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## **Influence of Psychological Factors on Self and Perceived Stigma and the Efficacy of Cognitive Behaviour Therapy in Symptoms Reduction among Mentally Ill Patients**

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Majority of people who might benefit from mental health care either opt not to pursue it or do not fully adhere to treatment regimes once begun. They choose not to pursue mental health services because they do not want to be labeled a "mental patient" or suffer the prejudice and discrimination that the label entails. This study was conducted to investigate the influence of self esteem, locus of control and self efficacy on self and perceived stigma among mentally ill patients. Also, to examine the efficacy of cognitive behavioral therapy (CBT) in symptoms reduction. The first stage of the study as a cross sectional study which adopted ex-post-facto design. The sample size is one hundred and thirty (130 patients) with mean age of forty (16-65) and the standard deviations .456. For the intervention stage, the researcher adopted quasi-experimental design with ten (10) participants. The instrument for data collection was Rosenberg self-esteem scale, Perceived self-efficacy scale, Craig locus of control scale, Self stigma scale and perception of stigmatization scale. The result indicated that self esteem has a significant effect on self-stigma ( $t=5.35$ ,  $df=118$ ,  $p<.001$ ). Also, there was significant effect of self-efficacy on patients self-stigma ( $t=2.80$ ,  $df=118$ ,  $p<.001$ ). In addition, there was a significant interactive effect of self-efficacy and locus of control on perceived stigma ( $F(1,116)=9.54$ ,  $p<.001$ ). The study was able to establish the efficacy of Cognitive behavioral therapy (CBT) in improvement of self-esteem ( $t=-8.67$ ,  $df=18$ ,  $p<.001$ ), self efficacy ( $t=-9.16$ ,  $df=18$ ,  $p<.001$ ) and reduction of self stigmatization ( $t=8.24$ ,  $df=18$ ,  $p<.001$ ). It is thereby concluded that self-esteem and self-efficacy significantly influence self-stigma. Also, there similarly, CBT also led to the reduction in self stigmatization among the patients. It is therefore recommended that certain psychological factors have been implicated in the level at which mental patients will perceive or stigmatize themselves. In addition, Cognitive behavioral therapy should be employed among mental health practitioner as an intervention package for reduction of self stigma among mentally ill patients.

**Keywords:** Self-Esteem, Self-Stigma, Perceived Self-Efficacy, Locus Of Control.

Mental illness is a serious health problem in spite of the availability of effective pharmacological and psychosocial treatments (Bruce et al., 2004). In Nigeria, health indicators show that 20-30% of the general population has one form of mental or psychological problems (WHO, 2001). Adewuya (2009) in a study he supervised found that five per cent of Nigerians, who are 18 years and above, suffer from "prominent mental disorders". Many of these mentally ill patients suffer silently, many suffer alone, some suffer stigma,

shame, exclusion, inhumane treatment, and more than we care to know death. Mental health problems remain a hidden burden, resulting from the consequences of stigma that lead to humiliation, isolation and unemployment. For the individual sufferer; mental illness completely dominates every aspect of life. Feelings about oneself, capacity for activity and all areas of social relationship are affected, including the family, marriage, sexual activity, work, reaction,

management of finance, relationship with the law and public life (Corrigan, 2007).

Many of the negative consequences of mental illness at the individual level are often a result of the stigma associated with the illness. The living conditions of people with mental illness do not only depend on the severity of the illness, but also on the level of their acceptance in the community. Despite recent treatment advances, those suffering from mental illness face a considerable stigma that limits access to treatment and hinders their full integration into society (Dikerson et al., 2002).

