Original paper

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Stigma among the stigmatized? Preferred social distance and associated factors among outpatients at a psychiatry clinic in Benin City, Nigeria

S O Osasona, C E Ofovwe

Abstract

Background

Researchers to date have focused largely on the public stigma towards people with mental illness, and evidence regarding stigma and discrimination among patients with psychiatric disorders themselves is inadequate. This gap in knowledge limits development of interventions that could reduce stigma and promote more tolerant attitudes and successful treatment outcomes for patients with psychiatric disorders.

Aims

To determine the prevalence of moderate to high social distance among patients with mental illnesses, and to explore factors that are associated with this social distance.

Methods

A descriptive cross-sectional design was conducted. Participants were patients attending the out-patient psychiatry clinic of a tertiary hospital in Benin City, Nigeria. Data was collected using a socio-demographic data collection sheet, the Bogardus Social Distance Scale, the World Psychiatric Association Stigma Questionnaire, and the Brief Psychiatric Rating Scale. Version 21 of SPSS was used to analyze the data at a statistically significant level of $p< 0.05$.

Results

The prevalence of moderate to high social distance was 67.8%. Social distance showed a statistically significant association with beliefs about evil spirits/witches, and heredity as causes of mental illnesses (MI), and beliefs about treatment outcome of MI. All these three variables independently predicted moderate to severe social distance.

Conclusions

The findings of this study add to the emerging evidence regarding high social distance and stigmatization among patients with psychiatric disorders, towards one another. Misconceptions regarding mental illnesses that influence high social distance among the general public are also shared by patients with psychiatric disorders.

Key words: stigma, social distance, psychiatric disorders, Nigeria

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Introduction

Stigma is a recognized phenomenon associated with mental illness, and is described as the loss of status, and discrimination triggered by negative stereotypes about individuals labeled as having a mental illness (1). Goffman defined stigma as the negative evaluation of a person as being tainted or discredited, on the basis of attributes such as mental illness, ethnicity, or physical disability (2). The word stigma can be used in more than one sense, but researchers have focused largely on two concepts of stigma, namely: public (external, enacted) stigma, and self (felt, internalized) stigma (3). While public stigma describes public perception and attitude towards people with mental illness (PWMI), and their experience of unfair treatment by others, self-stigma emerges when sufferers internalize others' attitude and experience shame and discrimination, which prevent them from seeking help (3,4).

Studies done across the globe on public and or self-stigma about mental illness report varying rates of prevalence: 40% in European countries, 20-33% in Israel, 33% - 36% in the US, and 14.5%-60.9% in Nigeria (5-9).

The damaging effects of stigma are enormous, and can result in social withdrawal, restriction of support, and poor utilization of mental health services (10). Many international studies show that stigma towards PWMI has a negative impact on their re-integration and acceptability as active members of the society, and cause significant relationship and marital problems (11,12). Both systematic reviews and meta-analysis on stigma regarding PWMI has shown that stigma is related to many factors, but more so to severity of illness and non-adherence to medication, compared to other factors (13).

Most research done on stigma has focused on public or self-stigma; the possibility of stigmatization among the psychiatric patients themselves has received little or no attention from empirical researchers (3,4,9-12). Besides creating a gap in literature, the paucity of empirical knowledge base on this topic portends a negative outcome for treatment and rehabilitation of the patients. Social distance is the proximity one desires between oneself and another person in a social situation (9,14). It is one of the indicators of tolerant or intolerant attitudes and is used by researchers commonly as a measure of stigma and discriminatory behaviour towards PWMI (14). Thus, the aim of this study is to determine the prevalence of moderate to high social distance and its associated factors among hospital-based sample of patients with mental illnesses.

Methods

Study location and design

This study, the first in the series of proposed studies regarding social distance, was conducted at a tertiary hospital in Benin City, Nigeria and a cross sectional descriptive design was adopted. Data was collected between January-April 2020.

Study participants and sample size

Participants included patients who attended the outpatient psychiatric clinic for their regular follow up visits. The minimum sample size required for this study (n=191) was determined using single population proportion formula for determining sample size in a cross sectional study (15). A social distance prevalence (p) of 14.5% reported in a previous local study was adopted in the calculation (9).

