UNIVERSITY OF GHANA, LEGON

PERCEIVED PSYCHOSOCIAL IMPACT OF STIGMA ON PATIENTS BEING TREATED AT ACCRA PSYCHIATRIC HOSPITAL

BY

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Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

DECLARATION

This is to certify that this thesis is the result of research undertaken by Gyamfi Kwadwo Sebastian towards the award of the Master of Philosophy Degree in Nursing in the School of Nursing, University of Ghana, Legon.

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The under signed hereby declare that the preparation and presentation of this thesis was supervised in agreement with the guidelines on the supervision of thesis laid down by the University of Ghana, Legon.

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DEDICATION

This work is dedicated to my family; my cherished wife, Josephine and my beautiful kids, Sebastina and Josephine Gyamfì, and my Mum, Agnes Obah for their unflinching support throughout the period. I also dedicate it to my mentor, Professor Kathleen Hegadoren for her immense support and kindness throughout the journey.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Content</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DECLARATION</td>
<td>i</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENT</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>x</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xi</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>xii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>xiii</td>
</tr>
</tbody>
</table>

| CHAPTER 1                                    | 1    |
| BACKGROUND OF THE STUDY                      | 1    |
| 1.0 Introduction                             | 1    |
| 1.1 Statement of the Problem                 | 7    |
| 1.2 Purpose of the study                     | 8    |
| 1.3 Objectives of the Study                  | 8    |
| 1.4 Research Questions                        | 9    |
| 1.5 Significance of the Study                | 9    |
| 1.6 Operational Definition of Terms          | 10   |

| CHAPTER 2                                    | 11   |
| REVIEW OF LITERATURE                         | 11   |
| 2.0 Introduction                             | 11   |
| 2.1 Theoretical Framework of Stigma          | 12   |
| 2.2 Key Elements of the Identity Threat Model| 13   |
| 2.2.1 Negative Treatment and Discrimination  | 13   |
| 2.2.2 Expectancy Confirmation Processes      | 14   |
2.2.3 Automatic Stereotype Activation-Behavior ........................................................... 14
2.2.4 Personal and Public Factors that Predict Stigma Stress Appraisal ......................... 14
2.2.5 Collective Representations ..................................................................................... 15
2.2.6 Situational Cues ...................................................................................................... 16
2.2.7 Identity Threat Appraisal ........................................................................................ 16
2.2.8 Involuntary Responses ........................................................................................... 18
2.2.9 Coping Responses (Voluntary) .............................................................................. 18

2.3 Individual Predictive Factors of Stigma ........................................................................ 21

2.4 Public Predictive Factors of Stigma .............................................................................. 27

2.5 Coping with Mental Illness Stigma ............................................................................... 34

2.6 Reducing stigma in the community .............................................................................. 39

2.7 Impact of Stigma ........................................................................................................... 41

2.8 Summary of Reviewed Literature ................................................................................. 44

CHAPTER 3 ....................................................................................................................... 46

METHODOLOGY .............................................................................................................. 46

3.0 Introduction ................................................................................................................... 46

3.1 Research Design ............................................................................................................ 46

3.2 Research Setting ............................................................................................................ 47

3.3 Target Population .......................................................................................................... 48

3.3.2 Exclusive Criteria ................................................................................................... 49

3.4 Sampling Technique and Sample Size .......................................................................... 49

3.5 Data Collection ............................................................................................................. 49

3.5.1 Data Gathering Tool ............................................................................................... 49

3.5.2 Data Collection Procedure ...................................................................................... 50

3.5.3 Field Notes ............................................................................................................. 50

3.6 Data Analysis .............................................................................................................. 51
3.7 Data Management ......................................................................................................... 52
3.8 Rigor .................................................................................................................................. 52
3.9 Ethical Considerations .................................................................................................... 53

CHAPTER 4 ....................................................................................................................... 54
FINDINGS OF THE STUDY ............................................................................................. 54
4.0 Introduction ................................................................................................................... 54
4.1 Demographic Characteristics of the Participants ..................................................... 54
4.2 Thematic Findings ............................................................................................................ 57
4.3 Individual Perceptions ................................................................................................... 58
  4.3.1 Self Stigma ............................................................................................................. 58
  4.3.2 Anticipated Stigma .............................................................................................. 59
  4.3.3 Perceived Discrimination ....................................................................................... 60
  4.3.4 Knowledge .............................................................................................................. 62
4.4 Public Attitudes ............................................................................................................. 63
  4.4.1 Social Isolation ....................................................................................................... 63
  4.4.2 Mocking .................................................................................................................. 64
  4.4.3 Labeling .................................................................................................................. 65
  4.4.4 Gossip ..................................................................................................................... 65
4.5 Coping Strategies .......................................................................................................... 66
  4.5.1 Secrecy ................................................................................................................... 66
  4.5.2 Avoidance ............................................................................................................... 67
  4.5.3 Relaxation Techniques ........................................................................................... 68
  4.5.4 Confrontation ........................................................................................................... 69
  4.5.5 Ignoring the Source of Stigma ................................................................................ 69
  4.5.6 In-group Comparison ............................................................................................. 70
  4.5.7 Diversion Activities ............................................................................................... 70
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

4.6 Reducing Stigma ........................................................................................................... 72
  4.6.1 Education ................................................................................................................ 72
  4.6.2 Laws and Mental Health Legislation ................................................................. 72
  4.6.3 Government Support .............................................................................................. 73
  4.6.4 Social Inclusion ...................................................................................................... 73
  4.6.5 Social Support ........................................................................................................ 74
4.7 Outcome of Stigma ....................................................................................................... 74
  4.7.1 Devaluing ............................................................................................................... 75
  4.7.2 Loss of Partner ........................................................................................................ 75
  4.7.3 Social Exclusion ..................................................................................................... 76
  4.7.4 Unemployment ....................................................................................................... 77
  4.7.5 Self Esteem ............................................................................................................. 78
4.8 Summary of the findings ............................................................................................... 78

CHAPTER 5 ....................................................................................................................... 79
DISCUSSION OF FINDINGS ........................................................................................... 79
5.0 Introduction ................................................................................................................... 79
5.1 Individual Perceptions ................................................................................................... 79
  5.1.1 Self stigma .............................................................................................................. 79
  5.1.2 Anticipated Stigma ................................................................................................. 80
  5.1.3 Perceived Discrimination ....................................................................................... 81
  5.1.4 Knowledge.............................................................................................................. 83
5.2 Public Attitudes ............................................................................................................. 84
  5.2.1 Social Isolation ....................................................................................................... 84
  5.2.2 Mocking .................................................................................................................. 85
  5.2.3 Labeling .................................................................................................................. 86
  5.2.4 Gossip ..................................................................................................................... 88
5.3 Coping Strategies .................................................................................................................. 89
5.3.1 Secrecy .................................................................................................................................. 89
5.3.2 Avoidance ................................................................................................................................ 90
5.3.3 Relaxation Techniques ........................................................................................................ 91
5.3.4 Confrontation ................................................................................................................... 92
5.3.5 Ignoring the Source of Stigma ........................................................................................ 93
5.3.6 In-group Comparison ......................................................................................................... 93
5.3.7 Diversion Activities .......................................................................................................... 94
5.4 Reducing Stigma .................................................................................................................... 95
5.4.1 Education ................................................................................................................ 95
5.4.2 Mental Health Legislation .............................................................................................. 97
5.4.3 Government Support ....................................................................................................... 97
5.4.4 Social Support and Inclusion .......................................................................................... 98
5.5 Outcome of Stigma ............................................................................................................... 99
5.5.1 Devaluing ....................................................................................................................... 99
5.5.2 Breakdown of Relationships ......................................................................................... 100
5.5.3 Social Exclusion ............................................................................................................. 101
5.5.4 Unemployment ............................................................................................................... 103
5.5.5 Low self Esteem ............................................................................................................ 103

CHAPTER 6 ................................................................................................................................... 105
SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS ....... 105
6.0 Introduction ......................................................................................................................... 105
6.1 Summary ............................................................................................................................. 105
6.2 Conclusion ........................................................................................................................ 106
6.3 Implications for Nursing Education, Nursing Practice, and Research ......................... 106
   6.3.1 Nursing Education ........................................................................................................ 106

viii
6.3.2 Nursing Practice ................................................................. 107
6.3.3 Future Research ................................................................. 107
6.5 Recommendations ............................................................... 108

REFERENCES .................................................................................. 113
APPENDICES .................................................................................. 135
Appendix A: Semi-Structured Interview Guide .......................... 135
Appendix B: Checklist Used To Select Research Participants .... 136
Appendix C: Consent Form ......................................................... 137
Appendix D: Ethical Clearance .................................................... 142
Appendix E: Ethical Approval ...................................................... 143
Appendix F: Grant of Permission ................................................ 144
Appendix G: Re: Permission to Use Your Model ..................... 145
LIST OF TABLE

Table 1: Demographic data of participants .................................................................56
Table 2: Themes and subthemes ..................................................................................57
LIST OF FIGURES

Figure 1: An Identity-Threat Model of Stigma

.................................13
LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td>American Psychological Association</td>
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<td>CMHA</td>
<td>Canadian Mental Health Association</td>
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<tr>
<td>CDC</td>
<td>Center for disease control and prevention</td>
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<td>CHPS</td>
<td>Community based health planning and services</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and statistical manual of mental disorders</td>
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<tr>
<td>DDNS</td>
<td>Director of Nursing Services</td>
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<tr>
<td>GHS</td>
<td>Ghana health service</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/ Acquired immune deficiency syndrome</td>
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<td>mhGAP</td>
<td>Mental health global action program</td>
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<td>MOH</td>
<td>Ministry of health</td>
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<tr>
<td>NRCD</td>
<td>National Redemption Council Decree</td>
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<tr>
<td>NGOs</td>
<td>Non-governmental organizations</td>
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<tr>
<td>OPD</td>
<td>Out-patient department</td>
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<tr>
<td>SADAG</td>
<td>South African Depression &amp; Anxiety Group</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
ABSTRACT

Individuals diagnosed with mental illness encounter stigma and discrimination under various circumstances and these negatively affect them. Even though support systems and attitudes of the general public act as sources of stigma, perceptions held by the patients also influence their sensitivity to the experiences they encounter. The purpose of this study was to describe the role of personal factors in bringing about stigma. It also explored the public attitudes toward individuals diagnosed with mental illness. The study described coping mechanisms used by individuals with mental illness in relation to their stigma experiences, as well as to identify ways of reducing the stigma against them. The effects of stigma on people diagnosed with mental illness were also described.

The research adopted a descriptive-exploratory method using semi-structured interview guide to elicit subjective responses from out-patients at the Accra psychiatric hospital. The investigator purposively sampled and interviewed 12 out-patients coming for review. All the interviews were conducted in English. Thematic content analysis was applied in analyzing the data. Even though the results revealed different public behaviors such as social isolation, discrimination, mocking, labeling and gossips, as disturbing, the participants were also found to stigmatize themselves. They used various mechanisms in dealing with stigma including secrecy, withdrawal, relaxation techniques, confrontation, interaction with people, ignoring the stigmatizing agent, and in-group comparisons. The impact of the stigma experiences on participants was diverse. These include devaluing, loss of their partners in the form of separation, and divorce, exclusion, unemployment and the loss of self esteem. The participants mentioned public education, enacting laws that seek to protect and promote patient rights as well as government support, social support and inclusion as measures that could help reduce mental illness stigma in the community.

To completely understand stigma associated with mental illness, the views of the patients...
in decision making is key. It is worth noting that despite the labels attached to them by society, no matter how they appear, they harbor ideas that would help them live independent lives such as training for good jobs, adequate salaries, taking part in social activities in the community, decent shelter, and effective and affordable healthcare. Patients would therefore need support from all sectors including families, friends, employers, the Ministry of health and its subsidiary the Ghana health service, and the general public in order to be able to overcome stigma and the effects associated with it.
CHAPTER 1

BACKGROUND OF THE STUDY

1.0 Introduction

Mental illness is a disturbance of mood or thought that can affect behavior, and cause distress to the person or those around him, such that the individual cannot function normally (Australian Government: Department of Health and Ageing, 2008). Stigma against mental illness is generally common among policymakers, health professionals, friends, family members and the society in general. This is because they attribute mental illness to supernatural and spiritual causes thereby portraying sufferers as outcasts who have nothing to offer to their community.

Globally, mental health problems affect approximately 450 million people (WHO, 2003). It is estimated that neuropsychiatric disorders account for about 14% of the global burden of disease (WHO, 2004; Prince, Patel, Saxena, Maj, Maselko, Phillips & Rahman, 2007). Of these, three-fourths of those affected live in developing countries with no access to the needed treatment (WHO, 2011; 2012).

Mental health cannot be considered distinct in terms of overall well-being of individuals, societies, and countries. This historical separation of mind and body has contributed to stigma; a “hierarchy of diseases where some would rather have a cancer diagnosis than a mental illness”. This has resulted in only a small group of people suffering from mental or behavioral disorder receiving treatment in health institutions. The World Mental Health Surveys carried out by Demyttenaere, Bruffaerts, Posada-Villa, Gasquet, Kovess, Lepine, Angermeyer, and Bernert (2004), in 14 countries in the Americas, Europe, Middle East, Africa, and Asia, involving 6 less developed and 8 developed countries showed that even for serious disorders that were associated with
substantial role disability, almost two-fifths of cases in developed countries and four-fifths in less developed countries received no treatment.

Mental health is the backbone of health (Prince et al., 2007). Yet, less than 2% of the health budget in most countries is assigned for mental health care (WHO, 2011). The importance of mental health has been acknowledged by the World Health Organization (WHO) since its inception, and demonstrated by the definition of health in the WHO Constitution as not just the absence of disease or ill-health, but rather, a state of total physical, mental and social well-being of an individual. Advances in neuroscience and behavioral medicine have shown that, like many physical illnesses, mental and behavioral disorders are the result of a multifaceted interaction between biological, psychological, and social factors. Mental health problems are also known to affect the sufferers’ physical health and wellbeing and vice versa. Compared with the general population, researchers have found that those with serious mental illnesses have an increased risk of chronic diseases and a higher morbidity and mortality rate (Robson & Gray, 2007). Those with chronic diseases have higher rates of mood and anxiety disorders than the general population (Goodwin, Jacobi & Thefeld, 2004; Tiemeier, Van, Hofman, Witteman, Stijnen, & Breteler, 2004; Coyne & Palmer, 2005; Von et al, 2005).

According to the World Health Organization (WHO), social stigma associated with mental hospitals acts as a barrier and reduces acceptability and accessibility. Service users are therefore reluctant to use these services except as a last resort, perhaps due to stigma. The hospitals are usually associated with poor outcomes attributable to factors such as poor clinical care, violations of human rights, nature of institutionalized care, and lack of rehabilitative activities.

The Canadian Mental Health Association, [CMHA], (2008) also see mental illness as that which can affect anyone, irrespective of the age, gender, ethnic and socio-cultural
status. Regardless of the background of the individual diagnosed with a mental illness, he or she is likely to encounter stigma in different forms. Thus, the WHO in 2001, declared stigma to be the most principal impediment to deal with in our quest to manage mental health problems in the society. The WHO see stigma as a behavioral manifestation accompanied by stereotyping, fear, embarrassment, anger, and rejection or avoidance; with myths and misconceptions associated with mental disorders, which negatively affect the sufferer of the disorder. It may also be characterized by guilt, concealment, isolation, and segregation, (Crabb, Stewart, Demoubly, Masson, Chabunya & Rajeev, 2012).

Stigma related to mental illness is a communal issue, endorsed by both men and women from all social classes, and of all ages under the influence of the general public including the media, towards those who suffer from mental illness (Arthur, Michael, Eileen, & Howard, 2005). The major concerns related to the impact of stigma on those with mental disorders include denying his or her symptoms, and becoming less likely to seek help. This may result in delayed treatment leading to suicide, difficulties with recovery, and lower self-worth and self-efficacy (Corrigan, Watson, & Barr, 2006; Bathje & Pryor, 2011; Pinfold, Byrne, & Toulmin, 2005; Pomppili, Mancinelli, & Tatarella, 2003; Weiss, Ramakrishna, & Somma, 2006).

According to Goffman (1963), stigma is an attribute that deeply discredits and reduces the individual from a whole to a soiled person with low social rank. It also defines individuals in terms of some distinctive features, and devalues them in the final analysis, (Dinos, Stevens, Serfaty, Weich & King, 2004). Stigma against people suffering from mental illness does not only affect the patients, but also their immediate and extended families, friends, and caregivers as well. The psychiatric patients experience immense distress and disability that can have profound impact on their social, psychological, emotional and occupational functioning (Dror, Young, & Corrigan, 2010). Several
different factors bring about stigma, including stereotyping, prejudice, discrimination, and ignorance. According to Zartaloudi & Madianos (2010), stereotyping constitutes a highly generalized perception about an individual, or a particular category of people. When the public accepts these perceptions, prejudice sets in. Corrigan (2004) described prejudice as the acceptance of a stereotype accompanied by untoward emotional responses.

Patients and caregivers alike speak of unfair treatment even in the hands of their own close associates. To Corrigan (2004) discrimination is a response to prejudice accompanied by avoidance due to fear of the stigmatized individual. Discrimination also leads to problems with accommodation, employment, relationships, interference with recovery, education, and even insurance cover, thereby influencing future prospects (Gonzalez-Torres, Oraa, Maialen, Fernández-Rivas & Guimon, 2007; Huxley & Thornicroft, 2003; Martin, 2010; Weiss, Ramakrishna & Somma, 2006). One stigmatizing attitude towards people with mental illness is that of labeling. The labels are damaging and trivializing in character. Such individuals labeled as ‘sick’ are usually underemployed and also underpaid than people with similar psychological problems who have not been officially assessed and diagnosed as suffering from a mental illness (Alexander & Link, 2003; Arthur, Michael, Eileen & Howard, 2005; Bathje & Pryor, 2011). The internalized effects of stigma could erode the morale of psychiatric patients.

According to Ritsher and Phelan (2004), the stigmatizing effects of mental illness could subjectively result in mood instability, lowered self esteem resulting in social withdrawal, and mistrust stemming from anticipated and untoward responses from the community. Social distance has been the bane of a lot of people diagnosed with mental illness. This is due to the negative responses they receive from the general population, thereby forcing patients to accept their predicament as imposed by the public. People who have had less contact with individuals diagnosed with mental illness are likely to embrace
the misconceptions about how dangerous mental patients are (Angermeyer, Matschinger & Corrigan, 2004; Angermeyer & Matschinger, 2005a; Couture & Penn, 2003; Phelan & Link, 2004; Rüsch, Angermeyer, & Corrigan, 2005; Van’t, Veer, Kraan, & Drosseart, 2006). Gureje, Lasebikan, Olusola, Olley, and Lola (2005), in a community study of the knowledge and attitude of mental illness in Nigeria, found that the public believed psychiatric patients were retarded intellectually, dangerous, and a nuisance to the public. To them, poor knowledge and ignorance about mental illness had a very negative effect on socialization with the mentally challenged. About 83% of the respondents were afraid to converse with psychiatric patients and 78% were not willing to work with them. Gureje et al. (2005) also found 81% of the respondents refusing to share a room with people diagnosed with mental illness, while another 83% hinted they would be ashamed if the public got to know that a family member of theirs was mentally ill. Appropriate treatment modalities can help people with mental illness lead normal lives. Individuals who feel neglected by society are less likely to disclose their health problems to close associates including friends, family members, colleagues, or other persons who have the capacity to help them (Center for Disease Control and Prevention, CDC, 2007).

In spite of the mounting burden of mental health problems and the consequential amount of distress for individuals and society, very little effort is made to address the issues at hand. This is predominantly visible in developing countries due to low budgetary allocations, of which Ghana is no exception (Saxena, Thornicroft, Knapp & Whiteford, 2007). Mental health policies may indicate a government's plan to tackle the mental health needs of its people. Many countries however either lack such policy, have non-operational or no policies at all. For instance, 53% of African countries have mental health policies that are considered obsolete (WHO, 2005; 2007). Development of plans alone may not be the solution. The parliament of Ghana showed commitment of government by passing the
Mental Health Bill, Act 846, in 2012, awaiting presidential assent into law. It seeks to promote access to basic mental health care in a liberal atmosphere in the community. It is also aimed at encouraging early identification and prompt treatment of patients at the district level, instead of the three main psychiatric hospitals that are difficult to visit due to stigma. According to Maye, Green, Bird, Mirzoev, Flisher, Kigozi, Lund, Mwanza, Ofori-Atta and Mental Health and Poverty Research Program Consortium, MHaPP, (2010), mental health policies in Ghana, South Africa, Uganda and Zambia are quite weak. Despite the development of a five-year program for mental health in Ghana, its implementation so far has not been encouraging. This could be attributed to the absence of a substantive unit in charge for issues of mental health in the Ministry of Health as well as its arm, the Ghana Health Service. Mental health policies have not been implemented fully due to lack of commitment and scarce resources.

All countries, including Ghana, should therefore endeavor to embrace the mental health global action program, (mhGAP) initiated by WHO in 2001 to promote the mental health of the population, enhance their capacity to reduce the risk of mental illness, stigma. This would also encourage the participation of people with mental disorders in family, community and civic affairs as well as access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programs that could in the final analysis ensure independent life of the individual.
1.1 Statement of the Problem

Stigma associated with mental illness should be an issue of great concern to all stakeholders including government, health professionals, families, friends, and the society as a whole. Very little is known from published literature on the attitudes of society towards mental illness in Ghana. An even more precarious situation prevails when it comes to published data about the stigma experiences of the mentally ill in Ghana (Barke, Nyarko & Klecha, 2011). The WHO (2005) estimated that nearly 650,000 people in Ghana suffer from severe mental disorder, and about 2.17 million from mild to moderate mental disorders with a treatment gap of 98% of the affected population. In a study of why patients abscond in Pantang Hospital, Gyamfi and Otuah, (unpublished) found that about 26% of patients ran away because of the fear of stigma. Most relatives refused to visit their wards in hospital, for fear of finger pointing (stigma). About 44.4% lost their jobs, whiles some 14.8% lost their partners and friends simply because, they were admitted to a psychiatric hospital.

According to Dr. Akwasi Osei, Chief Psychiatrist of the Ghana Health Service, out of the 1200 patients on admission at the Accra Psychiatric Hospital, only 800 of them have beds, with the rest sleeping on the floor (Ghana News Agency, GNA, 2010). A major contributor to this lack of resources is that relatives have refused to accept discharged patients back into their communities. The same picture could be painted at the Pantang Hospital. The social welfare office, as a mandate, traces relatives of abandoned patients for reintegration. Those who are not welcomed by their relatives are transferred to the vagrant ward. Some of these patients have stayed at the ward for well over thirty years. The relatives only come to the hospital to pick their corpse for burial. In a similar observation, Sodzi-Tetteh (2007), hinted of some 70 patients treated by the Ankaful Psychiatric Hospital, and yet, abandoned by their families.
Government release of funds for psychiatric care in Ghana has been quite erratic, in recent times. According to the Director of Nursing Services (DDNS) of the Ankaful Psychiatric Hospital, Mr. Abakah-Sey, the hospital was given only 26% of its annual budget in 2012. This resulted in premature discharge of patients since December, 2012. He also noted in a personal communication that, no patient has been admitted since December, 2012, due to financial difficulties faced by the hospital. Similarly, the Accra Psychiatric Hospital and Pantang Hospital respectively, are also not admitting patients due to the non-availability of funds. To increase understanding and appreciate the impact of the stigma of mental illness on those on treatment, it is imperative to get the perspective of those who experience it on daily basis. They can best inform us in their own words what stigma is, how it is conveyed, their coping mechanisms, and how stigma experiences affect their lives. All stakeholders, including government and non-governmental agencies, health professionals, community members as well as patient relatives should play their part in order to help improve mental health and mental health care in Ghana.