Stigma was conceptualized as an attribute that is deeply discrediting and makes the person carrying it different from others and of a less desirable kind. Stigma is a social construct that describes people in terms of distinguishing characteristics or marks and devalues them as a consequence (Jones et al., 1984; Dovidio et al., 2000). It is the negative evaluation of a person as tainted or discredited on the basis of attributes such as mental disorder, ethnicity, drug misuse or physical disability (Goffman, 1963). There is no doubt that such prejudice has substantial negative social, political, economic and psychological consequences for stigmatised people (Dovidio et al., 2000). They may feel unsure of how 'normal' people will identify or receive them (Goffman, 1963) and become constantly self-conscious and calculating about what impression they are making (Fisher et al., 1983).

Dovidio et al (2000) regarded stigma as a social process in which people out of fear of the disease want to maintain social control by contrasting those who are normal with those who are different. Weiss et al. (2006) described stigma as a social process, experienced or anticipated, characterized by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on a widely endorsed stigmatizing ideas may internalize these ideas and believe that they are less valued because of their psychiatric illness (Link, 1987; Link & Phelan, 2001; Rusch et al., 2006). It includes "buying into" a set of stereotypes: "That's right; I am weak and

unable to care for myself.", 'I will probably never have a life like everybody else, get married, have kids, have a house (Rusch et al., 2006). Studies examining this relationship among people with various mental illnesses in general (Link et al, 1989; Rusch et al., 2006) and with schizophrenia in particular have found strong empirical confirmation of the impact of stigmatisation. They are challenged by the stereotypes and prejudice that result from misconceptions about mental illness and as a result are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people (Yen et al., 2009).

Diagnostic classification frequently used by clinicians and social workers may intensify this stigma by enhancing the public's sense of "groupness" and "differentness" when perceiving people with mental illness (Corrigan & Patrick, 2007). However, patient's perception of his/her condition may be negative or positive. The valency of such perception will ultimately affect the person's behaviour and attention towards the illness (Vauth et. Al., 2009). Differences in perceived stigma have also been reported and factors which account for differences remain undetermined.

Certain psychological variables such as self-esteem, locus of control, self-efficacy and socio-demographics have been implicated as possible factors for the differential manifestation of self and perceived stigma from the angle of a mentally ill patient. Sequel to this, a better understanding of the psychological and social barriers to prognosis, such as self and perceived stigma, may enable us to identify important targets for clinical intervention to improve outcome.

The term Self-efficacy is used more often in literature; it has its origins in Social Learning Theory (Bandura, 1986). It is a global feeling of being able to accomplish most tasks. Individuals with low self-efficacy and demoralization has been shown to be associated with failing to pursue work or independent living opportunities at which people might otherwise succeed (Link, 1987). Mentally ill patients however may transfer this psychological weakness into their program or fail to pursue it.

Locus of Control refers to the extent to which individuals believe that they can control events that affect them. People with an external locus of control believe that powerful others, fate, or chance primarily determine events. Individuals with an internal locus of control believe that events result primarily from their own behaviour and actions. The internals have better control of their behaviour and tend to exhibit more social centered behaviours than externals and are more likely to attempt to influence other people; they are more likely to assume that their efforts will be successful. They are more active in seeking information and knowledge concerning their situation than do externals.

Self-esteem is operationalized as the evaluation of personal self-worth of an individual which could either be positive or negative. Research has shown that people with mental illness often internalize stigmatizing ideas that are widely endorsed within society and believe that they are less valued because of their psychiatric disorder (Link & Phelan, 2001). As a result, help seeking is often viewed as a threat to their self-esteem because seeking help from another is often internalized by the individuals as being inadequate or inferior and may lead the person to decide not to seek help, even when experiencing psychological distress (Fisher, Nadler, & Whitcher-Alagna, 1983).

Although the onset of mental illness often has a dramatic impact on the psychological functioning and personality of the individual, the perception of the illness has been identified as a significant factor in treatment seeking (Corrigan, 2009). According to him, "the large Nigerian study shows that the proportion of persons with mental illness receiving no treatment in the previous 12 months for all cases is 90 per cent and for serious cases, 82 per cent." "It takes an average of six years for most persons to receive treatment," he said, adding that consequences of mental illness included disability, mortality, suffering and unemployment and he further emphasized that the negative attitude of Nigerians to mental health is a major issue that needed to be looked into.

