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Social Constructions of Mental Illness: A Review

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Abstract
Social representations of certain identifiable images of mental illness that are adopted in examining the sanity of individuals are critical to understanding madness or mental illness as a concept. Identifiable images of the insane (Gilman 1988) that describe them as violent, dangerous, vagrant, unkempt, bizarre, childlike and blameworthy (Wahl 1992; Philo et al. 1996; Aina 2004; Knifton and Quinn 2008) characters have influenced standards adopted in the evaluation of individuals as sufferers of madness, an extension of which permits laymen and specialists to see the signs of danger and illness everywhere (Foucault 1965), particularly in ways that are influenced by socio-cultural practices. These socio-cultural practices, as it pertains to mental illness, vary in perception and practice across various cultures in different parts of the continent. In some cultural context, Africa specifically, mental illness is explained from views that are predominantly magical or supernatural, but in the western culture, violence and aggression are themes that are constantly evoked in mediated representations of mental illness. The media is also an important social structure that has been reported to reinforce existing social-cultural beliefs about mental illness. The differences and diversity in the way mental illness is understood across cultures are crucial to understanding the relativity and realism in social constructions of mental illness. This is so because social constructionism is concerned with putting in proper context which agency- human or social- is responsible for formulating and sustaining popularly held views about mental illness. Thus, this review analysed ways the media as an important social structure formulate or reinforce socially held views on manifestations of stigma and explanations of causes and treatments of mental illness. Also, this review made an attempt to fuel on-going debate about social constructionism, by explaining ways the individual creates or recreates personal views about mental illness while using social structures like the media and religion for these purposes. This review adopted social constructionism as explained by Burr (1998) and Berger and Luckmann (1966) to further explain the importance of magic and supernaturalism in the conceptualisation of mental illness in African and Asian societies, and the implication of these beliefs in the sustenance of psychiatry.

Keywords: Social constructionism, mental illness, magic, supernaturalism, media

1. Mental Illness or Madness: An Introduction

The adoption of madness as a grass root construction of lunacy, insanity, psychosis or mental illness has inspired consistent perceptions of mental illness through ages (Cross 2010): from the Middle Ages to the period of Renaissance (Foucault 1965); the fifteenth century (Gilman 1988); and to the twenty first century (Heaton 2013a), a persistence Cross (2010) argues, emanated from the social preservation of images of madness from the past to the present. The instantaneous identification of mental illness in the East and West; similarities in perceptions of madness across cultures, nations, tribes; and social production and reproduction of mental health beliefs give credence to the submission that social representations of madness is age long. Overtime and through different ages, the concept madness have evoked multiple meanings that are largely influenced by socio-cultural beliefs and practises of that time. Majority of these interpretations that were given to mental illness in these societies, although still evolving, have been nurtured and reinforced by significant individual and social agencies in these societies.

Meanwhile, academics in the field of psychiatry have argued that mental illness is a concept that encapsulates a broad spectrum of meaning and interpretation (Szasz 1987; Gilman 1988). A more specific interpretation of mental illness suggests the presence of disease in an 'other' (Foucault 1965; Szasz 1987). The use of 'illness' as a term for the description of the suffering of an 'insane person' or as an artefact of the society was the basis of Szasz's argument around insanity. Szasz focussed on denouncing 'mental illness' and described it as a 'man-made myth' (Porter 2002). For Szasz, 'diseases' can be created regardless of their biological, emotional and psychopathological source. In simple terms, Szasz's argument is that mental illness is a man-made disease that psychiatry fabricated in the interest to 'sanction easy solutions for problem people' (Porter 2002, p.2). Thus, mental illness is perceived more as a term that describes behavioural otherness from the point of view of psychiatry. This view is similar to the social model of disability which argues that disability does not exist in the individual with physical or mental impairment, but with the general or medical social groups that impose

certain strictures or qualities on ways the society identify and segregate the normal from the abnormal; the sane from the insane; and the able from the 'disabled' (Reeve 2004; Barnes and Mercer 2005; Davis 2006).

On the other hand, 'madness' as a terminology conceptualises images of mental illness in contexts that *exceed* psychiatric discourse (Harper 2005; Cross 2010). According to Foucault in *Madness and Civilisation* (1965), madness is a 'cultural construct that is sustained by a grid of administrative and medico-psychiatric practices (Porter 2002). Historically, madness invoked images of menace and mockery, 'the dizzying unreason of the world, and the feeble ridicule of men at the end of the Middle Ages' (Foucault 1965, p.13). Furthermore, in Gilman's terms (1988), 'madness' is an extreme state of imbalance. Imbalance in this context is interpreted as a state of disruption in mental balance, which was primarily understood from the point of view of the melancholic madwoman in the fifteenth century (Gilman 1988). According to Foucault (2001 in Sapouna 2012), 'madness' was part of everyday community life with wide spread perception of the mad as culturally playing a significant societal role during the Middle Ages and Renaissance. In other instances, madness was seen as a punishment, in for example early religious myth (Porter 2002).

