTAL HEALTH ISSUES

32. In the past month, approximately what proportion of your patients had mental health-related concerns (either diagnosed or suspected)?

☐ None ☐ 1–10% ☐ 11–30% ☐ 31–50% ☐ >50%

33. Frequency of mental health-related symptoms in patients:

☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

34. Do most cases go undiagnosed? ☐ Yes ☐ No

35. In the last month, how many mental health patients have you referred?

☐ None ☐ 1–5 ☐ 6–10 ☐ >10

36. Do undiagnosed mental health conditions worsen other health outcomes?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

SECTION F: STRATEGIES AND SYSTEM IMPROVEMENTS

37. Which strategies would improve awareness? (Tick all that apply)

☐ Community outreach ☐ Posters/leaflets ☐ Training of doctors ☐ Media campaigns ☐ other: ________

38. Should mental health education be part of routine care?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

39. Are there awareness programs in your facility? ☐ Yes ☐ No

40. If yes, how effective are they?

☐ Very effective ☐ Effective ☐ Neutral ☐ Ineffective ☐ Very ineffective

Which additional resources are needed? (Tick Yes/No)

41. Counseling centers ☐ Yes ☐ No

42. Video education ☐ Yes ☐ No

43. Printed materials ☐ Yes ☐ No

44. More funding ☐ Yes ☐ No

45. Should the government prioritize mental health education?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

46. How often should awareness programs be held?

☐ Monthly ☐ Quarterly ☐ Annually ☐ Not necessary

47. Can collaboration with religious/community leaders improve awareness?

☐ Yes ☐ No

48. Are healthcare workers in your department adequately trained for mental health screening?

☐ Yes ☐ No ☐ Not sure

49. Do you think mobile mental health services can reduce barriers to access?

☐ Yes ☐

ETHICAL CLEARANCE FORM

HEALTH RESEARCH ETHICS COMMITTEE (HREC)

UNIVERSITY OF BENIN TEACHING HOSPITAL

P.M.B. 1111 BENIN CITY NIGERIA Telephone: 052-600418 Website: ubth.org

CHIEF MEDICAL DIRECTOR	DIRECTOR OF ADMINISTRATION	CHAIRMAN
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HREC OFFICE:
Committee email: ubthresearchethics@gmail.com
Registration Number:
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL. VII/148654912592

PROPOSAL TITLE: "AWARENESS OF MENTAL HEALTH CHALLENGES AMONG PATIENTS-DOCTORS' PERSPECTIVE IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL, BENIN CITY, EDO STATE"

PRINCIPAL INVESTIGATOR(S): ONYEKWELU PRINCE SOMTOCHUKWU

DEPARTMENT/INSTITUTION: DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF BENIN, BENIN CITY, EDO STATE, NIGERIA

DATE CONSIDERED: AUGUST 11TH, 2025

DECISION OF THE COMMITTEE: APPROVED

THIS APPROVAL DATES 11/8/2025 TO 10/7/2026. IF THERE IS DELAY IN STARTING THE RESEARCH, PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI **SIGNATURE & DATE** 11/8/2025

SUPERVISOR (S): PROF. OBEHI H. OKOJIE

DECLARATION BY INVESTIGATOR(S):
PROTOCOL NUMBER (please quote in all enquiries)
Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual re-port to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification

Signature & Date...............................

ubthresearchethics@gmail.com Registration Number: NHREC/24/01/202

PLAGIARISM TEST FORM

INTELLECTUAL PROPERTY & TECHNOLOGY TRANSFER OFFICE (IPTTO)

Vice Chancellor's Office
University of Benin
PMB1154, Benin City, Nigeria

CLEARANCE FORM

DATE: 9th September, 2025

NAME: ONYEKWELU PRINCE SOMTOCHUKWU

MATRIC NO: MED1705939

DEPARTMENT: MEDICINE & SURGERY

FACULTY: MEDICINE

SESSION OF GRADUATION: 2022/2023

DIRECTOR
DATE ....
IPTTO (VCO)
UNIBEN, BENIN CITY.

Head Of Unit (IPTTO)