Attitudes towards People with Mental Illness among Professionals Working in a Psychiatric Hospital in Rwanda

Alfred Ngirababyeyi1,*, Charles Mudenge2, Eric Constant3

1Ndera Neuropsychiatric Hospital, P. O. Box 423 Kigali, Rwanda
2Department of Psychiatry, College of Medicine and Health Sciences, University of Rwanda, Rwanda
3Department of Psychiatry, University Clinics St Luc, Catholic University of Louvain, Belgium

Copyright©2018 by authors, all rights reserved. Authors agree that this article remains permanently open access under the terms of the Creative Commons Attribution License 4.0 International License

Abstract Aims: This quantitative study investigated the attitudes toward people with mental illness among professionals working in Ndera neuropsychiatric hospital in Rwanda. The purpose of this study was to determine whether there are differences in attitudes between direct care providers and supportive professionals towards the people with mental illness. Methods: The Community Attitudes towards Mentally Ill (CAMI) scale (Dear & Taylor, 1982) was used. A total of 72 members of the staff, including 55 directly involved staff members and 17 support staff members, participated in the survey. Results: The mean score is 3.98 for authoritarianism, 3.75 for social restrictiveness, 3.88 for benevolence, and 3.87 for community mental health ideology attitudes subscales. There is no statistically significant difference between the two groups in their overall scale scores. However, directly involved staff members had a greater mean score on many individual items (P≥0.05). Demographic variables did not account for the variance within the two groups (P≥0.05). 87.27% of our respondents think that staff members, patients and family members can be involved in the decision making process and 70.59% appreciate that it is good to involve staff, patients and family relatives in this process. Negative attitudes towards people with mental illness admitted to Ndera neuropsychiatric hospital are also present, even though the majority of our respondents have favorable attitudes towards the people with mental illness. There is the need to explore the influence of staff attitudes on the delivery of high quality healthcare.

Keywords Attitudes, Mental Illness, Professionals, Neuropsychiatric Hospital

1. Introduction

Until the 1960s, the large psychiatric institutions were the focus of psychiatric treatment. The reforms in the 1960s brought deinstitutionalization which is, in other words, the end of the rigid regimens and dehumanization of patients associated with many large institutions. Health care providers have been known to stigmatize patients who use psychiatric medications or services by offering discouraging advice, negative remarks, and rejecting behavior. This form of discrimination may have a negative impact on patients’ self-esteem and the way they seek help or adhere to prescribed medical treatments. [1-6]. Consequently, negative attitudes that manifest as apprehension or discomfort during interactions with patients may lead to ineffective counseling or the lack of essential medical services. [4], [7]–[9].

Before the 1960s, mental disorders in Rwanda were managed within the community by the traditional healers and then by the church. Since 1968, the unique psychiatric hospital was established with the mission to treat all psychiatric cases of the country. Mobile teams, training of psychiatric nurses, psychiatrists and other doctors in order to integrate MH care into general health care at all levels have been attempted. Nevertheless, some patients are hospitalized for long periods, and some are not reintegrated well within the society. In addition to this, some patients reported the violations of their basic human rights. One can ask whether the attitudes among either the directly involved mental health care providers (doctors, nurses and social workers) or support professionals (administrative assistants, etc.) have any influence on this situation.

2. Background

Rwanda is a small, landlocked country with an area of 10,169 square miles, of which 7,229 square miles are usable. Rwanda counts 12,337,138 populations in 2014. [10]. It is located in the heart of Africa with the Democratic
Republic of Congo to the west, Uganda to the North, Burundi to the south, and Tanzania to the east. It enjoys a mild climate, with an average temperature of 64°F. In 1994 Rwanda experienced genocide against the Tutsi population, during which almost 1,000,000 people were killed in only 100 days. These events psychologically affected Rwandans and created several problems for individuals, their families and also their surroundings. In traditional Rwandan culture, an illness is not simply the result of the malfunctioning of a body organ; it is essentially a break in the harmony of one’s life, attributed to either a physical problem created by a magical power, or an intangible force such as God, local spirits, or ancestral spirits. In Rwanda, therapeutic rituals are often addressed to Ryangombe, a divinity who is the source of peace, love, and fertility.

