Research Article

INTERNALIZED STIGMA AMONG OUTPATIENTS ACCESSING CARE IN A TERTIARY MENTAL HEALTH INSTITUTION IN NIGERIA

Ndubuka, Appolos Chidi1*, Ndubuka, Eucharia Tochukwu2, Odinka, Paul Chigozie3, Amadi, Kennedy Uzoma1, Muomah, Rosemary Chizobam1, Igwe, Monday Nwite4, Oduburu, Cecilia4, Madu, Geraldine4, Odinka, Jaclyn Ifeoma5

1Department of Psychological Medicine, University of Nigeria Enugu Campus
2Department of Nursing Services Federal Teaching Hospital Abakaliki, Ebonyi State
3Department of Psychological Medicine, Federal Teaching Hospital Abakaliki, Ebonyi State
4School of Psychiatric and Mental Health Nursing, Federal Neuropsychiatric Hospital, Enugu
5Social Sciences Unit, School of General Studies, University of Nigeria, Nsukka

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ABSTRACT

Background: Several factors, including experiences of stigmatization, influence patients' attitudes to healthcare. Despite the documented negative consequences of internalized stigma among people with mental illnesses, studies focusing on it among the mentally ill in Nigeria are still very few. The study is aimed at contributing to the body of knowledge needed to fill these gaps.

Method: A cross-sectional survey of 212 consecutive consenting clinic attendees at a tertiary mental health facility was conducted. A Socio-demographic questionnaire, the Oslo social support scale, the Rosenberg Self-Esteem Scale, and the Internalized Stigma of Mental Illness Scale (ISMI) were used to collect data.

Results: About 20.3% of the participants had a significant internalized stigma. Living in the rural area (p<0.001), low educational attainment (p=0.013), poor social support (p<0.001), and low self-esteem (p=0.001) were the factors that were associated with higher internalized stigma scores.

Conclusion: The findings will help in developing a framework for effective advocacy, policy formulation, and education program that will address internalized stigma in our environment. The mental health education program against stigma will pay special attention to those living in the rural area, self-esteem, and social support to reduce or to prevent stigma against those living with mental illnesses.

INTRODUCTION

Mental illnesses are leading causes of disability worldwide1 and there is increasing evidence to show that these illnesses can be treated and prevented2. Whereas thoughts are being devoted to bridging the gap between scientific pieces of evidence and practices of mental health provision3, the situation in developing countries still leaves much to be desired. Furthermore, this could be because of factors such as the low perceived need for treatment, low mental health literacy, financial considerations, and persisting negative and stigmatizing attitudes towards persons living with mental illness despite the increasing number of mental health personnel in the region. Whereas it is known that a range of personality traits, attitudes, and health beliefs can predict help-seeking behavior for mental health problems4, stigma stands out as a major contributor to why individuals may not put help-seeking intentions into actions. Jack-Ide and Uys (2013)5 and Adeponle et al. (2009)6 in their studies cited stigma among the major barriers to service utilization.

Although stigmatizing attitudes are not limited to mental illnesses, the public seems to disapprove of persons with psychiatric disabilities significantly more than persons with related conditions such as physical illness,7,8 and unlike physical disabilities, persons with mental illness are perceived by the public to be in control of their disabilities and responsible for causing them.7,9 Some researchers have reported high levels of stigma against the mentally ill in Nigeria.10,11 and prevalent negative views about mental illness across many groups in this culture.12-17 This situation is very conducive for a high level of stigmatization against the

*Corresponding author: Ndubuka, Appolos Chidi
Department of Psychological Medicine, University of Nigeria Enugu Campus
mentally ill. Unfortunately, besides being stigmatized by the public, persons with mental illness also maintain self or internalized stigmatizing attitudes.

