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A STUDY OF INTERNALISED STIGMA OF MENTAL ILLNESS IN BENUE STATE, NIGERIA

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ABSTRACT: Internalised stigma (IS) has consistently been considered as one of the major problems in the mentally ill populations. There are previous research attempts to examine its causes and proffer solutions. However, rates of internalized stigma of mental illness seem to have remained consistently high in Nigeria, especially in Benue State. This study examined the prevalence of internalized stigma among people with mental illness in Benue State. Data were collected in six selected local government areas in the State, Benue State University Teaching Hospital, Federal Medical Centre, Makurdi and six traditional psychiatric hospitals. A combination of multi-stage, simple random and purposive sampling methods, were used to select respondents for the study. A survey questionnaire was administered to 468 people living with mental illness and In-depth Interviews were held with people living with mental illness. Data collected were analysed using SPSS version 23. The findings revealed that 67.9% of the people suffering from mental illness had elevated internalized stigma. People living with mental illness who received traditional health care had elevated stigma scores more than those who attended orthodox hospitals (t = 4.404, df = 466, sig. 2-tailed (p) = 000). It was also revealed through in-depth interviews with people having mental illness that they took overdose of the drugs from the hospitals to forget about the public stigma they experienced. The paper recommended that government and non-governmental organizations should embark on public awareness to educate members of the public about mental illness, in order to reduce stigmatization against people living with mental illness.

Keywords: Stigma, Mental Illness, Internalized Stigma, Public, Family Members, Benue State

INTRODUCTION

Globally, the issue of internalised stigma has emerged as one of the greatest problems associated with mental illness. The internalization of stigma of mental illness has far reaching impact on self -concept and ultimately on the well-being of the person living with mental illness (Corrigan *et al.,* 2006). This can lead to isolation, unemployment, low income and inability to seek treatment (Wrigley, *et al.,* 2000). Empirical evidence suggests that internalised stigma is one of the most common problems experienced by people who are living with mental health problems. In India, a study by Ghanean, *et al.,* (2015) revealed that the prevalence of internalised stigma is 34.1%. In sub-Saharan Africa, it ranged between 21.6% in Nigeria and 46.7% in Ethiopia (Adewuya, *et al.,* 2010; Assefa, *et al.,* 2012). A cross-sectional study in Southern Ethiopia involving 317 participants, by Aserat, *et al.,* (2018), revealed that the

prevalence of internalized stigma was 32.1%, and female participants experienced more Internalized stigma more than male participants. A study by Ibrahim, et al., (2016) in Maiduguri showed that the respondents with poor social support were 4.5% times more likely to have high internalized stigma than those with good social support. Four-fifths of the respondents with poor levels of social support had high internalized stigma scores as against less than one-fifth of those with a good social support base. In Benue State, most of the psychiatric hospitals are concentrated in urban areas. The distance from rural to urban centres is much, because of this, most people who suffer from mental illness, attend traditional psychiatric hospitals. Consequently, data on internalised stigma of mental illness is not easily available in Benue State. To the best of the knowledge of the researcher, there is lack of literature on internalised stigma of mental illness in Benue State. Knowledge of the experiences of internalised stigma of mental illness will help develop interventions to assist people with mental illness overcome psychological and social effects of public stigma. This study therefore seeks to examine the internalised stigma of mental illness in Benue State, Nigeria.

The labelling theory was used as a theoretical framework for the study. The theory was first developed by Tanneubaum in his book Crime and Community (1938), and later applied to the term mental illness in 1966 by Thomas Scheff in his book, *Being Mentally Ill,* in which he presented a sociological model of mental illness that is the complete opposite of the medical model. In his presentation, rather than seeing mental illness as an abnormal condition which affects the individual, it is rather viewed as a label attached to persons who exhibit certain types of behaviour. Based on the theory of self-fulfilling prophecy, people with these labels unconsciously change their behaviour to fit societal expectations. The theory is important to this study because it describes the process by which the attitude of members of the public can alter the self-concept of people living with mental illness and shape their identity. They may develop a better concept of themselves if the attitude of members of the public towards them is positive; however, they are likely to internalize a negative concept of themselves if the reaction of members of the public towards them is negative.

