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SELF-STIGMA AMONG PARANOID SCHIZOPHRENIC PATIENTS IN NIGERIA

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Introduction

The sociological conceptualization of stigma was coined by Erwing Goffman in 1963. In his book on *Stigma: notes on the management of spoiled identity*, he painted the sociological concept of stigma thus:

> "When a stranger is present before us, evidence can arise of his possessing an attitude that makes him different from others and of a less desirable kind, or in the extreme, a person who is quite thoroughly bad or dangerous or weak. He is reduced to a tainted and discounted one. Such attribute is a stigma, especially when its discrediting effect is very extensive. Sometimes it is also called a failing, a shortcoming or a handicap. It constitutes a special discrepancy between virtual and actual identity" (Goffman 1990: 12-13).

While Spicker (1988) noted that in the creation of stigma, not only attributes are at work, but also the mediating effect of attitudes of others as well as the feelings of the stigmatized person(s), Thara *et al.* (2000) perceived stigma as a social devaluation of a person because of personal attribute leading to an experience of sense of shame, disgrace and social isolation.

Public-stigma connotes the reaction of the society to people with psychiatric illness while self-stigma represents the prejudice that psychiatric patients direct against themselves. Stigma either public or self is known to constitute a serious obstacle to mental

health care (Vezzoli *et al.* 2001). The societal views and attitude towards psychiatric topics strongly influence practical psychiatric services. This societal feeling has been attributed to lack/poor information, prejudices and misconceptions. Patients with mental illness report that they are confronted with a high degree of prejudice and exclusion, which considerably inhibits their recovery, integration and quality of life (Meise *et al.* 2001). The negative consequences for the treatment and way of life of those affected are such that Asmus Finzen spoke of a 'second illness', which may be caused by the stigmatization. The 'second illness' he explained, could be a result of the social consequences of stigmatization which include negative assessment, humiliating discrimination, undermined self esteem, decreased ability to cope and comply with treatment and default. These may hinder recovery process thereby strengthening remaining marks of the illness (Meise *et al.* 2001). Stigma therefore tends to enhance itself unless conscious effort is made to break the vicious cycle.

In a study among undergraduates in Hong Kong, China, Chung *et al.* (2001) reported that stigma tends to be more among females and if a person has no contact with someone with mental illness. In India, Thara *et al.* (2000) reported that young age and the female gender tend to be associated with increased level of stigma. Similarly, in Italy, Vezzoli *et al.*, reported that a person tends to have less stigmatizing attitude if he/she knows and have contact with someone with mental illness. This, they said, tends to translate to less fear of mentally ill patients and better employment opportunities for them in the community (Vezzoli *et al.* 2001). Though younger patients have been reported to perceive more stigma than older patients, stigma was found to predict treatment discontinuation only among the older patients (Sirey *et al.* 2001).

In spite of relatively few studies on stigma in Africa, reports have shown that stigma is generally less among Africans than Western nations (Fabrega 1991). This might be due to a dearth of research or a social system that does not promote stereotypes, prejudice and discrimination against the mentally ill. Another

possible reason might be that majority of people (about 70%) still patronize traditional healers who attribute the illness to supernatural and preternatural forces (Adelekan *et al.* 2001). The influence of genetics and environment in the causation of mental illness is thereby disbelieved, denied or played down. The populace therefore develops less stigmatizing attitude towards the patient especially when the illness is mild and resolves partially or completely with non-orthodox intervention.

While studies on public-stigma seem to examine attitude of groups of respondents to patients with various psychiatric disorders at a point in time (Thara *et al.* 2000, Vezzoli *et al.* 2001 and Chung *et al.* 2001), the relatively few studies on self-stigma tend to report findings on patients with specific disorders such as schizophrenia (Meise *et al.* 2001) and depression (Sirey *et al.* 2001). This study which, to my knowledge, is the first documented report on self stigma in the study area, and in line with the International Psychiatric Association's International Awareness Campaign Programme, is aimed at countering the myths and misunderstandings surrounding the schizophrenic illness and its name. This is done through a presentation of the stereotypes, prejudices and discriminating behaviours that paranoid schizophrenic patients have towards themselves. The goal is to have a baseline data on self stigma in the study area and most importantly have a better understanding of the inner feelings of the patients so that programmes can be designed to encourage earlier presentation, better services, better stay in treatment, better reintegration into the society and above all, better quality of life.