1.2 Purpose of the study

The purpose of the study is to describe the psychological and social effects of the stigma attached to mental illness as experienced by psychiatric patients at the Accra Psychiatric Hospital in Accra, Ghana.

1.3 Objectives of the Study

1. To describe the role of personal factors in bringing about stigma.
2. To explore the public attitudes toward individuals diagnosed with mental illness.
3. To describe coping mechanisms used by the individuals in relation to stigma experiences.
4. To identify ways of reducing stigma against individuals diagnosed with mental illness.
5. To describe the effects of stigma on people with mental illness.

1.4 Research Questions

- How do the perceptions of persons diagnosed with mental illness influence the stigma they experience?
- How is stigma conveyed to individuals diagnosed with mental illness in terms of public behavior?
- How do the mentally ill cope with stigma in the community?
- How could stigma be reduced against people diagnosed with mental illness?
- What are the effects of stigma and discrimination experiences on individuals diagnosed with mental illness?

1.5 Significance of the Study

The study will assist health professionals in both mental and general practice, as well as policy makers to understand, and appreciate the depth of stigma associated with mental illness, and how it affects the sufferers. Findings about the extent to which stigma affects people diagnosed with mental illness could assist in sensitizing all stakeholders into strategic planning activities that will help meet the needs of the mentally ill so as to enhance their quality of life. This study of stigma in the Ghanaian context will add further knowledge about stigma and its impact as perceived by patients and the meanings that they attach to the experiences related to the stigma phenomenon. Getting closely involved with the participants, and allowing their voices to be heard could enhance their self esteem and urge them to confront stigma wherever they find themselves.
1.6 Operational Definition of Terms

The following terms have been defined in the context of how they have been used in the study to help orientate the reader.

**Discrimination**: unfair treatment of somebody due to his illness.

**Psychosocial effects**: negative or positive psychological and social response to a behavior.

**Stigma**: Behaviors that reduce the value of an individual suffering from a particular illness.

**Mental illness**: A disorder that affects the individual’s ability to function physically, psychologically socially spiritually and economically.

**Population of interest**: Out-patients at the Accra Psychiatric Hospital.

**Impact**: The effect on the individual.

**Perception**: How one views a situation or person.

**Coping**: Dealing with or living with a situation.

**Attitude**: Behavior of somebody towards a situation or person.
CHAPTER 2

REVIEW OF LITERATURE

2.0 Introduction

The purpose of the study is to describe the psychological and social effects of the stigma attached to mental illness as experienced by psychiatric patients at the Accra Psychiatric Hospital in Accra. The stigmatization of mental illness, as well as HIV/AIDS, leprosy, tuberculosis, and hepatitis B is a clear depiction of the failure of stakeholders including the legislature, media, health professionals, as well as government. Stigma attached to mental illness has destructive impact on individuals and their families. Research shows that stigma against mental illness is widespread in many nations and cultures, constituting a major obstacle to successful treatment, decreasing important life opportunities, and predicting poor outcomes over and above the effects of mental illness itself (Stier & Hinshaw, 2007).

Search was widely and systematically done using the following databases: Hinary, PubMed, Medline, and Google scholar. Key words used were “stigma”, “stigmatization”, “discrimination”, “stereotype”, “prejudice”, “psychosocial effects”, “mental illness” and “mental patient”. Other referenced publications were also comprehensively reviewed. This successfully aided in identifying a wide variety of fundamental and opinion papers. In order to achieve a methodical review, this chapter was organized under the following themes: theoretical framework of stigma, personal predictive factors of stigma, public predictive factors of stigma, effects of stigma on the individuals diagnosed with mental illness, and the coping mechanisms used by the patients in dealing with stigma experiences.
2.1 Theoretical Framework of Stigma

Goffman (1963) viewed stigma as a disgraceful feature that reduces the stigmatized individual from a complete and normal person to a down-graded human being. The WHO define stigma as a behavioral manifestation accompanied by stereotyping, fear, embarrassment, anger, and rejection or avoidance; with myths and misconceptions associated with mental disorders, which negatively affect the sufferer of the disorder. Crabb et al. (2012) however describes stigma as one characterized by guilt, concealment, isolation, and segregation. Stigma can occur when human differences are labeled, or stereotyped, creating a cognitive disconnect between “us” and “them”. The accompanying status loss and unfair treatment result in reduced life opportunities within the perspective of who has the authority to allow these things to occur (Yang, 2007). The variety of emotive reactions that the perceiver (e.g., disgust) and the marked (e.g., shame or humiliation) encounter has also been added as a major constituent of stigmatization (Link, Yang, Phelan & Collins, 2004).

For this study, the ‘Identity threat model of stigma’ by Major and O’Brien (2005) was used to guide the work. This stress coping model deals with the psychological effects of social stigma on individuals experiencing threatened well-being. According to the model “stigma directly affects the stigmatized via mechanisms of discrimination, expectancy confirmation, and automatic stereotype activation, and indirectly via threats to personal and social identity” (Major and O’Brien, p. 393). The model also includes situational cues, collective representations of a person’s stigma status, personal beliefs and motives as key factors that combine to affect the cognitive appraisal of the importance attached to stigma-relevant situations, and subsequently, outcomes that largely depend on the interactive effect of individual and public perceptions.
2.2 Key Elements of the Identity Threat Model

The main concepts of the Identity Threat Model of Stigma have been discussed below.

2.2.1 Negative Treatment and Discrimination

Most people diagnosed with mental illness encounter maltreatment from family and friends as well as health care professionals in the form of disregarding the physical problems reported by the patients, and associating every illness to mental health problems (Chadda, 2000). Discriminatory attitudes restrict contact with significant life events thereby impacting negatively on the status of stigmatized individuals in their community, as well as their psychological and physical wellbeing (Major & O’Brien, 2005). According to Corrigan (2004), discrimination is a response to prejudice accompanied by avoidance and stereotyping. It also leads to problems with accommodation, employment, relationships, interference with recovery, education, segregation or isolation and even insurance cover, thereby influencing their future prospects (Huxley & Thornicroft, 2003; Weiss, Ramakrishna & Somma, 2006; Gonzalez-Torres, Oraa, Maialen, Fernández-Rivas & Guimon, 2007; Martin, 2010; Crabb et al., 2012).
2.2.2 Expectancy Confirmation Processes

Out-groups’ negative actions and anticipated thoughts, towards the intended stigmatize person or persons could exacerbate certain thoughts and feelings as well as behaviors that may authenticate the perceivers beliefs (Jussim, Palumbo, Chatman, Madon, & Smith, 2000; McKown & Weinstein 2002).

2.2.3 Automatic Stereotype Activation-Behavior

Awareness of existing cultural stereotypes of a person or group of people in the locality could influence the way they behave through reflex actions due to the memory connectedness of the stereotypes and the meanings attached to them. Initiation of stereotypes could involuntarily result in responses that integrate and agree with the actual stereotype (Dijksterhuis, Aarts, Bargh & Knippenberg, 2000; Wheeler & Petty, 2001). This can also happen to people who are not part of the stigmatized group, provided they become aware of the stereotype. But, Shih, Ambady, Richeson, Fujita & Heather, (2002) thinks stereotype activation among stigmatized individuals is more likely than it is in the non-stigmatized due to reduced threshold of stereotype activation in the stigmatized such as people diagnosed with mental illness.

2.2.4 Personal and Public Factors that Predict Stigma Stress Appraisal

Stigma is a key stressor for a lot of people suffering from mental illnesses (Corrigan, 2005; Hinshaw, 2007; Thornicroft, 2006). Stigma stress predictors consist of public and personal factors (Major & O’Brien, 2005; Rüsch, Corrigan, Wassel, Michaels, Olschewski, Wilkniss & Batia, 2009a). Some people with mental illness appear unaffected by stigma, while other individuals are profoundly affected; they feel demoralized, and develop serious clinical symptoms due to their reactions to it (Corrigan & Watson, 2002; Rüsch, Holzer, Hermann, Schrarrm, Jacob & Bohus 2006; Watson, Corrigan, Larson & Sells, 2007). Psychosocial investigations with stigmatized individuals
including mental patients have used various stress and coping models as frameworks to studying the range of perceptions and responses to stigma of mental illness among individuals and groups (Major, Shannon, Schmader, Gramzow, Levin & Sidanius, 2002; Miller, 2006; Rüsch et al., 2009a; Rüsch, Corrigan, Powell, Rajah, Olschewski, Wilkniss & Batia, 2009b).

Although addressing stigma requires a multi-dimensional approach related to societal attitudes, social policies and health resources, knowing the factors that could make one resilient or vulnerable to the stress of stigma could assist in reducing the impact of stigma on persons suffering from mental health problems (Rüsch, Corrigan, Wassel, Michaels, Olschewski, Wilkniss & Batia, 2009c). One area that has received research attention in relation to stigma is stress-reactivity. Stress reactivity encompasses the ability to respond to patterns of emotional, cognitive, physical, and behavioral domains recognized by the individual as possibly damaging, unsafe, and bad (De Rivera, De las Cuevas, Monterrey, Rodríguez-Pulido, & Gracia, 1993). Extensive studies on stress-reactivity among patients with schizophrenia have shown increased stress relating to both internal and external environments. (Myin-Germeys, Krabbendam, Delespaul, van Os, 2004; Horan, Ventura, Keith, Subotnik, Hwang, & Mintz, 2005; Myin-Germeys, van Os, 2007; Betensky, Robinson, Gunduz-Bruce, Serge, Lencz, Kane, Malhotra, Miller McCormack, Bilder & Szeszko, 2008). Key findings of these studies include: increased depression and negative symptoms, lowered control and management of negative and positive events. Heightened emotional reactivity to stress independent of cognitive impairment was also found in subjects vulnerable to psychosis. In addition, women were more likely to display elevated stress-reactivity than men.

2.2.5 Collective Representations

Based on their encounter with the stereotyping behavior of society, the stigmatized
come to share and accept the public point of view about their position in society. These may include acknowledgement of being devalued and discriminated against. These influence the perception and subsequent appraisal of circumstances that the stigmatized person might encounter even in the absence of noticeable activities that may demonstrate discrimination (Crocker, 1999; Major & O’Brien, 2005).

2.2.6 Situational Cues

Circumstances that prompt an individual of the danger of being undervalued, damagingly labeled and discriminated against vary due to their social identity or group (Steele, Spencer, & Aronson, 2002). Situational cues can include asking the individual or group to undertake an aptitude assessment, disclosing a secret publicly, being portrayed negatively in the media, or being overshadowed or instructed by someone belonging to a dominant out-group (Spencer, Steele, & Quinn, 1999; Davies, Spencer, Quinn, Gerhardstein, 2002; Marx & Roman, 2002; Sekaquaptewa & Thompson, 2003; Ben-Zeev, Fein, & Inzlicht, 2004; Quinn, Kahng, & Crocker, 2004). However, not all individuals recognize and respond to objective discrimination (Stangor, Swim, Sechrist, 2003a; Stangor, Swim, Sechrist, DeCoster, Van Allen, Ottenbreit, 2003b & Major et al., 2002).

2.2.7 Identity Threat Appraisal

The cognitive appraisal of stigma-related stress is the main element of the stress-coping model; the Identity threat model (Rüs ch et al., 2009a; 2009b). For instance, individual patients are likely to encounter problems associated with stigma when they feel that they do not have the capacity to deal with any dangers or losses, in the form of employment, accommodation issues and schooling, due to prejudice by the public. To them, such an appraisal could be primary, where the individual tries to quantify the probable effect of the stigma, or secondary, where the person assesses his capacity to deal with the stigma. Rüs ch et al., (2009c) in studying personal uniqueness looked at three
factors that could aid stress appraisal. To them persons suffering from mental illness could first of all, be very responsive when rejected in a relationship, making them easily susceptible to stigma with its resultant higher stress appraisal. The patient, who asks himself a lot of questions on the level of acceptance by his mates, or co-workers, is more likely to see stigma as a stressor (Mendoza-Denton, Purdie, Davis & Pietrzak, 2002). Secondly, individuals faced with stigma are usually encouraged to admit society’s attitude towards them as reasonable, and hence accept stigma as legitimate which, eventually tend to have a calming effect on such individuals, without necessarily elevating them status-wise (Jost, Pelham, Sheldon, & Sullivan, 2003; Major et al, 2002). Thirdly, the value individual patients place on their in-group (other patients) is likely to determine the extent to which they appraise stigma-stress related to mental illness. This is dependent on the degree of public stigma, since they are seen as part of the larger group of individuals being stigmatized.

In their quest to investigate the psychological usefulness of social groups, Correll and Park (2005) also found three factors that are likely to influence members of a group: the positive or negative appraisal of collective values, group identification; how strong the bond is among members (Watson, Corrigan, Larson & Sells, 2007) and entitativity; seeing the group as a rational and significant whole (Spencer-Rodgers, Hamilton & Sherman, 2007). Those who see the group as a strong positive identity are more likely to be unaffected by stigma. Persons who distant themselves from the group (low group identification, or entitativity) see stigma attitudes as not referring to them, and hence, are likely to experience less stigma-related stress (Corrigan & Watson, 2002; Correll & Park, 2005). However, when they do encounter obvious stigma-related experiences, they are more likely to feel isolated and personally devalued. To determine self-stigma in outpatients with mental illness, Watson, Corrigan, Larson, and Sells (2007) found that
stereotyping and self-concurrence mediated the relationships between group identification and perceived legitimacy and self-efficacy.

2.2.8 Involuntary Responses

Within the Identity threat model, stress appraisal results in two sets of responses: non-volitional emotional reactions and deliberate cognitive coping responses. Social anxiety and shame are key components of the emotional reactions in mental illness stigma that act as an emotive link of internalized stigma (Birchwood, Trower, Brunet, Gilbert, Zaffer & Jackson, 2007; Rüscher, Hölder, Hermann, Schramm, Jacob, Bohus, Corrigan, 2006; Rusch, Kieb, Gottler, Hermann, Schramm, Richter, Bohus, 2007). The internalization of stigma is concerned with central negative evaluative thoughts regarding the self that are connected to the experience of feeling different (Dave & Martina, 2004).

2.2.9 Coping Responses (Voluntary)

Coping responses can be seen as purposeful and volitional adaptive efforts in reaction to stressors (Miller, 2006). Crocker and Major (1989) studied three coping mechanisms that could assist in safeguarding the self-esteem of stigmatized persons. Group members can fail to recognize areas in which they stereotypically perform badly, such as work and education. Failures such as joblessness will then be less likely to have a negative impact on the individual because these incidents become unimportant in the self-concept of the person. Secondly, the individual can equate himself first with in-group members; for instance, other people with mental illness. Because the individual is characteristically grouped with similar members along specific dimensions, he or she is less likely to experience pain and self-esteem problems than if he compared himself with more accepted and preponderant out-group members (members of the general public). Thirdly, one ascribes negative feedback to discriminatory attitudes instead of
internalization of the cause such as the inability to perform, blaming societal beliefs and attitudes instead of blaming the self. According to Rüscher et al., (2009c), both emotional and cognitive stress reactions affect the overall behavior of the individual. But none of the reactions to stigma are exclusively positive or negative, since one coping mechanism could be helpful in one area but unhelpful in another. A person with mental illness may for instance use the coping mechanism of comparison with in-group members in order to establish a stabilized self-esteem.

2.2.10 Outcome

According to Rüscher et al. (2009c) lack of comparison with the general public could result in apathy, which could affect output in the individual’s day-to-day activities; thus, culminating in hopelessness. Hopelessness is a negative self-directed outcome, associated with dejection, devaluation, impaired self-experience as well as agreement with negative stereotypy, with its consequent suicidal orchestration (Brezo, Paris, & Turecki, 2006; Lysaker, Buck, Hammoud, Taylor, Roe, 2006; Lysaker, Salyers, Tsai, Yorkman, & Davis, 2008; Yanos, Roe, Markus, & Lysaker, 2008). Personal encounters with discriminating acts affect the psychological and physiological activities of the individual in several ways, including self-esteem, academic and health problems (Major & O’Brien, 2005). This is heavily influenced by the extent of devaluation by the domineering non-stigmatized group (Twenge & Crocker 2002). They also added that within stigmatized groups, the individuals who are most cherished are likely to experience higher levels of self-esteem than their other compatriots. Circumstances relating to academic performance that are evaluated as threatening to one’s identity might decrease intellectual performance as a result of diminished working memory, self-handicapping and withdrawal from other’s stigmatizing attitudes (Blascovich, Spencer, Quinn & Steele, 2001; Davies, Spencer, Quinn, & Gerhardstein, 2002; Keller 2002; Schmader & Johns, 2003; Bosson, Haymovitz,
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

& Pinel, 2004; Major & O’Brien, 2005). Stigmatized persons are more likely to suffer from depression, high cortisol level, high blood pressure, heart diseases and reduced life span due to frequent stress from the psychological, physical and social environments respectively (McEwen, 2000; Link & Phelan, 2001; American Heart Association, 2003; Chen & Matthews, 2003; Dickerson & Kemeny, 2004).

Mental illness stigma cuts across many nations and cultures, constituting a major obstacle to successful treatment, decreasing important life opportunities, and predicting poor outcomes over and above the effects of mental illness itself (Stier & Hinshaw, 2007). The model so far posits that individuals who experience stigma are at a high risk for stress or identity threat. In addition, collective representations (box A), situational cues (box B), and personal characteristics (box C) influence the appraisal of a situation (identity threat, box D). Reactions to identity threat could result in involuntary emotional, cognitive, physiological, and behavioral reactions like extreme anxiety states, and increased working memory load (box E) or Voluntary (conscious) coping efforts (box F) to control emotional, cognitive, behavioral, physiological, and environmental response to situations viewed as traumatic (Compas, Connor, Saltzman, Thomsen, & Wadsworth, 1999). All these may impact on the person’s life in the form of outcomes such as self-esteem, academic achievement, and health problems (box G). Although it can be argued that emotional, cognitive, physiological, and behavioral reactions are not wholly involuntary. This model is a strong fit to the complex issue of stigma attached to mental illness. The successful application of the Identity threat model by Rüsch et al 2009a; 2009b, in studying how individuals cope with the stress of stigma associated with mental illness gives evidence of the applicability of the model in guiding this study in a Ghanaian context using qualitative techniques. A lot more literature has therefore been reviewed below to identify other perspectives in relation to mental illness stigma.
2.3 Individual Predictive Factors of Stigma

Multiple personal factors influence the degree to which stigma occurs and how stigma-related experiences are perceived by those with mental illness. One such factor is self-stigmatization. After delving into the stigma experiences of individuals with mental health problems, and the relationships between stigma, psychiatric diagnoses, treatments, and social environments in Turkey, Yuksel, Bingol and Oflaz, (2013) identified self-stigma as a major factor mitigating against people with mental health problems. This was re-echoed by Brohan, Gauci, Sartorius and Thornicroft, (2010) where over one fifth of 1182 participants with bipolar disorder or depression reported self-stigma. Ben-Zeev, Frounfelker, Morris and Corrigan (2012) in their study of 24 schizophrenic patients in Chicago also found self-stigma to strongly link with participants’ present actions in terms of increased negative affect and psychotic symptom severity. In a similar vein, Livingston and Boyd (2010) found a positive correlation between internalized stigma and psychiatric symptom severity; in participants who had either used mental health services or suffered from mental illness for a period of about 15 years.

Studies have confirmed that high levels of internalized stigma existed among patients (Branka, Ijevic, Ivanec, Margetic, & Tosic, 2010; Lazowski, Koller, Stuart & Milev, 2012; Ehirlic-Ben, Ohayou, Feingold, Revital, Markweiser, & Lysaker, 2013). Other authors confirmed that participants experienced high levels of stigma irrespective of their diagnosis (Rusch et al 2009a; Tally, 2009; Branka et al., 2010; Livingston & Boyd, 2010; Barke, Nyarko, & Klecha, 2011; Assefa, Shibre, Asher & Fekadu, 2012; Drapalski, et al., 2012; Lazowski, Koller, Stuart & Milev, 2012; Sorsdahl, Ritsuko, Wilson & Stein, 2012; Üçok, Karaday, Emiroğlu, & Sartorius, 2013; Ehirlic-Ben, et al., 2013; Gerlinger, Hauser, Hert, Lacluyse, Wampers & Correll, 2013). Specifically, Rusch et al. (2009a) in their quest to determine the cognitive appraisal of stigma as a stressor in 85 out-patients in
Chicago, USA, found that individual factors play a significant role in stigma stress appraisal among people with mental illness irrespective of the diagnosis and clinical symptoms. But Lazowski, Koller, Stuart and Milev (2012) noted otherwise in terms of the degree of stigma in relation to a particular subtype of an illness. In determining the degree to which persons with bipolar disorder and depression were stigmatized, they found individuals diagnosed with bipolar disorder and their family members to be psychosocially more affected by stigma compared to those with depression. The claim made by Lazowski, Koller, Stuart and Milev (2012), does not seem strong enough, since their study was based on the subtypes of one major condition (Mood disorders), and the fact that their participants generally experienced stigma just as could be said of other major conditions.

It is likely the varying degree of stigma among their participants could be due to differences in their personality.

Branka, Ijevic, Ivanec, Margetic, and Tosic (2010) identified a relationship between self-stigma and personality dimensions. Age was found by several researchers, to play a significant role in individual attitudes in relation to stigma associated with mental illness (Tally, 2009; Branka, et al., 2010; Ward, Wiltshire, Detry, Michelle & Brown, 2013). Even though Tally, (2009) found similar relations between self stigma and age, only a minority of the adolescents he studied self-labeled. Most of the adolescents demonstrated uncertainty and confusion about the nature of their problems. Eventually, Tally, (2009) concluded that adolescents who self-labeled reported higher ratings on self-stigma and depression. While some were in agreement with Tally, (2009); on the role socio-demographic variables play in perpetuating stigma (Branka, et al., 2010; Assefa, Shibre, Asher & Fekadu, 2012; Ward, et al., 2013 & Gerlinger, et al., 2013) only marginally associated socio-demographic variables with stigma. However, Assefa, Shibre, Asher and Fekadu, (2012) found most of their respondents to be single and unemployed.
Gerlinger, et al., (2013) also added that psychosocial variables, like lower quality of life, and social anxiety showed overall significant correlations with personal stigma. Despite finding depression to be the most common mental illness among their participants, there was no gender difference in prevalence as well as causal factors of mental illness (Ward, et al., 2013). This seems to suggest that gender is not likely to play a significant role in the stigma process of individuals.

Benbow, Forchuck, and Ray (2011) explored structural forces shaping the health of Canadian mothers with mental illness experiencing homelessness and how they overcame existing barriers. The participants perceived experiencing discrimination based on their homelessness status, mental illness, income source and motherhood status. Despite their claims of multiple barriers and constant oppression, the participants were found to be resilient in dealing with the situations. Gerlinger, et al., (2013) therefore seem to have their claim established after similar submissions two years earlier by Benbow, Forchuck, and Ray (2011). But, some authorities disagreed, and stated women were more likely to display elevated stress-reactivity than men (Myin-Germeys, Krabbendam, Delespaul, van Os, 2004; Horan, et al., 2005; Myin-Germeys, van Os, 2007; Betensky, et al., 2008).

