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SOCIAL CAPITAL AND MENTAL HEALTH ISSUES IN THE NIGERIAN ENVIRONMENT

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Abstract
Social capital is an integral part of group dynamism and individual fulfilment as members of the human society. There is now increasing evidence as to the role played by social factors in the contribution to genesis and manifestations of mental health in modern society. This paper focuses on the importance of social capital in the socio-psychological and economic wellbeing of Nigerians. The paper specifically explores and examines the nexus between the social capital base of the individuals in the society and the levels of the incidences of mental/health problems in Nigeria. The paper examines the correlates with the size and complexity of an individual's social network, the spatial distance between an individual and the social world. Many Nigerians today are going through mental trauma occasioned by the harsh economic realities and breakdown of socio-cultural fabrics of the society and these have a far reaching impact on the mental health of Nigerians. The policy implication of this situation is discussed at the end of the paper.

Key words: *mental health; social capital; society; social networking; stigma; cultural values*

REVIEW

INTRODUCTION

Man by nature is a social being and finds fulfilment through association and interactions with other members of the environment and groups. Our membership of the various human groupings in the society shapes our personalities, dispositions, behaviours, perceptions and other aspects of our being. The forces that shape the quality of social interactions and social institutions in human society are what are known as social capital. Humans are social beings hence, the most important expression of this sociality is that we live, and have evolved to live in social groups. This basic fact has shaped not only what we do but also how our minds have evolved to enable us to do what we want to do at any point in time. Groups are not simply external features of the world that provide setting for our behaviour, instead, they shape our psychology through their capacity to be internalized and contribute to our sense of self. That is, groups provide us with a sense of social identity: knowledge that we belong to certain social groups together with some emotional and value significant to us of the group's membership (Tajfel 1972, Haslam et al. 2009). Global burden of disease estimates place mental illness in the top three causes of years lost due to disability. Wide variations in the rates of mental illness between geographical areas underline the need to investigate social and environmental causes. Building or sustaining healthy communities is now

considered an important weapon in a state's strategy to prevent mental health (De Silva et al. 2004).

Social capital refers to the dimension of social relationships which might facilitate cooperation for the achievement of common goals (Islam et al. 2006). Social capital is associated with better government performance, the functioning of democracy, the prevention of delinquency and also to improve health status (Kawachi et al. 1999, Fitzpatric et al. 2005, Kim and Kawachi 2007, Harpham 2009). Social scientists, policy makers and international institutions such as the World Health Organization (WHO) and the World Bank stated that social capital contributes to health inequalities within and between populations. There are many definitions of social capital but most of the definitions overlap one another. Social capital is a way of describing social relationship within societies or group of people. The most accessible definition and conceptualization of social capital used in the health sciences originates with its founder (Bourdieu 1986, Putnam et al. 1993). Social capital consisted of the following characteristics, namely: community networks, voluntary, state, personal networks, and density, civic engagement, participation and use of civic networks, local civic identity – sense of belonging, solidarity, and equality with other members, reciprocity and norms of cooperation, a sense of obligation to help others, and confidence in return for assistance; trust in the community (Ramlagan et al. 2013).

Similarly, Lochner et al. (1999) posited that "social capital is a feature of the social structure of the society: it is an ecologic characteristic. In this way social capital can be distinguished from the concepts of social networks and support, which are attributes of individuals" (p. 260). Social capital is the capital and resources that people and groups can achieve through relationship (and type of relationship) with one another. The positive impacts of social capital are represented in five domains of economic growth, preventing social damages, physical and mental health, affectivity of government and political institutions and improving educational operation. Societies that their rate of social capital decreases for any reason they face raptures and great gaps (Rafiejirdehi and Khothehsara 2013).

The aim of this paper is therefore to identify the nexus between social capital and mental health in the context of the social, economic and other realities of the Nigerian society. The paper specifically attempts to analyse the various indices of the adverse effects of the harsh economic situations occasioned by globalization, economic meltdown and other negative economic indices of the Nigerian economy. The paper further attempts an in-depth examination of the various cleavages, disenchantment, isolation, squalor, poverty, destitution, abandonment, alienation, and other problems occasioned by harsh socioeconomic, cultural and political realities of the Nigerian society.