In addition, non-adherence to treatment has frequently been noticed among people with mental illness. Perceived stigma associated with mental illness and individuals' views about the illness play an important role in adherence to treatment. Clinicians' attention to psychological barriers to adherence, such as perceived stigma, may enable us to identify important targets for clinical intervention to improve medication adherence and ultimately reduce under-treatment (Corrigan, 2009).

Furthermore, relapse, which is a recurrence of the illness after treatment, is a real threat even with good drug compliance (Corrigan, 2009). A better understanding of the psychological and social barriers to prognosis, such as self and perceived stigma, may enable us to identify important targets for clinical intervention to improve therapy and ultimately reduce relapse rate.

#### *Hypotheses*

1. Individual patient who score low on self-esteem will significantly report higher self-stigma than individuals who score high on self-esteem.
2. Individual patient who score low on self-efficacy will significantly report higher self-stigma than individuals who score high on self-efficacy.
3. Individuals with low self-efficacy and external locus of control will significantly report higher self-stigma than individuals with high self-efficacy and internal locus of control.
4. Self-esteem, self-efficacy, locus of control, level of social support from family and diagnosed illness will jointly and independently predict self and perceived stigma.
5. Patient's self-esteem will increase significantly after the intervention than they were before the intervention.
6. Patient's self-efficacy will increase significantly after the intervention than they were before the intervention.
7. Patient's level of self-stigma will reduce significantly after the intervention than they were before the intervention.



## Methodology

### *Design*

The study was a cross sectional survey. The research adopted an ex-post facto design. This was used because the researcher did not actively or directly manipulate any of the variables involved in the study. For the intervention stage, the researcher employed quasi-experimental design, with the use of control, and self-esteem while the dependent variables are self-stigma and perceived stigma.

### *Participants*

One-Thirty (120) patients from in and out-patient clinic participated in the study. There were 35 female and 85 male in the final sample. The mean age was 40 years (range 16-65 years) and the Standard deviation of .456. Most of these participants were single (61.7%), 35.8% were married, and 2.5% divorced. 55% of the patients are Yoruba, 30% are Igbo, 2.5% are Hausa while 16.7% are minority tribes in Nigeria.

### *Instruments*

The Instruments used for data collection of this study are Demographic Measures, Self-esteem scale, Perceived Self-efficacy scale, Locus of Control scale, Self-stigma scale, Perception of Stigmatisation scale, Intervention Stage (Cognitive-Behavioural Therapy)

The Demographic Measures has a set of questions for the background information of the respondents. This includes their age, gender, marital status, ethnic group, religion, educational status and employment background, diagnoses, duration of illness, level of family support.

The Self-esteem scale used in this study is the Rosenberg self-esteem scale (1965). The scale consists of 10 items that were to represent a continuum of self-worth statements ranging from statements that are endorsed by individuals with low self-esteem to statements that are endorsed only by persons with high self-esteem. The response format ranges from Strongly Agree (6), Generally Agree (5), Somewhat Agree (4), Somewhat Disagree (3), Generally Disagree (2), Strongly Disagree (1). Olley (2001) obtained a coefficient alpha of 0.94

and test-retest reliability of 0.74 among high school students. Akinkunmi (2008) obtained coefficient alpha of 0.79 among refugees. In this study the scale has achieved cronbach alpha ranging from .53 to .51. The split-half coefficient is .72.

The Perceived Self-efficacy scale was developed by Matthias Jerusalem & Ralf Schwarzer (1992). It was created to assess a general sense of perceived self-efficacy with the aim in mind to predict coping with daily hassles as well as adaptation after experiencing all kinds of stressful life events. The scale consists of 10 items. It was scored on a response format ranging from (1) not at all true (2) hardly true (3) moderately true (4) exactly true. In this study the scale has achieved Cronbach alpha ranging from, 64 to .60. The split-half coefficient is .71.