In other words, madness encapsulates all possible forms of describing *mental otherness*, all such images that are categorised under crazy, insanity, mental illness, or mental health problems. In his position on how mental illness as a concept is constituted, Cross (2010) argues that signs of madness are recognized from mediated images and representations of mental illness. In this vein, Gilman (1988) argues that the idea that the use of *mental illness* structures both perception of disease and its form appear as a contrast to some assumptions that mental illness is an artefact of the society or biology. The argument here is that the visual stereotype of what madness, mental illness or insanity looks like is activated by constructs of recognisable images of madness. The question then is, 'are images of mental illness or madness as we know them now socially constructed for us? Are mediated images of mental illness social constructions of cultural reality?

2. Mediated Madness as Social Construction of Reality

In Africa, attitude to mental illness is reportedly consistent with intolerance people show towards sufferers of mental illness (Gureje et al. 2005). In this vein, it is believed that if a substantial fraction of people gets their health-related information from television (Vogel et al. 2008), the next quest will be to explore if contents in the media are projections of social constructions or if media messages function as constructors of social values, beliefs and practice. Here, arguments on media representation of mental illness will move away slightly from the notion of media influence to theorising ways media messages function as constructs of social reality.

Social constructionism, as Burr (2003) puts it, is an approach in social psychology or sociology (Berger and Luckmann 1966), that seeks to explain knowledge and social action from cultural or historical perspectives without necessarily arguing that one way of understanding social interaction represent the truth about the world. Social constructionism holds the view that there are numerous possible constructions of the world, and that each individual construction provides a version of reality to only the social group that these constructions represent. In this context, the debate on realism of social construction is fuelled because social constructionism denies that knowledge is a direct perception of reality (Burr 2003). Knowledge here is seen more has something people do together, the creation and sustenance of social phenomena through social practices. The practice of social constructionism focuses on directing problems away from the *pathologised* to the social structure that *pathologises.*

Social constructionism is in twofold: the micro aspect focuses on individuals as agent in control of the construction process; and the macro structure focuses on the view that 'constructions are the product of social forces, either structural or interactional' (Burr 2003, pg. 20). One major criticism of social constructionism is in the dichotomy of the micro and macro structures. Burr argues that this dichotomy has not adequately theorised the relationship between the individual and society. The problem with theorising the relationship between the individual and society is in establishing which agency, human or social, is influencing the other: is the individual influencing social constructions and interactions or is the social structure influencing the individual? According to Burr, if the macro structure is emphasized in social constructionism as an approach, the existence of human agency; the critical importance of individual differences; and subjective experiences of life is threatened. And the problem with emphasizing human agency over social agency is with the notion that the individual cannot be said to be a sole constructor of the society. Thus, Burr argues that social constructionism should focus on an embodiment of human and social agency in the explanation of social constructions. The individual cannot exist without the society, and the society is meaningless without the individual, thus social constructionism is better approached by avoiding the individual/social dualism (Berger and Luckmann (1966).

Now, attempts made at contextualising media representation of mental health issues show that there exists doubt over views that the media construct social reality (Maier et al. 2013). The view that media present symbolic messages that reflect social reality is part of what is often contested. In some contexts, media in its own right has a powerful influence on the construction of views and attitudes in the real word without necessarily reflecting what is perceived to be real in the society. If the media truly influence attitudes and behaviour as argued earlier, this indicates that audiences are passive readers of media messages. The notion that readers of media messages are cultural dopes may have been debunked with argument that readers do not exactly read messages or give meanings to messages exactly the way producers want it (Gamson et al. 1992). However, Entman (2007) argues that the dichotomy implied in a well-known axiom that the media provides people with 'what to think' and not 'what to think about' is flawed. Entman (2007) argues that the influence of the media on what people decide, favour or accept in media messages is not entirely different from the notion that the media can influence action by giving people what to think about; and ensuring that they think about an idea in certain ways.

On another hand, framing is crucial to contextualising mediated images of mental illness as constructs of social reality. According to Gamson et al. (1992), cultural level analysis show that the political world we live in is framed through pre-organised reports of events brought to us through media messages without necessarily implying that receivers of messages are passive processors of texts. However, active processors of media contents make media sphere a site of struggle for many who compete for the construction of their own version of social reality through framing (Gamson et al. 1992; Dill 2009). The position held by Gamson et al. (1992) is that texts sometimes have a preferred meaning the reader or audience of a media message is invited to accept or reject based on preference for alternative readings. In other words, texts evoke multiple interpretations and meanings in audiences or readers, since there cannot be just one fixed way of interpreting signs and symbols in a context that is vulnerable to series of meanings.