Being diagnosed with and receiving treatment for a major mental illness based on ICD-10 diagnostic criteria, for at least six months; being an adult aged 18 years and above; being literate enough to understand the content of the questionnaire, provide needed information and sign the consent form with minimal assistance by the investigators, were considered as inclusion criteria. Eligible patients who expressed willingness to voluntarily participate in the study and who gave informed consent were included in the study.

A questionnaire, consisting of four sections – a socio-demographic and clinical data collection sheet, designed by the authors to collect participants' socio-demographic information, the Modified Bogardus Social Distance Scale, a modified version of the questionnaire developed for the World Psychiatric Association (WPA) programme, and the Brief Psychiatric Rating Scale (BPRS) – was utilized for the study (16-18).

The Modified Bogardus Social Distance Scale is a standard psychological testing scale developed by Emory S. Mogardus to empirically measure people's willingness to participate in social contacts of varying degrees of closeness with members of diverse groups, such as PWMI (16). It consists of seven items/statements designating various social distances, starting from item 1, which is the shortest (extreme) social distance; followed by items 2 to 7, designating other social distances gradually increasing in extent (less extreme). Respondents were asked to place a check mark against the item with which they agree and were given a score corresponding to the number of that item. The higher the score, the higher the social distance. The instrument has been used by previous researchers to determine public attitude (social distance) towards PWMI in Southwestern Nigeria (9). For the purposes of statistical analysis and categorization, the cut offs for low, moderate and severe social distance, were determined using the 25^{th}, 50^{th} and 75^{th} percentiles scores respectively. Thus scores <3; 3-5; and ≥ 6 were taken as low, moderate and high (severe) social distance respectively (9).

The modified version of the questionnaire developed for the World Psychiatric Association (WPA) programme to reduce stigma and discrimination because of schizophrenia, was used in this study (17). Gureje and his colleagues modified the questionnaire, largely to focus on mental illness rather than schizophrenia (18). This questionnaire has been previously used in a study exploring knowledge and attitude to mental illness and PWMI in Nigeria (18). It consists of four sections that elicit information regarding the aetiology of mental illness, the respondents' view of PWMI (example: "recovered PWMI are eligible to marry"), treatment and rehabilitation of PWMI and attitudes towards PWMI (example: "PWMI are dangerous"). Respondents are to give a categorical "yes" or "no" response to each statement and no scoring was required.

The Brief Psychiatric Rating Scale (BPRS) is an interviewer-administered schedule for measuring psychopathology profile developed by Overall and Gorhman (19). It evaluates different symptom areas such as: somatic concerns, anxiety, and depression. The 18-item version was used in this study, and the severity of each symptom was ranked using a scale of one to seven. The higher the score, the higher the severity of the illness. The instrument is widely used and has been used by researchers in Nigeria (20). All the tools were used in

English language and had been validated for local use, in previous studies (9,18,20).

Ethical issues

Ethical clearance was obtained from the Ethics and Research Committee of the University of Benin Teaching Hospital, Benin City, Nigeria (ADM/E22/A/VOL.VII/148259). Questionnaires were administered to consecutive attendees at the psychiatric outpatient department on each clinic day after explaining to potential participants the nature and purpose of the study. Participants were assured of confidentiality and those who gave informed consent were included.

Data analysis

Data was analysed using the SPSS version 21. Chi-squared test was performed to test the association of social distance with some categorical variables, while the Pearson correlation analysis was performed to assess the relationship between numerical data, such as social distance scores and BPRS scores. Multiple logistic regression was employed to determine independent predictors of high social distance, with social distance as the outcome measure. The following assumptions were made for the regression analysis: a) Model fit (the predicted would match the observed) and, b) Sample size would support the modeling using the assumption that 1 independent variable = 10 cases (respondents). The Hosmer and Lemeshow test showed a non-significant Chi square (X^2=4.310, p=0.635) which indicated that the data fitted the model well. The overall prediction success rate was 70.2%. A 0.05 criterion of statistical significance was employed ($p< 0.05$).

