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INTERNALIZED STIGMA AND STIGMATIZING CULTURAL BELIEFS ON PARENTING WITH MENTAL ILLNESS AMONG FEMALE PATIENTS WITH SCHIZOPHRENIA: A COMPARISON OF FEMALE PARENT VERSUS NON PARENT

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Abstract

Purpose: Differences in cultural values, norms and conceptualization of mental illness may influence mental illness stigma differently across the globe. Both public and self stigma have widely been researched globally however, little is known about the specific experiences of stigma that females, and in particular mothers, with schizophrenia encounter as parents in Nigeria. The study aims to explore and compare internalized stigma among female parents and female non-parents. The secondary aim is to explore if any association exist between cultural beliefs on parenting with mental illness and internalized stigma among female patients with schizophrenia.

Methodology: 142 female patients with schizophrenia attending the GOPD clinic at FNPH Maiduguri recruited through convenience sampling completed the study. They completed a socio-demographic questionnaire and a modified version of the Internalized stigma of Mental Illness Scale (ISMI). Analysis was done using Statistical Package for Social Sciences (SPSS). Differences in self stigma were compared using chi-square for categorical variables and student t- test for continuous variables. P-value was set at 0.05.

Findings: A total of 65 (75.6%) female parents and 32 (57.1%) of female non parents with schizophrenia had high self stigma. Female parents had a statically significant higher level of self stigma on the alienation subscale as well as the total score. Myths and misconceptions about parenting with mental illness were rampant.

Conclusion: Self stigma is more prevalent among female parents with schizophrenia, with cultural beliefs and practices playing an important role in influencing stigma of mental illness. Further research of the impact of cultural factors on stigma of mental illness and culture specific interventions should be explored to reduce self stigma among parents with mental illness.

Keywords: *Stigma, Culture, Schizophrenia, Female, Parent*

1.0 INTRODUCTION

Culture refers to the shared attributes, belief systems, and value orientations that a group of people have in common and that influence their customs, norms, practices, social institutions, psychological processes, and organizations (Fiske, Kitayama, markus, & Nisbett, 1988). It can also be stated as shared beliefs, values, and norms of a given racial or ethnic group. Cultural influences may impact on both public and self stigma (Abdullahi & Brown, 2011; Bracke, Delaruelle, & Verhaeghe, 2019). Abdullah & brown (2011) reported that the way in which culture impacts public stigma is analogous to the way in which culture impacts self-stigma. Cultural beliefs on the causation, mode of transmission, manifestation and treatment of mental illness (Okpalauwaekwe, Mela, & Oji, 2017) influence how the communities implement on practices that may potentially be detrimental to the patients (Gureje, Olley, Olusola, & Kola, 2006). Cultural values and norms vary across cultural groups and determine a group's predominant beliefs regarding people with mental illnesses (Gureje el al. 2006).

Differences in cultural values, socialization or cultural conceptualizations of mental illness influence stigma differently across cultural groups (Krendl & Pescosolido, 2020). For example, more African Americans believe that mentally ill persons are dangerous compared with Caucasians (Abullahi and Brown, 2011). People of African origin who value spiritualism might believe that those with mental illnesses are cursed by evil spirit and discriminate them because of that belief (Labinjo, Serrant, Ashmore, & Turner, 2020). Culture also contributes significantly to the meanings, practices, and outcomes of stigma (Kishore, Gupta, Jiloha, & Bantman, 2011), such as perceiving a person with mental illness as incompetent and mental illnesses are untreatable with medications (Corrigan, Drass, & Perlick, 2014) or psychiatric medications as addictive or harmful (Kranke, Guada, Kranke, & Floersch, 2012). Such cultural interpretations and expression may affect treatment seeking, medication adherence and recovery from mental illness (Okpalauwaekwe et al., 2017). Therefore, examinations of culture specific practices are critical for understanding the relationship between culture and mental illness stigma.