Ward, Wiltshire, Detry, Michelle and Brown (2013) in an exploratory, cross-sectional survey of 272 African-Americans, discovered that a good number of the respondents suffered from depression. Those individuals suffering from depression were also found to worry more about stigma associated with mental illness. Vauth, Kleim, Wirtz and Corrigan (2007) in Germany similarly found the presence of depression and reduced quality of life, dysfunctional coping and higher levels of anticipated stigma among respondents. In their quest to study the interactive effects of insight and internalized stigma on suicide risk in individuals with schizophrenia, Sharaf, Osman, and Lachine, (2012) found internalized stigma to be highly linked with depression.
Internalized stigma was also highly associated with suicidal risk of patients. They concluded that higher insight is associated with higher levels of depression that leads to suicide. In Israel, Ehirlc-Ben et al (2013) had similar results after using self-reports to explore the meaning in life among 60 individuals with severe mental illness. The results indicated that high levels of internalized stigma and high levels of insight resulted in poorer perceptions related to personal meanings in life. They also hinted that, loss of personal meanings in life was associated with increased suicide risk among patients.

Even though Drapalski et al (2012) did not comment on the relationship between insight and suicide risk, after looking into the prevalence of internalized stigma among 100 African-American out-patients, it was revealed that higher levels of internalized stigma is associated with low levels of self-esteem, low self-efficacy, low levels of recovery orientation as well as with more severe psychiatric symptoms (Shrivastava, Johnston, Thakar, Shrivastava, Sarkhel, Sunita, Parkar, 2011). Assefa, Shibre, Asher and Fekadu, (2012) also found high stereotype endorsement among 212 outpatients in Ethiopia, which differ with the claims made by Sorsdahl, Ritsuko, Wilson and Stein, (2012). Sorsdahl, Ritsuko, Wilson and Stein however disagreed with the assertions made by Drapalski et al., and Assefa, Shibre, Asher and Fekadu, (2012) after studying internalized stigma experienced by 142 members of the South African Depression & Anxiety Group (SADAG) in South Africa. Sorsdahl, Ritsuko, Wilson & Stein, (2012) found majority of respondents reporting with high levels of empowerment, self-efficacy and low levels of stereotype endorsement despite reported cases of alienation and shame (Assefa, Shibre, Asher & Fekadu, 2012; Sorsdahl, Ritsuko, Wilson & Stein, 2012; Gerlinger et al., 2013). According to Rüsch, Lieb, Bohus, and Corrigan, (2006); Brohan, Gauci, Sartorius and Thornicroft, (2010), low levels of perceived discrimination and of the legitimacy of discrimination leads to high self esteem and high empowerment. Brohan,
Gauci, Sartorius and Thornicroft, (2010) in a random cross sectional survey found a moderately high level of stigma resistance among participants. Rüsch et al., (2009c) also confirmed that patients who hold their group in high regard or reject stigma as unfair are more resilient to stigma. They also added that high group identification and entitativity predict positive reactions among stigmatized groups. After studying 186 individuals with serious mental illness, and with a history of recent involuntary hospitalization in Switzerland, Rüsch et al., (2013) explained that one’s sense of high empowerment was linked to lower levels of stigma stress and self-contempt. And that increased self-stigma and lowered sense of empowerment lead to poorer quality of life as well as reduced self-esteem.

Higher levels of anticipated stigma and discrimination have been widely reported by various studies (Vauth, Kleim, Wirtz & Corrigan, 2007; Struch, Levav, Shereshevsky, Baidani-Auerbach, Lachman, Noga, & Zehavi, 2008; Thornicroft, Brohan, Rose, Sartorius, Leese & INDIGO Study Group, 2009; Sanseeha, Chontawan, Sethabouppha, Disayavanish & Turale, 2009; Brohan, Gauci, Sartorius & Thornicroft, 2010; Sorsdahl, Ritsuko, Wilson & Stein, 2012; Thomé, Dargél, Migliavacca, Potter, Ajappur, Kapczinski, & Ceresér, 2012; Üçok, Karaday, Emiroğlu, & Sartorius, 2013; Gerlinger, et al., 2013; Hansson, Stjernswärd & Svensson, 2013). A greater proportion of those studies reported about individuals anticipating discrimination in relation to job (Struch, et al., 2008; Thornicroft, et al., 2009; Daumerie, Vasseur, Giordana, Bourdais, Caria, & Roelandt, 2012; Hansson, Stjernswärd & Svensson, 2013), education (Thornicroft, et al., 2009; Üçok, Karaday, Emiroğlu, & Sartorius, 2013; Hansson, Stjernswärd & Svensson, 2013), or starting intimate relationship (Struch et al., 2008; Thornicroft et al., 2009; Daumerie, et al., 2012; Üçok, Karaday, Emiroğlu, & Sartorius, 2013; Hansson, Stjernswärd & Svensson, 2013). Others also expected or anticipated avoidance from family members
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

(Hansson, Stjernswärd & Svensson, 2013; Yuksel, Bingol, Oflaz, & 2013), and other members of the community who knew about their diagnosis. Because of this, majority of the respondents concealed their diagnoses (Struch et al., 2008; Sanseeha, et al., 2009; Üçok, Karaday, Emiroğlu, & Sartorius, 2013. Majority of the respondents who concealed their diagnosis however, were younger, and more educated (Üçok, Karaday, Emiroğlu, & Sartorius, 2013). Others also perceived stigma linked to hospitalization thereby leading to poor functioning in such individuals (Thomé et al., 2012). This was also reechoed by Oleniuk, Duncan and Tempier (2011) where previously hospitalized patients who were currently receiving outpatient treatment were found to be more affected by stigma.

The perception of the individual about the cause of their illness has been found to influence their stigma perceptions in several ways. For instance, to uncover how people diagnosed with schizophrenia perceived themselves and their illness, Sanseeha, et al. (2009) conducted a qualitative descriptive study using purposive sampling technique and in-depth interviews with 18 Buddhist in North-Eastern Thailand. The participants believed the cause of their illness was due to supernatural powers, bad Karma from the past or biological factors. Participants also felt discriminated against by society. Ward, Clark and Heidrich, (2009) also agreed with this finding after looking at African American women's beliefs about mental illness, coping behaviors, and barriers to treatment seeking in the United States of America. Participants felt that a broad-spectrum of factors, as well as cultural specific factors can bring about mental illness. They also felt mental illness is unremitting, with negative life implications. But Shrivastava et al. (2011) differed after examining the perceptions of patients with schizophrenia in terms of the stigma and discrimination they faced in their lives in India. According to the patients’ point of view, ignorance about the characteristics of the illness was seen as the main cause for stigma and
discrimination. Drug-related causes were found not to play a significant role in the stigma process of their participants.

2.4 Public Predictive Factors of Stigma

Various public attitudes have played and continue to play a role in bringing about stigma amongst individuals diagnosed with mental illness. In a systematic review of thirty-six articles, Parcesepe and Cabassa (2012) studied public stigma of mental illness in the United States of America. Public stigma was found to be widespread; Children and adults alike felt that individuals with mental illness are dangerous, incompetent, violent and criminals. Similar claims have been made the world over in relation to public stigma (Kadri, Manoudi, Berrada & Moussaoui, 2004; Adewuya & Makanjuola, 2005; Angermeyer & Matschinger, 2005b; Abiodun, Adewuya,& Ayotunde, 2007; Struch, et al., 2008; Angermeyer, Holzinger & Matschinger, 2009; Kapungwe, et al., 2010; Leiderman, et al., 2010; Sorsdahl & Stein 2010; Trevor & Wang, 2010; Barke, Nyarko, & Klecha, 2011; Oleniuk, Duncan & Tempier, 2011; Schomerus, Schwahn, Holzinger, Corrigan, Grabe, Carta, Angermeyer, 2012; Sorsdal, Stein & Myers 2012; Hansson, Stjernswärd & Svensson 2013; Igbinomwanhia, James & Omoaregba, 2013; Yuksel, Bingol, Oflaz & 2013).

Parle, (2012) similarly reviewed some twelve articles. It was revealed that a lot of people diagnosed with mental illness were discriminated against in job search. Those who had a job were also discriminated against by their coworkers, bullied, ridiculed and even demoted. Traces of public stigma were also identified, as patients were physically and verbally attacked by neighbors and outsiders alike, leading to the collapse of the relationships existing between them and their partners, family members and close friends. The respondents were also debarred from entering shops, pubs and other places of socialization. Others even had their belongings destroyed by community members. The
review also brought to the fore instances where the patients were treated like children or unintelligent people. To them, this made them feel angered, depressed, anxious, insecure, isolated, guilty, embarrassed and hurt. The service users again complained of being ignored by general practitioners culminating into the refusal to attend hospital when sick with physical ailments. This according to Parle predisposes individuals with mental illness to a lot of physical health problems, involving cardiovascular disease, diabetes, obesity, respiratory problems and untimely deaths.

After studying the knowledge level and the impact of stigma on 100 Moroccan families who had relatives suffering from schizophrenia, most of the families were found to experience stigma and discrimination (Kadri, Manoudi, Berrada & Moussaoui, 2004). This was in the form of distrust, mockery, maltreatment, neglect by neighbors and other relatives, divorce, and ejection by landlords. Even though they lacked knowledge about the illness, most of the families believed it was severe, chronic, disabling and not curable. Family members have also been found to stigmatize their relatives who are sick (Kadri, Manoudi, Berrada & Moussaoui, 2004; Kapungwe, et al., 2010). Some of the families were found to lock the patients up in order to protect them; whiles others treated them with hostility and rejection. Others also reported giving the patients less difficult or less significant work due to distrust, or disability (Kadri, Manoudi, Berrada & Moussaoui, 2004).

Different views have been expressed about the role of gender and diagnosis in public stigma. To assess the awareness and attitudes toward stigma associated with psychiatric disorders among South Africans, Sorsdahl and Stein (2010) found Schizophrenia as being the most representative of a psychiatric disorder and post-traumatic stress disorder as the least representative. Respondents held more stigmatizing attitudes toward patients with substance abuse and schizophrenia, whereas post-traumatic
stress disorder was stigmatized significantly less than the other conditions. In a similar study again two years later, Sorsdal, Stein and Myers (2012) studied statements by members of the Northern and Central suburbs of Cape Town, about persons who used drugs as well as the gender of the individuals using the substance. The descriptive quantitative study used a convenience sample of 868 members of the community. Results showed high levels of public stigma existed in all classes of the substances studied.

Even though men and women were equally stigmatized in terms of being dangerous, blamed, segregated against and pitied, women who abused alcohol were however more likely to be given assistance compared to those who used substances like heroin, methamphetamine and cannabis. In terms of treatment seeking, it was discovered that men were more likely to be persuaded to go for treatment. The study also revealed that individuals who usually abused substances on a regular basis were less likely to offer assistance to abusers than those who do not abuse them. Even though Trevor and Wang (2010) seemed to tread the same path with Sorsdal and Stein (2010) and Sorsdal, Stein and Myers (2012) in terms of public views on the relationship between gender, diagnosis and stigma, their findings differed. In a cross-sectional telephone survey in Alberta, Canada, Trevor and Wang (2010) looked into descriptive epidemiology of stigma against depression in a general population sample in Alberta (n = 3047). The study revealed 45.9% of the participants endorsed that depressed individuals were unpredictable and 21.9% held the view that people with depression were dangerous. A greater proportion of men than women held stigmatizing views, whiles participants with higher levels of education reported less stigmatizing attitudes than those with less education. Sorsdal and Stein (2010) and Sorsdal, Stein and Myers (2012) could not vividly tell which gender stigmatized patients diagnosed with mental illness more than the other like Trevor and Wang (2010). Trevor and Wang were able to make this distinction probably because they
used participants with the same condition.

Social distance and avoidance by community members, colleagues and friends who had knowledge about mental illness has been reported widely (Adewuya & Makanjuola, 2005; Angermeyer & Matschinger, 2005a; Abiodun, Adewuya,& Ayotunde, 2007; Struch, et al 2008; Angermeyer, Holzinger & Matschinger, 2009; Kapungwe, et al, 2010; Leiderman, et al, 2010; Sorsdahl & Stein 2010; Trevor & Wang, 2010; Schomerus, et al., 2012; Sorsdal, Stein & Myers 2012; Hansson, Stjernwärd & Svensson 2013; Igbinomwanhia, James & Omoaregba, 2013; Yuksel, Bingol, Oflaz & 2013). For instance, in a multistage random sampling process, 1668 Nigerian university students interviewed by Adewuya and Makanjuola, (2005) revealed they would be scared about holding conversations, working with or keeping friendship with a person diagnosed with mental illness. Healthcare providers also distanced themselves. In a random sampling of 312 medical doctors from 8 selected health institutions in Nigeria, it was found that they did not want to have a close relationship with family members or friends with mental illness (Abiodun, Adewuya, & Ayotunde, 2007). Similarly, in Israel, Struch et al. (2008) explored stigma among adults undergoing outpatient psychiatric treatment in a cross-sectional study. A third of respondents reported they had experienced inappropriate treatment by their doctor. Kapungwe et al. (2010) also confirmed this. But they were of the view that mental illness stigma and discrimination was pervasive amid both general and mental health care providers. The clergy did not also want to associate themselves with people diagnosed with mental illness. In a cross-sectional study of Christian and Muslim clergy (N = 107) in Nigeria Igbinomwanhia, James and Omoaregba, (2013) tried to find out about the attitudes of the clergy towards persons with mental illness. A good number of the clergy (71.1%) felt that individuals diagnosed with mental illness were distinct from other people, 68.2% were also of the belief that individuals with mental illness must be
treated like kids. Majority of the clergy (more than 80%) were not happy staying in the same neighborhood with psychiatric patients. Others even suggested that psychiatric hospitals should be located away from residential areas. About 46% of the participants were not comfortable with women who once suffered from mental illness caring for their kids. More than 50% however, were of the opinion that psychiatric hospitals where individuals with mental illness were treated looked more like prisons than hospitals.

Several reasons have been given by various researchers for these attitudes from the public. Labeling has been mentioned as one of the probable cause of stigma and discrimination (Kadri, Manoudi, Berrada & Moussaoui, 2004; Adewuya & Makanjuola, 2005; Angermeyer & Matschinger, 2005b; Abiodun, Adewuya, & Ayotunde, 2007; Struch, et al., 2008; Angermeyer, Holzinger & Matschinger, 2009; Kapungwe, et al., 2010; Leiderman, et al., 2010; Sorsdahl & Stein, 2010; Trevor & Wang, 2010; Barke, Nyarko, & Klecha, 2011; Oleniuk, Duncan & Tempier, 2011; Schomerus, et al., 2012; Sorsdal, Stein & Myers, 2012; Hansson, Stjernswärd & Svensson, 2013; Igbinomwanhia, James & Omoaregba, 2013; Yuksel, Bingol, Oflaz & 2013). Some individuals mentioned that individuals diagnosed with mental illness were unpredictable (Angermeyer & Matschinger, 2005b; Trevor & Wang, 2010). Others felt they were dangerous (Angermeyer & Matschinger, 2005b; Abiodun, Adewuya, & Ayotunde, 2007; Trevor & Wang, 2010; Parcesepe & Cabassa, 2012; Sorsdal, Stein & Myers, 2012). Others mentioned poor prognosis (Kadri, Manoudi, Berrada & Moussaoui, 2004; Abiodun, Adewuya, & Ayotunde, 2007), but Angermeyer and Matschinger (2005b) thought there was no significant association between labeling and the anticipation of poor prognosis in patients. Some members of the public held the belief that persons with schizophrenia and other psychiatric illness suffered from split personality (Leiderman et al., 2010), were incompetent (Parcesepe & Cabassa, 2012), or violent (Leiderman et al.,
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

2010; Parcesepe & Cabassa, 2012). Others even described them as criminals (Parcesepe & Cabassa, 2012).

Public gossip about individuals diagnosed with mental illness has been found to contribute to stigma among patients. Aisbett, Boyd, Francis and Newnham, (2007) looked into the barriers to mental health service utilization for young people in rural communities in Australia. After a series of interviews with the participants, it came up that gossip among the rural folks contributed to stigma, social exclusion and the refusal to make use of mental health services, thereby retarding their recovery process. Moses (2010) also looked into adolescents' perceptions of how they were handled by family members, peers, and school staff due to their illnesses. Fifty-six adolescents were interviewed in the United States. The respondents reported stigmatization by staff of the school they attended, peers and family members in the form of distrust, avoidance, pity, gossip and devaluation.

Public knowledge about mental illnesses has been found to influence stigma perceptions in various ways. Knowledge about schizophrenia has been found to be connected with age (Leiderman, et al., 2010) and education (Leiderman, et al., 2010; Trevor & Wang, 2010). Participants with higher levels of education have been reported to have less stigmatizing attitudes than those with less education (Trevor & Wang, 2010). After engaging key stakeholders in Zambia, Kapungwe, et al (2010) found stigma to be fuelled by misunderstandings of mental illness etiology, fears of contagion, and the associations between HIV/AIDS and mental illness. Abiodun, Adewuya, and Ayotunde (2007) agreed with the assertions made by Kapungwe et al (2010) after studying doctors’ attitude towards people with mental illness in Western Nigeria. The doctors’ beliefs in supernatural causes were prevalent. It is probable that this might have accounted for them distancing themselves from the patients diagnosed with mental illness. It could also be that the knowledge they acquired during training as medical doctors was not
translated into practice. But Angermeyer and Matschinger (2005); Angermeyer, Holzinger and Matschinger (2009) and Schomerus et al., (2012) found in their respective studies that despite the increase in public knowledge about the biological basis for the causes of mental illness, stigmatization and discrimination were still high among the general public. Schomerus et al., (2012) also ascertained whether improved knowledge level on the biological causes of mental illnesses over the past ten years has resulted into better understanding of mental illnesses by the general public, or increased eagerness to obtain mental health care.

Systematic review of 16 studies published before 2011 on mental illness-related beliefs and attitudes in the general population worldwide showed that the more the public understood the biological bases for the causes of mental illnesses, the better they accepted professional treatment modalities for patients. The review however revealed higher levels of social rejection for mental patients over the past 20 years. To assess the awareness and attitudes toward, stigma associated with psychiatric disorders among South Africans, Sorsdahl and Stein (2010) used a convenience sample of 1081 members of the general public aged over 18 years. Even though psychosocial stress was reported more frequently than medical etiologies as a possible cause of mental disorders, seeking help from a health professional was also endorsed. Respondents however held stigmatizing attitudes toward patients. Even though Schomerus et al. (2012) agreed with Sorsdahl and Stein (2010) over professional help seeking and the continued existence of stigmatizing attitudes among the public, they disagreed on the etiological factors. Parcesepe and Cabassa (2012) however differed with Sorsdahl and Stein (2010), as well as Schomerus et al. (2012) in terms of public stigmatizing attitudes. After thirty-six systematic reviews, Parcesepe and Cabassa (2012) found the American public to generally hold positive attitudes toward seeking professional help for mental health problems. Parcesepe and Cabassa (2012) were
however silent on the relevance of etiological factors on the stigmatizing attitudes of the general public. To set the records straight, most of the 100 Moroccan families of schizophrenic patients studied mentioned drug use, stressful day-to-day occurrences like loss of property and bereavement, sorcery, organic disturbances, and heredity from parents (Kadri, Manoudi, Berrada & Moussaoui, 2004). The above findings seem to suggest that no particular etiological factor could be responsible for health seeking behaviors as well as the stigmatizing attitudes of the general public. For instance, Sorsdal, Stein and Myers (2012), mentioned gender as a key factor in determining health seeking. Even though their study found that men and women were equally stigmatized, it was discovered that men were more likely to be persuaded to go for treatment.

2.5 Coping with Mental Illness Stigma

Various authorities have reported on how individuals deal with mental illness stigma in their daily lives. Roe, Yanos and Lysaker, (2006) applied Schwarzer’s proactive coping theory (2000) to severe mental illness. Four coping mechanisms namely; reactive, anticipatory, preventive, and proactive were looked at. In an exploratory study, five individuals suffering from severe mental illness were interviewed. To them, Reactive coping is a transactional continuum, involving an interaction between the individual and the environment around them. They also think reactive coping could either be emotion-focused; trying to overcome one’s emotional reactions to a stressor, or problem-focus; altering or dealing with dangerous stressors, like looking for a new job after a previous job loss. Roe and colleagues also saw avoidant coping as distancing oneself from the problem rather than confronting it. Anticipatory coping was seen as measures put in place by the individual to deal with up and coming risks that are likely to affect him negatively with resources available, and that most patients with severe mental illness used this to prevent relapses. Preventive coping was however seen as much more universal preparatory
activities aimed at dealing with additional unidentified but likely stressors that are bound
to occur as time goes on. Proactive coping was seen in the light of the individual doing his
best to enthusiastically, search for fresh challenges, generating new opportunities, and
discussing appraisals so as to lessen the negative nature of the problems.

Similarly, Yanos, West, and Smith, (2010) in a telephone interview explored the
coping strategies, mood, and social functioning of 27 adults diagnosed with mental illness
in the United States of America. The most common coping strategies were problem-
centered, followed by neutral coping strategies and avoidant coping. Of the problem-
centered coping mechanisms, seeking social support, positive self-talk, seeking support
from treatment providers, prayer, problem-solving, and medication were identified. The
frequently used neutral strategies were behavioral distraction, cognitive acceptance,
ignoring the stressor, calming activities, neutral religious activities, and relaxation
strategies. The most frequent avoidant coping mechanisms were sleep, expression of anger
and other emotions, behavioral avoidance and isolation, drug use and violence. No major
correlation was however found between type of stressful event and type of coping strategy
used. But Lysaker, Bryson, Marks, Greig and Bell, (2004) had results that differed with
the assertion made by Yanos, West, and Smith, (2010) on the issue of type of stress and
coping strategy. They ascertained the degree to which different neurocognitive deficits and
personality characteristics linked to coping style among 71 outpatients diagnosed with
schizophrenia in the United States of America. Neurocognition and personality were
separately connected with coping style; advanced forms of various neurocognitive
impairment and neuroticism were found to predict the reliance on passive avoidant coping
strategies and decreased reliance on active problem solving. Yanos, Roe, Markus and
102 out-patients with schizophrenia in the United States. Internalized stigma was found to
increase avoidant coping in the form of active social avoidance. Service users utilize several coping mechanisms to deal with stigma. Among them is seeking information about the illness they suffer from in the form of education (Struch, et al., 2008; Ilic, Reinecke, Bohner, Röttgers, Beblo, Driessen, Frommberger, & Corrigan, 2012; Ward, et al., 2013). Others also cope with their problems by seeking for professional assistance, in the form of getting mental health services, efficient therapy, taking their medication (Yanos, West, & Smith, 2010; Ward, Clark & Heidrich, 2009; Shrivastava et al, 2011; Ward, et al., 2013) to prevent relapse (Shrivastava et al, 2011). Some even use drugs in the form of avoidant coping mechanisms to deal with stresses resulting from stigma (Yanos, West, & Smith, 2010).

