UNIVERSITY OF GHANA
COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY
STIGMA BY ASSOCIATION: EXPLORING THE EXPERIENCES OF MENTAL
HEALTH NURSES IN THE ASHANTI REGION OF GHANA.

BY

PETER ROGER KUNTANAAH

(10192309)

THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FULFILLMENT OF THE REQUIREMENT FOR AWARD OF MPHIL
NURSING DEGREE

SCHOOL OF NURSING AND MIDWIFERY

JULY 2018
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EXPERIENCES OF MENTAL HEALTH NURSES

DECLARATION

I, Peter Roger Kuntanaah, the writer of this thesis hereby declare that apart from references to literature and works of other researchers, which I have cited and duly acknowledged, this thesis is the product of my original work, which is toward the award of the Master of Philosophy Degree in Nursing in the University of Ghana, Legon.

Name      Signature      Date

Peter Roger Kuntanaah   ...........................................   ......./......./2019

Candidate

Dr. Gideon Puplampu   ...........................................   ......./......./2019

Supervisor

Rev. Alexander Attiogbe   ...........................................   ......./......./2019

Supervisor
DEDICATION

I dedicate this work to my mother, Mrs. Lynda Rockson Banful Mante, my wife Mrs. Alice Yelkuma Kuntanaah and my children, Mavis Anmenoba Puontigi, Emmanuel Ngmendaa Domanaang, Prosper Atwoora Puontigi, Daniel Sunbanyera Puontigi, Rebecca Ngmensombo Puontigi, and Miriam Yelabaaree Puontigi.
ACKNOWLEDGEMENT

God Almighty receives foremost acknowledgment for His special gift of life, protection, and for the fact that He has seen me through this level of my education.

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ABSTRACT

This study explored the experiences of Mental Health Nurses on stigma by association in the Ashanti Region of Ghana. The study adopted the exploratory descriptive qualitative design to select fifteen (15) participants from five district hospitals, one teaching hospital, and a Nurses’ Training School all in the Region. In-depth interviews were conducted in English language via face-to-face approach with participants who had more than one (1) year working experience from each district government hospital psychiatric unit. Data was subjected to thematic content analysis. The study was guided by the identity threat model of stigma and the findings from the data collected produced three (3) main themes and nine (9) sub-themes. The psychiatric nurses reported that the other health professionals mocked, labelled, stereotyped, and discriminated against them and others expressed concerns. They expressed their emotional responses as anger, fury and depression. The behavioural response to the stigma were ignoring, distancing and confronting. It was recommended that the sure way to minimize this type of stigma was through massive education and therefore the help of the media becomes needful. It was also suggested for the in-charges of various district hospitals to include Mental Health Nurses in sharing of logistics to enable them work effectively.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>ANA</td>
<td>America Nurses Association</td>
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<td>CMHW</td>
<td>Community Mental Health Worker</td>
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<td>CMHWs</td>
<td>Community Mental Health workers</td>
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<td>CMHOs</td>
<td>Community Mental Health Officers</td>
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<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<td>CPNs</td>
<td>Community Psychiatric Nurses</td>
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<td>CPOs</td>
<td>Community Psychiatric Officers</td>
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<td>CPU</td>
<td>Community Psychiatric Unit</td>
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<tr>
<td>GNA</td>
<td>Ghana News Agency</td>
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<tr>
<td>ITM</td>
<td>Identity Threat Model</td>
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<tr>
<td>LEKMA</td>
<td>Ledzokuku-Krowor Metropolitan Assemble</td>
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<tr>
<td>MHN</td>
<td>Mental Health Nurse</td>
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<tr>
<td>MHNs</td>
<td>Mental Health Nurses</td>
</tr>
<tr>
<td>MHPs</td>
<td>Mental Health Professionals</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>RMN</td>
<td>Registered Mental Nurse</td>
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<td>SBA</td>
<td>Stigma by Association</td>
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<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>U.S.A.</td>
<td>United State of America</td>
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<tr>
<td>W.H.O</td>
<td>World Health Organization</td>
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CHAPTER ONE

1.0 Introduction

This chapter presents the background to the study of stigma by association: exploring the experiences of Mental Health Nurses in the Ashanti Region, the statement of the problem and the objectives to the study. It covers the research questions, the purpose of the study significant of the study and the operational definition of terms used in the study.