The Locus of Control scale was developed by Craig et.al. (1984). It is a 17 items scale with two dimensional scales measuring external and internal locus of control. The scale was scored on the Likert scale response format ranging from Strongly Agree (5), Generally Agree (4), Somewhat Agree (3), Somewhat Disagree (2), Generally Disagree (1), Strongly Disagree (0). The scale has achieved the reliability range of 0.78 and above overtime. In this study the scale has achieved Cronbach alpha ranging from .83 to .89. The split-half coefficient is .69.

Self-stigma was referring to the subjective stigma reported by the participants. It is operationalised as the beliefs and feelings held by a mentally ill patient about issues relating to mental health problem. Self-Stigma was measured by Self-stigma scale developed by the researcher. This scale contains 20 items with a response format ranging from Strongly Agree (5), Agree (4), Undecided (3), Disagree (2), Strongly disagree (1). The researcher carried out a pilot study to standardise the scale using forty patients. Inter-item correlation and factor analysis were analysed on the responses. 14 items were finally retained after the analysis. The internal consistency for the scale after the pilot study was Cronbach's  $\alpha = .87$ . The retained items were then administered alongside an existing Self-Stigma Questionnaire (SSQ) developed by Adewuya et.al, (2003) and the new scale

achieved a concurrent validity of .65. In this study, the Self-Stigma scale achieved a Cronbach alpha ranging from .82 to .89. The split-half coefficient is .69. No item on the scale is to be reverse. Higher score indicates higher self-stigma.

Perceived stigma is operationalised as the extent to which an individual perceives the public to stereotype and discriminate against a stigmatized group. It was assessed using perception of stigmatisation scale developed by Bruce Link (1987). The scale originally contains 12 items but has gone through validation in subsequent studies conducted by Link et al; (2001) which reduced the scale to ten items. The scale is with a response format ranging from Strongly Agree (4), Slightly Agree (3), Slightly Disagree (2), Strongly Disagree (1). It has achieved internal consistency of .85 overtime. In this study the scale achieved a Cronbach alpha ranging from .82 to .86. The split-half coefficient is .84.

For the intervention stage, Ten participants whose scores on the Self-esteem Scale were lower than the norms (male= 5 female=5) were selected for this stage. The pre-test and the post-test were carried out using the same set of participants. The group members were seen in a quiet hall twice in a week (Wednesday and Fridays). The researcher employed Cognitive-Behavioural Therapy developed by Beck (1976) which lasted for 5 weeks; the account of the therapy sessions are presented below:

*Procedure*

A total of 130 copies of the questionnaires were administered to in and out-patient clinic Respondents for the study was selected through the use of purposive sampling technique. The inclusion criterion includes patients who assessment by the researcher, the patients must be settled. Ten eligible patients did not complete their questionnaire, and hence data from 120 respondents were used for further analysis.

*Data analysis*

Hypotheses 1, 2, 6, 7, 8, were analysed using t-test of independent measures to compare differences between two groups. Hypothesis 3 was analysed using Two-Way

ANOVA while hypothesis 5 was analysed using Multiple regression analysis.

**Results**

The results of the analyses are presented in Tables 1,2,3,4 and 5.

Table 1: Summary table of an independent sample (-test comparing patients self-esteem (high and low) on their self-stigma

Dependent variable	Self esteem	N	Mean	Std	Df	T-value	Sig
Self stigma	Low	63	49.95	11.01	118	5.347	<.001
	High	57	34.18	12.92			

The results of the t-test in Table 1 reveals that there was significant effect of self-esteem on patients self-stigma [t(118)=5.347, p<.001]. From the result, patients who are high on self esteem scored 34.18 on self stigma, while those who are low on self esteem scored 45.95 on self stigma with a mean difference of 11.77. This implies that patients with low self esteem have higher self stigma than those with high self esteem.