Stigma is an attribute that discredits an individual, makes the person different from others, and essentially reduces the person's status from a “whole and usual person to a tainted, discounted one” (Goffman, 1963). Another most encompassing definition describes stigma as a pervasive and global “devaluation of certain individuals on the basis of some characteristic they possess, related to membership in a group that is disfavoured, devalued, or disgraced by the general society” (Stier & Hinshaw, 2007). Applied specifically to mental illness, stigma refers to the social judgment, degradation, or devaluation of individuals because they have mental illness symptoms or have been labeled as having a mental illness (Corrigan & Watson, 2002a). Stigma consists of three components (Corrigan & Watson, 2002b), which are stereotype (a negative belief), prejudice (a negative emotional reaction), and discrimination (behavioural response). Public stigma is characterized by negative stereotypy of (e.g. dangerousness, incompetence), prejudice of (e.g. fear and disgust) and discrimination of (e.g avoidance, restricting opportunities) while self stigma occurs when one internalizes public views to

himself/herself (Corrigan & Watson, 2002b). Stereotypes, or stigmatizing beliefs, about individuals with mental illnesses are generally negative beliefs, and they can, if endorsed, lead to prejudice. Prejudice is an often negative, evaluative, stigmatizing attitude towards persons with mental illnesses that is at times coupled with an emotional reaction (Watson, Corrigan, Larson, & Sells, 2007). Prejudice can bring about discrimination, which is the behavioural manifestation of prejudice. Discrimination may include negative actions that are harmful in some way towards individuals with mental illnesses (Watson et al. 2007). Negative stigmatizing beliefs and poor knowledge on the causation, characteristics and management of mental illness was identified as a major obstacle to improving mental health in Nigeria (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005) and Abdulmalik et al. (2016) reported that the lack of available mental health information is a considerable challenge and recommended advocacy and awareness raising about mental illness through training and supportive collaboration to reduce stigma and discrimination against persons with mental illness.

Parenting is a complex social task where parents are expected to meet the needs of their children and to foster their children's physical, emotional and mental well-being. The parenting process is not limited to measures that ensures child's survival but also involves the provision of guidance, affection and support that promotes child's healthy growth and development (Seay, Freysteinson, & Mcfarlane, 2014). However, among parents with severe mental illness (SMI), self-stigmatization may negatively impact their parenting self-esteem and perceived self-efficacy, thus adversely affecting their overall competence as parents (Arvaniti, Spyropoulou, & Zervas, 2012). Studies have shown that majority of people with schizophrenia become parents and stigma for parents with schizophrenia is not only limited to the stereotypes about people with severe mental illness but also to their perceived social roles as parents (Arvaniti et al. 2012; Seeman, 2010). Stereotypes regarding parents with SMI are often associated with expectations about not only their presumed inability to look after themselves, but also their inability to adequately care for their children. People with SMI identify parenting as a meaningful role and a desired life goal, with parenting providing a sense of purpose, and also an incentive for recovery (Lacey et al. 2015). Despite the value they attach to their parenting role, health care professional also rarely ask about parenting experiences or offer support with parenting (Lacey et al. 2015).

Although studies have examined self-stigmatization among parents with SMI and their relationships with their children (Lacey et al. 2015; Chan, Ho, & Bressington, 2019; Chen, Reupert, & Vivekananda, 2021) most of these studies were small sample size qualitative studies (Chan et al. 2019; Chen et al. 2021) and conducted in Western cultures (Lacey et al. 2015) with most studies showing that mothers are more likely to experience stigma on parenting compared to fathers (Lacey et al. 2015; Campbell et al. 2012; Asrat, Ayenalem, & Yimer, 2018). Prior evidence also suggest that mothers are more likely than fathers to benefit from parenting support because of the more warmth and nurture they can provide for the children (Campbell et al. 2012) and research to date is yet to compare the self-stigma experiences for mothers and non-mothers with schizophrenia. Furthermore, prior evidence from non-parent population suggests that women may be

more likely to perceive and internalise stigma compared to men (Jenkins & Carpenter-Song, 2008). Additionally, only few literatures have focused on the impact of culture on mental illness among patients' with schizophrenia (Ran et al. 2021) with none among female parents with schizophrenia in the context of parenting. The available ones on the relationship of culture and stigma either evaluated on the cross- cultural differences in the levels of stigma (Abdullahi & Brown, 2011) or on the ethno-cultural beliefs, values and norms that shape stigma of mental illness (Ran et al. 2021). As Cultural beliefs and practices are also integral to understanding stigma of mental illness among special group of individual, cultural practices and beliefs that further compounds stigma among female parents (mothers) with schizophrenia have not been explored in Nigeria. Thus, this study hopes to explore stigmatizing cultural beliefs and practices on parenting and internalized stigma among female patients with schizophrenia. The outcome of this research will provide a basis on designing intervention programmes in improving their attitude and practice. Additionally, the outcome of this study will provide a foundation for a future research.