3. Literature on Attitude

**Attitude Structure**

The attitude of a person toward a certain object (person, word, or behavior) can be defined as a subjective evaluation of this object (Herkner, 1993). Historically, scientific study of attitude has focused on the general relationship between attitude and behavior. Though attitude is not observable and hence, difficult to define, it is important to study and understand attitudes because 1) attitudes guide our thoughts, 2) attitudes influence our feelings, and 3) attitudes affect our behavior [6, 9].

**Attitude Formation**

Smith and collaborators in 2017 (1975) stated that attitudes are formed by information processing and they develop from those beliefs that people have about the attitude object [11]. In addition, Yzer M. (2017) demonstrated a genetic component to attitudes after finding that identical twins raised in different environments had similar attitudes [11]. Attitudes are learned primarily through exposure, conditioning, and socialization. This theory is more widely accepted by psychologists and social scientists today. Socialization refers to the acquisition of language, values, and attitudes gradually through reinforcement, observation and learning processes [11-13]. Furthermore, direct experience can be acquired from exposure to a particular object. Direct experience repeated over time results in a preference for or against that object as compared to objects experienced less frequently. The more familiar the object or task, the more we generally like it [14].

Turning to people with disabilities, Leslie perceived the roots of prejudicial attitudes as belonging to the following categories: 1) social customs and norms; 2) child-rearing practices; 3) recurrence of childhood fears in frustrating/anxiety-provoking situations; and (4) discrimination-provoking behavior by persons with disabilities [14]. Finally, sources of negative attitudes toward persons with disabilities occur along six dimensions that include sociocultural, psychological, affective-cognitive, conscious-unconscious, past experience-present situation, internally originated-externally originated, and theoretical-empirical [15–18].

4. Objectives

The objectives of this study were to determine the attitudes, views and reactions of the directly involved staff (nurses, doctors and social workers) and support professionals (administrative assistants, etc.) towards people with mental illness and more specifically to identify factors that influence the attitude of nurses’ towards the people with mental illness in Ndera Neuropsychiatric Hospital.

5. Materials and Methods

Three hypotheses, which are listed below, were formulated for this study. First, doctors and nurses’ attitudes toward persons with psychiatric disabilities will be more positive than supportive staff’s attitudes; second, staff workers in professional positions will have a stronger belief in the need to include consumers in the decision-making process about their future than the support professionals; and last, professional background variables have an effect on professionals’ attitudes towards people with mental illness.

**Research Design**

The survey research method was used in this study.

**Participants**

Eligible participants for this study consisted of all staff. The criteria for participation in this study included meeting all the guidelines for employment as a mental health care provider or support staff members and accepting to participate in the research. A convenience sample consisted of any participants who were available at the time of data collection.103 mental health care professionals were targetted for the study and 72 volunteered to participate in the study. All 72 were met personally to be given the questionnaire. Of the 72 participants, 55 identified themselves as mental health direct care providers and 17 identified themselves as supportive professionals.

**Variables**

Two set of data were collected.
Dependent Variables

The four dependent variables are: Authoritarianism, Social Restrictiveness, Benevolence, and Community Mental Health Ideology.

Independent Variables

These are: Gender, age, academic discipline, training and experience, and occupation.

Instruments

The Community Attitudes towards the Mentally Ill (CAMI) is a 40-item questionnaire developed by Taylor et al. in 1979 [19], [20]. Four separate scales designed to measure attitudes towards the people with mental illness were created. These scales represent specific dimensions: authoritarianism, benevolence, social restrictiveness, and community mental health ideology.

Authoritarianism refers to a view of the mentally ill person as someone inferior who requires coercive handling. Social restrictiveness refers to the belief that the mentally ill patients are a threat to society and should be avoided. Benevolence corresponds to a paternalistic and sympathetic view of the mentally ill patient. Community mental health ideology concerns the acceptance of mental health services and mentally ill patients in the community.

Each dimension in the CAMI scale is measured by 10 statements of which an equal number are worded positively and negatively. A Likert-type scale measures attitudes on a scale of five points, from “strongly agree” (1) to “strongly disagree” (5).

Taylor et al. (1979) reported the alpha coefficient for each of the four scales from a data set of 1,090 subjects residing in Toronto (Canada), which varied from 0.68 to 0.88 (community mental health ideology, 0.88; social restrictiveness, 0.80; benevolence, 0.76; authoritarianism, 0.68). They also reported data about external validity, using factor analysis. Their results showed a four-factor orthogonal solution, accounting for 42% of the variance. In addition, the authors reported a positive correlation between a priori scales and factor scales.