1.1 Background of the Study

The World Health Organization (WHO) estimates that over 450 million people worldwide suffer from mental illness. Also, WHO indicates that one in four families is likely to have at least one person suffering from a mental disease (WHO, 2014). The same source reports that there is about 100 million to 500 million or higher people living with a mental illness. According to estimates around one million people die as a result of suicide annually (WHO, 2009). Additionally, one in four people globally will experience mental illness in her or his lifetime (WHO, 2010).

In Netherlands, a mental health survey and incidence study carried out in 2010 showed that around 42% of Dutch adults between 18 and 65 had suffered from a psychotic disorder at a point in their lives (De Graaf, Ten Have, & Van Dorsselaer, 2010). Also, the National Alliance on Mental Illness, (2013) indicates that one person in four people in the USA suffers from some kind of mental illness. The implication of these numbers is very serious for Mental Health Nursing. This is because as more people are diagnosed with mental illness, the higher the demand for Mental Health Nurses (MHN). Meanwhile people are not willing to pursuer mental health nursing as a profession because of stigmatization.
The field of mental health nursing has some negative connotations within the nursing profession as well as in the general public (Natan, Drori & Hochmanl, 2015). Nurses who choose to help this subset of the population are often stigmatized just like the patients they cater for. Therefore, there is a critical shortage of Mental Health Nurses and this shortage is expected to continue to increase as the mental health nurses who are in the practice reach the retirement age (Browne, Cashin, Graham, & Shaw, 2013). There are generally fewer nurses who specialize in mental health than the other specialties in nursing. For example, in the United States of America only 3.7% of all nurse practitioners specialize in Mental Health Nursing (American Association of Nurse Practitioners, 2015). In addition, the American Nurses Association (ANA), (2010), indicates that only 1.3% of all nurses are employed in psychiatric and substance abuse hospitals and 0.4% of nurses are employed in residential homes for mental retardation, mental health and substance abuse patients. The ANA, (2015) compared this to the 57.7% of nurses employed in medical/surgical hospitals to show that there are significantly fewer nurses employed as psychiatric/mental health nurses than nurses employed in non-psychiatric specialties.

Some scholars argue that baccalaureate nursing programs have contributed to the decrease in the number of graduates who go into the specialty of mental health nursing as they have shorter clinical rotations and more intense, less integrative exposure to this field (Browne, et al., 2013). Browne and his colleagues argue that nursing students are unable to appreciate the knowledge, skill set and holistic approach of Mental Health Nursing across populations (Browne, et al., 2013).

Also, some studies which focus on the stigmatization of mental illness in nurses have found that stigmatization is greater in nurses who work with patients in psychiatric inpatient settings due to the severity associated with mental illness (Martensson,
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Jacobsson, & Engstrom, 2014). In comparison, nurses who work in psychiatric nursing have fewer stigmas towards mental illness than those who care for psychiatric patients in somatic care locations (Martensson et al., 2014).

According to the Mental Health Authority in Ghana, there are about 10,000 people in the country who suffer from dementia, which is a neurological disorder that affects the brain leading to the gradual loss of the short-term memory of an individual. This illness also affects the ability of the affected people to understand what is happening around them and causes them to be confused as well as frustrated as they can no longer do things that they used to do without support from other people (GNA, 2017). The WHO, (2007) indicates that there are 650,000 persons in Ghana suffer from a severe mental disorder while 2.17 million people suffer from moderate to mild mental disorders. However, only 2% of people who suffer from mental illness receive adequate treatment due to inadequate Mental Health Nurses in the country. In Ghana, the stigmatization of psychiatric patients is a serious problem which permeates the mental health system. This assertion is evident in the history of the establishment of psychiatric services in Komfo Anokye Teaching Hospital, Kumasi. The clinic was referred “Headache Clinic” as mental illness was regarded as a taboo in the culture of Ashantis (Laugharne & Burns, 1999).