2.0 MATERIALS AND METHODS

2.1: Subjects

The study participants were female patients with schizophrenia who were recruited through a convenience sampling at the GOPD of FNPH Maiduguri with 142 patients with schizophrenia completing the study. The inclusion criteria are consenting patients between 18 -55 years who fulfilled the ICD-10 diagnosis of schizophrenia while the exclusion criteria are presence of co-morbid medical illness and presence of psychotic symptoms that interferes with the ability to comprehend the questions.

2.2: Measures

2.2.1: Socio-demographic and clinical data

A pre-designed socio-demographic questionnaire was used to collect data on socio-demographic (age, marital status, tribe, religion, employment status) and clinical variables (type of illness, duration of illness, number of hospitalization, number of relapse, and symptoms severity) of the participants.

2.2.2: Internalized stigma of mental illness scale (ISMI)

It is a 29 item questionnaire with five subscales: alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance. Each item is rated on a four-point Likert scale from 1 (strongly disagree) to 4 (strongly agree). The fifth stigma resistance subscale items are reverse-coded. A high total score on the ISMI scale indicates more severe internalized stigmatization. The internal consistency of the original version was 0.90 ($n = 127$) and the test–retest reliability coefficient was $r = 0.92$ ($n = 16$, $P < 0.05$). The internal consistency and test–retest reliability for the five subscales were: alienation, 0.79, 0.68; stereotype endorsement, 0.72, 0.94; discrimination experience, 0.75, 0.89; social withdrawal, 0.80, 0.89; and stigma resistance, 0.58, 0.80 (Ritsher, Otilingam, & Grajales, 2008). Previous research (Ritsher et al. 2008), defined a high level

of self-stigma as an average score above a midpoint of 2.5. The same cut-off point was adopted in this study.

2.2.3: 12 item questions on stigmatizing cultural beliefs.

The questionnaire designed was based on an outcome of focus group discussion among patients with schizophrenia and their care givers. Participants were asked to list all the challenges they encounter as mothers because of their mental illness of which mothers without mental illness or mentally ill patients without children do not experience. Just as the ISMI Scale, each of the items was listed with a four-point likert scale (strongly disagree, disagree, agree and strongly agree). Some of the responses generated include: "mental illness can be transmitted through breastfeed", "medications used to treat mental illness can harm the baby". Responses were then rephrased to be in keeping with the ISMI Scale to "I can transmit mental illness through breastfeeding to my child", "The medication I take for my mental illness can harm my baby" All the statements were negatively worded and they were subsequently dichotomized into two. Cronbach's alpha and item-total correlations were computed to check their internal consistency reliability. The scale demonstrated good internal consistency reliability with a Cronbach's alpha of 0.74.

2.3 Statistical Analysis

Data were entered into Statistical Package for Social Science (SPSS) version 18 for statistical analysis. Mean and standard deviation and frequencies and percentages were used to compute continuous and categorical variables respectively. Socio-demographic and clinical characteristics of the two groups were compared using chi-square while student t-test was used to compare stigma among the two groups. P-value was set at 0.05. Pearson's correlation was used to assess the association of self stigma and cultural beliefs.

2.4 Ethical Approval

Ethical Clearance was obtained from the Ethics Review Committees of the institution. All potential participants were requested to sign an informed consent form after due explanation of the study procedure with only those who consented were enrolled. Only Codes were used for data entry and analysis to ensure utmost confidentiality.

3.0 RESULTS:

3.1: Socio-demographic characteristics of the study participants

The result on table 1 showed that there is no statistical significant difference between the socio-demographic characteristics of female parents and non parents but they differed significantly in their clinical characteristics.