Data Collection Procedures

The questionnaire was distributed to the staff members who satisfied the inclusion criteria. Every staff member was approached personally and was given his/her questionnaire to ensure that he/she responded to it.

Data Analysis

After the data were collected, they were entered into SPSS 16.0 for Windows. When all data had been entered and cleaned, the hard copy of the data was destroyed. Descriptive statistics were computed first to ensure that all of the data were entered properly and to check for missing data. Descriptive statistics were also explored initially to observe the patterns in the data as well as to examine the normality of the dependent variables.

Bivariate analyses were performed initially to examine the predictive ability of each demographic variable in relation to each of the dependent variables.

Multivariate analysis of variance (MANOVA) was utilized to determine if a difference exists between groups of the independent variables on a linear combination of the dependent variables. MANCOVA also controlled for the demographic covariates which may affect the dependent variables.

6. Results

103 staff including 6 doctors, 65 nurses, and 4 psychologists, and 28 support staff were targeted for the study. 72 staffs volunteered to participate in the study. All 72 survey forms were completed and were included in the data analysis. Of the 72 participants, 55 identified themselves as mental health direct care providers and 17 identified themselves as supportive professionals.

Participants varied in age from 22 to 62 (Mean=33.60). 51% were males (N=37) while 50% were single (N=36). The highest level of education achieved was a master’s degree (N=4). According to their occupation, 50 % of our respondents were nurses (N=36).

Attitudes towards the Mentally Ill Patient

Regarding the attitudes of the Authoritarianism subscale of the CAMI scale, the majority of our respondents agreed with the positive attitudes and disagreed with the negative ones. The mean score for all the items is 3.98. However, 51% of the respondents think that as soon as a person shows signs of mental disturbances, s/he should be hospitalized.

Results from the Levene’s Test for Equality of Variances indicate that the scores in the group of directly involved staff members do not vary much more than the scores of the support staff members (p>0.05).

However, there is a significant difference of means on the item no. 2. “More tax money should be spent on the care and treatment of the mentally ill”. The scores (T=-3.26, p= 0.00) show that the mean score for the directly involved is greater than the score of the support staff members for this item.

The directly involved staff also have a higher mean score on the item “The best therapy for many mental patients is to be part of a normal community” (T= -1.67, p= 0.00).
Regarding the social restrictiveness attitudes, our respondents agreed to all the positive attitudes in this subscale. The mean score was 3.75.

Results from the Levene's Test for Equality of Variances indicate that the variability in our 2 groups is about the same. For example, the two groups have equal mean scores for the following items: “A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered” (T= 0.57, p=≥ 0.05). However, directly involved staffs show greater mean score than the supportive staff in some following items. E.g. “Increased spending on mental health services is a waste of tax dollars” (t=2.35, p≤0.05), “Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great” (t=2.74, p≤0.05).