Stigmatization usually results in serious social consequences for the people who are affected. For instance, seventy (70) patients who were treated by the Ankaful Psychiatric Hospital in Ghana have been abandoned by their families although they have been discharged from the hospital (Ghana News Agency, 2010). The situation is not different in the other psychiatric hospitals in the country like Pantang Psychiatric Hospital and Accra Psychiatric Hospital. A special Vagrant Ward was created for patients who have been rejected by their families because of stigma at the Pantang Psychiatric Hospital.
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The Ghana Medical Association posits that a third of the patients still on admission in the Accra Psychiatric Hospital are patients who have been treated and discharged. However, they remain in the hospital because their relatives have abandoned them due to stigma (Sodzi-Tetteh, 2007).

It is important to indicate that the diagnosis of mental illness does not only affect the affected person but his/her family members as well and those who cater for the mentally ill (Dalky, 2012). Sanden, Bos, Stutterheim, Pryor and Kok, (2014) opine that people who suffer from mental illness are not the people who are affected by stigma, but their families are also subjected to stigma by virtue of their relationship with them.

Furthermore, in spite of the importance of the role of Mental Health Nurses who attend to the unique needs of mentally ill patients, much attention is not given to the recruitment and retention of Mental Health Nurses (MHNs) in most countries including the USA (Delaney & Shattell, 2012). The average age of a registered nurse is 47 while the average age of a MHN is 50 (Health Resources and Services Administration, 2013). A study shows that only 13% of the MHN workforce is under the age of 30 while half of them go on retirement within the next 10 years. This indicates that the replacement of retiring MHNs may not be possible (Hanrahan, 2009). These statistics show a possible shortage of MHNs, which would be worsened by the tendency of new nurses to pursue careers in other specialty areas and not psychiatric mental health nursing (Delaney & Shattell, 2012).

Some studies in Europe and North America (Brockington et al., 2011; Gerlinger et al., 2013) have concluded that a child may be opened to bullying, teasing and high risk of psychological disturbance. The studies further report a higher level of stigmatization and discrimination from family and community members.
Stigmatization is a complex social process. It refers to over simplified conceptions, opinions or stereotypical images about an individual or group, negative attitudes that mirror such stereotypes (prejudice), and open damaging behavior judged towards people who suffer from a stigmatized state (Brohan, Slade, Clement, & Thornicroft, 2010). This type of devaluation appears to occur not only when there is a meaningful link between a non-stigmatized and a stigmatized individual; for example, family relationships and arbitrary connection due to pure proximity (Pryor, Reeder, & Monroe, 2012).

Unlike other forms of stigma, stigma by association includes cognitive, affective and behavioral aspects (Mak & Cheung, 2008). Just as public stigma and self-stigma, stigma by association involves dual processes. Explicit attitudes determine the spread of stigma to companions with a meaningful relationship with the affected person (e.g. a family member). Also, implicit attitudes moderate the spread of stigma when there is an arbitrary connection as well as when the connection is more meaningful, for example the relationship between the Mental Health Nurse and a psychiatric patient (Pryor et al., 2012).

The W.H.O, (2007) views stigma by association as a behavioral indicator which goes with stereotyping, fear, embarrassment, anger, and rejection or avoidance. It is also associated with myths and misconceptions related to mental disorders, which negatively affect the sufferer of the disorder and those who care for them. Stigma is characterized by guilt, concealment, isolation and segregation, (Crabb, Stewart, Demoubly, Chabunya & Rajeer, 2012). One stigmatising attitude towards community psychiatric nurses who care for mental patients is that of labelling. The labels are damaging and trivializing in character (Bathje & Pryor, 2011). This result in social exclusion, bullying, aggression, ridicule and devaluation of the self-worth of people and these can lead to harassment.
against such people in all facets of life including their ability to get housing, maintain steady employment, access education, engage in meaningful relationships and enjoy a quality life (Baffoe, 2013).