Conceptual and theoretical clarifications

While there are a number of definitions that draw upon the work of Putnam et al. (1993) and Coleman (1990), the context in which we use social capital here refers to the degree of connectedness and the quality and quantity of social relations in a given population. One of the conceptualization of social capital (Bain and Hicks 1998), cited in Krishna and Shrader (2000) disaggregates the resource into two components: structural and cognitive. The structural component includes extent and intensity of associational links or activity, and the cognitive component covers perceptions of support, reciprocity, sharing and trust. At the simplest level, these two components can be respectively characterized as what people do and what people 'feel' in terms of social relations (Harpham et al. 2002). A vital aspect of social capital is social bonding which Narayan (1999) defines as social cohesion within the group structure, while the other aspect is the bridging capital which refers to the type of social capital that links or cuts across different communities/groups. The bonding and bridging social capital construct partially overlaps with the horizontal/vertical construct of social capital which views social capital as either horizontal based, meaning that it inheres in the relationships between similar individuals or group in the same social context, such as between individuals, between communities or between youth groups, or vertically based meaning that it

inheres in the relationships between levels of society (e.g. community, local government, state government). The bonding and bridging construct is important as it highlights the role of government and the state within social capital and hence the relevance of political context.

Social capital is a way of describing social relationships within societies or groups of people. The conceptualization of social capital consists of five principal characteristics namely: (1) community networks, voluntary, state, personal networks, and density; (2) civic engagement, participation, and use of civic networks; (3) civic identity – sense of belonging, solidarity, and equality with other members; (4) reciprocity and norms of cooperation, a sense of obligation to help others, and confidence in return of assistance; (5) trust in the community (Coleman 1990). In the context of this paper the five tenets of social capital will be enunciated with special reference to the Nigerian society.

The theory of social capital emphasizes multiple dimensions within the concept. For example, social capital can be divided into a behavioural/activity component (for example participation) and a cognitive/perceptual component (for example, trust). These are referred to as structural and cognitive social capital and can also refer to linkages and perceptions in relation to people who are similar to each other such as others in one's own community or people of the same socioeconomic status (called bonding social capital), or to people who are different, such as people outside one's community or with a different social identity (called bridging social capital). Social capital can also occur through formal institutions such as between a community and local government structures, and this is termed linking social capital (Portes 1998). Social capital is capital and resources that people and groups can achieve through relationship (and type of relationship) with each other. The positive impacts of social capital are represented in five domains of economic growth, affectivity of government and political institutions and improving educational operation. Societies that their rate of social capital decreases for any reason, scientists of social capital believe that if social capital is not recreated by such society, it corrupts and fades also. If social relations are not preserved, it gradually disappears and norms depend on regular relationships (Biro 2001). Theorists believe that various factors are influential in the creation, preservation and decreasing of social capital.

In Pierre Bourdieu analysis, social capital has three different forms: economical capital that is changeable to money and is a potential factor in the right of ownership; cultural capital that under specific condition is changeable to economical capital and necessitates educational grades; finally, social capital that under specific conditions is changeable to economical capital and is represented in the form of identity and fame. The interpretation here is that social capital is the result of some types of personal or collective investment that is conscious or unconscious, that is looking for stabilization or reproduction of social relations that can be used directly in short term and long term (Kemande 2002). Therefore, social capital is a kind of accessing tool to economic and cultural resources through social relationship and it is a type of social product that is the result of social interaction.

Dimensions of social capital

Generally, social capital is a set of rules, norms and commitments, mutual relationship and trust in social relations, social structures and institutional hierarchy in the society that makes the members able to access personal and collective purposes. There are three dimensions of social capital and these are trust, participation and relationship (Inglehart 1994).