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Table 1: socio-demographic and clinical characteristics of the respondents

	Female parents		Female non-parent		Total		χ^2	p-value
	n	%	n	%	n	%		
Age								
18-25	9	10.5	9	16.1	18	12.7	3.169	0.366
26-35	30	34.9	22	39.3	52	36.6		
36-45	31	36.0	20	35.7	51	35.9		
46-55	16	18.6	5	8.9	21	14.8		
Marital status								
Single	7	8.1	12	21.4	19	13.4		
Married	30	34.9	17	30.4	47	33.1	5.755	0.218
Divorced	38	44.2	19	33.9	57	40.1		
Widowed	6	7.0	5	8.9	11	7.7		
Separated	5	5.8	3	5.4	8	5.6		
Educational status							2.788	0.594
No education	10	11.6	4	7.1	14	9.9		
Primary	16	18.6	9	16.1	25	17.6		
Secondary	23	26.7	45	39.3	27	31.7		
Tertiary	8	9.3	5	8.9	13	9.2		
Quranic	29	33.7	16	28.6	45	31.7		
Ethnicity								
Kanuri	31	36.0	13	23.2	44	31.0		
Hausa	10	11.6	6	10.7	16	11.3	6.777	0.148
Fulani	4	4.7	4	7.1	8	5.6		
Babur	10	11.6	15	10.7	25	17.6		
Shuwa	31	36.0	18	33.7	49	34.5		
Employment status								
Employed	21	24.4	12	21.4	33	23.2	0.170	0.680
Unemployed	65	75.6	44	78.6	109	76.8		
Duration of illness								
<1 year	6	7.0	13	23.2	19	13.4	8.151	0.043
1-5 years	48	55.8	27	48.2	75	52.8		
6-10 years	15	17.4	9	16.1	24	16.9		
>10 years	17	19.8	7	12.5	24	16.9		
No of hospital admission								
Nil	15	17.4	9	16.1	24	16.9		
1	55	64.0	21	37.5	76	53.5	14.45	0.002
2-5	14	16.3	25	44.6	39	27.5		
6-10	2	2.3	1	1.8	3	2.1		
No of relapse								
Nil	60	69.8	7	12.5	67	47.2		
1	10	11.6	33	58.9	43	30.3	50.51	0.000
2-5	15	17.4	14	25.0	29	20.4		
6-10	1	1.2	2	3.6	3	2.1		

More parents had at least one hospital admission (64.0%) compared with non parent (37.5%) while more non parents had 2-5 hospital admission (27.5%) compared with parents (16.3%). More female parents had no previous history of relapse (69.8%) compared with non parents (47.2%) and fewer parents had one or more history of relapse (11.6%) compared with non parents (58.9%). The participants were predominantly within the age group 26-35years and 36-45 years accounting for 72.5% of the population. Majority were either divorced (40.1%) or married (33.1%). Only 9.2% of the population had education up to tertiary level and only 23.2% are gainfully employed. The predominant tribes were kanuri and shuwa accounting for 65.5% of the population. Slightly above 50% of the participants had duration of illness within 1-5 years and almost a half of the participant had no history of relapse.

3.2: Prevalence of self stigma

Table two shows that the prevalence of self stigma was higher among female parents (75.6%) compared to non parents (57.1%) with the differences being statistically significant (p= 0.021). Female parents had a higher score on each of the ISMI Subscale except on the social withdrawal subscale, however the differences did not reach statistical significance in all the domains except on the alienation subscale where more female parents had high stigma 82.6% than non parent 44.6% with the differences being highly statistically significant (p= 0.000).

Table 2: Comparative analysis of the Prevalence of Self Stigma

Variables	**Female parents**		**Female non-parent**		**χ2**	**p-value**
Level of stigma	Low stigma n %	High stigma n %	Low stigma n %	High stigma n %		
Alienation	15(17.4)	71(82.6)	31(55.4)	25(44.6)	22.26	0.000*
Stereotypy endorsement	26(30.2)	60(69.8)	23(41.1)	33(58.9)	1.763	0.184
Discrimination	21(24.4)	65(75.6)	18(32.1)	38(67.9)	1.016	0.314
Social withdrawal	22(25.6)	64(74.4)	13(24.6)	43(76.8)	0.102	0.749
Stigma resistance	18(20.9)	68(79.1)	19(33.9)	37(66.1)	2.974	0.085
Total self stigma	21(24.4)	65(75.6)	24(42.9)	32(57.1)	5.327	0.021*

3.3: Mean differences on the ISMI Subscales:

As shown in table 3, female parents in general had a higher mean score on the ISMI Scale and subscale except on the discrimination scale and a statistically significant difference was observed on the alienation subscale (t=5.59, p=0.000).