Method

All consenting paranoid schizophrenic patients (hereafter referred to as respondents) attending an outpatient psychiatric clinic at the University Teaching Hospital, Ilorin over a two-year period (June 2001-June 2003) were included in the study. Respond-

ents' diagnosis must satisfy ICD-10 criteria and he/she must have been in full remission for at least twelve consecutive months prior to interview. This is to ensure that respondents' responses were not influenced by presence of psychopathology. After assurance of confidentiality, 20 consenting respondents (out of the 25 that satisfy the inclusion criteria) were interviewed using a pilot tested data collection sheet which sought information in the areas of socio-demographic variables: knowledge of someone with psychiatric illness, level of involvement in his/her care, etiology of mental illness, treatment options, stereotypes, prejudices and discriminating attitudes of significant others (parents, siblings, colleagues, religious group members, employers, etc.) to patient and, patient's stereotypes, prejudices and discriminating attitudes to self and/or others with mental illness. Highly literate respondents were allowed to self-administer the questionnaire, while low and moderately literate ones were assisted in filling the questionnaires. Since no respondent was completely illiterate, the back-translated Yoruba Version (the predominant language in the study area) was not used.

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Data analysis

Data was entered into a personal computer using Epi Info Version 6.02 (Dean *et al.* 1994). Frequency tables were generated. Where necessary, means and proportions were compared using t-test and chi square (χ^2) respectively. The level of statistical significance was set at 5%.

Result

Within the 2-year study period, 25 paranoid schizophrenic (respondents) patients satisfied the inclusion criteria. Of these, 20 consented to take part in the study with their ages ranging from 20 to 53 years with a mean of 35.3 years and a standard deviation

of 9.3. Twelve (60%) were males while 8 (40%) were females. Four (20%) had primary school education, 8 (40%) had secondary school education while 8 (40%) had tertiary school education. Four (20%) were professionals, 6 (30%) were skilled workers, 2 (10%) unskilled workers, 3 (15%) housewives, 4 (20%) were unemployed while 1 (5%) was a retiree. Seven (35%) were single, 12 (60%) were married while 1 (5%) was divorced (Table 1).

TABLE 1:
Sociodemographic attributes of respondents (N=20)

Variable	No of respondents	Percentage (%)
Age (years)		
Range	20-53	
Mean	35.3	
S.D	9.7	
Gender		
Male	12	60
Female	8	40
Educational Status		
Primary	4	20
Secondary	8	40
Tertiary	8	40
Occupation		
Professional I	0	0
Professional II	4	20
Skilled	6	30
Unskilled	2	10
Housewife	0	0
Student	3	15
Previous employed but not now	1	5
Never employed	3	15
Retiree	1	5
Marital Status		
Single	7	35
Married	12	60
Separated	0	0
Divorced	1	5

A more significant proportion of respondents believed that only demon, curse, hard drugs, and inheritance could predispose to mental illness. Also, there was a significant difference between those who believed in multifactorial causes (genetics and environment) as a predisposing factor to mental illness and those who did not. (Table 2)

TABLE 2:
Predisposing factors to self-stigma (N=20)

Factor	Yes (%)	No (%)	χ^2	P-value
Knowledge of someone with mental illness	11 (55)	9 (45)	0.1	0.7518
Have you witnessed an episode of illness	11 (55)	9 (45)	0.1	0.7518
Were you involved in the care giving	7 (35)	13 (65)	2.5	0.1138
What are the etiological factors to mental illness				
Demon	4 (20)	16 (80)	12.1	0.0005[c]
Curse	5 (5)	15 (75)	8.1	0.0044[b]
Hard drugs	6 (.30)	14 (70)	4.9	0.0269[a]
Genetics only	3 (15)	17 (85)	16.9	0.000[c]
Genetics Stress	11 (55)	9 (45)	0.1	0.7518

% in row brackets
χ^2 Yates corrected Chi square
[a] $p<0.05$
[b] $p<0.01$
[c] $p<0.001$

Table 3 shows that significantly more respondents believed that mentally ill patients who are in remission could marry (Yates corrected $\chi^2=36.1$; $p< 0.001$), get employed (Yates corrected $\chi^2=8.1$; $p<0.01$), and be retained in employment (Yates corrected $\chi^2=4.9$; $p<0.05$). Though more respondents claimed such patients should not hold important office in the community, the difference was not statistically significant (Yates corrected $\chi^2=0.9$; $p=0.3428$).

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TABLE 3:
Prejudice and discriminating behaviours to a mental patient (N=20)

Variable	Yes (%)	No (%)	χ^2	P value
Should not hold an important traditional office	8 (40)	12 (60)	0.9	0.3428
Advice divorce	1 (5)	19 (95)	28.9	0.0000[c]
Could marry	20 (100)	0 (0)	36.1	0.0000[c]
Could employ	15 (75)	5 (25)	8.1	0.0044[b]
Retain patient in employment	14 (70)	6 (30)	4.9	0.0269[a]

% in row brackets
χ^2 Yates corrected Chi square
[a] $p<0.05$ [b] $p<0.01$ [c] $p<0.001$

Table 4 shows patients' perception of prejudice held by some significant others against them. Significantly more respondents felt those significant others rate them same as other normal people. All the respondents rate themselves same as other people.