Trust

Trust is an individual's intention to risk a social situation. This tendency is based on the sense of insurance/social security to the point that others behave in the way that they expect and they get the supporting pattern as their duty. Trust is an expression and expectation that shows itself in a regular society by representing cooperative behaviour.

Participation

Participation means well-intention cooperation of every kind of forgiveness and voluntary help to others. Other than one's family and relatives. This also includes religious participation and in activities that

are derived from collective activities. Political participation means involvement of an individual in different levels of activities in political system from lack of conflict to having a formal political position and activities of private citizen to effect on the process of government's political decision making (Huntington 1994, Spellerberg 2001).

Relationship

Relationship means every type of relationship between two or several persons. This relationship can be in the form of independence, interaction and connection. The concept of relation means creating specific relationship features or process that through them the two-phenomena are related to each other.

The notion of societal conditions and the social environment as fundamental causes of health and disease is not new, dating back more than a century to the works of Durkheim and Virchow (Link and Phelan 1995). Social capital, a major attribute of the social environment, has garnered scientific and government attention over the last decade as a plausible broad determinant of population, health, educational outcomes, and economic growth (Kawachi et al. 2007). Social capital may be a property of context/collectives or individual's social network (Flap 1991, Berkman and Kawachi 2000). The novelty of social capital lies at the former collective level where it has been defined according to some scholars, as the features of social organization including trust, civic participation and reciprocity norms facilitating cooperation for mutual benefit (Putnam 2000).

At the contextual level, social capital may serve as a "public good" with positive spill over effects onto the health of members of a broader society. For example, collective will across a country may be mobilized to enact health promoting policies with potential benefits to all citizens. Comparatively, work by Putnam favours such a policy-related mechanism. He ascribes the story social bonds and high civic engagement in selected regions in Italy as the driving force behind the presence of smoothly functioning democracies (Putnam et al. 1993). Leverage social capital may therefore be a powerful means to improve the health of the population. The adverse effects of income inequality have been posited to take place, at least in part, through the erosion of social capital/cohesion (Kim et al. 2008, Kondo et al. 2009).

At the individual level, social capital may yield beneficial private health returns to personal investments. For instance, participation in a civic group boost one's health through psychosocial processes such as social support (Kim and Kawachi 2006).

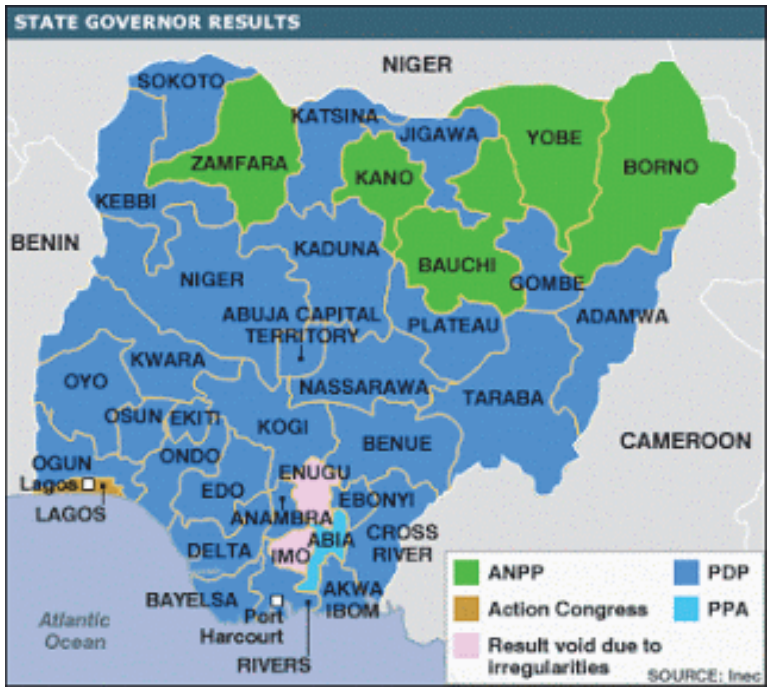
Despite the fact that multiple studies have investigated the relations between social capital at a contextual level (i.e. at the level of entire countries, states or neighbourhoods/communities), and general health and disease specific outcomes (e.g. cardiovascular disease, cancer) but findings have been conflicting to date (Lynch et al. 2001, Almedom 2005). A systematic literature (Abe-Kim et al. 2007) found that multilevel studies showed weaker, modest association for contextual trust than individual-level trust, and that the former estimates became attenuated to non-significance after controlling for the individual level of trust. (Kim et al. 2012).