METHODOLOGY

Location of the Study

The study was conducted in Benue State, which is located in the North Central geo-political zone of Nigeria. This is because of the existence of two tertiary psychiatric hospitals in the state - Federal Medical Centre Makurdi, and Benue State University Teaching Hospital Makurdi, Federal Medical Centre Makurdi and Benue State University Teaching Hospital Makurdi have psychiatric sections where people with mental illness are treated by trained orthodox health care professionals.

Population of the Study

The population of this study was drawn from 113,678 people receiving treatment for mental illness at the two-government owned psychiatric hospitals in Benue State (Records from FMC & BSUTH, 2015). The population consisted of both males and females diagnosed as having a

major mental illness (psychosis, mood disorders and substance disorders) by either an orthodox or traditional psychiatric doctor, and were receiving treatment at either the in-patient or out-patient Department (OPD) of the psychiatric units of Federal Medical Centre Makurdi and Benue State University Teaching Hospital Makurdi.

The Study Design

The study was a descriptive cross-sectional survey design. A key strategy of the study was the use of both quantitative and qualitative data. The main purpose for adopting this mixed method was to triangulate findings to achieve the aims of the study.

Sample Size Determination

The sample size for this study comprises of 468 people living with mental illness (399 attending Orthodox health care centres and 69 from Traditional). This number is justified because it will present a clear picture of the internalised stigma experienced by people with mental illness receiving treatment at both traditional and orthodox psychiatric centres. The sample size for people living with mental illness attending clinic at Federal Medical Centre Makurdi and Benue State University Teaching Hospital Makurdi was also arrived at using Taro Yamane (1967) formula;

$n = \frac{N}{1+N(e)^2}$ e = level of significance (0.05)

Where n = 113678= total population of people living with mental illness at Federal Medical centre Makurdi and Benue State University Teaching Hospital Makurdi and e = 0.05 is the level of significance.

$n = \frac{113678}{1+113678(0.05)^2} n = \frac{113678}{285.195} n = 398.59745 \approx 399$

This sample size for people living with mental illness receiving treatment from traditional hospitals was determined using Taro Yamane (1967) formula

$$n = \frac{N}{1 + N(e)^2}$$

Where; n = 83 = total population of people living with mental illness attending traditional healthcare at the selected centres in the six local government areas, and e = 0.05 is the level of significance.

$n = \frac{83}{1+83(0.05)^2} n = \frac{83}{1.2075} n = 68.7370 \approx 69$

The sample size for people living with mental illness receiving treatment at the Orthodox healthcare centres (399) were added to those receiving treatment at the traditional healthcare

centres (69) to give a total of 468 which formed the total sample size for people living with mental illness.

Sampling Procedure

To recruit the sample of people living with mental illness, the researchers and their research assistants regularly visited on clinic days, the psychiatric units of Federal Medical Centre Makurdi (Tuesdays and Thursdays) and the Benue State University Teaching Hospital Makurdi (Mondays and Fridays): They requested for a register of all the people living with mental illness reporting for treatment at the clinics, and with the assistance of healthcare professionals collected their case files and sorted them out according to those that met the inclusion criteria. Those that met the inclusion criteria for that day were then used to develop the sampling frame from which the selection was done. The sample obtained from Federal Medical Centre Makurdi (FMCM) and Benue State University Teaching Hospital (BSUTH) was done proportionately based on the number of people attending these hospitals as follows;

FMCM = $\frac{112200}{113678} \times 399$ = 394 participants, BSUTH = $\frac{1487}{113678} \times 399$ = 5 participants