There are several concerns which are linked to associative stigma. For example, Heyma, (2012), indicates that mental health nursing recruitment is usually difficult as their skills and roles are not valued or are perceived lowly; the perception of public with regard to mental health nurses is not good; the nursing profession sees these nurses in an unfavorable light. Many nurses in other specialties regard Mental Health Nurses as inferior and not real nurses as well as brand them as crazy.

Furthermore, a study by Ng, Kessler, and Srivastave, (2010), which discusses views of nursing professionals in relation to mental health nursing, indicates that it is a less likely career choice in comparison to other areas of nursing. Students are aware of the bad perception with which both mental health nursing and mental health nurses are given not just by the public but by those in the nursing profession as well. Unfortunately, this deters student nurses from pursuing a specialty in Mental Health Nursing.

In addition, Ng., et al., (2010), indicates that the public sees Mental Health Nurses as evil, corrupt and mentally unbalanced. This is not the most appealing image for someone to decide to pursue a career in the mental health care department. Consequently, some nurses do not have the desire to pursue a career in Mental Health Nursing due to the misconception that it is dangerous and largely because there is also the issue of stigmatization by society as well as other nurses.

1.2 Problem Statement

Generally, mental health nursing has been an undervalued profession (Groutroh, 2009). Mentally ill patients are viewed as prisoners and looked down while the people
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who take care of them are seen as wardens or custodians of prisoners. Even though treatment choices for mental health patients continue to advance and care is becoming more deinstitutionalized, mental health nursing is still an undervalued profession. The recruitment and retention of Mental Health Nurses are at particularly low in comparison to other areas of nursing (Quigley, 2015). Mental health nursing is not seen as a preferred career option by most nursing students and even experienced nurses (Ng et al., 2010).

One-on-one interactions with other health professionals including nurses revealed that Mental Health Nurses are usually tagged and branded as “mad men or women”, “act like their clients”. Additionally, they are denied basic logistics to work with. While the effects of stigma on those experiencing mental illness have been studied for decades, relatively little is known about its effects on those treating them, therefore, this hampers governmental and societal investments in mental health services and research (WHO, 2004).

Furthermore, according to a study on factors that affect the career choice and retention of Community Mental Health Workers (CMHW) in Ghana, it was discovered that stigmatization of the mental health workforce was high which had resulted in their desire to quit the profession (Agyapong Osei, Farren, & McAuliffe., 2015). One hundred and sixty-four (164) mental health workers from the ten (10) regions of Ghana comprising 71 (43.3%) Community Psychiatric Nurses, 19 (11.6%) Community Psychiatric Officers and 74 (45.1%) Community Mental Health Officers participated in this study. The CMHWs had been in the profession for between one (1) to forty (40) years in the field of mental health service with a mean time of 4.7 years and a standard deviation (SD) of 6.98 years. Nearly all the CMHWs 99.4% testified that stigma associated with working in a mental institution exists. In addition, they were asked if they had the intention of leaving the profession as a result of the stigma associated with it (Agyapong, Osei, farren, &
McAuliffe, 2015). A summary of the findings shows a high percentage of CMHWs communicated their worries about the dangers linked to working in the mental health department and those who had deliberately left the profession due to stigma. Also, 60.6% CPNs noted that they had been harmfully affected by stigmatization in mental healthcare as a result they had to leave the profession entirely to pursue other professions like anaesthesia, medical assistance or education. Furthermore, only 16.2% of CMHOs, 5.3% CPO and 28.2% of CPNs answered that they had deliberately left the mental health profession as a result of stigma. However, only four (4) psychiatrists reported that due to the stigma attached to CMHWs they wanted to quit the profession. In addition, 52.2% health policy coordinators affirmed that CMHWs are stigmatized. 41.4% of health policy coordinators reported that they knew some CMHWs who had considered quitting the profession as a result of stigma (Agyapong, et al., 2015).