The consequences of internalized stigma on the patient and his relatives are enormous. It could lead to low self-esteem, poorer compliance with treatment, poorer treatment outcomes, higher costs of treatment, and poorer scores on quality of life measures in the patient, thereby adding to the burden on the mentally ill and his family. In Ethiopia found that almost half of those who discontinued their treatment reported that they had done so because of perceived stigma. Moreover, those who had attempted suicide were more likely to have a high stigma score. They concluded that internalized stigma is a major problem among persons with schizophrenia in their outpatient setting. Furthermore, they concluded that internalized stigma has the potential to affect adherence substantially to medication and is likely to affect the recovery process.

Whereas it may be difficult to control stigmatizing attitudes of the public, it is the opinion of the authors that more focus should be on reducing internalized stigma among persons with mental health problems. The reason being that since they are more accessible to the mental health practitioner who should utilize the opportunity of consultation to do the needful. Despite the negative impact of internalized stigma on the patients and their relatives, the extent of internalized stigma being experienced by patients seeking care in our facilities are still largely unknown, so also the factors that are associated with it. This study is aimed at filling this gap in knowledge. It is hoped that the findings of this study would form part of the focus of psycho-education and psychotherapeutic interventions for people living with mental illnesses in this culture.

METHODS

Research design and setting

The study is a cross-sectional descriptive survey of outpatients at the Federal Neuropsychiatric Hospital Enugu. The hospital is one of the eight standalone federal neuropsychiatric hospitals in the country and provides mental healthcare to mainly the southeast geopolitical zone of the country. All patients get enrolled in the services of the hospital through the emergency/crisis intervention unit. After reviewing at the unit, a patient may either be admitted into the ward for inpatient care or discharged to the outpatient clinic for follow-up. Upon discharge from the wards, the patient is usually sent to the outpatient clinic of the hospital for follow-up. The outpatient clinic, therefore, is the final destination of all patients presenting to the hospital. The clinics run on weekdays except on Wednesdays, which is reserved for academic activities in the hospital. The hospital charges a token as a way to discourage patients from missing their follow-up appointments.

Target Population

All consenting patients presenting to the outpatient clinic of the hospital during the three months of data collection were eligible to be enrolled.

Inclusion criteria

- All consenting participants who are 18 years and above who are assessing care at the outpatient clinic of the hospital. Participants must be able to understand written or spoken English.

Exclusion criteria

- Participants who decline consent, Patients who are under 18 years of age, Patients who did not complete secondary education or declared that they do not understand spoken or written English as well as those who were too ill to participate were excluded from the study.

Instruments for data collection

A Socio-demographic questionnaire was used to obtain information regarding the age, gender, educational attainment, marital status, occupation of the participants. The perceived social support of the participants was assessed using the three-item Oslo Social Support Scale, which has been validated in the country. This 3-item questionnaire was preferred for this study because of its brevity. The patient’s compliance with treatment was assessed by asking if he/she has ever paid any fine for not coming to the clinic as appointed or if the patient often skips his medication. A positive answer to any of the questions is taken to imply non-compliance. The self-esteem of the patient was assessed using the Rosenberg Self-Esteem Scale. The scale is a 10 item self-rated instrument that has been used in the country to assess patients’ self-esteem. On this scale, Strongly agree is scored 3, agree is scored 2, disagree is scored 1 and strongly disagree is scored 0 for items 1, 2, 4, 6 and 7 while the reverse valence is for items 3, 5, 8, 9 and 10. The scale’s total score ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem. This instrument has been used in many studies in Nigeria.

The patient’s internalized self-stigma was assessed using the Internalized Stigma of Mental Illness Scale (ISMI). The ISMI Scale is a 29-item self-report scale designed to assess an individual’s personal experience of stigma related to mental illness. Each item is rated on a four-point Likert-type scale (0=strongly disagree; 1=disagree; 2=agree; and 3=strongly agree). Higher total scores are indicative of higher levels of internalized stigma. The Internalized Stigma of Mental Illness Scale can be categorized into five subscales: alienation (feelings of being a devaluated member of the community), stereotype endorsement (agreement with negative ideas about people with mental illness), discrimination experience, social withdrawal, and stigma resistance. Previous research has reported high internal consistency (α=0.90) and test-retest reliability (r=0.92) in a sample of psychiatric outpatients. This instrument has been used in some Nigerian studies.