TABLE 4: *Respondents' perception of prejudice held by some significant others towards them (N=20)*

	Feelings							
	Dangerous		Incompetent		Not trusted		Same as others	
	Yes	No	Yes	No	Yes	No	Yes	No
Significant others								
Friends	1 (5)	19[a] (95)	1 (5)	19[a] (95)	2 (11)	18[b] (89)	17 (85)	3[c] 1
Relations	1 (5)	19[a] (95)	1 (5)	19[a] (95)	2 (11)	18[b] (89)	17 (11)	3[c] (89)
Co-worshiper	2 (11)	18[b] (89)	1 (5)	19[a] (95)	1 (5)	19[a] (95)	17 (11)	3[c] (89)
Employer	1 (5)	19[a] (95)	1 (5)	19[a] (95)	1 (5)	19[a] (95)	17 (11)	3[c] (89)
Self	0 (0)	20[d] (100)	0 (0)	20[d] (100)	0 (0)	20[b] (100)	20 (0)	0[d] (100)

% in column brackets
[a] Yates corrected Chi Square=28.9; P<0.001
[b] Yates corrected Chi Square=22.5; P<0.001

/p. 183/ Table 5 shows the relationship between some respondents' attributes (age, gender, knowledge of someone with mental illness, etc) and their attitudes with respect to some stigmatizing behaviours such as marriage, employment, holding important office in the society. There was no significant relationship between these variables except when patients' gender was compared with whether or not a patient with previous history of mental illness could hold public office (Yates corrected χ^2=4.59; p=0.0321).

TABLE 5:

The relationship between some respondents' attributes (age, gender, knowledge of someone with mental illness, etc) and their attitudes with respect to some stigmatizing behaviours (N=20)

	Employ	Retain	Get married	Hold office
Age (years)				
(20-40 & 41-53 yrs)				
χ^2 (Y)	0.09	0.00	z	0.28
P value (F)	0.77	0.61	z	0.35
Gender				
χ^2 (Y)	0.28	1.20	0.00	4.59
P value (F)	0.35	0.16	1.00	0.03[a]
Know someone				
χ^2 (Y)	0.7	0.04	0.00	0.01
P value (F)	0.62	0.84	1.00	0.93
Involved in care				
χ^2 (Y)	1.83	2.68	0.00	0.08
P value (F)	0.11	0.05	1.00	0.64
Demon				
χ^2 (Y)	0.36	1.27	0.00	0.83
P value (F)	0.84	0.53	1.00	0.66
Genetic/environment				
χ^2 (Y)	0.00	0.00	0.00	0.00
P value (F)	1.00	1.00	1.00	1.00

[a] $p<0.05$

Z column data is zero, no analysis

Y Yates corrected Chi Square

F fisher exact s tailed p-value

Discussion

In spite of the small sample size of respondents, some of the findings seem worthy of consideration. Generally, this study shows that significantly more respondents did not feel stigmatized by /p. 184/ significant others such as relations, religious colleagues, friends and employers as evidenced by their assessment of whether these significant others rate them as dangerous, incompetent, to be feared or same as others. Though this seems in keeping with previous findings that Africans tend to have low stigmatizing attitudes toward mental illness, the observation must be interpreted with caution. Could it be a result of the relatively small sample size? Could it be because these significant others are not aware that respondents have mental illness as it has been reported that most patients tend to conceal or selectively disclose their illness (Chung *et al.* 2001)? Could it be that these significant others are really aware of the illness but have a less stigmatizing attitude because the respondents in this study have been mentally stable for a relatively long time (12 consecutive months) before the study? These attributes are likely to keep patient in employment and make him/her perform well (relative to his/her premorbid state) at work. We may therefore suggest that the relatively stable mental state and optimal performance of the patients might be the factor responsible for their positive rating by these significant others.

The study, unlike those reported from Asia (Hong Kong and India) and Europe (Italy), did not show that respondents' age, involvement in the care of and knowledge of someone with mental illness has any significant relationship with a tendency to stigmatize other patients or self. However, significantly more male respondents claimed that patients with mental illness should not be allowed to hold important office(s) in the community. This might be because males tend to be generally more grounded in tradition than females.