Simple random sampling using a table of random numbers was then used to select ten participants on every clinic day. This selection process was used because it eliminated bias by availing all the participants the opportunity of being selected. This was done by writing the names of all the people living with mental illness that met the inclusion criteria with serial numbers. These numbers were then compared with a table of random numbers. Those participants with serial numbers that fall within the required range of numbers on the table were approached and selected. This process continued until 399 participants receiving treatment at Federal Medical Centre Makurdi (FMCM) and Benue State University Teaching Hospital (BSUTH) were selected respectively. The selected participants were then issued with the questionnaire and later on interviewed. 24 people living with mental illness were selected purposively for the interview. The main inclusion criteria for selection of people living with mental illness were persons diagnosed with a major mental disorder (psychosis, mood disorders, and substance abuse disorder) by a modern or traditional psychiatrist, as showing gross mental condition (for example evidence of hallucination, delusions and grossly abnormal behaviour) but were medication compliant, and were capable of engaging in intelligible discussion as assessed by the healthcare professionals and relatives' of the person with mental illness. Those persons selected gave informed consent, were accompanied by a care giver and were aged 18 years and older.

The researcher purposively selected six (6) traditional health care centres, one from each of the six local government areas sampled for the study. The choice of purposive sampling at this stage was informed on the basis that these traditional health care centres possessed particular characteristics being sought. The main criteria for selection of the traditional health care centres were those that specialized in treatment of mental illness and must have operated the centre for more than six to ten years.

Instruments for Data Collection

The instruments of data collection for the study were questionnaire, in-depth interview guide. The questionnaire was selected because of their suitability for making statistical inferences from a sample of a parent population (Smith, 1988). To administer questionnaire to people living with mental illness, the study adopted a back translation method. This means that the English version of the questionnaire was translated in the local dialect and back translated into English language by selected lecturers of Benue State University who were from the ethnic groups selected for the study. The persons were knowledgeable in both English and the local dialect; they agreed on the exact translation of the meaning of all the questions in both English and the local dialects. The same questions were then administered to all the respondents for the study.

The questionnaire for people living with mental illness was adopted from the internalized stigma of mental illness scale developed by Ritsher *et al*., (2003) designed to examine an individual's personal experience of stigma related to mental illness. The scale was made up of twenty-eight items grouped into five subscales viz: alienation six items, stereotype endorsement 7 items, perceived discrimination 5 items, social withdrawal 6 items and stigma resistance 5 items. All the subscale measured aspects of stigma experienced by people having mental illness and were used in this study except stigma resistance because of its low reliability. Each item was rated on a four-point Likert scale (1(0) strongly disagree; 2(1) =disagree; 3= (2) agree; and 4(3) =strongly agree). The prevalence of internalized stigma was defined as an item mean score of 1.5 or above on the aggregate score. Higher aggregate scores indicated elevated internalized stigma. This means that the 1.5 will represent the midpoint on the 0-3 item scale (Brohan, *et al.,* 2010). This subscale has been used in previous studies (Ghanean, *et al*., 2011, Mahmoud and Zaki 2015). All the items on the questionnaire reported high internal consistency as the reliability analysis revealed a Cronbach Alpha coefficient of 0.918.

Instruments of Data Analysis

The data collected from the research were analysed using frequency counts, percentage, mean and standard deviation. An independent t-test was done to determine the prevalence of elevated internalized stigma for people living with mental illness attending orthodox and traditional healthcare in Benue State. For the analysis of the qualitative data, the interviews were tape recorded after consent from the respondents was received. The researcher then made decisions and conclusions on the data collected by analysing specific statements from the interview and triangulating them with the quantitative data. This involved presenting the statistical analysis of the quantitative data and complementing it with result of the qualitative data to present a robust result. All areas of convergence and divergence in the quantitative and qualitative data were noted and sociological reasons advanced appropriately.

Ethical Considerations

Ethical approval for this study was obtained from Health Research Ethical Committees of Benue State University Teaching Hospital Makurdi and Federal Medical Centre Makurdi.

Individual consent for participation was obtained through a participation information sheet, which was administered to the participants by the researchers and research assistants. The selected participants were assured that the information provided by them would be treated with confidentiality and used only for the purpose of the study. There were also assured that they were at liberty to withdraw from the interview whenever they wished.

DATA PRESENTATION AND ANALYSIS

1. Socio-Demographic Characteristics of Respondents

Table 1. Socio-demographic characteristics of people living with mental illness are presented.