Table 2: Summary table of an independent sample t-test comparing patient's self-efficacy (high and low) on their self-stigma

Dependent variable	Self-esteem	N	Mean	Std	Df	t-value	Sig
Self-stigma	Low	52	44.17	13.50	118	2.799	<.001
	High	68	37.44	12.45			

The results of the t-test in Table 2 reveals that there was significant effect of self-efficacy on patients self-stigma [t(118)=2.799, p<.001]. From the result, patients who are high on self efficacy scored 37.44 on self stigma, while those who are low on self efficacy scored 44.17 on self stigma with a mean difference of 6.73. This implies that patients with low self efficacy have higher self stigma than those with high self efficacy.

Table 3: Two-Way ANOVA showing interactive effects of self-efficacy and locus of control on self-stigma of patients

Source of variation	Df	Ss	Ms	f	Sig
Self-efficacy (A)	1	1582.231	1582.231	10.078	<.001
Locus of control (B)	1	1455.973	1455.973	9.274	<.001
A x B	1	7.369	7.369	0.047	>.05
Error	116	18211.557	156.996		
Total	119	21009.592			

Table 3 results shows that there is significant main effect of self-efficacy on self-stigma among patients [F(1,116)=10.078, p<.001]. Also, there was significant main effect of locus of control on self stigma of patients [F(1,116)=9.274, p<.001]. However, there was no significant interactive effects self efficacy and locus of control on self stigma [F(1,116)=9.274, p<.001]. Based on this result, the hypothesis was partially confirmed.

Table 4: Two-Way ANOVA showing Interactive Effects of Self-Efficacy and Locus of Control on Perceived stigma of Patients

Source of variation	Df	Ss	Ms	f	sig
Self-efficacy (A)	1	7.222	7.222	0.102	>.05
Locus of control (B)	1	29.435	29.435	0.415	>.05
A x B	1	676.422	676.422	9.541	<.001
Error	116	8114.320	70.899		
Total	119	8906.367			

Table 4 results shows that there is no significant main effect of self-efficacy on perceived stigma among patients [F(1,116)=0.102, p>.05]. Also, there was no significant main effect of locus of control on perceived stigma of patients [F(1,116)=0.415, p>.05]. However, there was significant interactive effects self efficacy and locus of control on perceived stigma [F(1,116)=9.541, p<.001]. Since, there was significant interactive effect of self efficacy and locus of control on perceived stigma of patients, a post-hoc test was conducted for multiple comparison. This is presented in the table below.

Table 5: Showing post-hoc test of multiple mean comparison of interactive effects of self-efficacy and locus of control on perceived stigma of patients

Self efficacy	Locus of control	N	Mean	Std	Mean difference			
					1	2	3	4
Low	External	29	24.97	8.05	-	-	-	-
Low	Internal	23	30.78	7.47	-5.81*	-	-	-
High	External	32	29.28	8.18	-4.31	1.50	-	-
High	Internal	36	25.47	9.43	0.50	5.31*	3.81	-

\* mean is significant at 0.05 level

Table 5 above shows that there was significant difference in perceived stigma of patients with low self efficacy and external locus of control ( $\bar{X}$  =24.97); and those with low efficacy and internal locus of control ( $\bar{X}$  =30.78) with a mean difference of 5.81. Also, there was significant difference in perceived stigma of patients with high self efficacy and external locus of control ( $\bar{X}$  =29.28); and those with high efficacy and internal locus of control ( $\bar{X}$  =25.47) with a mean difference of 5.81. Based on this result, it therefore implies that individuals with low self efficacy and internal locus of control significantly score higher on perceived stigma than individuals with low self efficacy and external locus of control. The result negates the state hypothesis and therefore not confirmed.