|                                                                                       | Sum of Squares | df | Mean Square | F       | Sig.       |
|---------------------------------------------------------------------------------------|----------------|----|-------------|---------|------------|
| **As soon as a person shows signs of mental disturbance, he should be hospitalized.** | Between Groups: 0.80  | 1  | 0.80        | 0.40    | 0.53       |
|                                                                                       | Within Groups: 141.64 | 70 | 2.02        |         |            |
|                                                                                       | Total: 142.44    | 71 |             |         |            |
| **More tax money should be spent on the care and treatment of the mentally ill.**     | Between Groups: 16.00 | 1  | 16.00       | 10.62   | 0.00       |
|                                                                                       | Within Groups: 105.50 | 70 | 1.51        |         |            |
|                                                                                       | Total: 121.50    | 71 |             |         |            |
| **The mentally ill should not be isolated from the rest of the community**           | Between Groups: 0.62 | 1  | 0.62        | 0.98    | 0.33       |
|                                                                                       | Within Groups: 44.70 | 70 | 0.64        |         |            |
|                                                                                       | Total: 45.32     | 71 |             |         |            |
| **The best therapy for many mental patients is to be part of a normal community**   | Between Groups: 1.24 | 1  | 1.24        | 4.89    | 0.03       |
|                                                                                       | Within Groups: 17.75 | 70 | 0.25        |         |            |
|                                                                                       | Total: 18.99     | 71 |             |         |            |
| **Mental illness is an illness like any other**                                      | Between Groups: 0.09 | 1  | 0.09        | 0.11    | 0.75       |
|                                                                                       | Within Groups: 59.41 | 70 | 0.85        |         |            |
|                                                                                       | Total: 59.50     | 71 |             |         |            |
| **The mentally ill are a burden on society**                                         | Between Groups: 3.34 | 1  | 3.34        | 2.08    | 0.15       |
|                                                                                       | Within Groups: 112.16 | 70 | 1.60        |         |            |
|                                                                                       | Total: 115.50    | 71 |             |         |            |
| **The mentally ill are far less of a danger than most people suppose**               | Between Groups: 0.56 | 1  | 0.56        | 0.45    | 0.50       |
|                                                                                       | Within Groups: 86.72 | 70 | 1.24        |         |            |
|                                                                                       | Total: 87.28     | 71 |             |         |            |
| **Locating mental health facilities in a residential area downgrades the neighborhood.** | Between Groups: 0.01 | 1  | 0.01        | 0.01    | 0.94       |
|                                                                                       | Within Groups: 147.10 | 70 | 2.10        |         |            |
|                                                                                       | Total: 147.11    | 71 |             |         |            |
| **There is something about the mentally ill that makes it easy to tell them from normal people** | Between Groups: 0.24 | 1  | 0.24        | 0.24    | 0.63       |
|                                                                                       | Within Groups: 69.26 | 70 | 0.99        |         |            |
|                                                                                       | Total: 69.50     | 71 |             |         |            |
| **The mentally ill have for too long been the subject of ridicule**                  | Between Groups: 0.95 | 1  | 0.95        | 0.99    | 0.32       |
|                                                                                       | Within Groups: 67.04 | 70 | 0.96        |         |            |
|                                                                                       | Total: 67.99     | 71 |             |         |            |
| Table 2. Independent sample T test for social restrictiveness | Sum of Squares | df | Mean Square | F   | Sig. |
|-------------------------------------------------------------|----------------|----|-------------|-----|------|
| A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered | Between Groups | 0.58 | 1 | 0.58 | 0.33 | 0.57 |
| Within Groups | 124.92 | 70 | 1.78 |
| Total | 125.50 | 71 |
| As far as possible mental health services should be provided through community based facilities | Between Groups | 0.81 | 1 | 0.81 | 0.69 | 0.41 |
| Within Groups | 82.69 | 70 | 1.18 |
| Total | 83.50 | 71 |
| Less emphasis should be placed on protecting the public from the mentally ill | Between Groups | 3.23 | 1 | 3.23 | 1.87 | 0.18 |
| Within Groups | 120.72 | 70 | 1.72 |
| Total | 123.94 | 71 |
| Increased spending on mental health services is a waste of tax dollars | Between Groups | 13.27 | 1 | 13.27 | 10.03 | 0.00 |
| Within Groups | 92.61 | 70 | 1.32 |
| Total | 105.88 | 71 |
| No-one has the right to exclude the mentally ill from their neighborhood | Between Groups | 3.80 | 1 | 3.80 | 6.03 | 0.02 |
| Within Groups | 44.14 | 70 | 0.63 |
| Total | 47.94 | 71 |
| Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great | Between Groups | 10.41 | 1 | 10.41 | 6.59 | 0.01 |
| Within Groups | 110.47 | 70 | 1.58 |
| Total | 120.88 | 71 |
| Mental patients need the same kind of control and discipline as a young child | Between Groups | 29.49 | 1 | 29.49 | 18.74 | 0.00 |
| Within Groups | 110.16 | 70 | 1.57 |
| Total | 139.65 | 71 |
| We need to adopt a far more tolerant attitude toward the mentally ill in our society | Between Groups | 0.17 | 1 | 0.17 | 0.30 | 0.58 |
| Within Groups | 39.83 | 70 | 0.57 |
| Total | 40.00 | 71 |
| I would not want to live next door to someone who has been mentally ill | Between Groups | 18.53 | 1 | 18.53 | 14.50 | 0.00 |
| Within Groups | 89.45 | 70 | 1.28 |
| Total | 107.99 | 71 |
| Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community | Between Groups | 0.98 | 1 | 0.98 | 1.47 | 0.23 |
| Within Groups | 46.67 | 70 | 0.67 |
| Total | 47.65 | 71 |

Regarding the benevolence attitudes from the CAMI scale, the majority of our respondents agreed to the positive attitudes. The mean score was 3.88.