Quite a number of studies have identified religious activities as ways by which people deal with their worries stemming from unfair treatments in their daily life (Ward, Clark & Heidrich, 2009; Yanos, West, & Smith, 2010; Ward, et al., 2013). While some get involved in neutral religious activities (Yanos, West, & Smith, 2010), some pray to cope (Yanos, West, & Smith, 2010; Ward, et al., 2013). Others were also found to either hold conversations with a pastor or read their bible (Ward, et al., 2013). A couple of the studies identified social support seeking from family members, friends, colleagues, and other community-oriented support groups as a coping strategy in stigmatized individuals (Lysaker, et al., 2004; Cooke, Peters, Fannon, Anantha, Ingrid & Kumari, 2007; Alvidrez, Snowden & Kaiser, 2008; Ward, Clark & Heidrich, 2009; Yanos, West, & Smith, 2010; Boardman, Griffiths, Kokanovic, Potiriadis, Dowrick & Gunn, 2011). This is usually possible if the support systems are perceived by the stigmatized individual as welcoming (Alvidrez, Snowden & Kaiser, 2008). Other patients prefer withdrawing from public places and other social gatherings as a coping mechanism (Jahoda & Markova, 2004; Roe, Yanos & Lysaker, 2006; Struch et al, 2008; Yanos, Roe, Markus & Lysaker, 2008; Ward,
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

Clark & Heidrich, 2009; Yanos, West, & Smith, 2010; Boardman, et al., 2011; Ilic et al., 2012). While Jahoda & Markova, (2004) think the individuals distance themselves due to the stigmatizing activities of the general public, Yanos, Roe, Markus & Lysaker, (2008), thought otherwise. To them, internalized stigma increases avoidant coping in stigmatized people.

In Israel, Struch et al. (2008) used cross-sectional design to explore stigma among adults undergoing outpatient psychiatric treatment. A convenience sample of service users was selected from three outpatient clinics N =167. It came up that Service users utilized several coping mechanisms including secrecy. Other studies also confirmed the use of secrecy as a strategy in dealing with stigma (Thornicroft, et al., 2009; Daumerie, et al., 2012; Ilic et al, 2012; Üçok, Karaday, Emiroğlu, & Sartorius, 2013). According to Üçok, Karaday, Emiroğlu, & Sartorius (2013) people conceal their diagnosis due to anticipated avoidance by others who know about the illness. But Ilic et al, (2012) contends that even though coping skills such as secrecy, careful disclosure as well as overcompensation or disproving stereotypes helps the individual to deal with stigma, low levels of self-esteem has been identified in such individuals.

Other coping styles have also been used by some individuals in dealing with unpleasant stressful situations. While some use denial (Cooke et al, 2007; Ward, Clark & Heidrich, 2009; Ward, et al., 2013), others manage stigma through the expression of anger, violence and other emotions, or by ignoring the source of the stigma altogether (Robilotta, Cueto, Yanos, 2010; Yanos, West, & Smith, (2010). Some individuals diagnosed with mental illness also coped by accepting and appreciating their own health as much more vital than the reaction of other people (Alvidrez, Snowden & Kaiser, 2008; Yanos, West, & Smith, 2010), thereby resulting in them having a positive stance of themselves (Ward, Clark & Heidrich, 2009) in the form of re-labeling; positive reinterpretation and growth.
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

(Cooke et al., 2007) and building on positive emotions (Boardman, et al., 2011). Whiles some people adapted by seeing themselves as part of a small group of people who reject prejudice (Jahoda & Markova, 2004), others coped by devaluing work, education, and by blaming discrimination for their failures (Rüsch et al., 2009b). According to Rüsch et al. (2009b), the act of devaluing work, education, and blaming discrimination for failures was linked to the hopelessness inherent in such individuals. Rüsch et al. (2009b) also found in-group comparisons as a way of dealing with stigma in some individuals diagnosed with mental illness. And that coping responses of in-group comparisons were found to shield self-esteem. They however think coping mechanism of in-group comparisons brought about poorer social performance as well as increased seating distance. Even though, cognitive coping responses of in-group comparisons were found to shield self-esteem, they could also weaken the enthusiasm as well as goal accomplishment in many aspects of life.

Ilic et al. (2012) tried to find adaptive strategies for dealing with the stigma of mental illness among individuals diagnosed with mental illness in Germany (N = 355). After responding to the questionnaire provided, it was realized that coping mechanisms such as community involvement, humor and positive in-group stereotyping correlated with elevated self-esteem. Efforts at overcompensation or disproving stereotypes, were present but with low levels of self-esteem. Coping strategies such as comparing one’s current social status with the past and seeking information about the illness were also present, but had no relationship with self-esteem. Similarly, after conducting a systematic review of 38 articles that dealt with self-help interventions by people suffering from depressive disorders, Morgan, and Jorm, (2008) found distractive behavioral activities such as exercise, humor, listening to music and singing as things that help the individuals to cope with problems relating to their sickness. In another instance, after studying fifteen community-dwelling African American women on how to cope with mental health
problems, some of the participants mentioned keeping oneself busy in the form of reading, getting involved in volunteer work, exercising regularly in order to continue to be physically and emotionally functional helped them to deal with unpleasant behaviors from people (Ward, Clark & Heidrich, 2009).

2.6 Reducing stigma in the community

After assessing the efficacy of an intervention with young people (N = 472) that sought to enhance mental health literacy and negating stereotypes in relation with severe mental illness brief educational activities in the form of seminars were identified as measures that could help with attitudinal change towards the reduction of stigma (Pinfold, Toulmin, Thornicroft, Huxley, Farmer & Graham, 2003). Corrigan and Matthews (2003), Kapungwe et al. (2010) and Shrivastava et al. (2011) also supported public education as a measure in minimizing stigma in mental illness. To other participants, the provision of good treatment and rehabilitation facilities, early recognition of psychiatric disorders (Shrivastava et al., 2011) and social integration of individuals diagnosed with mental illness (Kapungwe, et al., 2010; Shrivastava et al., 2011; Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012) would help reduce stigma in the community. According to Shrivastava et al., (2011), even though some patients families isolated them, they accepted them back home, offered them assistance medically and financially. Some of the 100 families studied by Kadri, Manoudi, Berrada and Moussaoui (2004) felt that the illness suffered by their relatives was in harmony with a normal life. And that the patients could work if given easy and secure duty. Evans-Lacko, Brohan, Mojtabai, and Thornicroft (2012) also explained that individuals diagnosed with mental illness and dwelling in countries with less stigmatizing attitudes had higher tendencies for seeking help and treatment, as well as more perceived right to use information available. To them, this
resulted in reduced incidence of self stigma along with reduced perceived discrimination. The study also revealed that patients in countries where the public felt more comfortable talking to people with mental illness had less self-stigma and felt more empowered.

Kapungwe et al. (2010) also suggested that the transformation of mental health policy and legislation and expansion of the social and economic opportunities of the mentally ill could reduce stigma. Rüsch, Angermeyer and Corrigan (2005) think information that counteract stigma help to significantly reduce stigma. And that this information could be disseminated using books, videos and structured teaching programs (Rüsch, Angermeyer & Corrigan, 2005). Additionally, Romer and Bock (2008) in a national survey of youth aged 14-22, (N = 1258) found that stories that center more on individuals who have successfully recovered play a key role among the public in reducing stigma in mental illness. In Chicago, Corrigan, Powell, and Michaels (2013) reechoed the claims by Rüsch, Angermeyer and Corrigan (2005), and Romer and Bock, (2008), after assessing the benefits of reading a positive, neutral or a negative journalism article that discusses mental illness. One hundred fifty-one adults were randomly assigned to read a newspaper story about mental illness. The recovery article was found to reduce stigma and increased affirming attitudes, whiles the dysfunctional public mental health system article increased stigma and decreased affirming attitudes. To them, not all journalistic stories have positive impact on attitudes about mental illness. Other researchers also observed that ensuring close contact with stigmatized individuals could further boost the influence of educational programs aimed at reducing stigma in the community (Corrigan & Matthews, 2003; Angermeyer, Matschinger & Corrigan, 2004; Rüsch, Angermeyer, & Corrigan, 2005). Rüsch, Angermeyer and Corrigan (2005) also suggested fighting for laws that could protect persons with mental illness from the public. Corrigan and Matthews (2003), Rüsch, Angermeyer and Corrigan (2005) also mentioned protest as a way of reducing stigma. And
that it could change both public and social media stereotyping behaviors, thereby
enhancing the quality of life of individuals diagnosed with mental illness (Rüsch,
added that the effectiveness and sustainability of protests cannot be guaranteed over time.

2.7 Impact of Stigma

Just like any other stigmatized group of people, individuals diagnosed with mental
illness are affected by stigma in several ways. The impact of stigma and discrimination has
been found to affect patients profoundly (Yanos, Roe, Markus & Lysaker, 2008; Rüsch et
al, 2009b; Oleniuk, Duncan & Tempier, 2011; Shrivastava et al, 2011; Assefa, Shibre,
Asher & Fekadu, 2012; Daumerie, et al., 2012; Lazowski, Koller, Stuart & Milev, 2012;
Parle, 2012; Thomé et al, 2012; Yuksel, Bingol, Oflaz, 2013). In an attempt to look into
how stigma affected people with mental illness, Parle, (2012) conducted systematic review
of twelve articles. The review revealed that a lot of people diagnosed with mental illness
were discriminated against in job search. Those who had a job were also discriminated
against by their coworkers. This took the form of demotion, bullying and ridicule. The
respondents were debarred from entering shops, pubs and other places of socialization.
Others even had their belongings destroyed by community members. This made the
patients feel angered (Parle, 2012), and depressed (Yanos, Roe, Markus & Lysaker, 2008;
Tally, 2009; Sibitz, Unger, Woppmann, Zidek, & Amering, 2011; Parle, 2012 &
Drapalski, et al., 2012). Respondents also reported social anxiety (Rüsch et al, 2009b)
insecurity and guilt (Parle, 2012). Some also experienced embarrassment and feelings of
shame (Rüsch et al., 2009b; Parle, 2012; Gerlinger, et al., 2013; Mashiach-Eizenberg, et
al., 2013) and pain (Parle, 2012). Similarly, Shrivastava et al. (2011) identified ill-
treatment at the work place, people making fun of individuals diagnosed with mental
illness in the community, as well as in the media. Oleniuk, Duncan and Tempier (2011) also found co-tenants making fun of them because of their illness. In France, Daumerie, et al. (2012) assessed the impact of schizophrenic disorders on privacy, social and professional life in terms of discrimination. After conducting qualitative and quantitative interviews with 25 people in Lille and Nice, about half of the participants were found to be disrespected because of contacts with psychiatric services. About 88% of the participants were also rejected by individuals who knew about their diagnosis. A further 76% were found to conceal their diagnosis. This probably was to help them cope with the stresses associated with stigma. Stigma has resulted in the breakdown of the interrelationships between patients and their support systems in the form of isolation and rejection (Kadri, Manoudi, Berrada & Moussaoui, 2004; Struch, et al., 2008; Shrivastava et al, 2011; Daumerie, et al., 2012; Parle, 2012). This has led to the collapse of the relationships existing between patients and their partners, patients and their family members (Parle, 2012) and close friends (Oleniuk, Duncan & Tempier, 2011; Shrivastava et al., 2011 & Parle, 2012). Further explanations were given after Shrivastava et al, (2011) examined 150 outpatients in Mumbai, India. According to them, patients who were married complained of having problems in their marriage, whiles the unmarried faced difficulties in getting partners. In a related issue, Kadri, Manoudi, Berrada and Moussaoui (2004) studied 100 Moroccan families and disclosed that some of the families locked the patients up claiming they were protecting them. Others too treated them with hostility and rejection. Some of the families were also stigmatized as a result of the illness of their close relatives (Kadri, Manoudi, Berrada & Moussaoui, 2004; Lazowski, Koller, Stuart, & Milev, 2012). This took the form of distrust, mockery, maltreatment, neglect by neighbours and other relatives, as well as divorce, and ejection by landlords (Kadri, Manoudi, Berrada & Moussaoui, 2004).
In Vienna, Sibitz et al. (2011) ascertained whether social network, stigma and empowerment directly and indirectly contributed to depression thereby influencing the quality of life in patients with schizophrenia and schizoaffective disorders. One hundred and fifty-seven respondents aged 18-65 successfully answered the questionnaire. Poor social network was found to contribute to a lack of empowerment and stigma that brought about depression, which resulted in poor quality of life. This was also corroborated by other researchers. Poor social support was found to play a role in bringing about depression and consequently poor quality of life (Livingston & Boyd, 2010; Mashiach-Eizenberg, et al., 2013). Other studies reviewed so far reveal a remarkable relationship between internalized stigma and self-esteem. Internalized stigma increases depressive symptoms in terms of low self-esteem (Yanos, Roe, Markus & Lysaker, 2008; Rüsch et al., 2009b; Livingston & Boyd, 2010; Shrivastava et al., 2011; Drapalski, et al., 2012; Rüsch, et al., 2013), leading to negative outcomes related to recovery, such as poor quality of life (Tally, 2009; Livingston & Boyd, 2010; Sibitz et al., 2011; Gerlinger, et al., 2013; Mashiach-Eizenberg, et al., 2013; Rusch et al, 2013), low levels of empowerment (Rüsch et al, 2009b; Livingston & Boyd, 2010; Drapalski, et al., 2012), leading to low self-efficacy (Livingston & Boyd, 2010; Drapalski, et al., 2012) and hopelessness (Yanos, Roe, Markus & Lysaker, 2008; Rüsch, et al., 2009b; Livingston & Boyd, 2010). This results in suicide and related risks (Assefa, Shibre, Asher & Fekadu, 2012; Drapalski, et al., 2012; Sharaf, Osman, & Lachine, 2012). According to Drapalski, et al., (2012), higher insight into the illness and awareness of the associated stigma is connected with higher levels of distress that leads to depression (Cooke, et al., 2007 & Drapalski, et al., 2012), and suicide (Drapalski, et al., 2012). The review also brought to the fore instances where the patients were treated like children or unintelligent people Parle, (2012). Most of them were unemployed (Oleniuk, Duncan & Tempier, 2011; Thomé, et al., 2012). Some participants
were also disturbed about being described as incompetent due to the difficulties they faced in getting job (Oleniuk, Duncan & Tempier, 2011). This probably explains why most psychiatric patients have difficulty in finding jobs.

Issues concerning stigma made the majority of patients primarily stay away or differ their treatment as those already receiving care usually encountered negative reactions from other people. This affected treatment adherence and socialization among the patients (Alvidrez, Snowden & Kaiser, 2008; Ward, Clark & Heidrich, 2009; Livingston & Boyd, 2010; Assefa, Shibre, Asher & Fekadu, 2012; Parle, 2012 & Yuksel, Bingol, Ofilaz, 2013). The service users again worried about being ignored by health professionals (Shrivastava et al., 2011; Parle, 2012) culminating into the refusal to attend hospital when sick with even physical ailments (Parle, 2012). This according to Parle (2012) predisposes individuals with mental illness to a lot of physical health problems, involving cardiovascular diseases, diabetes, obesity, respiratory problems and untimely deaths.

2.8 Summary of Reviewed Literature

The literature reviewed revealed a lot of studies on stigma of people diagnosed with mental illness in Europe and the United States of America. Most of these studies used quantitative methods (cross sectional designs), involving patients as well as the general public; and used structured questionnaire, vignettes, surveys, and systematic reviews to elicit responses. Few studies were identified in Sub-Saharan Africa. Quantitative methods however lack the capacity to explore in-depth personal experiences about a phenomenon since individual experiences are difficult to quantify numerically. The literature demonstrated personal characteristics as key determinants for stigma to occur, despite the existence of negative public attitudes. The coping strategies found during the review showed that patients used several mechanisms in dealing with stigma (voluntary and
involuntary responses). There was also evidence that stigma had both positive and negative effects on patients depending on the individual’s resilience. The study therefore applied qualitative designs to elicit information (naturalistic) from participants concerning stigma and its impact on individuals with psychiatric disorders. The involvement of outpatients in the study brought to bear their individual or group encounters with the community after being discharged from hospital. Most of the studies in the literature reviewed looked into the perceptions and prevalence of stigma, but not into the experiences of patients regarding their illness. The only known work on stigma of mental illness by Barke, Nyarko and Kleecha, about 2 years ago in Ghana, also looked into perceptions and prevalence, using quantitative methods. Therefore, exploring the psychosocial impact of stigma on people diagnosed with mental illness will give an idea of how these patients feel about society’s attitude and how it affects them. A fair knowledge about the impact of stigma could aid health policy direction, and also help shape future research efforts.
CHAPTER 3

METHODOLOGY

3.0 Introduction

Qualitative research method was used to describe the role of personal factors in bringing about stigma, explore the public attitudes toward individuals diagnosed with mental illness, describe coping mechanisms used by the individuals in relation to their stigma experiences, as well as to identify ways of reducing stigma against individuals diagnosed with mental illness. The effects of stigma on people with mental illness as experienced by out-patients at the Accra psychiatric hospital in Accra, Ghana were also described. This chapter includes: the research design, setting of the study, sampling method, data collection tools, data analysis, and ethical issues.

3.1 Research Design

The research approach was descriptive-exploratory method using semi-structured interview guide to elicit subjective responses from out-patients at the Accra psychiatric hospital. The primary objective was to collect primary qualitative descriptive data from the participants to allow their voices to be heard, and to understand how they perceived stigma and its effects as well as the coping mechanisms adopted in dealing with the phenomenon of stigma. According to Lobiondo-Wood and Haber (2013), qualitative research is “a systematic, interactive, and subjective research method used to describe and give meaning to human experiences” (p.148). To them, reality is socially constructed and that, the meaning of an observation is dependent on its circumstances and environment. The use of qualitative methods assisted the researcher to understand the phenomenon of stigma, and make the world of persons with mental illness visible through the interpretation of their narratives and the discovery of the meaning they attach to their spoken words (Lobiondo-Wood and Haber (2013). In qualitative methods, the collection
of information and data analysis usually takes place concurrently so that the investigator examines the data, understands it, and probes further where necessary in order to confirm the insights discovered in the course of the study. Stigma is a social and psychological problem, and as such, using the exploratory approach helped the researcher gain an in-depth understanding of how people with mental illness perceive and interpret their lived experiences, which would have been difficult to numerically quantify using quantitative methods.

3.2 Research Setting

The study was conducted at the Out-Patient Department (OPD) of the Accra Psychiatric Hospital. The Accra Psychiatric Hospital is the oldest among the three major psychiatric hospitals in Ghana. The others are Ankaful Psychiatric Hospital in the Central Region and the Pantang Psychiatric Hospital of the Accra-Aburi road in Accra. The Accra Psychiatric hospital receives referrals from both Ankaful and Pantang Psychiatric Hospitals, as well as psychiatric cases from general hospitals in the country and other West African States. The actual care of people with mental illness in Ghana began with the enactment of a legislative instrument known as the Lunatic Asylum Ordinance cap (79) in 1888 by the British Colonial government and signed by governor Sir Edward Griffiths to arrest and confine persons with mental disorders in a Lunatic Asylum. A vacated high court building, Victoriaborg in Accra, was used for this purpose with prison wardens in charge. The lunatic asylum ordinance virtually criminalized mental illness, hence their imprisonment.

In 1904, the Accra Psychiatric Hospital was established, and officially commissioned in 1906 to accommodate 200 patients. The patients were finally transferred from Victoriaborg to the Accra Psychiatric Hospital at Adabraka in 1907. This explains why the Accra Psychiatric Hospital is often referred to as an asylum by most people.
Psychiatric treatment was primarily custodial care. The Accra Psychiatric Hospital has undergone major expansion in the past 50 years, and currently accommodates about 1200 patients. Some of the services it offers include; psychotherapy, occupational therapy, electroconvulsive therapy, out-patient care and community psychiatric care.

Those admitted into the hospital have diagnoses that include schizophrenia, mania, depression, dementia, alcoholism and other drug abuse problems, epilepsy and mental retardation. Most of the patients on these units have lived with mental illness for years and have been abandoned by their relatives. The hospital has a workforce of about 600 including nurses, doctors, medical assistants, paramedics, security and laborers. On average about 2500 patients are admitted annually.

3.3 Target Population

For this study the target population was out-patients at the Accra Psychiatric Hospital. 

3.3.1 Inclusion Criteria

Criteria for the selection of respondents were that, one must be able to articulate his/her perceptions and experiences in response to questions asked. The participants must be out-patients coming for review. Eligible participants were expected to be able to speak English, Twi or Ga. Participants had to be between the ages of 18-65 years. According to the 1992 constitution of Ghana, these people are active adults, who can live or have lived independent lives, and therefore were likely to have a higher level of interaction and responsibility, as well as varied experiences in their day-to-day interactions with society that could be shared. The individual should have been diagnosed with a mental illness by a psychiatrist based on the American Psychological Association (APA, 1994) criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The participants’ mental statuses were assessed by the psychiatrist and the nurses at the OPD and the outcome compared with a checklist provided by the researcher. Those who met the
checklist criteria (see appendix B) were selected for data collection. The participants were ready to talk, and offered informed consent without coercion.

3.3.2 Exclusive Criteria

First time visitors to the Out-patient Department with mental illness were excluded from the study, since they were likely to be in crisis. Relapsed patients coming back for treatment at the OPD were not involved in the study, since they were not likely to respond appropriately to the research questions. Out-Patients, who could not speak English, Twi or Ga, were not part of the sample. Individuals below 18 years, and those above 65 years were also not considered for the study.

3.4 Sampling Technique and Sample Size

Purposive sampling technique was used to select the participants at the out-patient department of the Accra Psychiatric Hospital. This helped the investigator to select persons who had mental challenges before and were able to narrate or express themselves based on their experiences for the data collection process. Out-patients who met the checklist criteria were selected for data collection. The investigator interviewed 12 out-patients coming for review. Data collection continued until saturation; when no new themes emerged during the interviews.

3.5 Data Collection

Data collection is made up of data gathering tools, data collection procedure, and field notes documentation.

3.5.1 Data Gathering Tool

One on one interview was conducted to ensure privacy, as well as prevent the influence from others in order to elicit in-depth responses from participants. This helped
the researcher explore further other areas relevant to the research questions. The researcher conducted all the interviews in English, using a semi-structured interview guide (appendix A). All the respondents could speak English in addition to their native language. Therefore no interpreter was needed to interpret the questions being asked. Audiotape was used to capture the data during interview. Field notes were also kept during investigations. These consisted of non-verbal observations made by the researcher during the interview.

3.5.2 Data Collection Procedure

The investigator sought permission from the relevant authorities at the Accra Psychiatric Hospital by making available to them a letter requesting for permission, together with the Ethical Clearance Certificate from Noguchi. Once permitted, the study started in accordance with the hospital protocol after a successful pilot. The interview sessions lasted for about 40 minutes on average. A convenient place and time suitable to the participants was agreed on for the interviews, with repeat interviews in some instances after transcription, to fill in gaps, clarify answers and also to confirm issues raised by participants. They were also encouraged to speak until it became clear that the information being given by the participants were repeating what have been said by previous participants, and that no new themes were emerging (LoBiondo-Wood & Haber, 2013). This assured the investigator that the perspectives of the participants had been clearly and fully understood. The data collection and analysis process took place concurrently over a period of 2 months to ensure that enough time was spent collecting sufficient data. The interviews were tape-recorded with consent from respondents and later, manually transcribed verbatim and coded.

3.5.3 Field Notes

Field notes were also taken from observations during the interviews to form a full report that reflected the discussions, as well as other observations made during the study.
This ensured several sources of data collection that enhanced the validity of the study. All activities of the study were recorded and kept safely so that others could follow the evidences that led to the conclusions.