Variables	**People living with mental illness**		
Age		**Frequency**	**%**
n/r	n/r	10	2.2
18-25 years	18 – 25	122	26.1
26-35 years	26 – 35	158	33.7
36 and above	36 – above	178	38.0
Total	**Total**	**468**	**100.0**
Gender			
n/r	n/r	14	3.0
Male	Male	254	54.2
Female	Female	200	42.8
Total	**Total**	**468**	**100.0**
Marital Status			
n/r	n/r	8	1.7
Married	Married	170	36.4
Single	Single	234	50.1
Divorced	Divorced	27	5.8
Widowed	Widowed	28	6
Total	**Total**	**468**	**100.0**
Educational Qualification			
n/r	n/r	15	3.3
No formal	No formal	94	20.1
Primary	Primary	95	20.2
Secondary	Secondary	212	45.4
Tertiary	Tertiary	51	11
Total	**Total**	**468**	**100.0**
Religion			
n/r	n/r	5	1
Christianity	Christianity	409	87.4
Islam	Islam	27	5.8
Traditional	Traditional	27	5.8
Others	Others	-	-
Total	**Total**	**468**	**100.0**

Occupation			
n/r	n/r	7	1.6
Farming	Farming	166	35.4
Civil servant	Civil servant	89	19.1
Trading	Trading	10	2.1
Others	Others	196	41.8
Total	**Total**	**468**	**100.0**
Ethnic group			
n/r	n/r	14	3
Tiv	Tiv	217	46.3
Idoma	Idoma	108	23
Igede	Igede	53	11.4
Etule	Etulo	29	6.1
Abakwa	Abakwa	19	4.1
Nyifom	Nyifom	19	4.1
Jukun	Jukun	9	2
Others	Others	-	-
Total	**Total**	**468**	**100.0**

Source: Field survey

Table 1 shows that out of 468 people living with mental illness, 122 (26.1%) were between 18 and 25 years, 158 (33.7%) were between 26 and 35 years while those 178 (38.0%) were between 36 years and older. Most 254 (54.2%) were males, 200 (42.8%) were females. The majority, 234 (50.1%), were single, 170 (36.4%) were married, and 27 (5.8%) were divorced while 28 (8.0%) were widowed, 212 (45.4%), had secondary education, 95 (20.2%) had primary education, 94 (20.1%) had no formal education, while 51 (11%) had tertiary education. Majority 196 (41.8%), were engaged in other occupations, 166 (35.4%) were farmers, and only 89 (19.1%) were civil servants. Majority 409 (87.4%) were Christians, 27 (5.8%) were Muslims, while 27 (5.8%) practiced traditional religions. Majority 217 (46.3%), were Tiv, 108 (23.0%) were Idoma, 53 (11.4%) were Igede, 29 (6.1%) were Abakwa, 19 (4.1%), were Etulo, 19 (4.1%) were Nyifom whereas 9(2.0%) were members of Jukun ethnic group.

2. The Prevalence of Internalized Stigma among People Living with Mental Illness in Benue State

This was determined using the mean score of the views of people living with mental illness; the mean scores were further divided into minimal and elevated internalized stigma.

Table 2 Views of people living with mental illness on the belief that they withdraw or isolate themselves from the rest of the community

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	People without mental illness could not possibly understand me.	92	88	146	142	468	1.28	1.20	Minimal
2	Having a mental illness has spoiled my life.	173	97	132	66	468	1.81	1.09	Elevated
3	I am embarrassed in myself for having a mental illness.	186	103	141	38	468	1.93	1.01	Elevated
4	I am disappointed in myself for having mental illness.	309	85	50	24	468	2.45	0.90	Elevated
5	I feel inferior to others who don't have a mental illness.	195	100	125	48	468	1.94	1.05	Elevated
6	I feel out of place in the world because I have mental illness.	162	56	195	55	468	1.69	1.07	Elevated
	Grand Mean and standard deviations					**468**	**1.85**	**0.58**	**Elevated**

Source: Field survey, 2024.