As an example, 78% disagreed with the statement that anyone with a history of mental problems should be excluded from taking public office.

Results from the Levene's Test for Equality of Variances indicate that the variability in the 2 groups is about the same. However, the directly involved staff have a greater mean score than the supportive staff for the following items: “The best way to handle the mentally ill is to keep them behind locked doors” (t=2.94, p≤0.05), and “The mentally ill don’t deserve our sympathy” (t= -2.87, p≤0.05).
Regarding community mental health ideology attitudes, the majority agreed with the positive attitudes and disagreed with the negative ones. The mean score was 3.87. For example, 83% agreed with the statements that the mentally ill should not be denied their individual rights.

Results from the Levene’s Test for Equality of Variances indicate that the variability in the 2 groups is about the same. However, directly involved staff has a greater mean score on the following items: “Mental health facilities should be kept out of residential neighborhoods” (t=5.81, p≤0.05), and “It is frightening to think of people with mental problems living in residential neighborhoods” (t=2.38, p≤0.05).
Table 4. Independent sample T test for Community Mental health Ideology

| Statement                                                                 | Sum of Squares | df | Mean Square | F     | Sig. |
|---------------------------------------------------------------------------|----------------|----|-------------|-------|------|
| The mentally ill should not be denied their individual rights             | 3.03           | 1  | 3.03        | 2.32  | 0.13 |
| Within Groups                                                             | 91.41          | 70 | 1.31        |       |      |
| Total                                                                     | 94.44          | 71 |             |       |      |
| Mental health facilities should be kept out of residential neighborhoods | 43.59          | 1  | 43.59       | 33.79 | 0.00 |
| Between Groups                                                            | 90.29          | 70 | 1.29        |       |      |
| Total                                                                     | 133.88         | 71 |             |       |      |
| One of the main causes of mental illness is a lack of self-discipline and  | 4.95           | 1  | 4.95        | 4.22  | 0.04 |
| will power                                                                | 82.04          | 70 | 1.17        |       |      |
| Total                                                                     | 86.99          | 71 |             |       |      |
| We have a responsibility to provide the best possible care for the mentally | 0.01           | 1  | 0.01        | 0.02  | 0.90 |
| ill                                                                      | 46.86          | 70 | 0.67        |       |      |
| Total                                                                     | 46.88          | 71 |             |       |      |
| The mentally ill should not be given any responsibility                    | 0.93           | 1  | 0.93        | 0.75  | 0.39 |
| Within Groups                                                             | 87.02          | 70 | 1.24        |       |      |
| Total                                                                     | 87.94          | 71 |             |       |      |
| Residents have nothing to fear from people coming into their neighborhood | 0.07           | 1  | 0.07        | 0.06  | 0.81 |
| to obtain mental health services.                                          | 82.59          | 70 | 1.18        |       |      |
| Total                                                                     | 82.65          | 71 |             |       |      |
| Virtually anyone can become mentally ill                                   | 0.74           | 1  | 0.74        | 0.84  | 0.36 |
| Within Groups                                                             | 61.58          | 70 | 0.88        |       |      |
| Total                                                                     | 62.32          | 71 |             |       |      |
| It is best to avoid anyone who has mental problems.                        | 8.60           | 1  | 8.60        | 4.59  | 0.04 |
| Between Groups                                                            | 131.05         | 70 | 1.87        |       |      |
| Total                                                                     | 139.65         | 71 |             |       |      |
| Most women who were once patients in a mental hospital can be trusted as  | 8.24           | 1  | 8.24        | 4.18  | 0.04 |
| baby sitters                                                              | 138.07         | 70 | 1.97        |       |      |
| Total                                                                     | 146.32         | 71 |             |       |      |
| It is frightening to think of people with mental problems living in       | 10.16          | 1  | 10.16       | 7.74  | 0.01 |
| residential neighborhoods’                                                | 91.83          | 70 | 1.31        |       |      |
| Total                                                                     | 101.99         | 71 |             |       |      |

Relationship between Attitudes and Profile of the Participants

The demographic variables gender, age, family status, role, category, education, background, and experience did not significantly account for variance in the model with each of the individual predictors and authoritarianism as the dependent variable at p>0.05. The same was true for these variables and the categories of benevolence and social restrictiveness.