The instrument in the pilot study demonstrated an impressive internal consistency with a Cronbach’s alpha of 0.890. The various subscales also demonstrated internal consistency as follows: alienation - Cronbach's Alpha of 0.835, stereotype endorsement - Cronbach's Alpha of 0.714, discriminatory experience - Cronbach's Alpha of 0.852, social withdrawal - Cronbach's Alpha of 0.905 and stigma resistance - Cronbach’s Alpha of 0.551.
Method of data collection
Consecutive clinic attendees who met the inclusion criteria were respectfully approached for their consent while they were in the hospital records department to have their folders retrieved. Those who satisfied the inclusion criteria that gave their consent to participate in the study were given the questionnaires for data collection to complete. The researcher recorded their folder numbers. The patients completed the items on the questionnaires while waiting to see the doctor. They were provided with pens to enable them complete the questionnaires with minimal interference. The completed questionnaires were collected before they entered the consulting room to see the doctor.

Data were analyzed using SPSS version 20. Descriptive statistical analysis, including means and standard deviation, was used to describe the variables as appropriate. The student t-test was used to compare means of continuous variables. The level of significance was set at P< 0.05.

Ethical approval
Approval for the study was obtained from the ethical committee of the Federal Neuropsychiatric Hospital, Enugu and participation was entirely voluntary.

RESULTS

Characteristics of the participants
A total of 245 participants were approached for the study; however, only 212 of them completed the study, representing a response rate of 86.5%. Their ages ranged from 18 – 74 years, with a mean age of 35.95+/−13.47 years. Eighty (37.7%) of the participants were males, while 132(62.3%) of them were females. The majority (60.4%) of them were single, while 74(34.9%) of them were married. One hundred and seven (50.5%) of the participants were unemployed, compared to 55(25.9%) and 50 (23.6%) who were self-employed and civil servants, respectively. The majority (59.9%) of the participants were urban dwellers, while 85(40.1%) of them were rural dwellers. Ninety-two (43.4%) of the participants perceived their social support as being strong, compared to 66(31.1%) and 54(25.5%), who perceived their social support as being moderate and poor, respectively.

Forty (18.9%) of the participants had low self-esteem, while 140 (66.0%) had normal self-esteem. One hundred and thirty-seven (64.6%) of the participants complied with clinic appointments and treatments, whereas 75(35.4%) of them reported that they had been fined in the past for defaulting clinic appointments or reported often skipping their medications. The majority (77.4%) of them report that they know what medical condition they were being treated for, and 77(36.3%) of the participants have other relatives who also access mental health treatment in the same hospital. The mean scores on the various domains of the internalized stigma scale are as shown in table 1.

As shown in table 1, 43 (20.3%) of the participants scored above the cut-off in the total internalized stigma. The least endorsed domain was the stereotype endorsement (9.9%), while the most widely endorsed domain was the discriminating experience domain in 78(36.8%).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (s.d)</th>
<th>Present n(%)</th>
<th>Absent n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total internalized stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation domain</td>
<td>29.51±14.02</td>
<td>43(20.3)</td>
<td>169(79.7)</td>
</tr>
<tr>
<td>Stereotype endorsement domain</td>
<td>5.88±4.51</td>
<td>57(26.9)</td>
<td>155(73.1)</td>
</tr>
<tr>
<td>Discriminating experience domain</td>
<td>5.58±3.84</td>
<td>21(9.9)</td>
<td>191(90.1)</td>
</tr>
<tr>
<td>Alienation domain</td>
<td>5.42±3.95</td>
<td>78(36.8)</td>
<td>134(63.2)</td>
</tr>
<tr>
<td>Stigma resistance domain</td>
<td>5.46±4.10</td>
<td>55(25.9)</td>
<td>157(74.1)</td>
</tr>
</tbody>
</table>