Table 2 shows that people living with mental illness had elevated internalized stigma mean score of 1.5 and above on all the statements except the statement "People without mental illness cannot possibly understand me" which has a minimal internalized stigma with a mean score of 1.28 and a standard deviation of 1.20. The fact that respondents' mean scores were above the midpoint of 1.5 on almost all the statements on the alienation subscale is an indication that the experience of public stigma has affected people living with mental illness, and has decreased their self-esteem. This was expressed in the in-depth interview with a person having mental illness:

> I feel pity for myself, I feel very bad about my condition, I feel bad about my condition, I also feel bad when I see people that are in the same condition with me, because I take myself in their position. The mental illness has destroyed my life.
>
> (Male IDI/ 43/ married /Tiv/Christianity/ Degree holder)

2. **Mean and standard deviation on views of people living with mental illness on whether they agree with the negative stereotypes from members of the public**

Table 3 Mean and standard deviation on views of people living with mental illness on the public stereotype of mental illness

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	Because I have a mental illness, I need others to make decisions for me.	108	104	208	48	468	1.58	0.96	Elevated
2	People can tell that I have a mental illness by the way I look.	108	93	255	12	468	1.63	0.86	Elevated
3	Mentally ill people tend to be violent	94	121	205	48	468	1.56	0.92	Elevated
4	People with mental illness cannot live a good and rewarding life.	107	107	202	52	468	1.57	0.96	Elevated
5	Mentally ill people shouldn't get married.	80	326	46	16	468	2.00	0.64	Elevated
6	I can't contribute anything to the society because I have a mental illness.	123	94	187	64	468	1.59	1.02	Elevated
7	Stereotype about mental illness apply to me.	121	71	212	64		1.53	1.02	Elevated
	Grand Mean and standard deviations					**468**	1.64	0.45	**Elevated**

Source: Field work, 2024

Table 3 shows that all the mean scores on the subscale exceeded the midpoint of 1.5 thresholds. The highest mean scores of 2.00 and a standard deviation of 0.64 were found among respondents who felt that "Mentally ill people shouldn't get married". This was followed by respondents who believed that people can know they have mental illness just by looking at them; that group of respondents had a mean score of 1.63 and a standard deviation of .86. This

is an indication that respondents have endorsed the negative stereotypes of mental illness among members of the public. This was corroborated by a person having mental illness:

> Yes, people look down upon us and I feel bad. I am not yet married; I want to treat the problem I have before I will think of marriage. If I marry now my wife will not understand me, so I will have problem, I applied for job but was not successful, so because of my situation I decided to stay at home because the illness usually occurs but I think that is how God has made it to be.
>
> Male IDI / single / 40yrs / Tiv/Christian / SSCE.

3. **Perception of people living with mental illness on the stigma they experienced in their various communities**

This sub-section examines the actual experience of stigma by people living with mental illness.

Table 4. Mean and standard deviation on the discrimination experienced by people having mental illness in Benue State

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	Other people think that I can't achieve much in life because I have a mental illness	152	127	157	32	468	1.85	0.96	Elevated
2	People take me less seriously just because I have a mental illness	135	147	162	24	468	1.84	0.90	Elevated
3	People treat me like a child just because I have mental illness	164	108	144	52	468	1.82	1.04	Elevated
4	People discriminate against me because I have a mental illness	143	97	198	30	468	1.75	0.96	Elevated
5	Nobody would be interested in getting to me because I have a mental illness	91	239	102	36	468	1.82	0.83	Elevated
	Grand Mean and standard deviations					**468**	**1.82**	**0.62**	**Elevated**

Source: Field work, 2024.

Table 4 shows that there is an elevated score on all the statements with a grand mean of 1.82 and a standard deviation of .62. This means that the people with mental illness in the study experienced elevated internalized stigma because of mental illness. People with mental illness

interviewed narrated the experiences they faced every day because of mental illness. An interviewee said:

> Yes, people say I am not well, people don't talk to me and I feel bad. I don't go to public places, because of my mental illness, I don't go to public places, I am afraid. I have not looked for a job, and people say I am not well. Sometimes I will be talking to people and the person will tell me that I am not well. All my friends have run away from me because of my mental illness.
>
> (Female IDI/ 40/ Christian/ primary school/ Tiv/Married.).