The variables gender, age, family status, experience, category, education, and background did not significantly account for variance in community mental health ideology
attitudes at $p>0.05$. However, the variable role was again a significant predictor ($F = 2.45$, $p<0.05$, eta squared 0.32).

**Beliefs of the Respondents about Asking Patients Their Preferences**

87.27% of our respondents think that the directly involved staff member, patients and their families should be involved in the decision-making process. 70.59% of support staff members think that it is good to involve the staff member, consumers and their families in this process.

**Correlations between Inclusion and Involvement in Decision-making**

There is no correlation between attitudes of the professionals towards people with mental illness and their involvement in the process of decision-making.

### 7. Discussion

The primary questions of this study were: Is there any difference between the attitudes of directly involved and support professionals toward people with mental illness and demographic variables. Secondary it was hypothesized that directly involved professionals would endorse lower levels of mental health stigma than support staff; that directly involved professional would have a stronger belief in the need to include consumers in the decision-making process about their future than the supportive staff workers; and that professional background variables have an effect on the staff’s attitudes toward mentally ill patients.

The general finding is that the data from our study support the two first hypotheses and do not support the last one.

The present study showed that for the authoritarianism, our respondents did not believe that people with people with mental illness are inferior. They, however, think that as soon as a person shows signs of mental disturbances, s/he should be hospitalized.

The reason for this could be that their hospital is the only one in the country that can hospitalize patients for a long time, and the mental health services in general hospitals and primary care are at the early stage of development, hence, not yet well organized.

For the social restrictiveness subscale, the majority think that no one has the right to exclude the people with mental illness from the community, but directly involved staff show greater score than the support professionals on the items “Increased spending money on mental health services is a waste of tax dollars, “Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great”, “Mental patients need the same kind of control and discipline as a young child”, and “I would not want to live next door to someone who has been mentally ill”. This may be due to the fact that there are scarce mental health interventions in the community and the patients who are brought to Ndera hospital are often those with neglected hygiene, agitation and aggressivity, and other distressing conditions. In general, our respondents do not think that mentally ill patients are a threat to the society; they think that they should not be avoided.

The majority of our respondents showed a paternalistic and sympathetic view of the mentally ill patient. With the mean score of 3.88, they show an orientation toward care in general. The conclusion is that our respondents hold favorable attitudes towards mentally ill patients. Concerning the acceptance of mental health services and mentally ill patients in the community, the majority of our respondents agreed with the positive attitudes and disagreed with the negative ones. By contrast, a study conducted by Aghukwa Chikaodiri N. (2009) found many hospital workers, especially females; expressed anticipatory fears towards letting psychiatric patients obtain admission for treatment within a general hospital setting.

This view was very likely caused by the fact that many workers did not wish their place of work to contain psychiatric wards. This situation differs from the results of our study, probably because professionals at the psychiatric hospital have more time to spend with patients and to talk to them and this means that they might have more compassion compared to the other health professionals in general hospitals.

Although the majority of our respondents thought that the best therapy for mentally ill should be organized in the community, they also thought that as soon as a patient shows mental disturbance signs, he should be hospitalized.

This discrepancy might perhaps be related to the scarcity of resources and the presence of the treatment gap with regard to mental illness, especially at the community level.

Our findings support the work of Antonia Barke and collaborators in Ghana (Barke A. et al., 2010), who showed that regarding society’s attitude towards mentally ill patients, benevolent views tended to prevail and the responsibility for providing the best possible care was acknowledged by a large majority.

The first hypothesis for the current study was that directly involved professionals’ attitudes toward the inclusion of persons with psychiatric disabilities would be more positive than supportive staff’s attitudes.

The general finding is that our hypothesis is confirmed, the directly involved professionals’ attitudes towards mental illness are more positive than the support professionals’ attitudes.

This supports findings from Helio Gomes da Rocha Neto et al. (2016) who investigated Attitudes of Brazilian Medical Students Towards Psychiatric Patients and Mental Illness and showed that Participation in a psychiatric clerkship was associated with greater social acceptance but not with improvement on other attitudinal factors[21]. This
is likely the reason why directly involved professionals endorse lower levels of stigma than support professionals at Ndera neuropsychiatric hospital.