Stevens, Browne and Graham, (2013) carried out a longitudinal study on 150 nursing students in relation to a career in mental health. The findings indicate that mental health care was an improbable career choice for nursing graduates. The purpose of the study was to find out about the attitudes of nurses who wanted to pursue higher education at the postgraduate level in relation to psychiatric mental health clinical experiences; their preparedness to care for persons with mental illness; students’ perceived stigmas and stereotypes; and plans not to choose mental health nursing as a career (Stevens et al., 2013). The findings showed that Mental Health Nursing was one of the least career options the nurses would choose when given the choice.

In Ghana, Opare (2013) explored the experiences of Community Psychiatric Nurses in the discharge of their duties using twelve participants in six districts of the Community Psychiatric Units in the Accra Metropolis of Ayawaso, Osu-Klottey, Ablekuma, Okai-Koi, Ledzokuku-Krowor Metropolitan Assemble (LEKMA), and
Ashiedu-Keteke. The major findings of his study include the difficulty of locating the homes of patients due to poor home addresses and transportation, limited logistical support and irregular supply of medications. Also, he affirms that there exists stigmatization of Community Psychiatric Nurses, assaults from patients and the negative attitudes of relatives of patients which lead to relapses in discharged patients. Participants opined that they should be paid risk allowances in the event that they suffer any injury while they are at work.

Also, in an exploratory cross sectional survey of 272 African Americans, it was discovered that those who worry more about stigma associated with mental illness suffer depression (Ward, Witshire, Detry, & Brown, 2013). In Germany, it was revealed that anticipated stigma could result in reduced quality of life and depression (Vault, Klein, Wirtz & Corrigan, 2007). Sharaf, Ossman and Lachine, (2012) indicate that internalized stigma is linked to depression. In another study by Mystakidou, Tsilika, Parpa, Galanos and Vlahos, 2007, revealed that caregivers tendency to feel hopelessness is determined by patient’s characteristics as a patient’s depression is linked to that of the caregiver.

The consequences of stigma by association are devastating for Mental Health Nurses. Consequently, most Mental Health Nurses run into other professional specialisations such as Anaesthesia, Medical Assistantship, Critical Care, Education or practice as general nurses because of stigmatization, low self-worth, social withdrawal and emotional instability. There is diminished enthusiasm which results in low work output that leads to hiding of one’s self among professional nurses. This affects career progression in the field as nurses rather pursue other areas in the nursing profession. This study, therefore, intends to explore the issues of stigma by association suffered by Registered Mental Health Nurses in Ashanti Region of Ghana.
1.3 Purpose of the Study

The purpose of this study was to explore the experiences of stigma by association among Mental Health Nurses and assessed their emotional and behavioral responses to this form of stigma among Registered Mental Nurses (RMN) in the Ashanti Region of Ghana.

1.4 Objectives of the Study

The objectives of this study are to

1. To explore the experiences of Mental Health Nurses with regard to Stigma by Association in Ashanti Region of Ghana.
2. Explore the emotional response to stigma by association among Mental Health Nurses in the Ashanti Region of Ghana.
3. Describe the behavioral pattern of stigma by association among Mental Health Nurses in Ashanti Region of Ghana.

1.5 Research Questions

This study seeks to find answers to the following research questions:

1. What are the experiences associated to stigma by association among Mental Health Nurses in the Ashanti Region of Ghana?
2. What are the emotional responses to stigma by association by Mental Health nurses in Ashanti Region of Ghana?
3. What are the behavioral patterns of stigma by association by Mental Health Nurses in Ashanti Region of Ghana?

1.6 Significance of the Study

This research seeks to obtain information about stigma by association among Mental Health Nurses in the Ashanti Region of Ghana. This will enable Mental Health
Nurses in the country to identify areas of concern in relation to stigma by association in order to address their concerns so as to advance Mental Health nursing practice.

It is also envisaged that the data generated through this inquiry will contribute towards building a data base for future research and serve as a source of motivation for other nurses who may wish to pursue research in the field of Mental Health Nursing.

1.7 Operational Definition of Terms

**Stigma:** A negative view, attitude or label attached to a person or group.

**Association:** Having a link to a person or a group

**Mental Health Nurse:** A trained Registered Mental Health Nurse who is registered with the Nurses’ and Midwifery Council of Ghana.