Results

Of the 220 questionnaires administered, 208 were correctly filled and available for statistical analysis. Less than half the sample belonged to the age group of 28-37 years (43.3%), and more than half were males (58.2%). Almost half of the respondents (49.5%) had been ill for more than five years and 42.3% were receiving treatment for schizophrenia. The prevalence of moderate to severe social distance was 67.8% (95% CI = 61.5 - 74.0) (Table 1).

Table 1. Socio-demographic and clinical characteristics of participants

Variables	Frequency n=208	Percentage %
Age Group (Years)		
18-27	66	31.7
28-37	90	43.3
≥38	52	25.0
Sex		
Male	121	58.2
Female	87	41.8
Level of Education		
No Formal	21	10.1
Primary	41	19.7
Secondary	87	41.8
Tertiary	59	28.4
Religion		
Christianity	185	88.9
Islam	13	6.3
Others	10	4.8
Employment Status		
Employed	91	43.8
Unemployed	117	56.3

(Continued)

Variables	Frequency n=208	Percentage %
Income ($) (n=91)		
<50	29	31.9
51-99	38	41.8
≥100	24	26.4
Level of Social Support		
Good	124	59.6
Poor	84	40.4
Social Distance		
Low	67	32.2 (95% CI = 26.0-38.5)
Moderate/Severe	141	67.8 (95% CI = 61.5-74.0)
Illness Duration		
≤5 years	105	50.5
6-10 years	69	33.2
>10 years	34	16.3
Psychiatric Diagnosis		
Schizophrenia	88	42.3
Depression	40	19.2
Bipolar Affective Disorder	55	26.4
Others	25	12.0

Forty eight percent of the participants believed that mental illness is caused by witches/evil spirits, while the majority (84.1%), believed that they could recover with treatment (Table 2). A majority (76%) of respondents who believed that MI is caused by witches and evil spirit possession desired moderate to high social distance, as opposed to 60.2% of those who did not hold this belief (p=0.015) (Table 3). Further, there were statistically significant differences between respondents who believed that PWMI are dangerous, beliefs about the genetic (heredity) causation of MI, and perceptions about treatment outcome (Table 3). The inter correlation between social distance and the numerical variables revealed a weak, negative but significant correlation between social distance and monthly income (r=-.237, p=0.022) (Table 4). There was no statistically significant correlation between the BPRS and social distance (r = - 0.080, p=0.252).

Table 2. Respondents' perceptions about mental illness and PWMI

Variables	Frequency n=208	Percentage %
MI is caused by witches/evil spirit		
Yes	100	48.1
No	108	51.9
MI is hereditary		
Yes	95	45.7
No	113	54.3
PWMI may recover with treatment		
Yes	175	84.1
No	33	15.9
PWMI are dangerous		
Yes	106	51.0
No	102	49.0

MI – Mental illness PWMI – Persons with mental illness

Table 3. Associations between social distance and respondents' socio-demographic/ clinical features and perceptions about MI/PWMI

Variables	Social Distance			
	Low n=67 (%)	Moderate/Severe n=141 (%)	χ^2	p-value
Sex				
Male	40 (33.1)	81 (66.9)	0.095	0.758
Female	27 (31.0)	60 (69.0)		
Level of Education				
No Formal Education	6 (28.6)	15 (71.4)	3.268	0.352
Primary Education	10 (24.4)	31 (75.6)		
Secondary Education	27 (31.0)	60 (69.0)		
Tertiary Education	24 (40.7)	35 (59.3)		
Religion				
Christianity	63 (34.1)	122 (65.9)	3.889	0.143
Islam	1 (7.7)	12 (92.3)		
Others	3 (30.0)	7 (70.0)		
Employment Status				
Employed	28 (30.8)	63 (69.2)	0.154	0.695
Unemployed	39 (33.3)	78 (66.7)		
Level of Social Support				
Good Support	40 (32.3)	84 (67.7)	0.000	0.986
Poor	27 (32.1)	57 (67.9)		
MI is caused by witches/evil spirit				
Yes	24 (24.0)	76 (76.0)	5.947	0.015*
No	43 (39.8)	65 (60.2)		
MI is hereditary				
Yes	38 (40.0)	57 (60.0)	4.858	0.028*
No	29 (25.7)	84 (74.3)		
PWMI can recover with treatment				
Yes	66 (37.7)	109 (62.3)	15.296	<0.001*
No	1 (3.0)	32 (97.0)		
PWMI are dangerous				
Yes	25 (23.6)	81 (76.4)	7.367	0.007*
No	42 (41.2)	60 (58.8)		
Psychiatric Diagnosis				
Schizophrenia	29 (33.0)	59 (67.0)	3.275	0.351
Depression	10 (25.0)	30 (75.0)		
Bipolar affective disorder	22 (40.0)	33 (60.0)		
Others	6 (24.0)	19 (76.0)		