For example, frames of mental health in narratives produced in Nigeria projected mental health issues as social problems psychiatry cannot resolve alone. In the overall framings of mental health in movies studied by Aroyewun–Adekomaiya and Aroyewun (2019), culture-based beliefs (magic or spiritualism) were given salience over psychiatry, while predominant mental health options of treatment were largely magical, traditional or spiritual. They argued that tirades of meanings may be evoked if experientially, in an alternate culture, vagrancy and unkempt appearances - predominant themes found to present mentally ill characters in the movies - symbolise the presence of lack of means other than mental illness. Within such cultures, the interpretation of a vagrant and unkempt individual would be based on physical experiences of such images and what they are known to represent. In this context, Coëgnarts and Kravanja (2012) argued that such interpretations fit into the theory of image schema, which involves concrete interpretation of images by tapping into a wide range of experiences that are grounded in daily physical interactions with the world. It is in the context of diverse cultural manifestations of mental illness that it has been argued that social and movie representations shape and are shaped by the culture of a particular society (cultural psychology) (Burr; Wig 1999; Rashed 2013; Aroyewun–Adekomaiya & Aroyewun 2019).

Similarly, social constructionism upholds the view that there exists a potentially infinite number of alternative ways of presenting constructions of events (Burr 1998). For example, social interactions that make multiple perceptions of mental illness dominant will reflect social constructions that will relate mental illness to a number of possible interpretations. It is this multiplicity, diversity, fragmentation and localness that Burr (1998) referred to as the power of social constructionism. However, there is the problem of little guidance on which course of action is to be taken from the various options of social constructions. This lack of guidance has fuelled debates on realism and relativism in social constructionism. Burr (1998) argues in a debate on *Realism, relativism, social constructionism and discourse* that social constructionism questions the idea of the "objective fact" and at the same time characterizes the discipline and practice of psychology as partial, value–ridden and driven by implicit vested interest (Burr 1998, p.14).

Relativist view questions the reason for abandoning the notion of a reality which bears some relation to our construction of social events. Relativity in the way knowledge of social issues challenge reality claims thrives on resisting having reality all pinned down and described as a 'once and for all' way of situating real life issues (Burr 1998). However, realism on the other hand cannot be said to be entirely different from relativism. Realism is reality behind social phenomena and has become the reason why some researchers adopt relativism to explain what truly is a representation of reality (Burr 1998). What is true about reality is based on what appears to us as true in the way truthful reality affects our lives.

The existence of a multiplicity of perspective in interpreting social events leads to a bewildering array of alternatives, which brings with it the question of how one is then expected to decide between alternative perspectives. In Burr's (1998) view, the justification for advocating one view or social life over another and the possibility of avoiding 'moral relativism', informs some of the arguments that fuel relativism/realism debate in social constructionism. Also, Burr (1998) argues that social construction makes us conscious of the diversity and difference in humanity, but argues that if we insist on difference and diversity, we paralyze ourselves by denying the possibility of identifying collective interest.

Furthermore, social construction of reality as an approach encapsulates dissecting ways constructions of reality become relative and provide answers to why differences occur in the way knowledge interferes with what comes to be known as reality. Socially agreed upon knowledge that is drawn upon for interpreting social happenings affect how members of social groups interpret social issues. From the perspective of mental health, a society whose knowledge of madness is sourced from a particular point of view may find it difficult to activate alternative views as social reality. Illustratively, Africans are known historically to attribute magic or spiritualism to mental illness (Gureje et al. 2005; Fernando 2010). So, in rural areas where magical or spiritual views on mental illness are highly appreciated and access to some media (internet) is relatively low, a social rejection of psychiatry is a possible reality.

In the same vein, Collier (1998) provides further explanation on this by suggesting that reality can be best understood through concepts such as consciousness, experience, language and practise; and that language can only be learnt through reference to reality. In other words, reality is given to us through language, which is responsible for enhancing our predated experience with the real world (Burr 1998; Collier 1998). According to Berger and Luckmann (1966), knowledge in social construction of reality exist in the realisation that every individual is born into an objective social structure within which he encounters the significant others who take charge of his socialization. These significant others are imposed upon him. Definitions of life situation are posited for him as objective reality by the significant others. The significant others who mediate this world to him modify it in the course of mediating it. They select aspects of it in accordance with their own location in the social structure, and also by virtue of their individual, biographically rooted idiosyncrasies. The social world is 'filtered' to the individual through this double selectivity. Thus, a child born in the rural area in Nigeria will absorb magical interpretations of causes and treatments of madness, he will absorb images of madness

in the idiosyncratic coloration given it by his parents (or whatever other individuals are in charge of his primary socialization (Berger and Luckmann 1966). The implication of this is the establishment of an objective and subjective reality with a coherent and continuous identity (Berger and Luckmann 1966). Thus, social constructions of reality are culturally and historically specific. Thus, we are able to examine social constructions critically to make informed judgement about the appropriateness of our values based on the knowledge of reality that lies behind social phenomena (Burr 1998).