3.6 Data Analysis

Thematic content analysis was applied in analyzing the data. Content analysis enhances the representation of verbal expressions in a contextual form, while maintaining the main ideas irrespective of the volume of data involved. Analysis started after the first interview. The researcher listened to the audiotapes of the interview; transcribed them verbatim using sentences and phrases. The researcher reflected by listening to the audiotapes of the interviews several times, while visualizing each participant at the time of the interview to be able to understand and interpret the context in which the participants were speaking. The audiotapes and the transcribed data were then given to another person to go through and to ascertain whether the audio contents carried the same information as that contained in the transcribed data. Coding was done by numbering each line of the transcript at the left margin of each page. The investigator read through the initial transcripts, formulated more questions where necessary, and went back to reengage the participants for further probing. This helped to further address gaps in the previous interviews. The coded text was reduced by listing all key words, statements or ideas on a separate sheet of paper, after which they were put into common themes, categories and sub-categories. The first audiotape together with the transcript was presented to the thesis supervisor for validation. All audiotapes from the subsequent interviews were transcribed as was done for the first interview with appropriate follow-ups to fill in gaps until saturation was reached. After this, the emerging common themes from all transcripts were integrated, and then summarized into a narrative text for interpretation. The key statements
from the respondents were used to illustrate and support main ideas. These have been quoted in the report.

3.7 Data Management

All documents including audiotapes, field notes and all other relevant materials about the study were secured in a locked cabinet. Only the researcher and his supervisory committee had access to them. Data kept on the researcher’s computer was given a password that was only known to the researcher, thus, allowing him alone to have access to the data.

3.8 Rigor

According to Mayan (2009), “Rigor is demonstrating how and why (through methodology), the findings of a particular inquiry are worth paying attention to” (p.100). This is also called trustworthiness. A rigorous qualitative study should satisfy the following criteria; credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). The researcher asked open-ended questions, and in multiple ways in order to get rich description of the participant’s point of view. Field notes taken from observations during the interviews, audiotapes, transcriptions and all other relevant activities and materials were kept to form a full report that reflected the discussions held, as well as other observations made during the study. This ensured several sources of data collection, thereby enhancing the authenticity of the study. The investigator read through the initial transcripts, formulated more questions where necessary, and went back to re-engage the respondents for further probing. This helped to add further depth to the discussion. An independent coder was also engaged in the coding process to help ascertain or confirm the trustworthiness of the themes identified by the researcher. All activities of the study were recorded and kept safely so that others could follow the evidences for confirmation.
3.9 Ethical Considerations

The proposal for the study was submitted to the ethics committee of the Noguchi Memorial Institute (Appendix D), and the Ethics Committee of the Ghana Health Service (GHS) (Appendix E) respectively for approval. Letters were taken from the school to the head of the Accra psychiatric hospital to seek permission for the study (Appendix F). An informed consent (Appendix C) was obtained from participants after explaining the purpose of the research, procedures to be followed, and a description of the risks and benefits of the study to them. They were also given the opportunity to ask questions about the study. A convenient place for the interview session was agreed on with each participant for optimum privacy and participation. The participants were made aware that they had the liberty to withdraw from the study at any time, or could refuse to answer any questions at will. In addition, they were assured of confidentiality of all information provided. They were also assured that irrespective of their decision, the treatment to be offered them at the OPD would not be affected or changed.

Volunteers selected by the psychiatrist and nurses vis-à-vis the checklist provided by the researcher were interviewed. Verbal consent was sought, followed by the signing of formal consent (Appendix C) after explaining the content of the information section to them. No respondent was coerced to take part in the study. To ensure anonymity, pseudonyms of the participants were used on all expressions relating to them, and the audiotapes assigned numbers specific to each respondent for easy identification by the researcher. Every document dealing with ethical issues was also appended appropriately in the study. Participants were not unduly exposed to any psychological or physical harm; where participants became emotional in the course of their narrations, the clinical psychologist was informed to help calm down the participant before the interview recommenced.
CHAPTER 4
FINDINGS OF THE STUDY

4.0 Introduction

The purpose of the study was to describe the psychological and social effects of the stigma attached to mental illness as experienced by out-patients at the Accra Psychiatric Hospital in Accra. Data were collected from 12 informants who were purposefully selected and interviewed. The collected data were manually transcribed and thematic content analysis applied in analyzing the data. This chapter contains the major findings of the study. In describing the experiences of the participants, pseudonyms have been used (Joe, Nana, Adwoa, Sampson, Addae....Kumi) for anonymity. The demographic characteristics of the participants have been described first, followed by support systems that act as sources of stigma, individual perceptions that perpetuate stigma, public attitudes, outcomes of stigma and coping strategies used by the participants in dealing with stigma. The chapter ends with factors that could help in reducing stigma.

4.1 Demographic Characteristics of the Participants

Twelve (12) informants were successfully interviewed. There were 9 males and 3 females (see Table 1 below). These people suffered from different categories of illnesses. They had recovered and had been discharged home but were still coming for review on out-patient basis. Only 3 females participated in the study because most of those who met the criteria for the study did not give consent to be interviewed, with the reason that they were not ready to talk. The participants who were interviewed included people with schizophrenia (6), alcoholism (1), epilepsy (3) and bipolar disorder (2). All participants had received psychiatric treatment in the hospital over a period of time and the duration of their treatments ranged from 12 months - 18 years (mean treatment duration = 4.7 years). Their ages ranged between 18 and 50 years (mean age = 29.8 years). All the participants
had some form of education to a certain level, with two of them being university graduates. Most of the participants were unemployed, not married and lived with their parents or other family members. Seven of the participants were Akans (Fante, Ashanti, Kwahu). This could probably be due to Accra being the capital and a metropolitan area. The Akans make up the highest population in Ghana are likely to be represented in all spheres including illnesses. Concerning religious affiliation, majority of the participants were Christians. Only two were Moslems. This is probably because majority of Ghanaians are Christians (Ghana Statistical Service, 2012).
Table 1: Demographic data of participants

<table>
<thead>
<tr>
<th>Pseudonyms of participant</th>
<th>Age</th>
<th>Gender</th>
<th>Diagnosis</th>
<th>Duration of treatment</th>
<th>Education</th>
<th>Living arrangement</th>
<th>Ethnicity</th>
<th>Marital status</th>
<th>Occupation</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe</td>
<td>33</td>
<td>M</td>
<td>Schizo</td>
<td>4 years</td>
<td>Graduate</td>
<td>Lived with wife</td>
<td>Gonja</td>
<td>Married</td>
<td>Teaching</td>
<td>M</td>
</tr>
<tr>
<td>Nana</td>
<td>48</td>
<td>M</td>
<td>Alcoholism</td>
<td>2 years</td>
<td>MSLC</td>
<td>With family</td>
<td>Fante</td>
<td>Married</td>
<td>UNE</td>
<td>C</td>
</tr>
<tr>
<td>Adwoa</td>
<td>19</td>
<td>F</td>
<td>Epilepsy</td>
<td>3 years</td>
<td>SSSCE</td>
<td>With family</td>
<td>Ewe</td>
<td>Single</td>
<td>UNE</td>
<td>C</td>
</tr>
<tr>
<td>Sampson</td>
<td>20</td>
<td>M</td>
<td>Epilepsy</td>
<td>2 years</td>
<td>NVTI</td>
<td>With family</td>
<td>Fante</td>
<td>Single</td>
<td>UNE</td>
<td>M</td>
</tr>
<tr>
<td>Addae</td>
<td>31</td>
<td>M</td>
<td>Schizo</td>
<td>6 years</td>
<td>JSS</td>
<td>Brother and family</td>
<td>Ashanti</td>
<td>Single</td>
<td>Corn miller</td>
<td>C</td>
</tr>
<tr>
<td>Owusu</td>
<td>45</td>
<td>M</td>
<td>Schizo</td>
<td>Over 15 years</td>
<td>MSLC</td>
<td>With mother</td>
<td>Ashanti</td>
<td>Single</td>
<td>UNE</td>
<td>C</td>
</tr>
<tr>
<td>Dan</td>
<td>23</td>
<td>M</td>
<td>Bipolar</td>
<td>6 years</td>
<td>Graduate</td>
<td>With auntie</td>
<td>Kwahu</td>
<td>Single</td>
<td>SP</td>
<td>C</td>
</tr>
<tr>
<td>Evelyn</td>
<td>20</td>
<td>F</td>
<td>Bipolar</td>
<td>2 years</td>
<td>SSS 3</td>
<td>With mum</td>
<td>Ewe</td>
<td>Single</td>
<td>Student</td>
<td>C</td>
</tr>
<tr>
<td>Alex</td>
<td>38</td>
<td>M</td>
<td>Schizo</td>
<td>4 years</td>
<td>HND</td>
<td>Independent living</td>
<td>Ga</td>
<td>Separated</td>
<td>UNE</td>
<td>C</td>
</tr>
<tr>
<td>Ama</td>
<td>25</td>
<td>F</td>
<td>Epilepsy</td>
<td>8 months</td>
<td>JSS</td>
<td>With family</td>
<td>Ga</td>
<td>Divorced</td>
<td>UNE</td>
<td>C</td>
</tr>
<tr>
<td>Korankye</td>
<td>32</td>
<td>M</td>
<td>Schizo</td>
<td>5 years</td>
<td>JSS</td>
<td>With friend</td>
<td>Kwahu</td>
<td>Single</td>
<td>UNE</td>
<td>C</td>
</tr>
<tr>
<td>Kumi</td>
<td>23</td>
<td>M</td>
<td>Schizo</td>
<td>3 years</td>
<td>SSSCE</td>
<td>With family</td>
<td>Fante</td>
<td>Single</td>
<td>UNE</td>
<td>C</td>
</tr>
</tbody>
</table>

Key

M — Male
F — Female
Schizo — Schizophrenia
MSLC — Middle School Leaving Certificate
SSSCE — Senior Secondary School Certificate of Education
NVTI — National Vocational Technical Institute
JSS — Junior Secondary School
SSS — Senior Secondary School
HND — Higher National Diploma
UNE — Unemployed
M — Moslem
C — Christian
SP — Service Personnel

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4.2 Thematic Findings

After analysis of the transcribed data from the participant stigma experiences, five (5) major themes emerged. These were: Individual perceptions, public attitudes, coping strategies, reducing stigma, and outcomes of stigma: See table 4.2. Excerpts from the data collected from participants are presented below to support the themes identified and also to provide evidence of the participant’s experiences. According to most of the participants, attitudes of people have changed towards them since they fell sick. Even though they tried to cope, they suggested ways of minimizing the incidence and effects of stigma on them.

<table>
<thead>
<tr>
<th>Individual Perceptions</th>
<th>Public attitudes</th>
<th>Coping strategies</th>
<th>Reducing stigma</th>
<th>Outcome of stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self stigma</td>
<td>Social isolation</td>
<td>Secrecy</td>
<td>Education</td>
<td>Devaluing</td>
</tr>
<tr>
<td>Anticipated stigma</td>
<td>Mocking</td>
<td>Avoidance</td>
<td>Laws</td>
<td>Loss of partner</td>
</tr>
<tr>
<td>Perceived discrimination</td>
<td>Labeling</td>
<td>Relaxation techniques</td>
<td>Government support</td>
<td>Social exclusion</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Gossip</td>
<td>Confrontation</td>
<td>Social support and inclusion</td>
<td>Unemployment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ignoring the stigma source</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-group comparison</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diversion activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Themes and subthemes
4.3 Individual Perceptions

The participants spoke about how they see themselves and also feel in relation to their illness and how people behave towards them. The thoughts they expressed were mostly negative. And this seemed to have played a role in their stigma experiences.

4.3.1 Self Stigma

The participants were found to internalize the stigmatizing attitudes of the public. They expressed anxiety as a result. Alex was one of them.

The participant stated:

Am sure it’s because of this problem that my wife left me. Now I have no respect anymore…Like people back at my place that I was living [with] just speak to me anyhow. Some of them even see me and then they look at me and they laugh and they just go, as if am not human…For the things they are a lot but they all boil down to the stigma and the discrimination on me now. Sometimes I feel uneasy especially when I’m out, I’ll be looking around hoping not to see anyone I know, because I don’t know how the reaction will be, maybe the person might tell other people about my condition and the people will also get to know. That’s what I fear most. (Alex)

Evelyn too stated:

In my own opinion, I think it’s because of my illness that’s why he [my boyfriend] is no more interested in me. I feel rejected and discriminated against…I fear for the future. I think when this sickness comes back, people will know more that I’m sick and the stigmatization will increase. That’s what I fear in the future. I feel disturbed.
This participant made his feelings known:

It is a very strange feeling. I’m now like very withdrawn, but I truly believe that with much determination, perseverance I will be able to overcome. I think my self confidence has been shut down, ever since I was diagnosed with this illness so it will take some time for it to build back. My self esteem comes with physical value; a sense of being valued by family, friends or a group of people also come with knowing who you are deeply. I thought I knew who I was till I was diagnosed with bipolar but now I’m struggling with identifying with my personality, with being somebody who has this illness because I tend to see people with this illness and it deteriorates their well being, their life and everything. I’m just seeing just the negative aspect of it. I’m struggling to see the positive aspect of this illness. I think it will be able to help me to rebuild myself and boost my energy. (Dan)

4.3.2 Anticipated Stigma

The participants also expected to be stigmatized by the public in one way or the other.

One of the participants hinted:

It’s dawn on me in a couple of times as I walk into a room I hear my name and I hear the conversation that they are having, it’s quiet spontaneous, it’s a coincidence, it’s some kind of bad. I will go out for some time and as I walk in the room I will come and catch the last part of the conversation that they are having and it’s kind of very bad to me but you know it’s this thing that happen and they love people talk about you, but you don’t let that affect you, I also have a relative who works for the company, I think she is aware. I think she maybe told a couple of friends. (Dan)
This participant also said:

My friend, the one who has been visiting me…hears from other people referring to me as not being correct. When he comes to me I ask him…do I behave in a different way? And then he will say no, but I see with him also, he doesn’t even stay longer then he will leave. I think it’s the people around me. Those neighbours I’m staying with. [They] don’t show a good behaviour towards me. (Kumi)

Owusu also expressed his view. He said:

No one has actually confronted me but that is what I anticipate [stigma]. On my part no one has done anything against me yet that would disturb me. In my locality no one has overtly demonstrated any discrimination act for me to see. No one has spoken against me for me to hear.

To add to the other participants view, he commented:

Sometimes, I think about it [the illness]. And I pray that the thing [illness] should not come, especially when I go to bank, I’ll be there and I’ll be thinking and I’ll pray that, that issue should not happen there. Seriously, if it comes, all the people there would look at me and if they see me on the road side, they’ll say this boy collapsed at the bank, and every time they would be pointing at me. (Sampson)

4.3.3 Perceived Discrimination

The actions and inactions of the general public were also interpreted by most participants as discriminatory. Alex was one of such participants.

He disclosed:

I used to hear them say as I pass. I remember there was a time I went to a store nearby to buy bread and the reception wasn’t favorable at all. I went there I wanted to buy bread. There was bread there, but they told me that there was no bread. Then I said ooh…you say there is no bread, that is bread am seeing
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

there? Then the woman said that it is not for sale, I asked “why?” and she said I shouldn’t come and disturb her, the bread is not for sale… It wasn’t comfortable for me at all so I just had to leave.

This participant said:

There are so many things that make me think they treat me different from others. For instance, anytime I try to come closer to the children around, they [relatives] will call them. And the way and manner they call the children as if I want to harm them. Those who have got to know about my condition already are also portraying the same thing…They see us as no bodies, they see us as not part of the society and people try to ignore, and even as they talk about other health conditions like HIV how they always talk about it on the radio you don’t see them talking about mental conditions like that, so I see that we have been left in isolation, nobody cares about us. (Korankye)

These emotions were very evident in Ama. She noted:

The other time one of my friends came to me, she wanted to wear [eye] lash. That’s what I do, so when I was doing it for her, then she said ooh, yesterday we went to some place, and I said eih… you didn’t call me. She said ooh… one of our friends said when we go out with you, you’ll go and fall and things so that’s why we didn’t call you, and I said ooh okay, it’s a good idea too. This is what I told them. I feel sad, it pains me because the way I am with them when someone is sick, when someone needs something or even someone gets a problem, the way I behave and they are doing this to me, it pains me, because this is the time I need them and they said no!, they don’t need me so I have to leave them.
4.3.4 Knowledge

Various participants expressed different views about their illness, the cause and what the future holds for them.

Ama stated:

When it [the illness] started, people were saying it’s not real, so I’d been going to church; from one church to another. They will say bring this, bring that…so someone showed us Labadi polyclinic. I went there and they started treating me. I think maybe I’d been thinking too much that caused it. The doctor said that I’m sick, but he didn’t tell me the particular sickness, but he said he can help…The thing was very scary and dangerous. At that time I didn’t know it was a sickness. I thought maybe someone was doing me. I sometimes feel bad...

Dan was full of hopes. This is what he said:

I started to hear voices like those type of things so I went to the hospital to go check it and they told me it was bipolar…I think from my observation, people have been observing me very closely because I always have to come to a review every month…I think with God all things are possible. Even I’ve read on scientist who had bipolar disorder. It is giving me much hope that I can be somebody. Like I don’t want to is somebody who depends on their parents…asking them to help with how to pay my bills and those types of things [but] to be somebody who is very stable; somebody who is independent, somebody who has a good grasp on life, that’s what I think about myself.

Korankye noted:

It was when I was 28 when people around me [were] telling me that it seems all was not well with me. I also saw that I wasn’t behaving normally…When it happened that way they told me that it can be spiritual so they took me to a church for people to pray for me and because of that we were only
resorting to church. But after 2 years, those I stayed with [uncle] recommended that I go to hospital for further treatment. When I went to the hospital the doctor told me that, I had a problem. He used the term schizophrenia...Though it has affected me in so many ways, as I take in my medication and listen to the advice from the hospital, I’m getting better.

This participant also reported:

I was sick. I got up and I was in a hospital. I didn’t know what was going on. I asked my mum, and my mother said there was something [like foam] on my mouth but I didn’t understand why all this was going on…? [My mum and dad] were thinking about someone. And that I’ve done something [bad] and the person went to juju man and did something. I was also thinking the same way my mother and father were thinking. Because the time I was born I wasn’t like this. But me too I’ve not done anything to anyone.

(Sampson)

4.4 Public Attitudes

The participants described many different public behaviors as unfair and widespread. These included social isolation, discrimination, mocking, labeling and gossips.

4.4.1 Social Isolation

Most participants felt left out in terms of social activities due to their illness.

The emotional Ama described her ordeal:

At first, the way the thing was going, I couldn’t go out. I couldn’t go closer to somebody because, even some of my friends thought if they go out with me or like we sitting and talking; maybe the thing [illness] will come. So they don’t want to come closer to me, so me too I don’t go closer to anybody. I’ll always be in the house or be in the room. From room, I’ll come outside, sit a little and go back to the
room…The thing is they don’t need me now, so how can I go to them? I think maybe it’s about the sickness, because first it wasn’t like that. I’ll be in the house, they will call me “oh Ama, are you in the house or you went to the shop?” If I’m in the house I’ll tell them. If I’m in the shop too I’ll tell them [and they will come].

This participant expressed her view:

You know, people with epilepsy have people saying “Eih, saa nkrofu wo de”, in (Akan). Meaning…as for these category of people….). People shun them! When yours is very serious, in public, people know about you so people intend to shun such people…I’ve seen them on television saying their story, and those things. For me, my brother has been shunned by friends. He had problems; this one has insulted me, this one said this, this one said that one should not play with me. So as at my young age, I began to know that oh so, these people, they don’t like my brother because of this [illness]. So it has been there since S.S.S and still it’s there! I mean generally, the stigma and the shunning stuff are there. (Adwoa)

This participant also shared his experiences:

I have some friend at school. When I was in J.H.S, a certain girl, anytime I’ll see her collapse and they’ll take her to hospital. I’ve been seeing it. People were talking about her. When they close from school, the girl will walk to the house alone. She didn’t have friends. All of them were afraid of the girl. (Sampson)

4.4.2 Mocking

The participants disclosed they were disrespected through teasing.

Alex emotionally commented that:

People mock at me…When anybody else is walking they don’t make any funny comment or they don’t mock at the person but when I am passing by they pass funny comments
and I sometimes hear people giggling back and I hear them laughing. I feel I was being treated different.

Korankye was also not happy. The participant said:

… They will be pointing fingers at you. Sometimes, they laugh at you, and because of that it makes it very difficult moving around.

4.4.3 Labeling

Name calling was another worrying behaviour associated with the general public.

According to Kumi:

I don’t feel fine because of the attitude of people. Others treat me very bad. Some even will mock me with my condition. They will be teasing me with my condition. They even go saying I’m not correct; ‘this person is not correct, so you should not be talking to him’...My girlfriend went away because they say I’m crazy.

Alex too spoke. The participant stated:

The people with whom I lived in the same area got to know of my condition, and they were discriminating; the stigma was too much there. Sometimes you will be walking and then someone will make a funny statement as in ‘Ga’ they will say that “nye kwé aá së kë yelô o, lë ni yaa”, (look at that mental man, there he goes) and it wasn’t comfortable at all, so I had to leave the place.

4.4.4 Gossip

Neighbors and close family relations who were supposed to assist them were rather the biggest culprits of the rumor mongering.

This is what Evelyn said:

…my mum once told me that some people were gossiping about me that I was sick in the head…I think that they were
stigmatizing me in a kind of way, that I’m not normal…I think the way they behave toward me is discriminatory. They gossip about me, they don’t see me as they are. They see me to be different from them…I feel bad. Like they are isolating me as not being part of human beings anymore, [but] I think I’m part.

Ama also said:

When I came here [my mum’s house] I don’t feel happy around that place but I’ve no choice so I have to stay there like that. The way they are, I don’t like that place with the environment. They say a young girl with two children look at the kind of sickness she is going through. The way they talk and things, I don’t like it. The other time they were talking about it when my elder brother was also coming so he heard what they said. I have also heard [it] about two times… They group themselves, sitting down and then they will be talking about it. Even last week the same thing! They were sitting saying eih somebody who is sick look at how she is now, look at the way she dresses; goes out and comes back late. So someone heard it and he told me. I was annoyed and I told my mother, but she said I shouldn’t mind them.

4.5 Coping Strategies

Participants were posed with the question of how they dealt with the perceived distasteful feelings and experiences. They described various ways including Secrecy, withdrawal, relaxation techniques, confrontation, interaction with people, ignoring the stigmatizing agent, and in-group comparisons.

4.5.1 Secrecy

Some of the participants dealt with their stigma and discrimination by keeping issues concerning their illness away from members of the public.
The participant hinted:

I wouldn’t want somebody to know that I have a problem. Maybe I’ll go to a place and [everybody will be] enjoying, and I’ll collapse…People will not come near me, because they would tell others I have some problem, if they play with me I’ll collapse…I don’t want people to know. (Sampson)

This participant as well narrated:

Since I had the problem, nobody is aware, unless my family members. I have never told anybody. I have never revealed it to anybody. It’s only my family members who are aware. Nobody is aware. Maybe, when you tell them they would be mocking at you or something like that. They have been mocking at them [other patients]. [At school] I’ve been telling people that I’ve been going to hospital, but they are not aware that I have a problem. They are not aware that I’m sick. They are not aware. (Joe)

4.5.2 Avoidance

Most participants disclosed they avoided people who were likely to exhibit adverse attitudes towards them.