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Table 3: Mean ISMI scores by Items among Female Patients with Schizophrenia that were Parents and Non-parent

ISMI subscale	Female Parents (n=86)		Female non-parents (n=56)			
	Mean	SD	Mean	SD	t	ρ
Alienation	2.7829	0.39940	2.3929	0.41734	5.59	0.000*
Stereotype experience	2.6545	0 .35972	2.6224	0.43453	0.46	0.647
Discrimination	2.7907	0.44659	2.7929	.40535	0 -0.03	0.976
Social withdrawal	2.6531	0.39870	2.6399	0.32063	0.21	0.835
Stigma resistance	2.6250	0.27587	2.5804	0.36652	0.78	0.438

5.4: Prevalence of self stigma using each item on the ISMI Scale:

Differences were observed on two items on the alienation subscale, two items on the stereotype endorsement and two items on the stigma resistance subscale. More female parents (72.1%) agreed to the statement "I feel out of place in the world because I have a mental illness" compared to non parents (41.1%): $\chi 2=13.58$; p=0.000. So also, more female parent agreed on "people without mental illness could not possibly understand me ($\chi 2=24.84$; p=0.000) on the alienation scale. On the stereotype endorsement items, 59.3% of parents compared with 33.9% of non parents agreed on the statement "mentally ill people should not get married" ($\chi 2=8.736$; p=0.003) while more non parents (75.0%) compared with parents (46.5%) agreed on "I can't contribute anything to society because I have a mental illness" ($\chi 2=11.28$; p=0.000). On the stigma resistance scale, more female parents agreed to the statement " I can have a good, fulfilling, life, despite my mental illness" (32.6%) compared with 16.1% of non parents ($\chi 2=4.785$; p=0.029) while more non parents (58.9%) agreed on "People with mental illness make important contributions to society" to parents (34.9%) ($\chi 2=7.944$; p=0.005). Only statements with significant differences are shown on table 4.

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Table 4: comparative analysis of self stigma using each item on the ISMI Scale:

	Parent		Not parent		χ2	p-value
	SD/D	A/SA	SD/D	A/SA		
I feel out of place in the world because I have a mental illness	24(27.9)	62(72.1)	33(58.9)	23(41.1)	13.58	0.000*
People without mental illness could not possibly understand me	(27.9)	62(72.1)	33(58.9)	23(41.1)	24.84	0.000*
I feel inferior to others who don't have a mental illness	26(30.2)	60(69.8)	26(46.4)	30(53.6)	3.833	0.050
Mentally ill people should not get married	35(40.7)	51(59.3)	37(66.1)	19(33.9)	8.736	0.003*
I can't contribute anything to society because I have a mental illness	46(53.2)	40(46.5)	14(25.0)	42(75.0)	11.28	0.001*
I can have a good, fulfilling life, despite my mental illness	58(67.4)	28(32.6)	47(83.9)	9 (16.1)	4.785	0.029*
People with mental illness make important contributions to society	56(65.1)	30(34.9)	23(41.1)	33(58.9)	7.944	0.005*

SD (strongly disagree), D (disagree), A (agree), SA (strongly agree)

3.5: Prevalence of Stigmatizing Cultural beliefs and practices on parenting

About half of both parents and non parents agreed that they can transmit their mental illness through breastfeeding with more parents (60.5%) agreeing to "I cannot breastfeed my child because I have a mental illness. More non parents (64.3%) endorsed to "A child should be taken away from his or her mentally ill mother until she recovers, to avoid endangering the child" compared to parents (41.9%); $\chi2=6.824$, $p=0.009$. Almost three quarter of both groups believed that their mental illness was caused by evil spirit while almost three quarter disagreed to mental illness as being contagious. More non parents (67.9%) agreed to "The medication I take for mental illness can harm my baby" compared to 40.7% of parents with almost two-third of both groups disagreeing to "mentally ill women on medication should stop breastfeeding". More parents disagreed to "I cannot recover from my mental illness 59.3% compared to 47.3% of non parents with more than half of both groups endorsing a mentally ill mother is more burdensome than a patient with HIV, leprosy, tuberculosis or cancer. Other findings can be seen on Table 5.