Another interviewee also narrated the experience he had with members of the public because of his mental illness:

> I had friends before, but they have deserted me, all my friends as if I have no link with them. I don't go to public gatherings, when I go, people say bad things. If I say something, they tell me that what I say is not correct and other people will refuse to argue with me. I have not looked for a job before because of my condition. My neighbour calls me a mad man, I feel bad.
>
> (Male IDI / 30/ Christian / secondary school/ Igede/ single)

Another participant in the interview also narrated his experience of stigma and discrimination from members of the public thus:

> I don't have a friend, only God is my friend. Wherever I go they reject me, they call me useless man, when I stay with the people, and they insult me. I never marry but only God knows they disagree with anything I say, they tell me, don't mind that mad man. People don't come to my house, they keep away from me because of my problem I have, they will call me names and say when will this mad man die? They hate me.
>
> (Male IDI/ 35/ Christian/ primary school certificate/ Idoma/ single)

4. **Views of people living with mental illness on their self-exclusion from social events due to mental illness**

This was calculated using the mean and standard deviation. A score of 1.5 or lower indicates minimal social withdrawal, while a score of 1.5 or above is an indication of elevated social withdrawal.

Table 5 Mean and standard deviation on views of people living with mental illness on whether they exclude themselves from social events due to mental illness

S/N	Items	SA	A	D	SD	N	Mean	Std.	Remarks
1	I avoid getting close to people to avoid rejection.	67	187	126	88	468	1.50	0.96	Elevated
2	I don't talk about myself much because I don't want to burden others with my mental illness.	27	18	255	168	468	0.79	0.77	Minimal
3	Negative stereotypes about mental illness keep me isolated from the normal world.	99	63	274	32	468	1.49	0.90	Minimal
4	I don't get close to people much because my mental illness might make me look weird to them.	153	72	230	13	468	1.78	0.94	Elevated
5	I stay away from social gatherings in order to protect my family from embarrassment.	179	99	142	48	468	1.87	1.04	Elevated
6	Being around with people who don't have mental illness make me feel out of place.	0	0	257	211	468	0.55	0.50	Minimal
	Grand Mean and standard deviations					**468**	**1.33**	**0.43**	**Minimal**

Source: Field Survey, 2024.

Table 5 revealed that the highest mean scores of 1.87 and a standard deviation of 1.04 was recorded among respondents who stated that they stay away from social gatherings in order to protect their families from embarrassment because of the mental illness. The grand mean of 1.33 and a standard deviation of .43 show a minimal score on the social withdrawal sub scale. This means that although the respondents have experienced public stigma, their withdrawal from social interaction is minimal.

5. The levels of elevated internalized stigma among people living with mental illness.

This subsection determines the percentages of people living with mental illness who have minimal and elevated stigma.

Table 6 Levels of elevated internalized stigma among people living with mental illness using frequencies and percentages

Levels of Stigma	Frequency (%)	Percent (%)
Minimal Stigma	150	32.1
Elevated	318	67.9
Total	**468**	**100.0**

Source: Field survey, 2024.

Table 6 revealed that 67.9% of people living with mental illness sampled had elevated internalized scores while 32.1% of the respondents had minimal levels of internalized stigma.

6. This section examines socio-demographic attributes of people living with mental illness and levels of stigma using t-test analysis.

Table 7 Socio-demographic attributes and stigma levels of people living with mental illness.