Though significantly more respondents believed that demons, curse, hard drugs and genetic inheritance solely, could cause mental illness. This belief did not show a correspondingly significant relationship to stigmatizing behaviors such as employment, marriage and holding important offices by mentally ill patients. This might suggest that a belief in supernatural and preternatural forces does not imply a tendency to self-stigmatization. This might not be unconnected with the African belief that once supernatural and preternatural forces are remedied in a mentally ill patient, every other thing becomes normal (Adelekan *et al.* 2001).

It is also important to note that all the respondents rate themselves 'same as others'. This might to a large extent, determine the attitude and behaviour of patients to treatment and the community. As Alfred Adler posited, inferiority complex is a predisposing factor /p. 185/ to anxiety. The presence of persistent and pervasive anxiety could manifest as co-morbidity in a patient with paranoid schizophrenia. The absence of inferiority complex in mentally ill patients is therefore a good attribute that should be encouraged. Also, self-stigma has been identified as one of the factors that is associated with late presentation, dropping out of treatment and poor quality of life (QOL) in mentally ill patients (Meise *et al.* 2001). If the patient does not perceive himself stigmatized or self-stigmatizes him/herself, these poor prognostic factors could be reversed which in turn might invigorate a less stigmatizing attitude from the society.

Conclusion

In spite of the small sample size, this study strives to contribute to the understanding of a cohort of mentally ill patients' experiences and perception of their illness especially in an African society like Nigeria. It attempts an exploration of stigma among patients with paranoid schizophrenia in a Nigerian ter-

tiary hospital and also, highlights the challenges of stigma to rehabilitation and high quality of life (QOL) in psychiatric practice worldwide. Though the study shows a generally low self-perceived stigma among patients with paranoid schizophrenia, there are still opportunities for more concerted efforts towards even further reduction of such stigma.

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SUMMARY:

Aims and objectives: To identify the presence or otherwise of self/perceived stigma in the study group. *Method:* All consenting ICD-10-criteria-compatible paranoid schizophrenia patients attending a psychiatric clinic in a Nigerian tertiary hospital, within the study period were interviewed using a pilot tested self-administered questionnaire. *Result:* Twenty-five respondents satisfied the inclusion criteria. Of these, 20 consented to partake in the study with their ages ranging from 20 to 53 years with a mean of 35.3 years and a standard deviation of 9.3. Generally, significantly more respondents did not have self/perceived stigma as evidenced by their responses on issues of marriage, employment, holding important offices in the community and feelings of others towards them. *Conclusion:* In spite of the small sample size, the study shows a generally low self-perceived stigma among the respondents. It concludes that there are still opportunities for more concerted efforts towards even further reduction of such stigma. This will enhance early presentation, better stay in treatment, better rehabilitation and higher quality of life (QOL) of psychiatric patients.

Key words: • Self-stigma • Paranoid schizophrenia • Nigeria.

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RÉSUMÉ :

L'AUTO STIGMATISATION PARMI LES PATIENTS SCHIZOPHRÈNES PARANOÏDES AU NIGERIA

Buts et objectifs : identifier la présence ou non de la perception personnelle du stigmate dans le groupe d'étude. *Méthode* : tous les patients schizophrènes paranoïdes, selon les critères de la Classification internationale des maladies

(CIM-10), fréquentant une consultation externe d'une clinique psychiatrique dans un hôpital nigérian (CHU d'Ilorin) pendant la période d'étude de deux ans (juin 2001 à juin 2003) ont été interviewés en utilisant un questionnaire autro-administré, questionnaire pilote testé. *Résultats* : vingt-cinq des sujets ayant répondu correspondaient au critère d'inclusion (présenter une rémission totale depuis au moins 12 mois consécutifs avant l'entretien). Vingt parmi eux ont consenti à prendre part à l'étude : ils avaient de 20 à 53 ans, avec une moyenne de 35,3 ans et une déviation standard de 9,3. De manière générale, un nombre significativement plus important des sujets de l'enquête ne présentaient pas une auto-perception de stigmate comme le montrent leurs réponses aux items relatifs au mariage, à l'emploi, à la tenue d'une fonction importante dans la communauté et aux sentiments des autres à leur égard. *Conclusion* : malgré le caractère fort modeste de la population étudiée, l'étude montre une auto-perception du stigmate généralement faible parmi les sujets de l'enquête. Elle conclut qu'il y a encore des opportunités pour plus d'efforts concertés dans le sens d'une réduction d'un tel stigmate attaché à la maladie mentale. Elle serait de nature à contribuer à favoriser une présentation plus précoce des patients aux consultations, un meilleur suivi des traitements, une meilleure réhabilitation et une meilleure qualité de vie pour les patients en psychiatrie.

Mots clés : • Auto-perception du stigmate • Schizophrènes pafranoïdes
• CHU d'Ilorin • Nigeria