3. 'Madness' or Mental Illness across Cultures

Culture is a complicated and contested word because the concept does not represent an entity in an independent object world (Rashed 2013). In order words, culture has multiple meanings and the multiplicity in meaning and usage of culture occurs across different disciplines (Barker 2004; Rashed 2013). Culture represents a signifier that enables distinct and divergent ways of talking about human activity for a variety of purposes (Barker 2004). Cultural beliefs or values are identifiable through shared meanings that enable proper understanding of social situations (Rashed 2013). Culture is crucial in the way people define 'what is abnormal and deviant, how illness is defined and how and where help is sought' (Bhugra 2006, p.17). Lauber and Rössler (2007) state that culture influences the way mental illness is conceived, perceived, experienced, recognised, labelled and classified in terms of causes and treatments. In comprehending culture as a concept, Swidler (1986 cited in Gamson et al. 1992, p.389) describes culture 'as a 'tool kit' of symbols, stories, rituals, and world-views, which people use in varying configurations to solve different kinds of problems'.

Report from studies carried out in different climes and cultures have shown that the manifestation of symptoms; prevalence and characteristics of stigma; and perceptions of causes and treatments of mental illness vary across cultures (Aina 2004; Bhugra 2006; Rashed 2013; Islam and Campbell 2014). According to Bhugra (2006), cultural identity is crucial to the ways in which symptoms of mental illness are conceived, identified and treated, thereby reiterating the notion that symptoms of mental illness and experiences of diseases vary significantly across cultures. The importance of cultural knowledge and experience of disease was considered in the development of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994) where for example, bizarre delusions or bizarreness as a symptom of schizophrenia was described as been difficult to judge across cultures. In relation to this, Atilola and Olayiwola (2011a) also argue that culture influence mental health attitudes and help seeking behaviour in Nigeria.

A number of studies have explained the ways that conceptions of madness vary across cultures (Wig 1999; Gureje et al. 2007; Lauber and Rössler 2007; Barke et al.2011; Islam and Campbell 2014). For example, Wig (1999), in a review of the role of spirituality in the life of an Indian established that Indian belief in mental illness differ from Western theory of body and mind dichotomy. Spirituality is at the core of existence of Indians who practise many of the popular religions of the world: Islam, Christianity, Judaism, Hinduism, Buddhism, Jainism, Sikhism, and Zoroastrianism.

Similarly, in a comparative study of widespread mental health stigma in Western and developing Asian countries, Lauber and Rössler (2007) reported a similarity in perceptions of violence and aggression in the mentally ill. Also, stigma of mental illness has been reported in African societies (Gureje et al. 2007; Barke, Nyarko and Klecha 2011). However, the presence of stigma in Western, Asian and African continents does not signal a similarity in the cultural manifestation of stigma. For example, stigma in Southern Ghana has been reported in the social use of the term "headache clinic". Historically, Headache Clinic referred to the first psychiatric clinic in Ghana and was adopted in order to evade the "taboo" people of Ashanti culture in Southern Ghana ascribed to mental illness (Barke et al.2011). A similar example can be found in ways geographical areas where mental institutions are located have become terms used to refer to the mentally ill in Nigeria. For example, terms like 'yaba' or 'yaba left' in reference to Federal Neuro-Psychiatric hospital located in Yaba, a province in Lagos; and 'aro' in reference to Neuropsychiatric Hospital located in Aro, a province in Abeokuta, are now been used arbitrarily to refer to bizarre behavioural traits.

Similarity also exists in belief and religious practises associated with mental illness in African and Asian communities. Explanations of causes and treatments of mental illnesses from spiritual, religious and magical perspectives can be found in both continents. This view is contextualised in situations where traditional and science-based help seeking approaches are assembled in resolving distress when encountered by people; with traditional healers enjoying popularity and social acceptance more than psychiatry (Gureje et al. 2005; Lauber and Rössler 2007).