Variables			Level of Stigma		Total	Statistics		
			Minimal Stigma	Elevated Stigma		x^2	Df	Sig (2-sided)
Age	NR	Count	2	8	10	1.949	3	.583
		Expected Count	3.2	6.8	10.0			
	18-25	Count	37	85	122			
		Expected Count	39.1	82.9	122.0			
	26-35	Count	48	110	158			
		Expected Count	50.6	107.4	158.0			
	36 and above	Count	63	115	178			
		Expected Count	57.1	120.9	178.0			
Total		Count	150	318	468			
		Expected Count	150.0	318.0	468.0			
Sex	NR	Count	3	11	14			
		Expected Count	4.5	9.5	14.0			
	Male	Count	79	175	254			
		Expected Count	81.4	172.6	254.0	1.179	2	.555
	Female	Count	68	132	200			
		Expected Count	64.1	135.9	200.0			
	Total	Count	150	318	468			
		Expected Count	150.0	318.0	468.0			
	NR	Count	3	12	15	4.288	4	.368

Education		Expected Count	4.8	10.2	15.0			
Qual.	No formal education	Count	32	62	94			
		Expected Count	30.1	63.9	94.0			
	Primary	Count	25	70	95			
		Expected Count	30.4	64.6	95.0			
	Secondary	Count	69	143	212			
		Expected Count	67.9	144.1	212.0			
	Tertiary	Count	21	31	52			
		Expected Count	16.7	35.3	52.0			
	Total	Count	150	318	468			
		Expected Count	150.0	318.0	468.0			
Occupation	NR	Count	2	5	7			
		Expected Count	2.2	4.8	7.0			
	Farming	Count	48	118	166			
		Expected Count	53.2	112.8	166.0			
	Civil servant	Count	30	59	89	2.196	4	.700
		Expected Count	28.5	60.5	89.0			
	Trading	Count	2	8	10			
		Expected Count	3.2	6.8	10.0			
	Others	Count	68	128	196			
		Expected Count	62.8	133.2	196.0			
	Total	Count	150	318	468			
		Expected Count	150.0	318.0	468.0			

Source: Field survey, 2024.

Table 7, reveals that 115 respondents with an expected frequency of 120.9 within the age range of 35 and above had elevated internalized stigma, more than those within the age range of 18 and 25. Also, 175 males with an expected frequency of 172.6, more than 132 females with an expected frequency of 135.9, had elevated internalized stigma. More respondents with secondary education (143 with an expected frequency of 144.1) had elevated stigma than those without formal education, and 128 respondents with different occupations not mentioned constituted the highest proportion of those with elevated internalized stigma followed by respondents who were farmers.

7. This section used t-test statistics to examine the mean difference in the views of people living with mental illness who attended traditional and orthodox healthcare centres

Table 8: t-test statistics indicating mean differences in the views of people living with mental illness who attended traditional and orthodox health care centres

Nature of Health Care		N	Mean	Std. Dev.	Df	T	Sig. (2-tailed)
The views of people living with mental illness on the alienation sub scale of social stigma	Traditional	399	1.86	0.58	466	.497	.619
	Orthodox	69	1.82	0.60			
The views of people living with mental illness on the stereotype endorsement subscale	Traditional	399	1.65	0.44	466	1.817	.070
	Orthodox	69	1.55	0.47			
The views of people living with mental illness on the stigma they experienced in their various communities	Traditional	399	1.82	0.61	466	.176	.861
	Orthodox	69	1.81	0.67			
The views of people living with mental illness on the social withdrawal subscale	Traditional	399	1.34	0.43	466	1.262	.208
	Orthodox	69	1.27	0.45			
Prevalence of elevated internalized stigma among the people living with mental illness	Traditional	399	0.90	0.48	466	4.404	.000
	Orthodox	69	0.63	0.35			

Source: Field survey, 2024

Table 8 shows that on the alienation sub-scale of social stigma, the $p > 0.05$., which shows the p-value of .619, which is greater than 0.05. This means there is no significant difference in the views of people living with mental illness who attended traditional and orthodox health care centres on the alienation sub-scale of social stigma.

The table also shows that on the stereotype endorsement sub-scale, the p-value is .070, which shows that the $p > 0.05$. This also means that there is no significant difference in the views of people living with mental illness who attend traditional and orthodox health care centres on the stereotype endorsement subscale. The table also shows that on the stigma they experienced in their various communities, the p-value is .861, which shows that the $p > 0.05$, which means that there is no significant difference on the stigma they experience in their communities. On the social withdrawal subscale, the result shows that the p value is .208, which shows that the $p >0.05$. This shows that there is no significant difference on the social withdrawer subscale of people living with mental illness attending orthodox and traditional healthcare centres.