**Experiences:** Practical involvement or contact with and observation of happenings.
CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter consists of two sections which include a description of the theoretical/conceptual framework used in the study and a review of relevant literature to the subject under discussion. The identity threat model was used to guide this study on stigma by association in relation to the experiences of Mental health Nurses in the Ashanti Region of Ghana.

2.1 The Theoretical/Conceptual Framework of Stigma by Association

The theory or framework utilized is based on an individual’s identity which results from the internal and external forces that interact to safeguard his identity. During this process, a person often loses his or her previously held identity (example e.g. as student, worker, parent) while the stigmatized illness’ identity becomes dominant (Yanos, Roe, & Lysaker, 2010).

2.1.1 Identity Threat Model (ITM)

The Identity Threat Model (ITM) methodology in social psychology was introduced in the early 1970s by the research of Henri Tajfel and his colleagues on intergroup processes. One of the foundations to this methodology is an assertion that the manner in which psychological processes play out is determined by social context. The aim of the model was to explain when and how social structures and belief systems affect the actions of people.

The stereotype threat denotes situations where people feel they may be judged negatively due to stereotyped behaviour. Females, for instance, may experience stereotype
threat when they solve a problem in mathematics; this is because the general assumption of some people is that males perform better in solving mathematical problems. Findings indicate that stereotype threat in many contexts has led to reduced performance, triggers anxiety and reduces the effort people put into tasks (Schmader, Johns, &, Forbes, 2008).

Also, social identity threat signifies occasions when people feel that their group has been appraised negatively. In summary, the social identity theory is based on the assumption that people try to keep up a positive perception of their groups. If this positive perception is challenged, people feel threatened which manifests as negative emotions or reinforces behaviours that support their group’s norms (Walton, &, Cohen, 2003).

Specifically, stereotype threat raises concerns of people about themselves. In contrast, social identity threat also evokes concerns in people in relation to the perceptions they hold about their groups and collectives (Derks, Inzlicht, & Kang, 2008).

2.2 Consequences of Stereotype and Social Identity Threat on Performance

Usually, stereotype threat increases the possibility of people’s bad or reduced performance in tasks in which they are regularly assumed to be deficient in. For instance, when females are reminded of the stereotypical assumption that they perform poorly in mathematics, their performance in solving mathematics tasks reduces (Krendl, Richeson, Kelley, & Heatherton, 2008). Similarly, when males are reminded of the stereotypical assumption that they are deficient in verbal skills, their performance in events that require the use of verbal skills reduces (Ford, Ferguson, Brooks, & Hagadone, 2004; Seibt & Forster, 2004).
2.2.1 Learning

Also, stereotype threats can hamper learning and not just performance. In some studies carried out by Rydell, Rydell, and, Boucher, (2010), selected females were exposed to the stereotypical assumption that females are lacking in mathematics. Some other females were not exposed to this stereotype. Findings from the studies indicate that the females who were exposed to this stereotypical assumption performed poorly in mathematics as their ability to study mathematical rules significantly reduced.

2.2.2 Burnout

According to findings from research, stereotype threat leads to an increment in the possibility of mental exhaustion and burnout (Hall, Schmader, & Croft, 2015). In a study, when female engineers did not feel accepted or felt a lack of respect from their male colleagues, they were more probably to feel social identity threat. Consequently, they agree with statements such as "Today at work, I was concerned that, because of my gender, my actions influenced the way other people interacted with me". This feeling is closely linked to exhaustion and burnout, Hall, et al, (2015).

Probably, as a result of social identity threats, people are made to feel that they have to prove their abilities. Due to this, they try to impress others, which cause them to deviate from their normal inclinations or personal intuitions. Hence, their mental energy is drained which increases the possibility of being burnout.

2.3. Social Identity

When the individuals experiencing social identity threat, their capacity to operate working memory and uphold effort diminishes (Inzlicht, & Kang, 2010). In response to these forms of threat, the individuals experience an involuntary negative state. That is, stereotype threat and social identity threat evoke negative emotions, such as anxiety or
anger. These negative stereotypes might contradict the positive perceptions the individuals form about themselves (Schmader, Johns, & Forbes, 2008). This conflict evokes a series of uncertainties and emotions.