Table 6: Showing multiple regression analysis of the influence of self-esteem, self-efficacy, locus of control, level of social support from family and diagnosed illness on self and perceived stigma of patients

D.V	I.V	Beta value	t-value	Sig	R	R <sup>2</sup>	P	F
Self stigma	Self-esteem	-0.393	-3.979	<.001				
	Self-efficacy	-0.108	-1.079	>.05				
	Locus of control	0.110	1.277	>.05				
	Family support	0.037	0.446	>.05	0.481	0.231	<.001	6.850
	Diagnosed illness	-0.051	-0.623	>.05				
Perceived Stigma	Self-esteem	-0.200	-1.832	>.05				
	Self-efficacy	0.055	0.496	>.05				
	Locus of control	0.113	1.185	>.05	0.249	0.062	>.05	1.511
	Family support	-0.095	-1.047	>.05				
	Diagnosed illness	-0.033	-0.366	>.05				

Results from table 6 shows that all the independent variables jointly predicted self-stigma of individual patient [F(5,114)=6.85, p<.001]. The multiple R obtained was 0.48 with R<sup>2</sup> of 0.23. This shows that the predictor variables co-jointly account for about 23% on self stigma. However, the result of the independent prediction from the predictor variables showed only self esteem independently predicted self stigma significantly ( $\beta = -0.39$ ,  $t = -3.98$ ,  $p < .001$ ). Self efficacy, locus of control, level of social support from family and diagnosed illness did not predict self stigma independently ( $\beta = -0.11$ ,  $t = -1.88$ ,  $p > .05$ ;  $\beta = 0.11$ ,  $t = 1.28$ ,  $p > .05$ ;  $\beta = 0.04$ ,  $t = 0.45$ ,  $p > .05$ ; &  $\beta = -0.05$ ,  $t = -0.62$ ,  $p > .05$ ). Based on the result, the hypothesis is partially confirmed.

Table 6 also shows that all the independent variables jointly predicted perceived stigma of individual patient [F(5,114)=1.51, p>.05]. The multiple R obtained was 0.25 with R<sup>2</sup> of 0.06. This shows that the predictor variables co-jointly account for about 6% on perceived stigma. However, the result of the independent prediction from the predictor variables showed that none of the independent variable predicted perceived stigma significantly ( $\beta = -0.20$ ,  $t = -1.83$ ,  $p > .05$ ;  $\beta = 0.06$ ,  $t = 0.50$ ,  $p > .05$ ;  $\beta = 0.11$ ,  $t = 1.19$ ,  $p > .05$ ;  $\beta = -0.10$ ,  $t = -1.05$ ,  $p > .05$ ; &  $\beta = -0.03$ ,  $t = -0.37$ ,  $p > .05$ ) for self esteem, self efficacy, locus of control, level of social support from family and diagnosed illness respectively. Based on the result, the hypothesis was not confirmed.

### Result of the Intervention

Table 7: Summary table of an independent sample t-test comparing patients (pre and post-test) score on their self esteem

Pretest & posttest	Self-esteem	N	Mean	Std	df	t-value	Sig
Self-esteem	Pretest	10	26.90	3.67	18	-8.67	<.001
	Posttest	10	48.70	7.06			

Results as indicated in Table 7 show that there was significant difference between patient’s self-esteem before the intervention and their self-esteem after the intervention [t(18)=-8.67, p<.001]. The mean score of patients self esteem before the intervention was 26.90 while after the intervention it increased to 48.70. This implies that the intervention significantly increased the self esteem of the patients.

*Table 8: Summary table of an independent sample t-test comparing patients (pre and post-test) score on their self-efficacy*

Pretest & posttest	Self-esteem	N	Mean	std	df	t-value	Sig
Self-efficacy	Pretest	10	17.20	3.43	18	-9.16	<.001
	Posttest	10	32.80	4.16			

Results as indicated in Table 8 show that the cognitive behavior therapy has significant effect on the self efficacy of the patient [t(18)=-9.16, p<.001]. Before the intervention, the mean score of patients self efficacy was 17.20 while after the intervention it increased to 32.80. This implies that the intervention significantly increased the self efficacy of the patients.