**Table 1** The mean scores and proportion of participants who scored above the cut-off on the various domains of ISMI scale

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean total ISMI score (Std deviation)</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger adults n=148</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male n=90</td>
<td>29.34±14.84</td>
<td>0.210</td>
<td>0.787</td>
</tr>
<tr>
<td>Female n=132</td>
<td>29.91±12.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domicile:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban n=127</td>
<td>31.55±16.60</td>
<td>1.656</td>
<td>0.099</td>
</tr>
<tr>
<td>Rural n=85</td>
<td>28.27±12.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married n=74</td>
<td>34.20±10.23</td>
<td>4.133</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Not married n=138</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently working n=105</td>
<td>28.58±13.17</td>
<td>0.705</td>
<td>0.482</td>
</tr>
<tr>
<td>Currently not working n=107</td>
<td>30.00±14.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational level:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowly educated (only secondary education) n=30</td>
<td>35.40±12.14</td>
<td>2.514</td>
<td>0.013*</td>
</tr>
<tr>
<td>Highly educated (above secondary education) n=182</td>
<td>28.53±14.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with follow up:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliant n=137</td>
<td>28.18±14.46</td>
<td>1.873</td>
<td>0.062</td>
</tr>
<tr>
<td>Not compliant n=75</td>
<td>31.93±12.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social support:</td>
<td></td>
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<td></td>
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<tr>
<td>Poor/moderate n=120</td>
<td>33.30±13.04</td>
<td>4.715</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Strong n=92</td>
<td>24.56±13.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem :</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low n=40</td>
<td>41.62±13.25</td>
<td>6.650</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Normal / high n=172</td>
<td>29.69±12.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge about health:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes n=164</td>
<td>29.70±14.60</td>
<td>0.367</td>
<td>0.714</td>
</tr>
<tr>
<td>No n=48</td>
<td>28.85±11.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having other relatives with mental illness</td>
<td>29.66±11.11</td>
<td>0.120</td>
<td>0.905</td>
</tr>
<tr>
<td>Yes n=77</td>
<td>29.42±15.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No n=135</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

*Statistically significant at P =<0.05

As shown in table 2, participants from rural areas had a higher mean internalized stigma score than those from the urban areas (t=4.133, P<0.001). Similarly, those with lower educational attainment had higher internalized stigma scores than their counterparts with higher educational attainment (t=2.514, P= 0.013). Internalized stigma was also associated with poor social support (P<0.001) and low self-esteem (P< 0.001), respectively, among the participants.

DISCUSSION
This study finds that 20.3% of patients attending the outpatient clinic of the tertiary mental health facility reported significant levels of internalized stigma. This is similar to the rates reported in other Nigerian studies. For instance, it agrees with...
the 21.6% reported by Adewuya et al. (2011) among mentally ill patients in Lagos, Nigeria and by Temilola et al. (2013) and Mosanya et al. (2014) who found prevalence of moderate to severe self-stigma in 18.8% of their patients in another Nigerian study. These rates are by far lower than that reported in other countries. For instance, Ran et al. (2018) found moderate to severe self-stigma in 94.7% of their patients in a rural Chinese study. Picco et al. (2016) in Singapore also reported that 43.6% of their patients had experienced moderate to severe internalized stigma.

Similarly, Shrestha (2019) in a study in Nepal also found internalized stigma in 51.5% among their patients. Interestingly, the rate reported in this study is much higher than the 8.1% reported by Kim et al. (2015) in a Korean study. It is likely that cultural differences, among other factors, could account for the wide variations in rates across countries, with the cultural proximity accounting for the close similarities with the findings of other Nigerian studies.

Surprisingly and contrary to the findings of West et al. (2011) that more women than men had elevated internalized stigma scores, this study did not find any difference in the mean internalized stigma scores between males and females. The import of this finding is not clear.