On the Prevalence of elevated internalized stigma among people living with mental illness, the p-value is 0.00, which shows that $P < 0.05$, which means that the prevalence of elevated

internalized stigma among people living with mental illness who attended traditional health care, is more than those who attended orthodox.

DISCUSSION OF FINDINGS

It was established from the study that 67.9% of people with mental illness were categorized as having elevated internalised stigma, while 32.1% had minimal stigma scores. This shows that internalised stigma is high among the respondents in the study area. This is relatively high compared to studies by Ibrahim at al. (2016), which reported 22.5% in Maiduguri, Nigeria and Ghanean *et al.,* (2011) who reported 12% in Sweden. A possible explanation to this high prevalence of internalized stigma is the low level of awareness among members of the public about prognosis, nature and treatment of mental illness in Nigeria. This invariably results to negative attitude of members of public towards mental illness, thus promoting a feeling of loss of self efficacy among people with mental illness. Another possible reason for the prevalence of elevated internalized stigma among people with mental illness in Benue State could be lack of counselling and psycho-education programs at the clinics to reduce the impact of stigma on people receiving treatment. The third possible reason for the difference could be because of different scoring systems used by other studies and the cultural variation among the different studies.

The study also established that males had higher mean scores than females on elevated internalized stigma. This is different from a study by Khan, *et al.,* (2015) which showed that women experienced more elevated internalized stigma than men. The possible reason for this could be cultural differences between the two study areas. This highlights the problem women face in traditional Africa societies. Women are at disadvantage in all spheres of life, even when they experience the same condition with their male counterparts. People with mental illness that received traditional care had more elevated internalized stigma than those that attended the orthodox psychiatric hospitals. This finding has not previously been covered in the literature. This may be because of the harsh therapy applied by traditional doctors, where people with mental illness receiving treatment are chained, beaten and restrained by the traditional doctors in the full glare of members of the community, and the proximity of the traditional treatment centres to communities where mental illness is highly stigmatized. This might be responsible for the feeling of elevated internalized stigma among people with mental illness attending traditional psychiatric centres.

It was also revealed that the proportion of people with mental illness reporting been inferior because of mental illness were relatively high. This is an indication that people with mental illness have elevated internalized stigma. This might be because of the accumulative effect of stigma from members of the public. This finding has serious implications on the mental health of people living with mental illness; it will affect the self concept and self efficacy of people with mental illness, who are living among members of public. This finding is corroborated by studies by Koschorke *et al*., (2014). This is also an indication that people with mental illness have accepted the public stigmatization of mental illness. This finding has implications for policy making as there is an urgent need to reduce the stigma and discrimination experienced by people having mental illness.

Conclusion and Recommendations.

Mental health is an important precursor of human health and is fundamental in our ability to live well with other members of the society and contribute meaningfully to the development of the society. The maintenance and protection of good mental health should therefore be a fundamental concern of individuals, society and nations over the globe. The absence of good mental health can constitute a serious problem to the global health and is a consequence of poverty, ill health and stigma. Stigma is a central challenge to integrity of the people who are affected, their family members and the society at large. It affects individuals' capacity to perform social roles and their capacity to contribute meaningfully to the development of the society.

Based on the findings of this study, the following recommendations are made with policy implications and implementation strategies.

i. There is therefore the need for Government and non-governmental organizations to undertake psycho educational programs and counselling targeted at people with mental illness receiving traditional psychiatric care. The psycho-social programs should be aimed at reducing stigma among people living with mental illness which is informed by what matters most to them in terms of their sense of worth and acceptance.
ii. Government and non- governmental organizations should also introduce interventions to end stigma among people living with mental illness. These interventions should focus on helping people to overcome feeling of alienation and low self-esteem, this means involving people with mental illness in stigma intervention support groups where people with mental illness can share their experiences of stigma and ways to cope with stigma of mental illness.

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