Contrary to accounts of stigma in western societies, the mentally ill may be less stigmatised in Arab/Muslim countries (Lauber and Rössler 2007). Reduced stigma in Muslim communities has been observed in perception of causes of mental illness or insanity sometimes attributed to brain dysfunction or humoral imbalance. To further understand how mental illness is understood in Muslim communities, Islam and Campbell (2014) embarked on a thematic analysis of four English translations of the Muslim religious book, the Holy Quran. The aim was to explore evidences that suggest a connection between spiritual possession and mental disorders or "madness". The result from Islam and Campbell's (2014) study show that a common belief in attributing mental illness to jinn-possession in Muslim communities may be linked to a pagan practice that is targeted at taunting and labelling people. Islam and Campbell argue that belief in jinn–possession as causes of madness is deeply entrenched in the ideological framework of Muslim communities. The source of this ideological representation is Islamic religion (the Quran). The argument here is that belief in jinn-possession among Muslims may have led to under-utilisation of main stream mental health care services. Their study suggests that, although madness and possession appeared in contents of the Quran, correlation between mentions of madness in the Quran and jinn-possession was not confirmed. Their study also demonstrated that association of jinn–possession with madness is a pagan view that is inconsistent with the message of Islam (Islam and Campbell 2014).

However, this led them to argue that stigma associated with mental illness in Muslim communities is multifaceted. Self-stigma becomes apparent in widespread belief that the spiritually weak become mentally ill from the devil's influence. Community/family stigma exists in communities that thrive on evil possession in causal explanations of mental illness. A major limitation to the argument made by Islam and Campbell (2014) on the non-existence of a direct connection between jinn-possession and madness in the Quran, is in the idea that analysis of the content of the Quran is incomplete without reference to the Sunnah, statement and actions of the Prophet of Islam, Muhammad. Within the Muslim community, the Quran and Sunnah are primary sources from where guidance is sourced. For example, the exact way of carrying out some religious rituals such as the performance of the five daily prayers and ritual baths are not directly described in the Quran, but prayers and ritual baths are observed in specific ways across all Muslim communities. This is so because teachings of the Sunnah are as important as contents of the Quran among Muslims. Thus, the fact that there are no direct references made to jinn-possession and mental illness in the Quran do not discredit belief in jinn-possession as an acceptable cultural interpretation of causes of mental illness in Muslim communities. The argument here is that if jinn-possession exists in Sunnah teachings, then attributing causes of mental illness to jinn-possession has a credible connection to the core values of Muslims.

Furthermore, the prominence of science-based mental health in Western cultures and the inability to scientifically prove efficacy of spiritual or religious beliefs in mental health does not imply that psychiatry is a better option for attending to issues bordering on mental health. In a situation where superiority is attributed to psychiatry over many possible alternative explanations of causes and treatments of mental illness, a steer towards ethnocentrism is observable. According to Wig (1999), ethnocentrism is reflected when psychiatry or spiritual beliefs are promoted as a better belief system over another. Although, Wig (1999) speculated that we may be 'moving towards some kind of merger between spiritual and scientific cultures', especially because the social influence of psychiatry appear to be waning from source: in its conception of diagnosing mental illness; and in its explanation of why psychiatry is superior to other options (Porter 2002). Illustratively, Wig (1999) argues that psychiatry identified excesses in certain qualities of man as mental disorders by leaving others out. Thus, the criteria for deciding how excesses of some and not all human qualities attract description as mental disorders have been questioned. Excess of anxiety and depression are interesting examples of human qualities that psychiatry has chosen to refer to as mental disorders. On the other hand, excess of human qualities such as greed, lust, or wickedness have been left out as forms of mental disorders. In other words, psychiatry as a science-based guideline for explaining causes and treatments of mental illness may be insufficient to attend to mental health needs across cultures. These lapses that exist in some explanations of mental illness by psychiatry may affect absolute absorption of psychiatry in Asian and African nations, thus the suggestion that psychiatry may need to look at culturally associated practices of mental health in African and Asian nations to improve existing practices of psychiatry (Wig 1999; Fernando 2007). This is so because explanations of mental illness are incomplete without explanations from social and cultural contexts (Agbayani-Siewert, Takeuchi and Pangan 1999)

Although, medicine in its nature suspends belief in the supernatural (Porter 2002), the claim that psychiatry is superior to other options of attending to mental illness is yet to be fully embraced in African and Asian communities as studies show that belief in the supernatural is still prominent in these communities (Wig 1999; Gureje et al. 2005; Atilola and Olayiwola 2011a; Islam and Campbell 2014; Aroyewun-Adekomaiya & Aroyewun 2019). Although, there may be need for further studies to explore reasons why differences occur in treatment values of psychiatry and alternative methods; and why people prefer to uphold spiritual explanations over psychiatry in African and Asian settings (Heaton 2013a; Islam and Campbell 2014), the presence of ethnocentrism, the view that psychiatry is superior to many other possible explanations of causes and treatments of mental illness, may hinder absolute absorption of psychiatry in African and Western nations (Wig 1999; Fernando 2007).