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Table 5: Cultural beliefs on parenting with mental illness

	Parent		Not parent		$\chi 2$	p-value
	SD/D	A/SA	SD/D	A/SA		
I cannot breastfeed my child because I have a mental illness	34(39.5)	52(60.5)	34(60.7)	22(39.3)	6.096	0.014*
I can transmit mental illness through breastfeeding to my child	43(50.0)	43(50.0)	29(51.8)	27(48.2)	0.061	0.805
A child should be taken away from his or her mentally ill mother until she recovers, to avoid endangering the child	50(58.1)	36(41.9)	20(37.5)	36(64.3)	6.824	0.009*
When a woman becomes psychotic during pregnancy, the pregnancy should be terminated to safe the unborn child	66(76.7)	20(23.3)	47(85.5)	8 (14.5)	1.599	0.206
Mental illness is always transmitted from parents to children	40(46.5)	46(53.5)	37(66.1)	19(33.9)	5.228	0.022
It is important to enquire about the family history of mental illness before making any marriage contract						
Mental illness can be transmitted to others by touching, staying in the same room or by sharing spoon with patients	58(67.4)	28(32.6)	47(83.9)	9 (16.1)	4.785	0.029
My mental illness is caused by evil spirit	24(27.9)	62(72.1)	16(28.6)	40(71.4)	0.007	0.931
The medication I take for mental illness can harm my baby	51(59.3)	35(40.7)	18(32.1)	38(67.9)	10.48	0.001
Mentally ill women on medications should stop breast feeding	56(65.1)	30(34.9)	34(60.7)	22(39.3)	0.283	0.595
I cannot recover from my mental illness	51(59.3)	35(40.7)	26(47.3)	29(52.7)	1.958	0.162
A mentally ill mother is more burdensome than a patient with HIV, leprosy tuberculosis or cancer	38(44.2)	48(55.8)	17(30.4)	39(69.6)	2.733	0.098

SD (strongly disagree), D (disagree), A (agree), SA (strongly agree)

3.6: Correlation between ISMI Scale and Stigmatizing beliefs

Table 6 shows that the stigmatizing beliefs positively correlated with all domains except the stigma resistance subscale and the association of the stigmatizing beliefs reached statistical significance on the domains of alienation (p=0.001), stereotype endorsement(p=0.000) and social withdrawal (p=0.000) as well as on total self stigma (p=0.000).

Table 6: Correlation between ISMI and stigmatizing beliefs

	Alienation		Stereotypy		Discrimination		Social withdrawal		Stigma resistance		Total stigma	
	r	p	r	p	r	p	r	p	r	p	r	p
Stigmatizing beliefs	0.279	0.001	0.450	0.000	0.143	0.089	0.500	0.000	-0.005	0.950	0.833	0.000

3.7 Discussion

This study evaluated on the experiences of self stigma among female patients with schizophrenia and particularly comparing self stigmatizing belief on parenting among females that were parent and non-parent. To the best of the author's knowledge, this is the first study that evaluated and compared self stigma among female patients with schizophrenia that are mothers and non-mothers in Nigeria. The study revealed a high prevalence of self stigma among female parents compared to non parents. High self stigma was observed in 75.6% of female parents compared to 57.1% of non-parents. These findings on the prevalence rate of self stigma is higher than previous study in Nigeria reported in a range of 22.5%-47.3% (Ibrahim et al. 2016; Oduguwa, Akinwolu, Adeoye, & Oduguwa, 2014) however it is comparable to a prior study in Egypt of 70% (Shalaby, Sabra, Mohamed, 2014) and its lower than a study conducted in china of 94.7% (Ran et al. 2018). The higher level of self stigma in this study could be explained by the selection of study participants of only females. Some studies in the literature have demonstrated that females have a higher level of stigma than males for the following reasons. Firstly, females are more emotionally sensitive and are more likely to internalise concerns, while males tend to cope with emotions in a more external manner (Zlomke & Hahn, 2010). Secondly, more females are likely to anticipate and experience discrimination than males (Khan, Kausar, Khalid, & Farouq, 2015). Additionally, females also have limited marriage opportunities and married ones are more likely to be divorced than males (Fadipe et al. 2018).