*Table 9: Summary table of an independent sample t-test comparing patients (pre and post-test) score on their level of self-stigma*

Pretest & posttest	Self-esteem	N	Mean	Std	df	t-value	Sig
Self-stigma	Pretest	10	52.70	6.08	18	8.24	<.001
	Posttest	10	29.80	6.38			

Table 9 above shows that there is a significant difference between patients level of self-stigma before the intervention and after the intervention [t(18)=8.24, p<.001]. The mean score of patients self stigma before the intervention was 52.70 while after the intervention the mean reduced to 29.80. The result implies that the intervention significantly reduced the extent to which patients self stigmatized themselves.

## Discussion

Hypothesis one which posited that individual patients who score low on self-esteem will significantly report higher self stigma than individuals who score high on self-esteem was confirmed. The result revealed that there was significant effect of self esteem on patients self stigma .This finding of significant effect of self-esteem on self stigma is consistent with (Link et. al; 2001; Gureje, et al; 2004) in their study on self-esteem of patients who have recovered from psychosis: profile and relationship to quality of life. They reported about 24%-43% of the patients having low self-esteem are prone to self-stigmatization. Older participants reported lower level of self-stigma than younger participants. However this study does not concur with (Sing Fai et al, 2000; Brekke, et al; 2001; Link et al; 2001), who found no association between the level of self-esteem and general clinical information on mental illness.

Hypothesis two which posited that individual patients who score low on self-efficacy will significantly report higher self-stigma than individuals who score high on self-efficacy was confirmed. The result reveals that there was significant effect of self-efficacy on patient’s self-stigma. This result is consistent with the works of Vauth R. et. al. (2007) who carried out a study aimed at demonstrating how the evaluative dimension of self-concept (self-efficacy and empowerment) mediates the psychological effects of self-stigmatizing and coping with stigma. They found out that a 51% of the empowerment reduction was explained by reduction in self-efficacy and higher levels of anticipated stigma.

Hypothesis three which posited that individuals with low self-efficacy and external locus of control will significantly report higher self-stigma than individuals with high self-efficacy and internal locus of control was partly confirmed. The result showed that although there are significant main effects of self-efficacy and locus of control on self-stigma among patients, there was no significant interactive effects of self-efficacy and locus of control on self-stigma. This result of significant main effects of self-efficacy on self-stigma is consistent with Vauth (2009), while that of self-efficacy and empowerment as outcomes of self-

stigmatizing and coping in schizophrenia. The result agrees with Vauth (2009) in a study on Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia. Results showed that a measure of self-stigma was associated with self-efficacy, which then corresponded with low quality of life. Again, the result of the significant influence of locus of control on self stigma is consistent with Martin-Harrow et al; (2009) in their study on locus of control: Relation to schizophrenia, to recovery, and to depression and psychosis. A more external locus of control is significantly related to fewer periods of recovery, to both depressed mood and psychosis, and to various aspects of personality. Finally, the non-interactive effect of self-efficacy and locus of control on self-stigma agrees with Simon and Charles (2007) on their work on the roles of locus of control and self-efficacy in hallucination- and delusion-proneness in a non-clinical sample. The result reveals that the interaction between self-efficacy and locus of control was not a significant predictor of either hallucination-like experiences or delusion-like beliefs.

Hypothesis four which posited that self-esteem, self-efficacy, locus of control, family support and diagnosed illness will jointly and independently predict self and perceived stigma. The result shows that all the independent variables on the independent prediction of self-esteem are consistent with Ben-Shiom (2002) in their study on what are the determinants of quality of life in people with cervical dystonia. They found that both physical and mental quality of life scores were predicted by self-esteem and self-deprecation, educational level, employment status, social support, response to botulinum toxin, disease severity, social participation, stigma, acceptance of illness, anxiety, and depression. The result of independent non- prediction of self-efficacy is consistent with Forsyth & Carey, (1998) who found that Self-efficacy is irrelevant to the study of HIV-related risk behavior and stigmatization. However, this study is inconsistent with Bandura (1977, 1986, 1997) who opined that Self-efficacy reflects confidence in the ability to exert control over one's own motivation, behavior, and social environment.