Studies have explored associations between social capital measured at the country level and individual self-rated health (Poortinga 2006, Mansyur et al. 2008). While the findings to date, would appear to discount the utility of leveraging contextual social capital to improve the health of the population, their interpretation is challenged by fundamental concern which plagues this burgeoning literature; all of these studies which have been observational in design have relied on conventional regression estimates, and are prone to bias because the exposure (social capital) does not randomly vary – a problem referred to as "endogeneity". Endogeneity may result in bias which may occur if one estimates country-level associations of social capital with health, but fails to account for unobserved country characteristics correlated/co-varying with social capital, leading to spurious statistical relationships (Kim et al. 2009). But isolating the random variation in exposures, instrumental variables can overcome such bias and can yield more valid effect estimates (Wooldridge 2010).

Social capital and mental health in Nigeria

Nigeria is located in West Africa in the southern hemisphere and is the most po-

pulous nation of Africa (see Fig. 1). It is bounded to the north by Niger and Chad, to the east by Cameroon, to the south by the Atlantic Ocean and to the West by Benin Republic (Nwachuku and Uzoigwe 2004). Nigeria is a very large country with a total area of 923,768 sq. km. The National Population Commission (2011) reported that Nigeria's population is 167 million, while the CIA World Factbook reports that Nigeria population is now 174,507,539 (July 2013 estimate). Nigeria is equally multicultural with over 350 cultures, languages and a religiously volatile population along an ethno-religious divides (World Bank 2006). Nigeria accounts for 47 percent of West Africa's population and 41 percent of the region's Gross Domestic Product (GDP) (World Bank 2006), although a recent estimate of GDP was 455.5 billion dollars (CIA 2012).



Source: CIA Fact Book (2012)

Fig. 1. Map of Nigeria showing the states and the strenght of political parties before the merger of all opposition parties to form APC against ruling party the PDP

The six geopolitical zones of Nigeria:

1. **North Central States:** Kogi, Niger, Benue, Kwara, Plateau, Nassarawa and the Federal Capital Territory.
2. **North-Eastern States:** Taraba, Borno, Bauchi, Adamawa, Gombe and Yobe State.
3. **North-Western States:** Kaduna, Kebbi, Zamfara, Sokoto, Kano, Jigawa and Katsina State.
4. **South-Eastern States:** Ebonyi, Enugu, Imo, Abia and Anambra State.
5. **South-Southern States:** Akwa-Ibom, Bayelsa, Edo, Cross River, Rivers and Delta State.
6. **South-Western States:** Oyo, Ogun, Lagos, Ondo and Osun State.

Nigeria is a country of ethnic diversity with a population of over 170 million people and over 250 local languages with English language being the common official language. The country has 36 states with Federal Capital

Territory (FCT) in Abuja but is divided into six geo-political zones: South-South, South-East, South-West, North-East, North-West and North Central.

Nigeria National Mental Health Policy and National Plan were formulated to integrate Mental Health care into Primary Health services only in 1991. By promulgating this policy mental health became the ninth component of Nigeria's primary health care (PHC) services (promote, protect, prevent, restore and rehabilitate) that will ensure a socially and economic productive and fulfilling life to every individual. Despite the 1991 policy, mental health care services have been systematically excluded from Nigeria's Primary Health Care (PHC) facilities (Gureje and Alem 2000, WHO-AIMS 2005) with no trained psychiatric health professionals being stationed at Community Health Center. Public service mental health care facilities are only provided at twelve hospitals in the country with eight Schools of Psychiatric Nursing and twelve Medical Schools to serve a population of over 150 million people (Jack-Ide et al. 2012).