*Statistically significant association.

MI – Mental illness PWMI – Persons with mental illness

Table 4. Inter correlation between social distance and age, monthly income, illness duration and BPRS Scores

Correlations		Social Distance Score	Age (years)	Average Monthly Income ($)	Illness Duration	BPRS Score
Social distance score	r	1	-.006	-.237*	-.062	-.080
	P		.926	.022	.374	.252
Age (years)	r		1	.169	.654**	-.010
	P			.104	.000	.885
Average monthly income ($)	r			1	.231*	-.044
	P				.025	.676
Illness duration	r				1	-.006
	P					.928
BPRS Score	r					1
	P					

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

r = Pearson correlation, and *p* = significant/p-value.

Multiple logistic regression analysis showed that the perception of witches and evil spirits as causes of MI had a significant positive relationship with moderate to severe social distance (OR= 2.116, p=0.025, 95% CI=1.098-4.078), while the belief that heredity is a cause of MI (OR= 0.391, p=0.004, 95% CI= 0.205- 0.746), and that PWMI may recover with treatment (OR= 0.062, p=0.007, 95% CI=0.008- 475) had a significant negative relationships with moderate to severe social distance (Table 5). Although dangerousness also independently predicted moderate to severe social distance when it was entered into the logistic model as a single predictor variable, its significant effect disappeared following simultaneous entry of all the variables into the model. These variables jointly accounted for about 22.0% of the variance in social distance.

Table 5. Independent predictors of social distance

	B	S.E.	Wald	df	P	Exp (B)	95% Confidence Interval	
							Lower	Upper
Evil spirits cause MI	.750	.335	5.017	1	0.025	2.116	1.098	4.078
Heredity causes MI	-.939	.330	8.121	1	0.004	.391	0.205	0.746
PWMI may recover with treatment	-2.778	1.038	7.163	1	0.007	.062	0.008	0.475
PWMI are dangerous	.519	.330	2.469	1	0.116	1.680	0.880	3.208
Constant	3.165	1.069	8.774	1	0.003	23.699		

Reference categories: Evil spirits do not cause MI, Heredity is not a cause of MI, PWMI may not recover with treatment, and PWMI are not dangerous.

P = Statistical significance value

Exp(B) = odds ratio

Coefficient of determination (R^2) = 22.0%

MI – Mental illness PWMI – Persons with mental illness

Discussion

This study examined social distance and factors that are associated with moderate to high social distance among a clinic-based sample of psychiatric patients. The preponderance of young adults, as found among the respondents, was, perhaps, a reflection of the relatively early age at onset which characterizes most psychiatric illnesses. Earlier reports of low level of education among a considerable proportion of psychiatric patients was corroborated in this study, wherein more than two-thirds of the patients had below tertiary level of education (1).