Prior research has consistently reported that contact with people with mental illness influences positive attitudes and increases the level of comfort in interacting with people with mental illness [15], [19], [20], [22]–[24].

Another objective was to identify possible factors which influence the attitude towards mentally ill people in Ndera Neuropsychiatric hospital.

The findings suggest that the demographic variables gender, age, family status, category, education, background, and experience did not significantly account for variance in the model with each of the individual predictors and the subscales of the CAMI scale.

The last hypothesis was that directly involved professionals would have a stronger belief in the need to include consumers in the decision-making process about their future than the supportive staff workers.

This assumption was supported by our results, as the majority of directly involved staff members agree to ask mentally ill patients about their preferences while the majority of support staff members do not agree.

As the two groups of professionals have different views on the mental illness, activities aiming the fight against stigma and negative attitudes towards the mentally ill patient should be organized frequently in the hospital.

There are still many areas to explore within the field of attitudes to mental illness and persons with mental illness in Rwanda. Since mental health services are not yet well organized in the community, there is a need for further research on the attitudes towards the people with mental illness in the general population. It would also be of interest to explore what people with mental illness themselves consider, regarding these research findings as well as their experiences of contact with the public.

It is hard to know if the displayed attitude is in accordance with the respondent’s inner belief or if it is an idealized description, so called ‘Beautiful Painting’ in order to position oneself as politically correct. Therefore it is of interest to explore if it is possible to adapt the CAMI scale to the Rwandan population.

Before starting this study, two basic assumptions were made. First, it was assumed that directly involved staff and supportive professionals who participated in this study have awareness and understanding of the concept of mental health care. Second, it was assumed that the two groups who participated in this study would be honest and accurate in their responses to the questionnaire on attitudes.

This study has some limitations to highlight. First, as it is for every other survey, participants may not be very accurate in answering the questionnaires. Second, is the attitude towards the researcher? As the researcher was a member of the group proposed for this study, participants may feel hesitant to reveal true information on the questionnaires for fear of exposure.

8. Conclusions

Health care professionals should be explicitly made aware of the impact their judgments of disadvantaged groups can have in their caring role so that they become able to overcome any inherent prejudice and meet the demands of their patients irrespective of individual circumstance.

A summary interpretation of the main findings in this paper reinforces the assumption that negative attitudes towards people with mental illness received in Ndera neuropsychiatric hospital are in existence, even though the majority have favorable attitudes toward the mentally ill.

This study also demonstrates that the directly involved professionals have been found to have more positive attitudes than the supportive professional and this seems to show that as individuals improve their ability to interact with persons with mental illness, they become more tolerant.

The present study demonstrates that the sociodemographic variables tested have no impact on the attitudes of the professionals working in Ndera neuropsychiatric hospital.

Finally, this study demonstrates that there is no correlation between the attitudes towards mentally ill patients and their inclusion in the process of decision-making.

REFERENCES

[1] C. S. Siau, L. H. Wee, S. Yacob, S. H. Yeoh, T. H. Binti Adnan, J. Haniff, K. Periaalthan, A. Mahdi, A. B. Rahman, C. L. Eu, and S. Binti Wahab, “The Attitude of Psychiatric and Non-psychiatric Health-care Workers Toward Suicide in Malaysian Hospitals and Its Implications for Training,” Acad. Psychiatry, vol. 41, no. 4, pp. 503–509, 2017.

[2] Z. Xu, M. Müller, K. Heeckeren, A. Theodoridou, D. Dvorsky, S. Metzler, A. Brabban, P. W. Corrigan, S. Walitza, W. Rössler, and N. Rüsch, “Self-labelling and stigma as predictors of attitudes towards help-seeking among people at risk of psychosis: 1-year follow-up,” Eur. Arch. Psychiatry Clin. Neurosci., vol. 266, no. 1, pp. 79–82, 2016.

[3] S. Gyamfi, K. Hegadoren, and T. Park, “Individual factors that influence experiences and perceptions of stigma and discrimination towards people with mental illness in Ghana,” International Journal of Mental Health Nursing, 2017.

[4] P. Corrigan and A. Bink, “The Stigma of Mental Illness,” Encycl. Ment. Heal., 2016.

[5] Y. Wang, X. Wang, W. Zhang, X. Liang, D. Tian, and Z. Qu, “Risk factors of the stigma towards psychiatric patients among primary healthcare workers in China: a county study,” BMC Psychiatry, vol. 17, no. 1, p. 62, 2017.