Ismaila and Usul (2013) carried out a research to estimate diseases and mental health situation in Yola and environs in North Eastern Nigeria and concluded that there is still gross inadequacy both in terms of health facilities and physicians. These situations worsen the situation of mental health and other related diseases in the North East geo-political zone of Nigeria. A similar study was carried out in Kaduna Metropolis and environs by Aliyu and Shebe (2013), the result of that study revealed that Kaduna state and other states in the North Central geo-political zone on Nigeria need to establish more hospitals and primary health care centers to cater for many people who cannot access the health facilities in the area.

In the South-South Nigeria, Jack-Ide et al. (2013) reported in the study of mental health situation in the Niger delta that it is evident from the results that mental diseases are on the rise in the geopolitical zone where only two Federal Neuropsychiatric Hospitals serve the entire zone. More importantly, the study reveals that religious and traditional healers are the first choice for treatment of mental health cases. The finding is similar to a previous study in the South Western geopolitical zone of Nigeria by Lasebikan et al. (2012), which indicated that though mental health cases are on the increase in the region. The result shows that 78.9% of the respondents first sought treatment from spiritual healers due to their confidence in the efficacy of the herbal cure for mental ailments. In Nigeria, evidence shows that people with signs and symptoms of mental health issues usually first patronize traditional health providers like herbalists, diviners, traditional/religious healers rather than consult doctors at the primary care centers or general physicians. However, religious/traditional healers play minor roles in the mental health care services pathways because the services have failed to reduce the steady increase in mental health cases (Odejide and Marakinyo 2003, Nonye and Oseloka 2009, Ogunsemi et al. 2010, Jack-Ide et al. 2013). The mental health situation in Nigeria is adversely affected by the centralization of the Mental Hospitals. As earlier mentioned, there are twelve Mental Health Hospitals for the entire Federal Republic of Nigeria's population of 176,544 million people. Of these twelve hospitals, eight hospitals are owned by the Federal Government and these hospitals are located in the six geopolitical zones. South Western geopolitical zones have three Neuropsychiatric hospitals and this enhances the citizens' access to mental health care in the area. The remaining four are owned by State Governments.

In Nigeria, the incidence of mental health is steadily on the increase. The reasons adduced for this increase include (but not limited to) the harsh socio-economic realities, the state of normlessness, the breakdown of socio-cultural bonds and communalistic life style of Nigerians, the embrace of individualistic life style of Nigerians and the isolation of the less privileged and vulnerable members of the society who are exposed to the negative effects of the vagaries and vicissitudes of the comatose economy of Nigeria. The gradual breakaway from the communalistic life style where people are their brother's keeper and where the social solidarity and bond between the people was very strong, as a result of harsh economic realities of Nigeria help to reduce the effectiveness of social capital which Nigerians were hitherto known for.

Mental health problem is on the increase also because of breakdown of cultural value

systems of the Nigerian people. Prior to the advent of colonialism and the eventual introduction of capitalism into Nigeria, wealth of the community were equitably shared among the members of the society. The less privileged and even the indigents were catered for. The rich and powerful members ensure that his/her people are assisted in one way or the other. Mental health cases were rare then. The introduction of capitalism whereby one person is richer than 20 million persons in Nigeria resulted in rich people secluding themselves from others and focusing on their immediate nuclear family members only. The state of despair and level of helplessness are therefore on the increase because of the frustrations among the youths, the aged and even the able bodied members of the society who are for example unemployed or very poor. The level of dejections and frustrations leads to despairs, depression and later schizophrenic disorder, and sometimes full-blown mental illness.