4. Summary

In summary, the theory of social construction of reality emphasises the role of language, experience and social practice in the way reality is conceptualised. The diversity in representations of reality clearly points to truth as a relative component of reality. Reality in African clime is that magically explainable causes have constituted a major model for explaining mental illness. This is the truth as perceived by many and represented in social structures such as the media and religious beliefs. The role of investigating if the media is responsible for the continued existence of such belief is a reason for further empirical inquiry. However, from the argument so far, religion is a significant social structure that impacts ways mental illness is understood in African and Asian societies. Also, belief in magic and spiritualism as major underpinnings of interpreting causes and treatments of mental illness, particularly in Nigeria, may be suggestive that these conceptions of reality are constructions that media and religion produce or reproduce from existing constructions that reside in cultural and historical beliefs in mental illness. The less prominence of psychiatry in media representations and conflicting conceptualisation of mental illness in religious and psychiatric settings do not suggest an outright rejection of psychiatry in these societies. Since religion plays an important role in the way mental illness is understood, the question is, do the views and explanations psychiatry provides for explaining mental illness confirm or negate some important components that nurture cultural beliefs in mental illness? Also, how effectively has psychiatry striven to position itself as an important social agency in African and Asian societies in other to play the role of formulating and reproducing views that would become dominant in these societies? These are important questions further research will need to provide answers to.

5. References

i.   Aina, O. F. (2004). Mental illness and cultural issues in West African films: Implications for orthodox psychiatric practice. *Medical Humanities,* 30, 23-26. [Online] Available at http://mh.bmj.com/ Accessed: 22/ 07/ 2014.

ii.   Aroyewun-Adekomaiya, K.& Aroyewun F. T. (2019). Representation of mental illness in movies: a Nigerian perspective. *African Journal for the Psychological Studies of Social Issues,* 22(2),103 – 117. [Online] Available at ajpssi.org Accessed: 15/ 08/ 2019.

iii.   Atilola, O.& Olayiwola, F. (2011a). Mind frames in Nollywood: Frames of mental illness in Nigerian home videos. *Research journal of medical sciences,* 5(3),166-71. [Online] Available at http://docsdrive.com/pdfs/medwelljournals/rjmsci/2011/166-171.pdf [Accessed: 23/03/2015].

iv.   Atilola, O. & Olayiwola, F. (2011b). The Nigerian home video boom: Should Nigerian psychiatrists be worried? Lessons from content review and views of community dwellers. *International journal of social psychiatry,* 58(5), 470-476. [Online] Available at http://bjp.rcpsych.org/ [Accessed: 08/09/2014].

v.   Ayonrinde, O., Gureje, O. & Lawal, R. (2004). Psychiatric research in Nigeria: Bridging tradition and modernization. *British journal of psychiatry: Psychiatry round the world,* 184, 536–538. [Online] doi: https://dx.doi.org/10.1192/bjp.184.6.536 [Accessed: 28/03/2017].

vi.   Barke, A. Nyarko, S. & Klecha, D. (2011). The stigma of mental illness in Southern Ghana: Attitudes of the urban population and patients' views. *Social Psychiatry and Psychiatric Epidemiology,* 46, 1191–1202 [Online] doi: 10.1007/s00127-010-0290-3 [Accessed: 30/ 08/ 2016].

vii.   Barker, C. (2004). *The Sage dictionary of cultural studies.* London: Sage.

viii. Barnes, C. & Mercer, G. (2004). Theorising and Researching Disability from a Social Model Perspective.In C. Barnes&G. Mercer (Eds.) *Implementing the Social Model of Disability: Theory and Research*(Ch. 1, pp. 1-17). Available at http://disability-studies.leeds.ac.uk/research/ [Accessed: 15/12/2016].

ix.   Barnes, C. & Mercer, G. (2005). Understanding Impairment and Disability: towards an international perspective. [Online]. C. Barnes &G. Mercer (Eds.) *'The Social Model of Disability and the Majority World.* (Ch. 1, pp. 1-16). Available at http://disability-studies.leeds.ac.uk/files/library/Barnes-EMW-Chapter-1.pdf[Accessed: 25/11/2016].

x.   Berger, A. A. (1991). *Media analysis techniques.* California: Sage.

xi.   Berger, A. A. (2014). *Media and communication research methods: An introduction to qualitative and quantitative approaches.* Los Angeles: Sage.

xii.   Berger, P. L. And Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge.* England: Penguin Books.

xiii. Bhugra, D. (2006). Severe mental illness across cultures. *Acta Psychiatra Scrand,*113, 17–23. [Online] doi: 10.1111/j.1600-0447.2005.00712. x. [Accessed: 30/08/2016]

xiv.   Burr, V. (1998). Overview: Realism, relativism, social constructionism and discourse. In I. Parker (Ed.) *Social constructionism, discourse and realism.* London: Sage.