Korankye noted:

I want to be alone so that no one will point fingers at me anymore or say anything that will hurt me again. I know it’s difficult, but sometimes too I don’t want to be going out and see people pointing fingers at me. So when it happens that way I prefer being in the room.

Another participant stated:

If I think about it [the illness] I don’t try to go to places where people are gathered. I stay in the house then I’ll be browsing on the net using my modem. (Sampson)
4.5.3 Relaxation Techniques

A good number of the participants applied relaxation techniques to deal with problems resulting from unfavorable attitudes towards them.

Dan shared his experience:

I stay calm that is the best thing to do when you feel like restless, nervous. I pray and I also engage in breathing techniques whenever I feel like there is a “rush.” Sometimes, I also think about the good times I had in my life. I feel like there is a season and a time for everything so now I’m in a kind of bad times in my life and I feel like this will also pass away... like there is a season and a time for everything. So I have to move forward in life basically.

Korankye revealed:

Sometimes when it gets too much I just stay in the room and watch television. Sometimes I just sleep and relax. I listen to music; the words in it encourages me, so I listen to it and as I sing, sometimes I pray and by the time I finish I feel okay.

Owusu also added:

When it happens like that, I read the bible to calm myself down. I feel comforted and this makes me stop the thinking. At times, we go round for evangelism. I also go for group discussions! We have our church elders who lead the discussions and explain things for us to understand. I usually chat with my friends with whom I attend the discussions. This helps to calm me down because, they give me encouragement. We talk about issues in the bible. In the bible, God has promised changing this earth for the better. That he would give us a better place to stay on earth so when we talk about it, it gives me hope, and this takes away a lot of negative thoughts.
4.5.4 Confrontation

Some of the participants just tackled issues head-on. Kumi was one of them. The participant stated:

Sometimes too if I’m very angry I will just exchange words with the people so that I will be free...So that they will know that I’m also a human being.

Alex also reported:

…there was a day one of my co-workers made a statement and I couldn’t contain it any longer so I exchanged words with him, trying to make him know that am also a normal human being just like he is. It was a very heated argument that we had.

4.5.5 Ignoring the Source of Stigma

The majority of participants reported disregarding the negative attitudes that people portrayed towards them. According to them, this helped them deal with stigma.

For instance, this participant stated:

I have heard [someone talk about the illness] before, but I didn’t take it. I didn’t mine the person. They were two, sitting there and talking. During their conversation, I heard one of them say ooh this brother is very cool, and the other one said, nooh, they say he was once ill and mad, and he was treated. I didn’t turn to look at him for saying that. I just passed by to where I was going. I didn’t retaliate at all. What made me not to retaliate was that there are certain things that when someone says and you think of retaliating, maybe it will not bring good news so it wasn’t necessary. I didn’t make it worry me at all. I don’t think too much about things to worry about them… (Addae)
Dan too shared a thought:

I think everybody is entitled to their own opinion, I don’t think [my colleagues] are perfect, I don’t think I’m perfect. Everybody has their deficiencies. Everybody has fallacies and so they being able to pin point my fallacies and they having their conversations revolving around there, I don’t think that is helping them to talk about somebody’s fallacies. It will be good to talk about somebody’s achievement rather than spending time to talk about service personnel’s fallacies. I think they’re just indulging in useless gossips.

4.5.6 In-group Comparison

Some participants reported that weighing their illness against that of other patients gave them hope and the free mind to move on in life.

Addae emphatically noted:

…for illness everybody can get sick, and it isn’t me alone that has fallen sick. Some people have suffered some illnesses before. At the hospital, some people’s problems were more than mine. So I got to know that if mine is like this then why should I go and follow someone so that I worry about myself? So I don’t let that worry me. When you come, you will see I’m free, sitting there and chatting with others, doing my own work. With sickness, anybody at all can get sick. I don’t let that worry me that I’m in such [a] situation.

Another participant spoke:

I got to know of people having similar problem as I’m having, and even others which are even worse that I cannot compare mine to, but they are coping. So it gives me hope, it motivates me to be able to cope with my condition. (Alex)

4.5.7 Diversion Activities

Most of the participants said they resorted to activities that sought to take their minds of the problems they faced such as listening to music, singing, listening to radio
programs, watching movies or television, taking short walks, to deal with stigma on daily basis.

Alex hinted:

I really like this program on the radio ‘wo haw ne sen?’ (what is your problem) on Peace Fm; Maafia’s program. I’ve been listening to it every afternoon and I think it’s helping me. In the evening too I listen to preaching and sometimes listen to gospel music as well. Lying down and feeling more relaxed and listening is more pleasing to me than reading. At times too at night...when staying indoors becomes too much, I go out and then I walk and think of the way forward for me. Usually, it helps because [whiles] walking, maybe I’ve read a verse in the bible or I’ve listened to these motivational programs on the radio so I reflect on it and then I just get some hope that things will definitely be okay.

Korankye also spoke of how he coped:

My friend has a video deck and he has, Mr. Bee and other movies that create comic relieve so when it happens that way I just watch and as I begin to watch the comic relieve I laugh at it. By the time I realize I [would be] okay. When it becomes worse and sometimes if there is no light I just sleep and relax. [I] listen to music... the words in it encourages me, so I listen to it and as I sing, sometimes I pray and by the time I finish I feel okay.

Ama disclosed:

Sometimes I’ll just sit, watch movies or be listening to the radio, or I’ll be sitting outside with my brother [and] we’ll be chatting...
4.6 Reducing Stigma

At the end of the interaction with the participants, the view of each participant was sought on what could be done to bring down the unpleasant behaviors from people. They mentioned several ways of dealing with the problem including, education, enacting laws, government support, social inclusion, and social support.

4.6.1 Education

The participants suggested that people should be informed about issues concerning mental illnesses. Alex noted:

I think it all comes down to the knowledge people have about the condition. So I think people should be educated on some of these conditions so that when they see someone suffering from this condition they will know how best to help other than stigmatizing.

Evelyn also put this forward:

I think people have to be educated for them to understand that mental illness can happen to anyone so that the discrimination can reduce. For example, doctors and nurses coming to my school to educate them [the students] for them to know that mental conditions can happen to anyone.

4.6.2 Laws and Mental Health Legislation

Some participants mentioned the enactment of laws in order to punish individuals who will look down on them.

Alex observed:

Above all, I think because my basic human rights are been flouted day in day out, I think the government can make laws that will protect people with such conditions so that their rights will also be protected in the country.
Kumi who was emotional and frank also suggested:

Me, I want all those who have been behaving badly or who have been talking badly to people who have psychological problems to be jailed. They should be sent to court so that they will know that they don’t have to laugh or tease them [the patients].

4.6.3 Government Support

A good number of the interviewees also solicited for government assistance so that they could live independent lives. This according to them will reduce the unlikable attitude of people.

According to Dan:

The government could offer houses for those of them who don’t have a place to stay like group homes to be able to live a normal life, have some job, pay for their own things, go to the market to shop for their own produce, and stuff like that so [that ] they [could] defend themselves.

Yet another participant noted:

The drugs that we have been using, you will go to the hospital and they will tell you to buy. So I think the government can come in and give us some drugs so that we can feel fine.

(Kumi)

4.6.4 Social Inclusion

Participants appealed to the general public to have compassion, and involve them in their activities both at home and in the community.

One of the participants stated:

People with problems like this shouldn’t be neglected. The moment they are not liked then stigma comes in; you know it tends to increase the kind of pain they go through. I didn’t experience stigma, but my brother experienced it. I think they [public] should just try to know how to mingle because
I don’t think it’s contagious. At least they should try to do the least they can do to make the person feel okay. (Adwoa)

Evelyn also had this to say:

People who are having these mental conditions can be given jobs to be done so that they get money, buy things on their own, and become independent.

4.6.5 Social Support

The participants cited direct involvement of their close relatives in their care as a big booster to reducing stigma.

Adwoa revealed:

My mum would be there. In fact, she’ll help you regain your consciousness. She’ll be asking you things; what you’ll eat, sorry and stuff. She helped a lot. So I think people who have these problems should have such people to just be close to them.

Korankye too pointed out:

To me I think we should be treated just like any other person. At the work place if you have a condition like that [it] doesn’t mean we cannot do anything. So the people should accept us, after we have gone for treatment and everything is going well.

4.7 Outcome of Stigma

The participants were affected in diverse ways as a result of their experiences over the years. These include devaluing, loss of their partners, social withdrawal, exclusion, unemployment and loss of self esteem.
4.7.1 Devaluing

The participants who were employed before their predicament talked about the problems they had with their employers and other employees.

Alex painfully recounted:

…He [my boss] cut down my salary… I was just managing because I couldn’t just go home and do nothing. I was just trying to cope with the situation…at my work place I was very competent with the job I was doing, but because I had just fallen sick and I came back I was taken from that field to a different side which doesn’t even befit my qualification.

Another participant too reported:

I went for fitting. When I completed I was working for my master as work and pay. When I was treated and I came back, the amount of money that I was supposed to earn at the end of the month became less than that of my colleagues, and even my juniors whom I have taught… I was given 104 Ghana cedis. When I asked, he [my master] told me business is not as good as it used to be formerly. But when I asked my juniors, they were still receiving 200 Ghana every month.

(Korankye)

4.7.2 Loss of Partner

Even their intimate relationships broke down as a result of their illnesses.

Korankye shared his experience:

I have tried to be in relationships, but most at times people come around to tell whoever I am with that I have suffered a condition before and because of that the ladies shun away from me. Some also accept the relationship but later when they get to know, they also run away from me… out of these 5 relationships, have ended nothing.
Kumi recounted:
I’m not married. Previously I was having but due to my condition, I broke up. The lady broke up with me. So now I am not having. She was with me, before this illness and after I had this problem she was not coming to me, so I find out why, and she was saying people have been mocking her with my condition that I’m not correct, I’m crazy. She felt bad and she thought not moving with me again. I even personally went to her to see how things will be better but I wasn’t able to convince her so she left.

Ama also disclosed:
I was [married] but now am single. The man just woke up some morning, asked me we can’t go on again so we have to break up… I asked him but he did not give me any good answer… I’ve been asking myself, I don’t know anything about it.

4.7.3 Social Exclusion

Participants also shared their experiences of how friends and colleagues ruled them out of certain group activities. They spoke of how they were ignored by their compatriots in decision making. These bitter experiences according to the participants embarrassed them. This forced them to distance themselves from social activities.

Korankye hinted:
Sometimes when someone brings a fault and I try to share my idea about it, they ignore me. Sometimes they even go on to tell the person that he shouldn’t mind me, and that I have a problem with my head. My master is part and some of the workers at the place too. Some of the people don’t normally want to come close to me, and sometimes if they say something and I want to come in, they just ignore me and move on… I feel rejected, neglected and sometimes I don’t even want to talk to anybody at all.
Kumi too said:

Earlier on, I was having friends but now, I don’t have a best friend. They don’t come to me again…it is like they don’t want to move with me anymore or come closer to me like they used to do. This started after I was brought back from the Hospital. They don’t come to me now.

Alex shared this:

I was appointed as one of the leaders in the men’s’ fellowship. But after the incident, someone else was put in my place to take over my duties. Sometimes too you will raise your hand [at a meeting] you want to say something, they won’t call you. Even if they call you and you make any statement, they will just have that face like you don’t have anything better to say so let’s continue. So I had to leave.

4.7.4 Unemployment

Most of the participants found it difficult finding jobs. Others too left their jobs because of stigma. For instance, this participant stated:

I don’t have any meaningful job…This issue of job, when I came to Accra I had a cleaning job for one year. I worked for a contractor. It was a contract for one year. After the contract ended, I’ve not had a job again. If I get the job I’ll do, just that I don’t get it. I have been asking. I even went to Zoom Lion to search for job. But I was told my strength cannot march up for the job. I don’t know why they said so. I didn’t ask them. I am seriously searching for a job. I have even asked my friends to help me find one. So far they’ve not found one yet. (Owusu)

Another participant also disclosed:

I started my own business and it collapsed and since then I haven’t been able to set it up. Before, I have been taking some video coverage and as at now, it’s not moving like before. It’s not like every week they would come and call you that come and take my funeral or birthday shots, it’s not happening. It’s
only my wife who is supporting me, and she is a trader.

(Nana)

4.7.5 Self Esteem

Some of the interviewees disclosed they no longer saw themselves valuable as before. According to them, the respect they commanded had dwindled.

Dan shared his view:

…I feel at this age I should be more out-spoken about family issues but I’m still very reserved. You see the illness makes me withdrawn, sort of. I just feel like I’m not being of myself most of the time when I’m with my family or with friends.

Ama too hinted:

…I don’t think I can marry again. I don’t think any man or any boy will like to marry someone who is sick, I don’t think…

4.8 Summary of the findings

In all, the results of the study revealed that even though support systems and attitudes of the general public acted as sources of stigma, perceptions held by the participants also influenced their sensitivity to the experiences they encountered. The participants were disregarded, considered as incompetent; incapable of independent life, and work. They felt undervalued and disrespected. These factors made them react in various ways to be able to cope with the situations encountered. They also suggested ways of reducing the impact of stigma in order to make life better for them. In all, the observations made by the participants seemed to suggest they were not happy about the way they were treated.
CHAPTER 5
DISCUSSION OF FINDINGS

5.0 Introduction

The purpose of this study was to describe the psychological and social effects of the stigma attached to mental illness as experienced by out-patients at the Accra Psychiatric hospital. In this chapter, the investigator deliberated on how the findings of the study supported other research works on stigma, how they contrasted and also how these findings add to the existing literature on stigma.

5.1 Individual Perceptions

The participants spoke about how they saw themselves and also felt in relation to their illness and how people behaved towards them. The thoughts they expressed were mostly negative. This seemed to have played a role in their stigma experiences. Their perceptions included Self stigma, anticipated stigma, perceived discrimination, and knowledge about the illness.

5.1.1 Self stigma

The participants were found to internalize the stigmatizing attitudes of the public. They felt sad as a result. They also looked down on themselves. This finding is consistent with some studies in Africa (Barke, Nyarko, & Klecha, 2011; Sorsdahl, Ritsuko, Wilson & Stein, 2012) and elsewhere (Branka, et al., 2010; Lazowski, Koller, Stuart & Milev, 2012; Ehirlie-Ben, et al., 2013; Yuksel, Bingol & Oflaz, 2013). The participants probably stigmatized against themselves due to the legitimization of public perceptions of them and the subsequent demoralizing effect. According to the Identity Threat Model of Stigma, stigma affects people through discrimination, the anticipation and confirmation of the stigmatizing attitudes of the public, stereotype activation, and threats to personal and social identity of the person (Major & O’Brien, 2005). The model also includes situational
cues, collective representations of a person’s stigma status, personal beliefs and motives as key factors that affect the cognitive appraisal of the importance attached to stigma-relevant situations. The individual’s level of awareness about his illness is also likely to direct all public attitudes onto the self resulting in self-blame and devaluation. The stigmatized individual comes to share and accept the public point of view about their position in society. Persons diagnosed with mental illness may not outwardly show their feelings due to anticipated public reactions. The public should therefore be made aware of the role they play in the internalization of stigma among patients.

5.1.2 Anticipated Stigma

Majority of the participants in the study expected to be stigmatized by the public in one way or the other. Even though some of the respondents admitted that no one confronted them with any disturbing issues, they still foresaw unfair treatment from partners, family members, friends, employers, colleagues and the general public. This finding is consistent with earlier studies (Vauth, Kleim, Wirtz & Corrigan, 2007; Struch, et al., 2008; Thornicroft, et al., 2009; Sanseeha, et al., 2009; Brohan, Gauci, Sartorius & Thornicroft, 2010; Thomé, et al., 2012; Üçok, Karaday, Emiroğlu, & Sartorius, 2013; Gerlinger, et al., 2013; Hansson, Stjernswärd & Svensson, 2013). These studies reported people anticipating unfair treatment in relation to employment and starting intimate relationships. The studies also mentioned that individuals anticipated avoidance from family members and other members of the community. People may expect to be stigmatized based on their own previous experiences, media stories, or seeing other individuals with similar condition being unfairly treated. The work of Üçok, Karaday, Emiroğlu, and Sartorius (2013), was also confirmed by the study finding. According to Üçok, Karaday, Emiroğlu, and Sartorius (2013) 64% of the participants stopped themselves from applying for work, training or education because of anticipated
discrimination; and that those who experienced discrimination were more likely to be affected by anticipated discrimination or self stigma. A further 72% concealed their diagnosis due to anticipated avoidance by others who knew about their diagnosis. Majority of the respondents who concealed their diagnosis were younger and more educated. Again, participants who perceived that others were discriminating against them were more likely to distance themselves from intimate relationships.

In Ghana, individuals diagnosed with mental illness go through many humiliating experiences such as chaining at prayer camps, and being refused employment or marriage among others. Even though laws have been enacted over the years to protect the mentally ill (National Redemption Council Decree, NRCD 30), the effectiveness of these laws are yet to be felt in both formal and informal institutions. Respect for the patients, effective laws and positive media portrayal of people diagnosed with mental illness will go a long way in reducing their negative expectations and replace them with hope.

5.1.3 Perceived Discrimination

The actions and inactions of the general public were also interpreted by most participants as discriminatory. The pervasiveness of stigma was found to permeate various aspects of the individual’s interactions with their support systems. The participants reported unfair treatment from various sources. These included partners, co-workers, friends, family and other community members.

Partners in intimate relationships are expected to support each other at all times including times of sickness. In this study however, one of the commonest source of prejudice and discrimination identified by the participants was issues concerning their partners. Their partners deserted them after they were discharged from hospital. Interviewees also mentioned behaviors by their co-workers as very disturbing. Close friends and co-workers who were expected to offer a helping hand in order to boost their
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

morale also deserted them. Discriminatory attitudes against the mentally sick has been reported in many studies across Africa and the world over (Brohan, Gauci, Sartorius & Thornicroft, 2010; Kapungwe, et al., 2010; Sorsdahl, Ritsuko, Wilson & Stein, 2012; Hansson, Stjernswärd & Svensson, 2013). According to the Identity Threat Model of Stigma, personal encounters with discriminating acts affect the psychological and physiological activities of the individual in several ways, including self-esteem, academic and health problems (Major & O’Brien, 2005). Rüsch, Lieb, Bohus, and Corrigan (2006) looked into why some people with mental illness self-stigmatize, and develop perceived low self-esteem whiles others remain indifferent to stigma and found that low level of perceived discrimination and of the legitimacy of discrimination leads to high self esteem and high empowerment.

The study findings revealed persistent myths and misconceptions associated with mental disorders, which negatively affected the sufferer based on their encounter with the stereotyping behavior of society. They acknowledged being devalued and discriminated against. These probably had an effect on the perception and appraisal of circumstances that the stigmatized encounter even in the absence of noticeable activities that might have demonstrated discrimination. This is also consistent with the work of Crocker, 1999, and Major & O’Brien, 2005).

The finding of the current study also found similar results by Parle (2012). The participants revealed they were discriminated against in job search. Those who had a job were also discriminated against by their coworkers, bullied, ridiculed and even demoted. Traces of public stigma were also identified, as patients were physically and verbally attacked by neighbors and outsiders alike, leading to the collapse of the relationships existing between them and their partners, family members and close friends.

According to Kadri, Manoudi, Berrada and Moussaouï, (2004), most of the
families experienced stigma and discrimination from members of the general public in the form of distrust, mockery, maltreatment, divorce, neglect by neighbors and other relatives, and ejection by landlords. This is however inconsistent with the findings of the current study. It is worth noting that none of the respondents in this study mentioned that their family members were stigmatized. This could probably be due to the fact that only individuals suffering from mental illness were interviewed. Future studies could therefore look into how stigma impacts on the families of individuals diagnosed with mental illness in Ghana.

5.1.4 Knowledge

The participants of the study expressed diverse views about their illness, the cause, and what the future holds for them. All the participants were aware that something was wrong with them even though some of them could not specifically tell what was wrong. Some mentioned they fell sick because they were thinking too much. Others also described their illness as scary and dangerous. Spiritual causes were also prominent in the descriptions of their illnesses. The perception of the individuals about the cause of their illness has been found to influence their stigma appraisal in several ways. This confirms the work of Sanseeha et al. (2009). The participants (18 Buddhist in North-Eastern Thailand) believed the cause of their illness was due to supernatural powers, bad Karma from the past or biological factors. According to the participants, they were discriminated against by society because of these. Ward, Clark and Heidrich, (2009) also found similar results after looking at African American women's beliefs about mental illness, coping behaviors, and barriers to treatment seeking in the United States of America. Participants felt that a broad-spectrum of factors, as well as cultural specific factors can bring about mental illness. They also felt mental illness is unremitting, with negative life implications. But Shrivastava et al., (2011) differed after examining the perceptions of patients with
schizophrenia in terms of the stigma and discrimination they faced in India. According to the patients’ point of view, ignorance about the characteristics of the illness was seen as the main cause of stigma and discrimination.

Ghanaians are highly religious people. As such, most illnesses are linked to spiritual causes such as curses and possession by demonic powers. Highly educated people including health professionals also harbor these perceptions. This is probably the reason why the public and some health professionals alike show prejudice against patients diagnosed with mental illness. Most spiritualists therefore perform various rituals such as flogging, fasting, restraining in order to exorcise the evil spirits and deliver them. These beliefs and attitudes subsequently create a negative perception about the patient and all who care about them. The patients who internalize these negative opinions are likely to legitimize public opinion leading to self stigma.

5.2 Public Attitudes

The second objective of the study was to explore the public attitudes that engendered stigma toward individuals diagnosed with mental illness. Various public attitudes were reported to have played a role in bringing about stigma amongst individuals diagnosed with mental illness. These behaviors were described as unfair and very prevalent. The findings included social isolation, mocking, labeling and gossips.

5.2.1 Social Isolation

Most participants felt left out in terms of social activities due to their illness. Social distance and avoidance by community members, colleagues and friends who had knowledge about their mental illness was reported by participants as a result. This finding agreed with other previous studies in Africa and the world over (Struch, et al., 2008; Angermeyer, Holzinger & Matschinger, 2009; Kapungwe, et al., 2010; Trevor & Wang, 2010; Sorsdal, Stein & Myers, 2012; Hansson, Stjernswärd & Svensson, 2013; Yuksel,
The following studies in Nigeria were also confirmed by the current study. Adewuya and Makanjuola (2005) interviewed 1668 Nigerian university students. The students revealed they were scared about holding conversations, working with or keeping friendship with a person diagnosed with mental illness. Even healthcare professionals moved away from persons diagnosed with mental illness. Abiodun, Adewuya, and Ayotunde, (2007) also found that doctors did not want to have any close relationship with family members or friends with mental illness. The study by Igbinomwanhia, James and Omoaregba, (2013) revealed that a good number of their participants (clergy) felt that individuals diagnosed with mental illness were distinct from other people, and that individuals with mental illness must be treated like kids. Because of this, they were not happy staying in the same neighborhood with psychiatric patients. Others even suggested that psychiatric hospitals should be located far away from residential areas.

Ghana and Nigeria share a lot of cultural, traditional and religious beliefs in common. It is therefore not surprising that most of the findings from the studies in Nigeria seem to reflect a similar situation in Ghana. People probably see the patients as outcasts and therefore refuse to either visit them in hospital or associate with them when they are discharged home.