While slightly less than half the patients believed that mental illness is hereditary, a higher proportion attributed mental illness to supernatural forces, such as witchcraft and evil spirit possession. In Nigeria, and perhaps the wider African society, beliefs about the existence and activities of witches, sorcerers, ancestral and demonic spirits, still hold sway despite the growing influence of Christian and Islamic religions, and Western civilization (21,22). Although the Nigerian society does not entirely exclude the biopsychosocial perspective of causation, especially genetics, beliefs about supernatural causes are predominant and widespread (21). These beliefs are culturally enshrined, and because PWMI are part of this society, the misconceptions extend among them as well, fuelling social distancing among them (23). In order to improve the mental health of the populace and that of psychiatric patients, it is important to remove etiological misconceptions, through appropriate and adequate education and awareness campaigns.

It was interesting to find that more than half of the respondents held the belief that their fellow mentally ill patients are dangerous. A public perception of dangerousness about psychiatric patients is common in the Nigerian society. That perception partly accounts for the public stigma against them; it is worrisome that respondents appeared to share this public perception and hold a view of dangerousness about themselves or other patients. This may engender resentment and intolerance among them, and portend grave consequences for their social and interpersonal interactions, as well as treatment outcomes. It is however reassuring to know that a vast majority believed that mental illness is treatable and that patients can recover with treatment. The implication of this for medication adherence is significant; patients are likely to adhere reasonably well to their medication when they believe that their condition is treatable.

About two-thirds of the patients preferred a moderate to high social distance from other psychiatric patients. When compared with previous studies that used the same instrument to measure public stigma towards PWMI, the desire for social distance towards PWMI is more prevalent in the general population than it is among the patients in this study (9). Despite that observation, it is a matter of concern that as much as 67.8% of the patients preferred moderate to high social distance towards other psychiatric patients. This high rate could be explained, perhaps partly, by the belief of dangerousness and evil spirit possession that the patients held about their fellow patients. Smith and his colleague reported that the beliefs and attitudes that people hold towards mental illness and PWMI influence their desired social distance (24). This finding portends serious implication for treatment outcomes. Due to intolerance and resentment, the expected social interaction among the patients during in-patient treatment and rehabilitation may be hampered. Furthermore, the double jeopardy of stigma from the public and fellow patients may adversely affect a patient's self-esteem and help seeking behaviour – indicating an imperative need to develop anti-stigma strategies among the patients and the public.

The correlates of high social distance found among the patients in this study, are largely similar to reported correlates of public stigma against psychiatric patients (9,25,26). Thus, public misconception about mental illness and PWMI are shared by the psychiatric patients themselves; perhaps this is not surprising because the patients are part of the larger population and enshrined beliefs and attitudes in the society are likely to be shared by them. It is important to note that those correlates were largely related to beliefs and conceptions rather than socio-demographic variables. Education and awareness programmes that will broaden the knowledge of patients regarding causation, nature and treatment of mental illness, and may significantly reduce the desire for social distance among the patients. Contrary to previous research, the severity of psychopathology (BPRS) had no statistically significant relationship with social distance in this study (13). The reason for this finding is not clear but may be related to the fact that the respondents in this study were outpatients on follow-up treatment, with relatively stable mental status.

Limitations

Some of the associations observed in this study, such as that between social distance and the belief that witches and evil spirit possession are causes of mental illness, may be explained by cultural beliefs, and therefore may not be generalizable. Secondly, the scope of this study, in terms of sample size and institutional/geographical coverage, is relatively small. Thirdly, the relatively novel nature of the study limited the opportunity to compare some of the findings with previous findings.

Conclusions

Our findings support the emerging evidence of high social distance and stigmatization among psychiatric patients towards one another, akin to reported public stigma regarding PWMI. We recommend that anti-stigma

programmes that have hitherto been targeted at the public should be extended to patients, and rehabilitation programmes be structured to strengthen social contact and vocational functioning among the patients, to reduce the effects of stigma.

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Statement of contribution

SOO conceived the design of the study and collected data. SOO and CEO analysed the data and drafted the manuscript. Both authors approved the final version.

Conflicts of interest

None declared.

S O Osasona, Department of Mental Health, University of Benin Teaching Hospital, Benin City, Nigeria

C E Ofovwe, [2]Department of Mental Health, University of Benin, Benin City, Nigeria

Corresponding author: S O Osasona

Email: samuelosasona@gmail.com

http://orcid.org/0000-0002-0585-4385

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