[6] A. L. Klose, “The effects of internalized stigma of mental illness on self-efficacy.,” 2010.
[7] N. Rüsch and Z. Xu, “Strategies to Reduce Mental Illness Stigma,” in The Stigma of Mental Illness - End of the Story?, 2017.

[8] C. G. Strassle, “An evidence-based approach for reducing the stigma of mental illness,” in An Evidence-Based Approach for Reducing the Stigma of Mental Illness, 2014.

[9] R. Cunningham, D. Peterson, and S. Collings, “Like minds, like mine: Seventeen years of countering stigma and discrimination against people with experience of mental distress in New Zealand,” in The Stigma of Mental Illness - End of the Story?, 2016.

[10] Index Mundi, “Rwanda Demographics Profile 2017.” [Online]. Available: https://www.indexmundi.com/rwanda/demographics_profile.html. [Accessed: 11-Dec-2017].

[11] J. R. Smith and S. A. Haslam, Social psychology: Revisiting the classic studies. Sage, 2017.

[12] M. Yzer, “Theory of Reasoned Action and Theory of Planned Behavior,” Int. Encycl. Media Eff., 2017.

[13] K.-Y. Kao, C. Spitzmuller, K. P. Cigularov, and C. L. Thomas, “A Moderated Mediation Model of Safety Knowledge, Safety Attitude, and Safety Performance,” in Academy of Management Proceedings, 2016, vol. 2016, no. 1, p. 16128.

[14] M. Saxton, Child language: Acquisition and development. Sage, 2017.

[15] J. Lu and K. H. Kim, “Understanding self-report Multidimensional Attitudes Scale Toward People with Disabilities: An exploratory analysis,” Rehabil. Psychol., vol. 62, no. 2, p. 110, 2017.

[16] T. P. Dirth and N. R. Branscombe, “Disability Models Affect Disability Policy Support through Awareness of Structural Discrimination,” J. Soc. Issues, vol. 73, no. 2, pp. 413–442, 2017.

[17] R. M. Roberts, G. M. Neate, and A. Giersch, “Implicit attitudes towards people with visible difference: findings from an Implicit Association Test,” Psychol. Health Med., vol. 22, no. 3, pp. 352–358, 2017.

[18] S. Leslie, “The Original Sin of Cognition: Race, Prejudice, and Generalization,” J. Philos., 2016.

[19] S. Ochoa, F. Martínez-Zambrano, R. Vila-Badia, O. Arenas, E. Casas-Anguera, E. García-Mora-Merales, R. Villaleñas, J. R. Martín, M. B. Pérez-Franco, T. Valduciel, and others, “Spanish validation of the social stigma scale: Community Attitudes towards Mental Illness,” Rev. Psiquiatr. y Salud Ment. (English Ed.), vol. 9, no. 3, pp. 150–157, 2016.

[20] K. S. Mosaku and A. H. Wallymahmed, “Attitudes of Primary Care Health Workers Towards Mental Health Patients: A Cross-Sectional Study in Osun State, Nigeria,” Community Ment. Health J., vol. 53, no. 2, pp. 176–182, 2017.

[21] H. G. da Rocha Neto, R. A. Rosenheck, E. A. Stefanovics, and M. T. Cavalcanti, “Attitudes of Brazilian Medical Students Towards Psychiatric Patients and Mental Illness: A Quantitative Study Before and After Completing the Psychiatric Clerkship,” Acad. Psychiatry, vol. 41, no. 3, pp. 315–319, 2017.

[22] R. Mojtahai, S. Evans-Lacko, G. Schomerus, and G. Thornicroft, “Attitudes toward mental health help seeking as predictors of future help-seeking behavior and use of mental health treatments,” Psychiatr. Serv., vol. 67, no. 6, pp. 650–656, 2016.

[23] T. A. Ryan and K. Scior, “Medical students’ attitudes towards health care for people with intellectual disabilities: a qualitative study,” J. Appl. Res. Intellect. Disabil., vol. 29, no. 6, pp. 508–518, 2016.

[24] C. A. Hoffner, Y. Fujioka, E. L. Cohen, and A. Atwell Seate, “Perceived media influence, mental illness, and responses to news coverage of a mass shooting,” Psychol. Pop. Media Cult., vol. 6, no. 2, p. 159, 2017.