5.2.2 Mocking

The participants disclosed they were disrespected through teasing, funny comments, giggling and finger pointing. This finding is in line with the results of Shrivastava et al. (2011) who identified people passing funny comments against their colleagues at the workplace who were found to be sick. They also found people making fun of individuals diagnosed with mental illness in the community, as well as in the media. Similarly, Oleniuk, Duncan and Tempier, (2011) also found co-tenants making fun of
certain individuals because of their mental illness.

In Ghana, it is a common sight to see or hear comedians depict people with mental illness in a disparaging manner in order to make fun of them and also to create humor and laughter for their audience. These artistes either tease the patients intentionally or are ignorant of the fact that some of their listeners or audiences include individuals who are suffering from mental illness, and therefore are likely to be hurt by such negative remarks. Such unfair comments go unpunished. It is an everyday occurrence to see ‘relatively normal’ people enthusiastically follow mental patients and call them names. Because the patients are also human, they respond when they feel offended. These responses take the form of anger, aggression and in more severe instances violence. At this juncture, the public turns against these people because they are in the minority and accuse them of being sick for responding to unfair and unnecessary behaviors from them. Because behaviors are usually learned, children model these attitudes and also make fun of the people suffering from mental illness. Even though there are laws that are supposed to protect individuals diagnosed with mental illness, they are not effective, thereby leaving the patients to their faith to fight it alone in the workplace, in their relationships and in the community as a whole.

5.2.3 Labeling

Name calling and tagging was another worrying behavior associated with the general public. The participants were hurt by the descriptions from people. They were portrayed as sick, crazy, not correct, mad, weak, and that people should be careful with them. This confirmed previous findings from Africa (Kadri, Manoudi, Berrada & Moussaoui, 2004; Adewuya & Makanjuola, 2005; Abiodun, Adewuya, & Ayotunde, 2007; Kapungwe et al., 2010; Sorsdahl & Stein 2010; Barke, Nyarko, & Klecha, 2011; Oleniuk, Duncan & Tempier, 2011; Iginomwanhia, James & Omoaregba, 2013) and other studies
elsewhere (Angermeyer & Matschinger, 2005; Struch, et al., 2008; Angermeyer, Holzinger & Matschinger, 2009; Trevor & Wang, 2010; Schomerus, et al., 2012; Yuksel, Bingol, & Oflaz, 2013) that saw categorization of the mental patients as one of the probable causes of stigma and discrimination in the community. The labels are belittling and damaging in character thereby resulting in self-stigma and increased public stigma and discrimination. Such individuals labeled as ‘sick’ are usually underemployed and also underpaid, than people with similar psychological problems who have not been officially assessed and diagnosed as suffering from a mental illness due to these stigma perceptions. This is consistent with other studies (Alexander & Link, 2003; Arthur, Michael, Eileen & Howard, 2005; Bathje & Pryor, 2011).

The participants of the current study mentioned name-calling and tagging as a regular feature especially with tenants and close relatives. This probably could be due to the fact that these people live with them in the same house so they get to know what is going on with the patients. Even in the midst of this secrecy, these close associates try by any means to find out what is wrong with such individuals especially when their movements tend to follow a particular trend such as going for reviews every month. These community members usually use this against the patients in times of heated arguments or petty quarrels just to silence them, and in the process, expose them to the general public. Such disclosures likely affected the careers and even relationships of these patients.

In Ghana, most people diagnosed with mental illness are therefore faced with unemployment and relationship problems due to the public and media stereotype. A strong public education machinery and positive image portrayal of the mentally sick in the media landscape of Ghana could immensely help stop this menace.
5.2.4 Gossip

The study participants mentioned neighbors and close family relations as the major culprits of the rumor mongering. The participants disclosed that the attitude of public gossip made them feel as if they were not part of society. This affected them in many ways, and confirmed previous findings by Aisbett, Boyd, Francis and Newnham (2007). They looked into the barriers that affect mental health service utilization in rural communities in Australia. After a series of interviews with the participants, it was found that gossip among the rural folks contribute to stigma, social exclusion and the refusal to make use of mental health services, thereby retarding their recovery process. Moses (2010) also found that friends and family members stigmatized patients in ways such as distrust, avoidance, pity, gossip and under-estimation of their capabilities.

In Ghana, the tendency to gossip about other people is common no matter your status in society. This seems to be a human feature that helps to spread information, both positive and negative. But the kind of hearsay that takes place in the community concerning mental patients is always negative and shrouded in secrecy. This attitude is demeaning to the victim. However, the perpetuators regard it as good news in order to buttress their ingenuity of ‘harvesting news’. The role of culture and tradition, religion and spiritualism played a significant part in issues concerning mental illness. Mental illness is still linked to punishment from the gods. The gods are therefore consulted through the fetish priest, for remedies or to treat the sick person. Some of these activities are most likely responsible for the rumor mongering whenever someone suffers from mental illness. There is the need to be mindful of the role societal beliefs play in stigma production with its ripple effect on the use of mental health services in the community. The establishment of mental health units in all hospitals and clinics in all the ten regions of Ghana is likely to
help bring down the apprehension that goes with not wanting to be seen in a ‘psychiatric hospital’ setting.

5.3 Coping Strategies

Participants were asked how they dealt with the perceived distasteful feelings and experiences. They described various ways including secrecy, withdrawal, relaxation techniques, confrontation, interaction with people, ignoring the stigmatizing agent, and in-group comparisons. These findings were quite encouraging as they portrayed the spirit of perseverance and mental fortitude of human beings even in instances where all odds are against them.

5.3.1 Secrecy

Some of the participants dealt with their stigma and discrimination by keeping issues concerning their illness away from members of the public. They concealed their illnesses in order to prevent public avoidance, mockery, gossip and disrespect from people. This finding was consistent with other previous studies encountered in the literature review. For instance, Struch et al. (2008) used cross-sectional design to explore stigma among adults undergoing outpatient psychiatric treatment. The results showed that Service users utilized several coping mechanisms including secrecy. Other studies also confirmed the use of secrecy as a strategy in dealing with stigma (Thornicroft et al., 2009; Daumerie, et al., 2012; Ilic et al., 2012; Üçok, Karaday, Emiroğlu, & Sartorius, 2012). According to Üçok, Karaday, Emiroğlu, & Sartorius, (2012) people concealed their diagnosis due to anticipated avoidance by others who know about the illness. But Ilic et al. (2012) contended that even though coping skills such as secrecy, careful disclosure as well as overcompensation or disproving stereotypes helps the individual to deal with stigma, low levels of self-esteem had been identified in such individuals.
In Ghana, the results of Barke, Nyarko, and Klecha (2011) were confirmed by the current study. The work of Barke, Nyarko and Klecha (2011) also reported high levels of experienced stigma with secrecy concerning the illness as a wide spread coping strategy among the participants. Individuals who felt neglected by society were less likely to disclose their health problems to close associates including friends, family members, colleagues, or other persons who have the capacity to help them (CDC, 2007). Secrecy in mental illness could probably be linked to factors such as anticipatory stigma, self stigma, institutional stigma, previous experience related to public interactions, stereotyping attitudes from the public and the media as a whole. Secrecy as a coping strategy in mental illness is likely to result in non-compliance and subsequent relapse. Anti-stigma activities such as workshops and conferences that seek to engage patients, health professionals, educational institutions, journalists, as well as the general public so as to enhance public advocacy in order to augment the confidence level of the victims. This would encourage them to stand up and face stigma wherever they find themselves.

5.3.2 Avoidance

Most participants disclosed they avoided people who were likely to exhibit adverse attitudes towards them. They preferred to be alone so that no one would point fingers at them or say things that would hurt them further. This was in line with previous studies that found patients withdrawing from public places and other social gatherings as a coping mechanism to public stigma (Jahoda & Markova, 2004; Roe, Yanos & Lysaker, 2006; Struch, et al., 2008; Ward, Clark & Heidrich, 2009; Yanos, West, & Smith, 2010; Boardman, et al., 2011; Ilic et al, 2012). However, Yanos, Roe, Markus and Lysaker (2008), thought otherwise. To them, self stigma increased avoidant coping in people diagnosed with mental illness.

In Ghana, individuals diagnosed with mental illness possibly anticipate rejection
from the ‘relatively normal’ people. This causes them to limit their social interactions with community members who they feel know about their sickness. They therefore use withdrawal as a possible defense mechanism in order to deal with the anxiety usually associated with public interactions and also to help reduce the likelihood of future rejection tendencies. Public acceptance of those suffering from mental illness will go a long way to solving the perception of rejection thereby urging the patients to get involved in social interactions that would enhance their self-esteem and public confidence.

5.3.3 Relaxation Techniques

A good number of the participants applied relaxation techniques to deal with problems resulting from unfavorable attitudes towards them. They mentioned praying, reading, sleeping and exercise as calming activities that helped them to de-stress whenever they were hurt. This confirmed other studies (Ward, Clark & Heidrich, 2009; Yanos, West, & Smith, 2010; Ward, et al., 2013) that identified activities such as sleeping, holding conversations with a pastor or reading their bible and exercising regularly in order to continue to be physically and emotionally functional to help them to deal with unpleasant behaviors from people. Reactions to identity threat could result in voluntary (conscious) coping efforts in order to control emotional, cognitive, behavioral, physiological, and environmental responses to situations believed to be traumatic to the individual (Compas et al., 1999). These techniques most probably helped to reduce depression that the patients usually experienced whenever they felt hurt. The health implications of such calming activities are positive and enormous in terms of boosting immune systems, elevation of mood and the motivation to carry on with life. It would therefore be prudent if the Ghana health service could encourage health professionals to educate patients at the OPD and to also assist them to choose the appropriate techniques that suite them in their day to day living.
5.3.4 Confrontation

Some of the participants just tackled issues head-on. The participants mentioned exchanging words with the people who treated them in ways that demeaned them so that they would know that they are also human beings. They contended this made them feel relieved. This finding was consistent with the results of Roe, Yanos and Lysaker, 2006 and Yanos, West, and Smith, 2010. According to these previous studies, some people manage stigma through the expression of anger, violence and other emotions directed towards the offending person. Confrontation may be used by the participants as a defence mechanism in order to deal with the tension that goes with the negative treatment emanating from interactions with the general public. This coping strategy is likely to create problems for the individual patient since the public as well as health professionals are likely to misinterpret this reaction as a case of relapse or a symptom of mental illness forgetting that the patients are also human beings with emotions and the innate capacity of self defence whenever they feel threatened.

In Ghana, patients are faced with this predicament almost every day. Any slight misunderstanding between a ‘relatively normal’ person and a patient is easily taken as relapse. Some of these patients are at times chained or locked up in the room. Others are attacked by relatives or community members for being assertive and demanding some kind of dignity. These supposed relapsed patients are forcibly admitted on the request of relatives especially if the conflict was between them and the patient. This attitude by the health professionals leaves no room for explanation on the part of the patient. The law does not protect the patient when it comes to issues of human rights abuse. The new mental health law, (Act 846) is therefore expected to address some of these deficiencies in order to uphold the rights and dignity of people diagnosed with mental illness.
5.3.5 Ignoring the Source of Stigma

The majority of participants reported disregarding the negative attitudes that people portrayed towards them. They consciously refused to acknowledge negative comments passed by people about their illness. According to them, no one is perfect and that such attitudes from the public were unimportant to them. This helped them deal effectively with stigma. This was consistent with previous findings elsewhere (Roe, Yanos & Lysaker, 2006; Robilotta, Cueto, Yanos, 2010; Yanos, West, & Smith, 2010). Some individuals diagnosed with mental illness also coped by accepting and appreciating their own health as much more vital than the reaction of other people (Alvidrez, Snowden & Kaiser, 2008; Yanos, West, & Smith, 2010), thereby resulting in them taking a positive perspective of themselves (Ward, Clark & Heidrich, 2009) in the form of re-labeling; positive reinterpretation and growth (Cooke, et al., 2007) and building on positive emotions (Boardman, et al. (2011). Individuals with mental illness are likely to pay no attention to sources that perpetuate stigma if the source is so powerful that they cannot confront it. The best action would likely be for them to refuse to respond to the potential stressor. Others might not take notice of events relating to their illness if they found such attitudes as ‘useless’. They may possibly attach no importance to such behaviors resulting in resilience against stigma. Health professionals and other non-governmental organizations (NGOs) who work with people with psychological problems should therefore do their best to encourage the patients to exercise restraint even in situations when people make the conscious effort to degrade them. This is likely to de-motivate the perpetrators overtime thereby enhancing the public image and respect for these patients.

5.3.6 In-group Comparison

Some participants reported that weighing their illness against that of other patients gave them hope, free mind and the energy to move on in life. According to them, they
found some of their colleagues at the hospital to be worst in terms of their conditions, and that they were not the only ones who were sick from mental illness. This motivated them to be able to mingle with other people and to continue with their work. This outcome was in agreement with the findings of Rüscher et al. (2009c). According to them, patients who hold their group in high regard and reject stigma as unfair are more resilient to stigma. They also added that high group identification predicted positive reactions among stigmatized individuals. Rüscher et al. (2009b) also found in-group comparisons as a way of dealing with stigma in some individuals diagnosed with mental illness. Coping responses of in-group comparisons were found to shield self-esteem. They also felt the coping mechanism of in-group comparisons brought about poorer social performance as well as increased social distance stemming from weaken enthusiasm and need for accomplishment in many aspects of life. This aspect of the findings by Rüscher et al. (2009b) is however not consistent with the findings from the current study as some of the participants interviewed spoke of how they regularly interacted and worked happily with other people. This difference probably had something to do with the personality of the participants, the stressors around them, as well as the social network that supported them. Rusch et al. (2013) explained that one’s sense of high empowerment was linked to lower levels of stigma stress and self-contempt. Increased self-stigma and lowered sense of empowerment lead to poorer quality of life as well as reduced self-esteem. Therefore, encouraging individuals diagnosed with mental illness to form welfare groups in their localities will go a long way to help fight stigma.

5.3.7 Diversion Activities

Most of the participants said they resorted to activities that sought to take their minds off the problems they faced such as listening to music, singing, listening to radio programs, watching movies or television, and taking short walks. This confirmed the
findings of Morgan and Jorm (2008); Yanos, West and Smith, (2010) and Ilic et al. (2012). According to these studies, people who experienced dejection emanating from unfair treatment benefited a lot from distractive behavioral activities such as exercise, humor, listening to music and singing. Such distractive behaviors helped the individuals to cope with problems relating to their sickness. Individuals who resorted to such calming activities solely might benefit from the short term effects but in the long term, these people are likely to suffer from depression due to the lack of frequent interaction between them and the general public. After all, all human beings have an inherent need to socialize with others. Therefore isolation of oneself might not exclusively sustain the quest to wholly deal with stigma. Stigmatized individuals should therefore be encouraged to get involved in social activities that foster close contact with other people. This will go a long way to boost patient confidence and also to enhance public trust.

5.4 Reducing Stigma

Participants’ views were sought on what could be done to bring down the unpleasant attitude of the general public. They suggested several ways of dealing with the problem including, education, enacting laws, government support, and social support/inclusion.

5.4.1 Education

Public knowledge about mental illnesses has been found to influence stigma perceptions in various ways. The participants suggested that people should be informed about issues concerning mental illnesses. Other studies have also acknowledged the influence of education on reducing stigma. For instance, participants with higher levels of education have been reported to have less stigmatizing attitudes than those with less education (Trevor & Wang, 2010). Brief educational activities in the form of seminars
were identified as measures that could help with attitudinal change towards the reduction of stigma (Pinfold, et al., 2003). Corrigan and Matthews, (2003), Kapungwe et al. (2010) and Shrivastava et al. (2011) also supported public education as a measure in minimizing stigma in mental illness. Rüsch, Angermeyer and Corrigan (2005) thought information that counteracted stigma helped to significantly reduce stigma. This information could be disseminated using books, videos and structured teaching programs. Additionally, Romer and Bock, (2008) found that stories that center more on individuals who had successfully recovered played a key role among in reducing public stigma in mental illness. In Chicago, Corrigan, Powell, and Michaels in 2013 reechoed the claims by Rüsch, Angermeyer and Corrigan (2005), as well as that of Romer and Bock (2008). Other researchers also observed that ensuring close contact with stigmatized individuals could further boost the influence of educational programs aimed at reducing stigma in the community (Corrigan & Matthews, 2003; Angermeyer, Matschinger & Corrigan, 2004). However, Angermeyer and Matschinger (2005; Angermeyer, Holzinger and Matschinger (2009) as well as Schomerus et al. (2012) found in their respective studies that despite the increase in public knowledge about the biological basis for the causes of mental illness, stigmatization and discrimination were still high among the general public.

Other factors including cultural differences; the belief in spiritual powers; demon possession; curses; and punishment from gods could probably be responsible for the disparities. It is necessary to educate the general population on the physical, social, psychological, spiritual and economic impact of mental illness on persons diagnosed with the illness. Discounting myths associated with mental illness is likely to promote positive attitudes towards patients.
5.4.2 Mental Health Legislation

Participants mentioned basic human rights abuses in the hands of members of the general public and hoped the laws will protect them. Some participants mentioned the enactment of laws in order to punish individuals who will look down on them or treat them unfairly. This is consistent with the findings of some studies (Rüsch, Angermeyer & Corrigan, 2005; Kapungwe, et al., 2010) that suggested fighting for laws that could protect persons with mental illness from the public. The parliament of Ghana showed commitment of government by passing the Mental Health Bill into law in 2012. This law seeks to promote access to basic mental health care in a liberal atmosphere in the community. It is also aimed at encouraging early identification and prompt treatment of patients at the district level, instead of the three main psychiatric hospitals that are inaccessible due to poverty and stigma. According to Maye, et al. (2010), mental health policies in Ghana, South Africa, Uganda and Zambia are quite weak.

In Ghana, this could be attributed to the absence of a substantive unit in charge of issues of mental health in the Ministry of Health as well as its arm, the Ghana Health Service (GHS). Despite the enactment of the new mental health law (Act, 846), mental health policies have still not been implemented. This could probably be due to lack of political will and commitment as well as scarcity of both human and financial resources. The mental health board is therefore urged to expedite action by ensuring the full implementation of the law so as to enhance effective and efficient management of all cases of mental illnesses and also to ensure the welfare of patients in both hospital and community settings.

5.4.3 Government Support

A good number of the interviewees also suggested the need for government assistance so that they could live independent lives. According to respondents, this would
reduce the unpleasant attitude of people in the society. They suggested shelter for those who had no place to stay. They also mentioned that the government should assist them by giving a hand to the hospitals so that they can procure the drugs and make them accessible to them. The participants also asked for assistance in finding jobs so that they can live independent lives. Kapungwe et al. (2010), who found that the transformation of mental health policy and legislation and the expansion of the social and economic opportunities of the mentally ill could reduce stigma, supported these suggestions. According to Saxena, Thornicroft, Knapp and Whiteford (2007), mental health care in developing countries such as Ghana are faced with low budgetary allocation. The psychiatric hospitals are neglected. They have poor infrastructure, non-availability of food and medication. Relatives who send their wards to these hospitals are refused admission because there are no drugs to cater for them. As such, relatives purchase the drugs at high prices from pharmacy shops outside the hospitals. Mental health policies of every country may indicate how the government plans to tackle the mental health needs of its people. According to the WHO (2005; 2007), 53% of African countries that have a mental health policy are considered obsolete. Ghana’s new mental health bill enacted in 2012 may not be obsolete. Implementing the policies embedded within the law is likely to strengthen the modalities of care for patients, enhance effective treatment and recovery, while lessening relapse rate and stigma among patients.

5.4.4 Social Support and Inclusion

The participants cited direct involvement of their close relatives in their care as a big booster to reducing stigma. They also appealed to the general public to have compassion, and involve them in their activities both at home and in the community. The participants said the public should mingle with them and not discriminate especially in job search. Previous studies found similar findings (Kapungwe, et al., 2010; Shrivastava, et
al., 2011; Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012). The provision of good treatment and rehabilitation facilities, early recognition of psychiatric disorders and social integration of individuals diagnosed with mental illness would help reduce stigma in the community. According to Shrivastava et al. (2011), even though some patients families isolated them, they accepted them back home, offered them assistance medically and financially. Some of the 100 families studied by (Kadri, Manoudi, Berrada & Moussaoui, 2004) felt that the illness suffered by their relatives was in harmony with a normal life, and that the patients could work if given easy and secure duty.

5.5 Outcome of Stigma

The participants were affected in diverse ways as a result of their experiences. These include devaluing, loss of their partners, social withdrawal, exclusion, unemployment and loss of self esteem. The impact of stigma and discrimination was found to affect patients profoundly.

5.5.1 Devaluing

The participants who were employed before being diagnosed with mental illness talked about the problems they had with their employers and other employees. Their salaries were reduced, and some cases, they were moved to different departments which they felt did not befit their qualification. Similar findings have been reported by some previous studies. For instance, in France, Daumerie et al. (2012) assessed the impact of schizophrenic disorders on privacy, and social and professional life in terms of discrimination. After conducting qualitative and quantitative interviews with 25 people in Lille and Nice, about half of the participants were found to be disrespected because of contacts with psychiatric services. Stigma defined individuals in terms of some distinctive features, and devalued them in the final analysis (Dinos, et al., 2004). Parle (2012) also found instances where patients were treated like children or unintelligent people by
individuals they interacted with. Individuals whose conditions were known to the public experienced more underemployment and underpayment, than people with similar psychological problems who had not been officially assessed and diagnosed as suffering from a mental illness (Alexander & Link, 2003; Arthur, Michael, Eileen & Howard, 2005; Bathje & Pryor, 2011). This could probably be one of the reasons why some people concealed their illness in order to safeguard their status at work and in their community. Such people are likely to refuse going for reviews since they would not want anyone to see them. The consequence of this could be a relapse leading to workplace absenteeism, inefficiency, job loss or demotion.

The general population including families, health professionals and employers and employees alike should be entreated to support individuals who in one way or the other are sick, so as to enhance social integration, self esteem, adherence to treatment regimen and recovery. Individuals who for genuine reason need to be moved to different departments of the work setting should be counseled before such actions are undertaken. This collective agreement will demonstrate respect, acceptance, and support for the people. Sustaining these attitudes would go a long way in fighting the stigma in all facets of life.

5.5.2 Breakdown of Relationships

Participants reported that even their intimate relationships broke down as a result of their illnesses. According to some of the participants, their partners left them because people were mocking them that they were sick and crazy. The partners felt bad and left. The participants revealed their partners deserting them immensely affected them socially and psychologically. This finding confirms the following studies (Rüsch, et al., 2009; Shrivastava, et al., 2011 & Parle, 2012) that persons suffering from mental illness could be very responsive when rejected in a relationship, making them easily susceptible to stigma and related stress responses.
The picture painted by the interviewees seems to prevail in the Ghanaian society. The extended family system in Ghana makes it very possible for the whole family to carry the problems of a kinsman. As such, even if the partner is not willing to leave the relationship, the pressure from family members would make the separation inevitable. Family systems in Ghana are governed by the belief in culture, tradition and religion. Traditionally, the families of the couple are the ones that play active roles in ensuring the success of the union. Because of this, most families do background checks on potential in-laws before marriage ceremonies are performed. This is to ensure all possible illnesses are ruled out so that the offspring that would come out of such relationships are healthy. Unfortunately, people diagnosed with mental illnesses are seen as outcasts in the eyes of the public. Others even think that mental illness is not curable. Patients may lose their partners due to this family influence and the negative perceptions associated with the illness. It could also be that the partners come to agree with the public prejudices. Because of the fear of stigma by association, they desert the partners. Effective educational drive in schools and communities with emphasis on social contact with patients is likely to dispel the myths surrounding mental illnesses.