xv.   Burr, V. (2003). *Social constructionism* (2nd ed). London: Routledge

xvi.   Coëgnarts, M. And Kravanja, P. (2012) Embodied visual meaning: Image schemas in film. *Berghahn Journals,* 6(2), 84–101.[Online] doi: 10.3167/proj.2012.060206 [Accessed: 26/01/2017].

xvii. Collier A. (1998). Language, Practise and Realism. In I. Parker (Ed.) *Social constructionism, discourse and realism.* London: Sage

xviii. Cross, S. (2010). *Mediating madness: Mental distress and cultural representation.* Hampshire: Palgrave Macmillan.

xix.   Cross, S. (2014). Mad and bad media: Populism and pathology in the British tabloids. *European Journal of Communication,* 29(2), 204–217 [Online] Available at http://journals.sagepub.com/doi/abs/10.1177/0267323113516734 [Accessed: 29/07/2015]

xx.   Davis, L. J. (2006). Constructing normalcy. In Davis L. J. (Ed.) (2006). *The disabilities studies reader.* New York: Routledge.

xxi.   Demyan, A. L. (2009). *The effects of a brief, mass-media intervention on attitude and intention to seek professional psychological treatment.* Unpublished doctoral thesis, Ohio University, College of Arts and Sciences.

xxii. Dill, K. E. (2009). How fantasy becomes reality: Seeing through media influence. New York: Oxford University Press.

xxiii. DSM-IV (1994). *Diagnostic and statistical manual of mental disorders: Fourth edition.* American Psychiatric Association: Washington.

xxiv. Entman, R. M. (1993) Framing: Towards clarification of a fractured paradigm. *Journal of communication,* 43(4), 51–58. [Online] Available at https://www.researchgate.net/profile/Robert_Entman/publication/209409849_Framing_Toward_Clarification_of_A_Fractured_Paradigm/links/0deec52e3d7f32deb3000000.pdf [Accessed: 20/12/2016]

xxv.   Entman, R. M. (2007) Framing bias: Media in the distribution of bias. *Journal of communication,* 57, 163–173. [Online] Available at file:///C:/Users/Khadijah/Desktop/Framing%20bias,%20media%20in%20the%20distribution%20of%20power.pdf [Accessed: 20/12/2016]

xxvi. Fernando, S. (2007). Spirituality and mental health across cultures. In P. Gilbert, T. Gordon And F. Bill (Eds.) *Spirituality, Values and Mental Health: Jewels for the Journey,* Ch. 3. Jessica Kingsley Publishers: [n.p].

xxvii.   Fernando, S. (2010). *Mental health, race and culture.* Hamsphire: Palgrave Macmillian.

xxviii.   Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). New York: Vintage Books

xxix.   Gamson, W. A., Croteau, D., Hoynes, W. & Sasson, T. (1992). Media images and the social construction of reality. *Annual review of sociology*, 18, 373-393. [Online] Available from: http://www.jstor.org/stable/2083459 [Accessed: 24/04/2015].

xxx.   Gureje, O., Lasebikan, V.O., Ephraim-Oluwanuga, O., Olley, B.O. & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *British journal of psychiatry,* Issue 186, 436-441. [Online] Available at http://bjp.rcpsych.org/content/186/5/436 [Accessed: 20/02/2016]

xxxi.   Gureje, O., Chisholm, D., Kola, L., Lasebikan, V. & Saxena, S. (2007). Cost-effectiveness of an essential mental health intervention package in Nigeria. *World Psychiatry*, Issue 6, 42-48. [Online] Available at http://www.who.int/choice/publications/p_2007_cea_mental_health_Nigeria.pdf [Accessed: 18/11/2016].

xxxii.   Gilman, S. L. (1988). *Diseases and representation: Images of illness from madness to AIDS.* Ithaca: Cornell University.

xxxiii.   Happer, C. & Philo, G. (2013). The role of the media in the construction of public belief and social change. *Journal of social and political psychology,* 1(1), 321- 336. [Online] Available at http://jspp.psychopen.eu/article/view/96/37 [Accessed: 30/04/2016.

xxxiv.   Harper, S. (2005). Media, madness and misinterpretation. *European journal of communication,* 20(4), 460-483. [Online] Available at http://www.inquiriesjournal.com/articles/129/exclusion-misrepresentation-and-discrimination-still-prevalent-for-women-in-american-media-and-politics [Accessed: 23/07/2015].

xxxv.   Heaton, M. (2013a). *New African histories: Black skin, white coats: Nigerian psychiatrists, decolonization, and the globalization of psychiatry.* Athens: Ohio University Press

xxxvi.   Henderson, L. (1996). Selling suffering: mental illness and media values. In G. Philo,(Ed.) *Media and mental distress.* Harlow: Addison Wesley Longman.