The study found that those from rural areas scored higher than their counterparts from the urban areas in the internalized stigma scale. This is contrary to the expectation that those from urban settings should score higher in internalized stigma, given that urban living places more burden on the mentally ill compared to those in rural areas. It is not surprising that those with lower levels of education had higher internalized stigma scores than those with higher education. The observation brings out the possible role of ignorance in sustaining the beliefs that nourish internalized stigma and the possible role of education in reducing the level of internalized stigma experienced by people living with mental illnesses.

The study found that those with poor social support had a higher mean internalized stigma score compared to those with good social support. The observation is not surprising since lack of social support could make it more difficult for people with mental illness to cope with their problems, access healthcare, and in turn, worsen their outcome.

Surprisingly, there was no difference in the mean scores on internalized stigma by their employment status. This finding is contrary to the findings of James & Kutty (2015), Adewuya et al. (2011) and Mosanya et al. (2014) where the unemployed had higher scores on internalized stigma scales. It, however, agrees with the findings of Livingston & Boyd (2010) in a systematic review and meta-analysis that no sociodemographic variable consistently and strongly correlated with levels of internalized stigma.

The study found that those with low self-esteem were more likely to report internalized stigma than those with normal-to-high self-esteem. The finding agrees with the report of Picco et al. (2016) that self-esteem was the only psychosocial variable that significantly and negatively associated with internalized stigma. The association could be a reflection of the negative impact of stigma on the self-esteem of participants. Similarly, Livingston & Boyd (2010) had reported that there is a striking and robust relationship between hope, self-esteem, and empowerment with internalized stigma. Tourino et al. (2018) had found that internalized stigma was associated with higher suicide risk in the last one year, a higher number of attempted suicide and current suicide risk and low self-esteem could be at the background of these findings. This brings to the fore the need to urgently put measures in place to reduce the experience of stigma by persons living in mental illness.

Jack-Ide and Uys (2013) identified self-stigma as a major barrier to mental health services in Nigeria. The study, however, did not find a significant association between compliance with follow-up appointments and the experience of self-stigma. Our finding of the study is at variance with the findings of Fung, Tsang & Corrigan (2008), who found it to be a significant predictor of poor psychosocial treatment adherence. The finding may, therefore, suggest that a number of other factors could be influencing whether a patient complies with treatment or not. Internalized stigma has been reported to predict erosion of morale among psychiatric outpatients, and to be associated with poorer quality of life in all its domains. Moreover, reduction in self-stigma and improvement in self-efficacy have been shown to positively predict changes in the community living skills of patients.

Implications for mental health service provision

The findings of this study have various implications for mental health service providers. Mental health workers need to put measures in place to lower internalized stigma experienced by patients by exploring avenues and opportunities for delivering mental health education to patients and mental health needs. The study also brings to fore the need for evaluation of social support and self-esteem of patients with high internalized stigma to improve their overall wellbeing.

Future studies may need to look beyond internalized stigma in understanding factors that contribute to non-compliance with follow-up appointments by persons with mental illness.

CONCLUSION

Participants in this study experienced internalized stigma at a rate comparable with that reported in other studies within the country but differed from that reported in other cultures. Certain sociodemographic characteristics are associated with higher internalized stigma scores. These could guide screening people living with mental health problems in this culture for internalized stigma. Patients' self-esteem and social support could be the target of a program that would address stigma in our environment.

Recommendations

There is a need to put measures in place to lower the stigmatization experienced by persons living with mental illness, and there is also the need to fully evaluate the cultural variables that could be influencing the experience of self-stigma in our environment.

Limitations of the study

This study relied on patient self-report. Having to conduct this study on the clinic days is a limitation as to the need for the
patients to see the doctor provided distractions for them and could affect their responses. The instruments used in the study were not translated into Igbo; thus, only patients who were literate enough to complete the questionnaire were enrolled in the study, and this could, therefore, limit the extent of generalization of the findings of the study. This study did not evaluate how diagnostic categories affected the experience of stigmatization.

References

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