Hypothesis five which posited that patient self-esteem will increase significantly after the intervention than they were before the intervention was tested using an independent sample t-test. The mean score of patient's self-esteem before the intervention was 26.90 while after the intervention it increased to 48.70. Thus, there was a significant effect of the intervention on the self-esteem of the patients. The result implies that the intervention significantly increased the self-esteem of the patients.

Hypothesis six which posited that patient's self-efficacy will increase significantly after the intervention than they were before the intervention was tested using an independent sample t-test. Before the intervention, the mean score of patient's self-efficacy was 17.20 while the mean score of patients after the intervention was 32.80. Therefore, there was a significant effect of the intervention on the self-efficacy of the patients. This implies that after the intervention there was an increase in the self-efficacy of the patients.

Hypothesis seven which posited that patient's level of self-stigma will reduce significantly after the intervention than they were before the intervention was tested using an independent sample t-test. The mean score of patient's self-stigma before the intervention was 52.70 while after the intervention the mean score reduced to 29.80. Thus, there is a significant effect of the intervention on the level of self-stigma experienced by the patients. The result implies that the intervention significantly reduced the extent to which patient's self stigmatised themselves.

This study provides initial empirical evidence on the influence of self esteem, self efficacy and locus of control on self and perceived stigma and also provides basis for future intervention to assist people to combat with self and perceived stigma associated with mental.

## Conclusion

To reduce self-stigma and increase a sense of empowerment among people with mental illness, we need to better understand why individuals react differently to self and perceived stigma. This study provides initial empirical evidence on

the influence of self-esteem, self-efficacy and locus of control on self and perceived stigma and also provides basis for future intervention to assist people to combat with self and perceived stigma associated with mental.

The study revealed there was a significant effect of self-esteem on patient's self-stigma. The study also revealed that there was a significant effect of self-efficacy on patient's self-stigma. Although, there were significant main effects of self-efficacy and locus of control on self-stigma among patients but there were no significant interactive effects of self-efficacy and locus of control on self-stigma.

Although there was no significant main effect of self-efficacy and locus of control, it could predict the perception of stigmatization. Similarly, patients who reported to perceive stigmatization had more severe symptoms than the patients who did not perceive stigmatization. Positive symptoms and general psychopathology scores were significantly higher in the group perceiving stigmatization. Patients reporting stigmatization were significantly more disabled with the group negative for perceived stigmatization. Demographic variables were not different between the two groups.

All the independent variables significantly and jointly predicted self-stigma of individual patient. However, only self-esteem significantly and independently predicted self-stigma of patients. Self-efficacy, locus of control, level of social support from family and diagnosed illness did not independently predict self-stigma of patients.

There was a significant effect of the intervention on the self-esteem of the patients. This implies that the cognitive-behaviour therapy significantly increase the self-esteem of the patients.

There was a significant effect of the intervention on the self-efficacy of the patients. This implies that the cognitive-behaviour therapy significantly increase the self-esteem of the patient.

There was a significant effect of the intervention on the level of self-stigma of the patients. This implies that the cognitive-behaviour therapy significantly reduce the self-stigma of the patients.

## Recommendations

Longitudinal studies in therapeutic settings may inform us whether self-esteem, self-efficacy and locus of control have any consequences on self and perceived stigma. Also, there is need for our findings to be replicated among individuals with other mental illnesses, such as social phobia and patients with borderline personality disorders to further examine possible differences between individuals with different disorders. Future research should use a comprehensive assessment of self-stigma and its components, including coping orientations and emotional reactions.

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