Among female parents, the highest frequency of high stigma was seen on the alienation subscale (82.6%), followed by the stigma resistance subscale (79.1%) and the least was observed on the stereotype endorsement scale (69.8%). While among female non-parents the highest frequency of self stigma was observed on the social withdrawal scale (76.8%). Previous studies in Nigeria have shown that people with schizophrenia have a higher score on the alienation subscale compared to the other subscales (Ibrahim et al. 2016; Odugowa et al. 2014; Fadipe et al. 2018). These findings are also comparable to a study conducted in India (Singh, Mottoo, & Grover, 2016) with 81% of patients with schizophrenia experiencing stigma on the alienation subscale; however their least score was obtained on the social withdrawal subscale with a frequency of 16%. These findings are contrary to a report by Maharjan & Panthee 2019 in Asia who reported that the alienation subscale had the lowest score among the subscales. The alienation subscale which reflects on how a person devalues himself/herself compared with other members in the society was highly prevalent among female parents (82.6%) compared to 44.6% of female non parent ($p=0.000$). This finding suggest that female parents are more likely to see themselves as incompetent and this could be partly be attributed to the role restriction as well as to the cultural influences on parenting with mental illness. When individual items on the alienation subscale were compared female parents rated higher on the statements "I feel out of place in the world because I have a mental illness" and People without mental illness could not possibly understand me". As parenting is predominantly a female role, mothers may in fact experience greater alienation stigma as a result of role restriction in fear of either harming the child or transmitting mental illness to the child, on

the believe of it been contagious or transmissible through breast milk (Ueno & Kamibeppu, 2008). Despite more parents devaluing themselves on the alienation subscale, more parents disagreed to a stereotypic statement of "I can't contribute anything to the society because I have a mental illness". A possible reason for this could be the value they attach to their parenting role. Lacey et al. 2015 reported that despite high proportions of parents who perceived stigma, the majority of all parents reported that being a parent had helped them try to better manage their mental illness. Furthermore, in this study, More parents (32.6%) compared to non parents (16.1%) endorsed to "I can have a good, fulfilling, life despite my mental illness". Though there are no studies to compare on the individual statement, a plausible explanation could be the sense of them being able to reproduce and nurture for their kids could be a possible reason to believe on having a satisfactory life (Rampou, Havenga, & Modumo, 2015). Furthermore, Diaz-Caneja & Johnson 2004 reported that most of the mothers who were able to look after their children described motherhood as rewarding and central to their lives.

Surprisingly, more parents agreed to the statement "mentally ill people should not get married. The study cannot explain why more parents should endorse that but a plausible explanation may be the burden associated with family responsibility while coping with mental illness and medication side effects (Rampou et al. 2015). Another possible explanation is the fear of divorce after marriage. Even though some parents may conceal history of mental illness of their daughters during marriage, however in most cases as the age range of female marriage in North-eastern Nigeria of 16-25 years parallels the time of onset of schizophrenia, when a woman first begins to show signs of mental illness after marriage or after child birth, the husband perceives he is being cheated and deceived by family members for non disclosure of her illness prior to their marriage leading to higher rate of divorce. This study showed that more than 40% of the population are divorced.

On comparing mean scores of the ISMI Subscales, female parents had a higher score on all the domains except on the discrimination subscale. Though there is no existing data that has compared the mean score among female parent and non parents, the mean score obtained is higher to a previous study in Australia that compared female and male parents with schizophrenia (Lacey et al. 2015). They also reported that female parent had higher self stigma than males. The mean scores for the alienation, stereotype endorsement, discrimination, social withdrawal and stigma resistance were also comparable with previous study in Nigeria (Ibrahim et al. 2016) as well as in some western countries (Ran et al. 2018; Girma et al. 2013). However, a mean alienation score of 2.78 in the present study is higher than the reported range in previous studies in Nigeria (Fadipe et al. 2018; Odugowa et al. 2014).