5.5.3 Social Exclusion

Participants also shared their experiences of how friends and colleagues ruled them out of certain group activities. They spoke of how they were ignored by their compatriots in decision making. These bitter experiences according to the participants embarrassed them. This forced them to distance themselves from social activities. In an attempt to look into how stigma affected people with mental illness, Parle, (2012) conducted systematic review of twelve articles. The review revealed that a lot of people diagnosed with mental illness were discriminated against in a job search. Those who had a job were also discriminated against by their coworkers. This took the form of demotion, bullying and
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

ridicule. This made them feel insecure all the time. Other studies also corroborated the findings of this current study (Rüsch, et al., 2009b; Crabb, et al., 2012; Drapalski, et al., 2012; Gerlinger, et al., 2013; Mashiach-Eizenberg, et al., 2013). In Vienna, Sibitz et al. (2011) ascertained whether social network, stigma and empowerment directly and indirectly contributed to depression and quality of life in patients with schizophrenia and schizoaffective disorders. Poor social network was found to contribute to a lack of empowerment and stigma that brought about depression, which resulted in poor quality of life.

Despite the strong family bonds that exist in Ghana, individuals are still discriminated against. This is quite prominent in members of the general public and some extended family members. It is rare that one finds siblings from the same maternal and paternal parent unfairly treating a sibling with mental illness. This could probably be attributed to the close connection that exists between the siblings compared to other family members. People are likely to victimize individuals diagnosed with mental illness when they perceive them as incompetent, violent, dangerous, unintelligent or cursed. Gureje et al. (2005), in a community study of the knowledge and attitude of mental illness in Nigeria, found that the public believed psychiatric patients were retarded intellectually, dangerous, and a nuisance to the public. To them, poor knowledge and ignorance about mental illness had a very negative effect on socialization of the mentally challenged. About 83% of the respondents were afraid to converse with psychiatric patients; 78% were not willing to work with them at all. It could be concluded that social rejection contributes immensely to mental illness stress among patients. These incidents intensify feelings of self-depreciation, depression, low self-esteem and withdrawal from public places.
5.5.4 Unemployment

Most of the participants found it difficult finding jobs. Others lost their jobs because people were not willing to work with them. This result confirmed earlier studies which found most people diagnosed with mental illness to be unemployed (Oleniuk, Duncan & Tempier, 2011; Parle, 2012; Thomé, et al., 2012). According to the World Health Organization (2001), people with mental illness have very poor prospects of employment. Individuals with mental illness have difficulties with employment probably due to incompetence or discrimination.

In Ghana, both social and government support for people with mental illness is inadequate. People who are not working have no access to unemployment benefits because it is nonexistent. It is not part of government policy. A prolonged period of unemployment is likely to lead to poverty with its attendant consequence of poor quality of life, begging, that leads to low self-esteem, depression, and frequent relapse.

5.5.5 Low self Esteem

Some of the interviewees disclosed they no longer saw themselves valuable. According to them, the respect they commanded had dwindled. Some felt they had lost their boldness in public. Others hinted they would not be able to enter relationships anymore and no one would be ready to be with them because of their illness. This finding is in line with earlier studies. According to Rusch, et al. (2013) one’s sense of high empowerment was linked to lower levels of stigma stress and self-contempt. Increased self-stigma and lowered sense of empowerment lead to poorer quality of life as well as reduced self-esteem. Drapalski, et al. (2012) revealed that high levels of internalized stigma was associated with low levels of self-esteem, low self-efficacy, low levels of recovery orientation as well as more severe psychiatric symptoms. Other studies reviewed revealed a remarkable relationship between internalized stigma and self-esteem.
According to these studies, internalized stigma increases depressive symptoms in terms of low self-esteem (Vauth, Kleim, Wirtz & Corrigan 2007; Yanos, Roe, Markus & Lysaker, 2008; Rüscher, et al., 2009b; Livingston & Boyd, 2010; Shrivastava, et al., 2011) leading to negative outcomes related to recovery, such as poor quality of life, low levels of empowerment, low self-efficacy, hopelessness and suicide (Tally, 2009; Sibitz et al, 2011; Sharaf, Osman, & Lachine, 2012; Ehirlic-Ben, et al., 2013). Other studies were however found to be inconsistent with this study’s findings. For instance, Sorsdahl, Ritsuko, Wilson and Stein, (2012) found majority of respondents reported with high levels of empowerment, self-efficacy and low levels of stereotype endorsement despite reported cases of alienation and shame. According to Rüscher, Lieb, Bohus, and Corrigan (2006) and Brohan, Gauci, Sartorius and Thornicroft (2010), low levels of perceived discrimination and the rejection of the legitimacy of discrimination leads to high self esteem and high empowerment. Rüscher et al. (2009) also confirmed that patients who hold their group in high regard or reject stigma as unfair are more resilient to stigma. They also added that high group identification predicted positive reactions among stigmatized groups. These differences could probably be influenced by personality factors, cultural and belief systems that prevail in a particular geographical area, previous experience with stigma, insight, level of understanding about the cause of one’s illness and the reaction of the general public to mental illness. When persons diagnosed with mental illness receive negative feedback during interactions with members of the general public, they are likely to respond with negative emotive behaviors such as anger, isolation, despair, self-blame, shame and violent behaviors in desperate situations. When these individuals find that they have no authority to change the situation in which they find themselves, these experiences are internalized; self-stigma is likely to occur, leading to the concealment of the illness. They may even stop treatment leading to relapse.
CHAPTER 6
SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

6.0 Introduction

In this chapter, the findings of this study have been summarized, and conclusions drawn. The implications of the research to nursing practice and research have been outlined. Recommendations have also been suggested.

6.1 Summary

The purpose of this study was to describe the psychological and social effects of the stigma attached to mental illness as experienced by out-patients at the Accra Psychiatric hospital. The study described the role of personal factors in bringing about stigma. The study also explored public attitudes that engendered stigma in individuals diagnosed with mental illness. The study described how individuals diagnosed with mental illness dealt with their stigma experiences as well as its impact on their lives. For this study, the ‘Identity threat model of stigma’ by Major and O’Brien (2005) was used to guide the work. The research approach was a descriptive-exploratory method using semi-structured interview guide to elicit subjective responses from out-patients at the Accra psychiatric hospital. The study was conducted at the Out-Patient Department (OPD) of the Accra Psychiatric Hospital. The purposive sampling technique was used to select the participants at the out-patient department of the Accra Psychiatric Hospital. The investigator interviewed 12 out-patients who came for review. Thematic content analysis was applied in analyzing the data. Emerging common themes from all transcripts were integrated, and then summarized into a narrative text for interpretation. After analysis of the transcribed data from the participants’ stigma experiences, five (5) major themes emerged. These were: Individual perceptions, public attitudes, coping strategies, reducing
6.2 Conclusion

The stigmatization of individuals suffering from mental illnesses is widespread and persistent in all facets of life. Informants’ account of their stigma experiences so far depicts stigma as a key factor in their recovery and survival in everyday life. To completely understand stigma associated with mental illness, the views of the patients in decision making is key. It is worth noting that despite the labels attached to them by society, no matter how they appear, they harbor ideas that would help them live independent lives such as training for good jobs, adequate salaries, taking part in social activities in the community, decent shelter, and effective and affordable healthcare. No one is immune to mental illness. Patients would therefore need support from all sectors including the Ministry of Health and its subsidiary the Ghana Health Service, in order to be able to overcome stigma and its after-effects.

In all, the observations made by the participants suggest they were not happy about the way individuals diagnosed with mental illness are perceived and treated in Ghana. There is the need to make a conscious effort aimed at closing the gap created by deliberate act of discrimination and lack of support for the sick in communities. Every Ghanaian therefore has a responsibility in ensuring that stigma is dealt with in their social setup.

6.3 Implications for Nursing Education, Nursing Practice, and Research

6.3.1 Nursing Education

More community psychiatry nurses should be trained to augment the care given by mental health nurses in the hospital by attaching them to community based health planning and services (CHPS) compounds. This would enhance treatment seeking and adherence to
treatment regimen by patients and subsequently reduce the impact of stigma through community health education programs.

The Nursing and Midwifery Council of Ghana should be urged to add the subject of stigma in mental illness to the mental health nursing curriculum so that all nursing students would be equipped with stigma issues that affect patients.

6.3.2 Nursing Practice

The health implications of relaxation techniques in the life of individuals are positive and enormous in terms of boosting the immune system, elevation of mood and the motivation to carry on with life. It would therefore be prudent if the Ghana Health Service could encourage health professionals to routinely teach patients at the OPD and to assist them to choose the appropriate techniques that suit and calm them in their daily lives.

The Ghana Health Service should put measures in place so that all patients who attend hospital for treatment are counseled by nurses on routine basis. This would empower them and also enhance their self-esteem whiles calming them.

Nurses at the OPD should be encouraged to inculcate health education on the psychiatric conditions as routine activities so that the patients would be aware of the nature of their conditions, the causes, symptoms, and the treatment modalities that are involved. This would empower them since knowledge in its real sense is power.

6.3.3 Future Research

The following areas will need investigation in future studies:

1. Further studies will need to be done using quantitative methods in order to ascertain the relationship between self stigma and the variables (personality dimensions, age, and psychopathology of the illness). This would help tackle stigma issues holistically taking into consideration the individuality of the person involved.
2. The psychological and social impact of stigma on the caregivers (relatives and health professionals) of mental patients in terms of their encounters with the public should be investigated.

3. The public perception about mental illness in Ghana will need to be looked into using quantitative methods.

6.4 Limitations of the Study

People were not willing to participate in the study because they did not want other members of the public to know their problems. Respondents were people who were being treated on out-patient basis. The perspectives of patients on the streets as well as those on admission concerning the effects of stigma were therefore not captured. The participants of the study were relatively high functioning; they had recovered enough to be able to respond to the interview questions. Therefore individuals who were considered as not yet stable in terms of their condition were not included in the study. A broader sample that includes all other groups will therefore be useful in future studies so that the findings could be generalized to a larger population.

6.5 Recommendations

The following recommendations have been suggested to help fight the stigma menace.

**Enforcement of Mental Health Legislations**

In Ghana, individuals diagnosed with mental illness go through so many humiliating experiences such as chaining at prayer camps, being refused employment or marriage among others. Even though laws have been enacted over the years to protect the mentally ill (NRCD 30, 1972), they have been ineffective. The establishment of a mental health board that includes health professionals and representatives of all stakeholders
including patients would enhance the effective implementation of the new mental health law (Act, 846) enacted in 2012. Despite the enactment of the new mental health law (Act, 846), mental health policies have still not been implemented. The successful implementation of the law is likely to give hope and boost respect for the people diagnosed with mental illness whiles diminishing negative media portrayal of people diagnosed with mental illness. The mental health board is therefore urged to expedite action by ensuring the full implementation of the law so as to enhance effective and efficient management of all cases of mental illnesses and to ensure the welfare of patients in both hospital and community settings. According to the WHO (2005), 53% of African countries that have a mental health policy are ineffective. Therefore, making a conscious effort at implementing such policies embedded within the law will go a long way to strengthen the modalities of care. This will enhance effective treatment and recovery and lessen relapse rate and stigma among patients.

**Mental Health Educational Programs**

Measures such as effective educational campaigns in schools centered on the explanations for the biological basis of the causes of mental illness will help to dispel the myths surrounding mental illnesses whiles enhancing social contact with patients thereby reducing discrimination in the community.

Even though there are laws designed to protect individuals diagnosed with mental illness, they are not effective, thereby leaving the patients to their faith to fight it alone in the workplace, in their relationships and in the community. Strong public education machinery and positive image portrayal of the mentally sick in the media landscape of Ghana could immensely help stop this menace. This would go a long way to make the public aware of the role they play in taking care of individuals diagnosed with mental illness. It is quite necessary to educate the general population on the physical, social,
psychological, spiritual and economic impact of mental illness on persons diagnosed with the illness. In order to achieve this, multiple educational strategies should be employed involving recovered patients, health professionals, the mass media, educational institutions, NGOs, religious and traditional leaders and community members. This would help discount myths associated with mental illness and to promote positive attitudes towards patients.

**Social Involvement**

Health professionals and other non-governmental organizations (NGOs) who work with people with psychological problems should do their best to encourage the patients to get involved in social activities that foster close contact with other members of the community whiles urging them to exercise restraint even in situations when people make the conscious effort to degrade them. This will go a long way to de-motivate the perpetrators overtime thereby enhancing the public image and respect for these patients as well as public trust.

**Welfare Groups**

Increased self-stigma and lowered sense of empowerment lead to poorer quality of life as well as reduced self-esteem. Therefore, encouraging individuals diagnosed with mental illness to form welfare groups in their localities will go a long way to help fight stigma by enhancing their self-esteem and ultimately empowering them to go all out to face life regardless of what society think about them.

**Engaging Employers**

Health professionals are entreated to engage employers and employees alike on a special target educational drive to implore them to support individuals who in one way or the other are sick, so as to enhance social integration, self esteem, adherence to treatment
regimen and recovery. Employers should also be entreated to counsel individuals before moving them to different departments of the work setting. This collective agreement will demonstrate respect, acceptance, and support for such individuals. Sustaining these attitudes would go a long way in fighting stigma in the workplace.

**Rehabilitation**

To enhance the dignity and usefulness of these patients to society, it would be imperative to call on government support for the establishment of vocational and rehabilitation centers in the communities. This will allow those with previous technical skills to sharpen them whiles, others with no employable skills would be trained to gain skills so as to be able to employ themselves. The provision of half-way homes or hostels for individuals who need shelter will go a long way to support and stabilize them so that they do not end up on the streets. This would enable them to take care of themselves and prepare for future independent family life as well.

**Making Resources Available**

The MOH needs to collaborate with the GHS to procure more effective drugs and also to intensify the training of more physician assistants and advanced nurse practitioners who are specialized in mental health. These professionals could be sent to the various psychiatric units in the numerous hospitals and clinics in all the ten regions to assist with the early assessment, diagnoses and treatment of individuals with psychological problems. This would make mental healthcare accessible, affordable, and available. Since these units are within the general health setting, people are more likely to patronize mental healthcare services than in the main stream psychiatric hospitals which epitomize stigma in the eyes of the public and the patients themselves.
Public Advocacy

The Ghana Health Service is being urged to seek for funds in order to organize regular anti-stigma activities such as workshops and conferences that seek to engage patients, health professionals, educational institutions, journalists, as well as the general public should be promoted so as to enhance public advocacy in order to boost the confidence level of the victims. This would give assurance to both patience and relatives to stand up and face stigma wherever they find themselves.

Strengthening Social Networks

The extended family system practiced in most parts of Ghana makes people responsible for each other. Everybody therefore becomes his brother’s keeper. This could be a major ingredient in enhancing and harnessing the needed support that individuals diagnosed with mental illness would require. Other support systems such as health professionals, employers, religious groups, NGOs, and other community members should join forces with the patients as they try to battle stigma and its effects. This collective effort aimed at supporting and understanding people with mental illness would encourage the public to learn more about mental illnesses, thereby enhancing social inclusion at all levels of social interaction. This would go a long way to help the patients cope with and endure the perceived negative attitudes of the public.
REFERENCES


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http://dx.doi.org.login.ezproxy.library.ualberta.ca/10.1016/j.socscimed.2008.11.00


Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital


APPENDICES

Appendix A: Semi-Structured Interview Guide

1. Please kindly tell me about yourself. (Demographic data; age, sex, marital status, employment history, diagnosis, history of hospitalization).

2. Where do you live? Tell me how it feels like living in the area.

3. Who do you stay with? Any reasons for your action?

4. Do you think you are being treated different from other people? Why do you think so?

5. How do you feel about the way people treat you?

6. How has this different treatment affected your life?

7. How do you deal with the way you are treated on daily bases?

8. What do you think can be done about the way you are treated?

9. What else would you like to say about how people with mental illness are treated?
## Appendix B: Checklist Used to Select Research Participants

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<td>Level of consciousness</td>
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<td>Speech patterns</td>
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<td>Motor activity</td>
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<td>Affect and mood</td>
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<td>Thought processes</td>
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<td>Perception disturbances</td>
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<td>General attitude</td>
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<td>Memory</td>
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<td>Constructional ability</td>
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<td>Abstract reasoning</td>
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Examiner's comments:
Appendix C: Consent Form

Title: Perceived Psychosocial Impact of Stigma Patients being treated at Accra Psychiatric Hospital.

Principal Investigator: Gyamfi Kwadwo Sebastian, MPhil Student
School of Nursing, University of Ghana, Legon

Address: CHNTS
P.O. Box 273, Winneba.
Tel: 0244151301
E-mail: gsampaus@yahoo.com

General information about the research

The aim of this research is to find out about what people suffering from psychological problems go through when community members refuse to accept them due to their sickness. Several factors are said to affect individuals with psychological problems. This study is therefore being conducted to look into what brings about stigma, its effects as well as how people coming for out-patient care deal with the stigma they face in the community. The participants (patients coming for review at the out-patient department) would be used for this research at the Accra Psychiatric hospital. If you agree to participate you will be interviewed by the researcher, and your responses will be tape recorded. If you cannot speak or understand English very well, a person who can understand your language would be provided to interpret the questions to you. I will however make sure you are comfortable with the person before we start the interview. The information that will be needed during the interview will include your age, educational level and marital status. You will also be asked by the researcher to speak about how people treat you and how you feel about the treatment. The researcher will ask you a lot of questions that can last for more than one hour. There are no wrong answers in this
interview. You are free to ask any questions concerning the research. I will listen to you attentively and I will encourage you to freely share your feelings. The interview will be carried out in a private place of your choice. You are kindly informed that the questions you will be asked are for academic purposes and that they are not meant to cause any pain to you. After the interview you will be given the opportunity to share your experience. The researcher may invite you again for another interview to enable him to ask other questions he would think of after the first interview. The second interview will not go beyond 30 minutes.

Possible Risks and Discomforts

It is not expected that you will face any injury by participating in this study. However, you may experience some emotional pain due to some questions you may be asked. The researcher being a nurse with several years of working experience will deal with any discomfort that will arise. In case you experience severe discomfort I will interact with the clinical psychologist and hand you over for further counseling.

Possible Benefits

Taking part in the study may not directly benefit you. But it is hoped that the knowledge gained from talking to you will help policy makers make decisions or changes that will enhance the care that people with mental illness receive.

Confidentiality

The interview will take place at a location convenient to you such that no one will hear or know about what you said. The interview will be tape-recorded and be typed out later. Fake names will be used on all documents written about our talk. Numbers will also be written on the audiotapes and the typed papers so that the researcher will be the only person who will be able to know the identity of the one interviewed. Everything you say
will be kept under lock so that no one will have contact with it. The information given will be put into a report after the researcher has spoken to many people about what they went through due to their illness. The researcher will use what you say during the interview to help him understand what it is like to be unjustly treated. A copy of the report will be given to nurses and decision makers on health issues to help them make better plans to meet the needs of people who are treated unfairly. A copy of the report will also be given to you if you want. These reports will however not have your names in any of them.

Compensation

You will not be given any monetary reward. However, you will be given a soft drink of your choice and biscuit after the interview. You will also be given lorry fare to take care of your transportation back home after the interview.

Voluntary Participation and Right to Leave the Research

Your participation in the study is voluntary. You have the right to participate in the study or not. You can choose to withdraw from the study at any time. You only need to inform the researcher. Your refusal to take part in the research will not in any way affect your treatment.

Termination of Participation by the Researcher

Your participation in the study will be terminated if you do not sign the consent form and if you are not willing to give information regarding the study.

Contacts for additional Information

For more information about the study, you can also contact the following people:

Rev. Alex Atiogbe, Lecturer, University of Ghana; Tel: 0278066255. P.O. Box LG 43, Legon. Rev. S. Ayete-Nyampong (Chairman) C/o NMIMR, University of Ghana.
Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

P. O. Box LG 581, Legon, Accra, Ghana. Tel: +233 244 079872

Email: sayete-nyampong@hotmail.com

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org.
VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research on the perceived psychosocial impact of stigma with patients being treated at the Accra Psychiatric hospital has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_________________________  _________________________________
Date                               Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_________________________  _________________________________
Date                               Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_________________________  _________________________________
Date                               Name /signature of person who obtained consent
Appendix D: Ethical Clearance

7th December, 2013

Ethical Clearance

Federal Wide Assurance FWA 00001924

NMIMR-IRB CEN 011/13-14

On 7th December 2013, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) conducted expedient review and approved your protocol titled:

Title of Protocol: Perceived Psychosocial Impact of Stigma on Patients Being Treated at Accra Psychiatric Hospital

Principal Investigator: Gyanfelt Kwadwo Sebastian, MPhil Card.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 6th December, 2014. You are to submit annual report for continuing review.

Signature of Chair:

Mrs. Chris Didie
(NMIMR – IRB Chair)

Co: Professor Kwadwo Kuma
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon
Appendix E: Ethical Approval

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

Research & Development Division
Ghana Health Service
P. O. Box MB 199
Accra
Tel: +233 301 685300
Fax: +233 242 651474
Email: ethnews@ughs.org.gh
29th January, 2014

Sebastian K. Gyamfi,
School of Nursing
College of Health Sciences
University of Ghana

ETHICAL APPROVAL - III NO. GHS.ERC. 26/09/13

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Perceived Psychosocial Impact of Stigma on patients being treated at Accra Psychiatric Hospital"

This approval requires that you inform the Ethics Review Committee (ERC) when the study begins and provide mid-term reports of the study to the Ethics Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedure and results of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are required to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol.

SIGNED: ..................................................
PROFESSOR FRED MUHAN
(Chairman)

Copied: The Director, Research & Development Division, Ghana Health Service, Accra
Appendix F: Grant of Permission

Acra Psychiatric Hospital
P.O. Box 1365
Accra

28th October, 2013

CONTIS
P.O. BOX 273
WINNEBA
CENTRAL REGION

Dear Mr. Gyamfi,

GRANT OF PERMISSION

I write to inform you that your request to undertake a study on the research topic “perceived psychosocial impact of stigma on patients being treated at Accra Psychiatric Hospital” has been granted.

You are therefore being advised to contact the deputy director of nursing service in-charge for any assistance.

Yours sincerely,

[Signature]

Nana Akosua Adjei
B.D.N.S., B.C.
For Medical Director
Appendix G: Re: Permission to Use Your Model

From

- Brenda Major

To

- Sebastian Gyamfi

you have my permission

Professor Major

On Sat, Apr 27, 2013 at 6:11 PM, Sebastian Gyamfi <gsampaus@yahoo.com> wrote:

I will be very grateful if your outfit could grant me permission to use your Identity threat model in my thesis. I am a master of philosophy in nursing student at the University of Ghana, Accra. I am a Ghanaian. My thesis topic is the Psychosocial impact of stigma on psychiatric patients at the Accra Psychiatric hospital. after reading the model, I realized that the concepts could be applied in my work. I would therefore be very happy if you could allow me to use it in my work.

Counting on you. Thanks!

--

Brenda Major, Ph.D.

Professor, Department of Psychological and Brain Sciences

University of California Santa Barbara, Santa Barbara, CA 93106