In the light of these stereotypes or social identity threats, certain people build up an alternative social identity; they join a different club or institution (Nadler, Harpaz Gorodeisky, & Ben-David, 2009). Based on this, the individuals might observe their performance more carefully, to outwit errors. In addition, individuals might attempt to regulate negative emotions. Thus, they might attempt to orient their attention to pleasant memories, evoking positive feelings instead. Finally, they might strive to curb unfavorable thoughts. They might, for example, divert their attention from the negative stereotypes of their collective to the positive achievements (Logel, Walton, Spencer, Iserman, von Hippel, & Bell, 2009).

Based on Goffman’s, (1963), study it is demonstrated that courtesy stigma is obtained through association with stigmatized people. Nonetheless, most of the data available on courtesy or associative stigma processes are generally gotten from researches on family members of people who have mental health issues. This angle gives a limited understanding of associative stigma which is specific to family members. Other people connected to persons who suffer from mental health issues are not studied in relation to associative stigma. The dynamics between mental health workers and their patients (a professional relationship) might greatly differ from the relationship between family members. While professionals are associated with their patients merely through a social relationship, family members also have a biological relationship with them (Phelan, 2005).
2.4 Main Element of the Identity Threat Model

At the point when people who are connected to stigmatized people such as their family members or health professional, associative stigma is directed by obvious or more conscious negative attitudes of being overweight (Pryor, et al., 2012). This implies that as relationships with stigmatized persons become more serious, the person who is associated with them experiences an increment in more explicit types of associative stigma from the public. Stigmatized people experience status loss, discrimination, rejection, and exclusion which leads to negative outcomes like demoralization, restricted social networks as well as reduced earnings (Link, et al., 2001).

2.4.1 Negative Treatment and Discrimination

Currently, stigma is not viewed as a physical mark or feature but rather as an attribute that leads to widespread social disapproval (Bos, Pryor, Reeder, & Stutterheim, 2013). This sort of devaluation appears to occur not just when there is a significant relationship between a non-stigmatized individual and a stigmatized person (e.g. family relationships) but similarly when the relationship is purely arbitrary; for instance, because of closeness (Pryor et al., 2012). SBA can result in social exclusion, avoidance of social interactions, and negative treatment while some people may use their efforts to hide their
familial relationship with a stigmatized individual (Larson, & Corrigan, 2008). Findings indicate that SBA can also influence the welfare of family members of persons who suffer from conditions which are stigmatized such as mental illness. This results in psychological and physical health complaints (Van der Sanden, Bos, Stutterheim, Pryor, & Kok, 2013).

All over the world, persons who suffer from mental disorders, mental health service providers, mental health professionals and even the idea of mental health are negatively regarded by the public and, therefore, stigmatized and discriminated against despite the growing evidence of the significance of mental health for development (Sadik, Bradley, Al-Hasoon, & Jenkins, 2010). Ross, and Goldner, (2009) establish that Mental Health Nurses belong to a stigmatized group. In addition, they form negative attitudes of blame, fear and discrimination themselves.

This disagreeable phenomenon usually goes with stereotyping, rejection, status loss and discrimination (Link, & Phelan, 2001). Byrne, (2000) posits that stigma is an indication of disgrace or dishonour which alienates someone from others or a group. This could occur as a result of different factors like superstition, ignorance, lack of knowledge, belief systems as well as the fear and exclusion of persons who are considered as different (Baffoe, 2013). Likewise, Crabb, et al., (2012), postulate that the experience of stigma is characterized by shame, blame, secrecy, labelling, isolation, social exclusion and discrimination. Since stigma is usually entrenched in social attitudes, people who suffer from mental illness in Ghana are normally disliked, rejected and shunned; consequently, they can experience sanctions, harassment and even violence.