As the nature, determinants and consequences of stigma varies across culture, this study tried to explore on how certain cultural beliefs and practices add up to the stigma of mental illness among mothers with mental illness. In this study about 50% of mothers agreed that they could transmit mental illness to their children through breastfeeding. Negative stigmatizing attitudes and practices of not allowing a mother to breastfeed her

child based on the assumption that mental illness can be transmitted through breast milk by the family members and the community will lead a mother to perceive herself as being incompetent, a failure or feeling of guilt which are all stigmatizing attributes further deteriorating her condition (Dolman, Jones, & Howard, 2013). Additionally, more than 50% of parents also agreed that mental illness is always transmitted from parents to children, while evil spirit possession was cited by more than 70% of both groups as their cause of mental illness. In Nigeria, Religious beliefs influence explanation for mental illness, for e.g. possession by jinns can cause mental illness (Ibrahim et al. 2016).

About 40% of parents also believed that psychotropic medications can harm the baby while 34.9% agreed that women on psychotropic medication should stop breastfeeding. This finding is in keeping with Kranke et al. 2012 who reported that the black culture has a perception of psychotropic medications as being unsafe compared to Caucasians. More parents disagreed to the statement "I child should be taken away from his or her mentally ill mother until she recovers, to avoid endangering the child". This is indicating that despite the challenges mothers face as a result of their mental illness while parenting, they still wish to be responsible for taking care of their children and they don't perceive themselves as a source of danger to their children. In this study, more than half of both groups endorsed that "a mentally ill mother is more burdensome than a patient with HIV, leprosy, tuberculosis and Cancer. This finding cannot be compared with other studies because the instrument used was designed following a focus group discussion on the possible challenges parents with mental illness face in the context of parenting.

3.8 Limitations

Even though this study adds significantly to research on self stigma and parents with severe mental illness, there are some limitations that need to be mentioned. Firstly, the sample was homogenous with absence of control group (females without mental illness) as only female patients with schizophrenia were interviewed. Thus the outcome of this study cannot be generalized to male patients with schizophrenia. Secondly, it is a hospital based study, thus the outcome of this study cannot be generalized to those in the community. Thirdly, because of the cross-sectional design of the study, inferences on the relationship between self stigma and stigmatizing cultural beliefs cannot be made. Additionally, convenience sampling was used as the most feasible option. Finally, standardized instrument was not used to assess for the stigmatizing cultural beliefs on parental practices. The strengths of the study are fairly large sample size, studying an under-researched special group of population while taking into cognisance of cultural influences. It is also the first study to our knowledge that explored and compared self stigma among female parents and non parents in Nigeria.

4.0 CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Our study demonstrated that female parents with schizophrenia have a higher rate of self stigma compared to non parents. This study also gave an insight on the potential influence of the society on parental practices among mentally ill mothers. Thus, there is

the need for community educational programs in Northeastern Nigeria aimed at demystifying mental illness and modifying detrimental parental practices.

Recommendations

It is hoped that future research may continue to investigate this area to provide further knowledge to better support parents and reduce the impact of stigma for mothers with SMI. Future research should also explore differences in stigma between mothers and fathers, as well as comparing the differences in the stigma experiences of parents with and without SMI. Researchers and intervention developers should also recognize the complexity of stigma in a cultural context and attempt to find other ways to measure it instead of relying solely on perceived dangerousness and social distance scales. For example, most of the scales measuring attitudes towards the mentally ill focussed on dangerousness, social distance, job entrustment, marriage and societal acceptance with none focusing on the aspect of parental care/responsibility. There is also the need for further qualitative study to explore on the knowledge, attitudes towards and impeding factors to mental wellbeing among parents with schizophrenia. Such study could assist in identifying factors negatively impacting on the mental health and wellbeing of the mother as well as the child.

Conflict of interest

The authors declare that there is no conflict of interest

Author's contribution

Baba Shettima Falmata: Conceptualization, design of the study, data collection, data analysis and manuscript writing; Isa Bukar Rabebbe: conceptualization, interpretation, manuscript writing, and review of the manuscript, Musa Abba Wakil: design of the study, interpretation and review of the manuscript; Abdu Wakawa Ibrahim: editing and review of manuscript. All authors' approved the final manuscript.

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