xxxvii.   Islam, F. And Campbell, R. A. (2014). "Satan has afflicted me!" Jinn-possession and mental illness in the Quran. *Journal of religion and health.,* 53, 229-243. [Online] doi: 10.1007/s10943-012-9626-5 [Accessed: 30/08/2016].

xxxviii.   Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M. & Mcdaid, D. (2006). *Economic barriers to better mental health practice and policy,* 157-170. London: Oxford University Press. [Online] Available at http://heapol.oxfordjournals.org/ [Accessed: 08/09/2014].

xxxix.   Knifton, L. & Quinn, N. (2008).Media, mental health and discrimination: a frame work for understanding reporting trends. *The international journal of mental health*, 10(1), 23-31. [Online] http://www.scie-socialcareonline.org.uk/media-mental-health-and-discrimination-a-frame-of-reference-for-understanding-reporting-trends/r/a1CG0000000GPMpMAO [Accessed: 16/03/2016].

xl.   Lauber, C. & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International Review of Psychiatry,* 19(2), 157- 178. [Online] doi: 10.1080/09540260701278903 [Accessed: 30/ 08/ 2016]

xli.   Maier, J.A., Gentile, D.A., Vogel, D.L., & Kaplan, S.A. (2013). Media influences on self-stigma of seeking psychological services: The importance of media portrayals and person perception. *Psychology of Popular Media Culture.* [Online] doi: 10.1037/a0034504 [Accessed: 11/11/2014].

xlii.   Philo, G. (Ed.) (1996). *Media and mental distress.* Harlow: Addison Wesley Longman.

xliii.   Philo, G., Mclaughlin, G., & Henderson, L. (1996). Media content. In G. Philo (Ed.) *Media and mental distress.* Harlow: Addison Wesley Longman.

xliv.   Philo, G. & Miller, D. (2000). Cultural compliance and critical media studies. *Media culture & society,* 22, 831-839. [Online] Available at http://journals.sagepub.com/doi/abs/10.1177/016344300022006007 [Accessed: 29/07/2015].

xlv.   Porter, R. (2002). *Madness: A brief history.* New York: Oxford University Press.

xlvi.   Rashed, M. A. (2013). Culture, salience, and psychiatric diagnosis: exploring the concept of cultural congruence & its practical application. *Philosophy, ethics, and humanities in medicine,* 8(5), 1-12. [Online] Available at http://www.peh-med.com/content/8/1/5 [Accessed: 12/05/2016].

xlvii.   Reeve, D. (2004). *Psycho-emotional Dimensions of Disability and the Social Model.* [Online] In C. Barnes & G. Mercer (Eds.) *'Implementing the Social Model of Disability: Theory and Research'* (Ch. 6, pp. 83-100). Available at http://disability-studies.leeds.ac.uk/files/library/Barnes-implementing-the-social-model-chapter-6.pdf [Accessed: 15/12/2016].

xlviii.   Sapouna, L. (2012). Foucault, Michel (2001) Madness and Civilization: A history of insanity in the age of reason, London, Routledge classics. *Oxford University Press and Community Development Journal.* [Online] doi:10.1093/cdj/bss032 [Accessed: 18/02/2017]

xlix.   Szasz, T. S. (1974). *Perspectives in abnormal behavior: Pergamon General Psychology Series.* New York: Pergamon Press.

l.   Szasz, T. S. (1987). *Insanity: The idea and the consequences.* New York: John Wiley & Sons.

li.   Vogel, D.L., Gentile, D.A., & Kaplan, S.A. (2008). The influence of television on willingness to seek therapy. *Journal of clinical psychology*, 64(3), 276–95. [Online] Available at http://onlinelibrary.wiley.com/doi/10.1002/jclp.20446/abstract [Accessed; 12/12/2015].

lii.   Wahl, O. F. (1992). Mass media images of mental illness: A review of the literature. *Journal of community psychology*, 20, 343–52. [Online] Available at https://rampages.us/univ200spring2015/wp-

content/uploads/sites/4894/2015/02/Mass-Media-Images-A-Review-of-the-Literature.pdf[Accessed: 05/03/2016].

liii. Wahl, O. F. (2003). News media portrayal of mental illness: Implications for public policy. *The American Behavioral Scientist,* 46(12), 1594 – 6000. [Online] Available at http://abs.sagepub.com/cgi/content/abstract/46/12/1594 [Accessed: 02/10/2014].

liv. Wig, N. N. (1999). Mental health and spiritual values. A view from the East. *International Review of Psychiatry,* 11, 92–96. [Online] Available at http://www.tandfonline.com/doi/abs/10.1080/09540269974230 [Accessed: 30/08/2016].