The second reason for the increase is because of the secrecy and stigma associated with mental health. This is also a fall-out of the decline in social capital capacity of an average Nigerian in the society. In Nigeria, mental illness is always associated with the supernatural. Nigerians believe in the supernatural causality of mental health issues, irrespective of their educational status (Odejide et al. 1989, Aina 2004). The secrecy associated with mental health always compels people with mental health cases to prefer treatment in spiritual/traditional healing homes rather than public hospitals where they likely to be seen by people (Kabir et al. 2004, Adewuya and Makenjuola 2009). The poor social capital status of the poor, unemployed, frustrated, dejected and rejected members of the society compounds the mental health problems in Nigeria. When this categories of people listed above develop symptoms of mental illness, there is usually delay a in seeking treatment because of the situation of aloneness, helplessness, poverty, despair and isolation coupled with the stigma associated with mental health cases in Nigerian society. The help seeking behaviour and the exploration of pathways for treatment in neuropsychiatric hospitals are adversely affected.

As earlier mentioned though the National Mental Health Policy and Action Plan of 1991 were formulated to integrate Mental Health Care into Primary Health Services which sought to promote, protect, prevent, restore and rehabilitate people with mental health cases to ensure a socially and economic productive and fulfilling life to every individual, the available or existing neuropsychiatric hospitals in the country are grossly inadequate. The breakdown of social fabric and cultural norms and value systems in Nigeria coupled with the problems associated with individualism; modernism and postmodernism where people are self-absorbed are worsening the incidence of mental illness in Nigeria. Other factors are the unwholesome acquisitive spirit associated with capitalism and the comatose economy of Nigeria, all help to compound the increase in mental health problems in Nigeria. The leaders and those who wield power and authority seem to be interested only in amassing wealth and creating fiefdoms in their domain where they hope to continue to dominate, exploit and oppress the poor and vulnerable members of the society.

Implication for policy development in Nigeria

The importance of social capital in the wellbeing of the individual in every society in the world cannot be overemphasized. The gradual decline in social capital base in Nigeria has serious implications. The level of frustration and helplessness in Nigeria is alarming. Social loafers and uprooted members of the society are on the increase and most of them end up in mental health asylum. There is the need therefore for a strong advocacy, policy shift and commitment to the socio-economic wellbeing of Nigerians. Social workers and the civil society should mount sustained pressure on the need for good governance in Nigeria and for leaders to be responsive and responsible to the Nigerian populace.

There is also the need for cultural revival and re-evaluation of our so-called civilization and modern ways of doing things where Nigerians are now care less about others in the society including our extended family and kin group members. Being our brother's keepers

will help reduce the level of frustration, helplessness and hopelessness which is mostly the remote and immediate causes of mental health problems in Nigeria. The revival of the family values, bond and communalistic life style that Africans are known for will in no small way reduce the incidences of mental health problems in Nigeria. Most people take to drugs or slip into depression out of despair and frustrations. There is the need to retrace our footsteps in the manifestations of the tenets of modernism and post modernism in our dealing with one another as Nigerians. These unfriendly behavioural dispositions to others are alien to Nigerians as a people. Nigerians are known to be loving, caring, accommodating and protective of their fellow community members.

There should be a policy shift in mental health care services in Nigeria. All the 774 Local Government Areas should have a health centre specially established to cater for mental health cases in Nigeria. The present situation where they have to travel long distance to seek medical care in cities is despicable and retrogressive.

CONCLUSION

This paper explores the import of social capital in the socio-psychological and economic wellbeing of the individuals. The dwindling fortunes of the economic opportunities occasioned by the comatose economy results in economic hardships, frustrations, despairs, and hopelessness in the Nigerian society. The social capital base and networking of individuals which help restore confidence and hope in people all over the world is waning in Nigeria. This is because of the radical increase in individualistic life style of Nigerians especially the elites and powerful who now avoid the burden of the 'extra mouth' to care for and hence shut the doors against the less privileged members of the society. The victims of these unfortunate situations are usually the youths, the aged and the physically challenged. The level of the incidences of mental health cases is therefore on the increase among the aforementioned categories of the members of the Nigerian society.

The re-evaluation and revival of the cultural heritage of Nigerians will redress these unfortunate trends in social dislocation of the people because of the dwindled social capital base of the people in Nigeria.

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