2.4.2 Expectancy Confirmation Processes or Self-fulfilling Prophecies

People are affected by stigma through the expectancy confirmation process, where the stigmatized tend to accept and live with societal perception (Jussim, Palumbo
Chatman, Madon, & Smith, 2000; McKown & Weinstein, 2002). Expectations and negative stereotypes can result in directly affecting the behavior of those stigmatized (Jussim, et al., 2002). The behavior of persons stigmatized is usually in line with or toes the line which has been prescribed for them by others (MaKown, & Weinstein, 2002)

2.4.3 Automatic Stereotype Activation-Behavior

This deals with negative in-group stereotypes which are as a result of the understanding that cultural stereotypes may affect conduct through reflex action because of known cultural stereotypes (Wheeler, & Petty, 2001). This can happen if the person is conscious of what the stereotype is, the stereotype needs to be triggered in a state, and the stereotype must be relevant to the behavior preview. Situations that trigger adverse stereotypes and damage responsibility occasionally affect those who are not stigmatized.

2.4.4 Associative Stigma

Stigmatized groups have similar views and experiences because of their experience and awareness that they are discriminated against, devalued and looked down upon in the eyes of others. At a very tender age they recognize stereotypes in their various societies (McKown & Weinstein, 2003).

It is able to disturb the conduct of the stigmatized in the nonappearance of clear practices of sidelining conduct on the part of others (Major, & O’Brien, 2005). This perception does not give a holistic understanding of associative stigma that is specific to family relationships and does not shed light on other types of relationships. The relationship between mental health professionals and their patients might differ from that of their family members. Whereas healthcare providers are connected to their patients by just a social relationship, their relatives additionally have a biological relationship with them (Phelan, 2005). Furthermore, the professional nature of the social relationships
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between mental health professionals and their patients might be seen in numerous ways (Kitson, 2003; Scanlon, 2006). Professional relationships are built based on work and are limited in time and location. This kind of relationship is not personal as healthcare providers are usually responsible for many patients at any point in time. Moreover, the contractual and explicit therapeutic nature of this relationship is in contrast to lay caring, which is based on motivations such as love, altruism, duty, and necessity. As a result, this study focuses on the work context and the exact dynamics which exist between mental health caregivers and mental health service providers.

2.4.5 Burnout

In this study much attention is given to the assessment of the effects of associative stigma on mental health professionals. Specifically, the effects of work-related welfare are discussed as associative stigma among mental health professionals is acquired through their connection with mentally ill persons in their workplaces. Associative stigma is treated as a job stressor. Burnout is a major indicator of work-related well-being, particularly among people who cater for other people or whose work involves emotions. Work-related well-being is seen as a reaction to chronic emotional and interpersonal stressors on the job (Maslach, Schaufeli, & Leiter, 2001). Hence, associative stigma would be considered as a chronic emotional and interpersonal stressor which may lead to burnout. The link between associative stigma and the three types of burnout—cynicism or depersonalization, emotional exhaustion, and perceived inefficacy will be examined (Maslach, et al., 2001).

2.4.6 Job Satisfaction

Job satisfaction is a common indicator of work-related quality of life. It is expected that stress linked to associative stigma would result in a reduction in job satisfaction.
These indicators of work-related well-being are interconnected and their underlying order is not usually clear-cut, but in line with other research, (Maslach, et al., 2001).

Also, poor relationships might increase the stigma experiences of service users. According to Goffman (1963) and Schulze, (2007), poor contacts with mental healthcare professionals and the poor quality of mental health services are the second and third most frequent stigma experiences cited by service users as well as their relatives.

2.4.7 Self Stigma

Patients feel stigmatized by people’s lack of interests in them personally. Patients do not receive the personal attention they crave. They crave for personal contacts with other people not their fellow-patients. Another study revealed that impersonal and standardized care can contribute to self-stigma (Verhaeghe, & Bracke, 2008).

Stigma experiences of service providers may also contribute to feelings of stigma among service users due to processes of emotional contagion that can take place in emotional labor (Pugh, 2001). When service providers display their emotions, it can influence the moods of service users and hence, affect their attitudes towards the services provided (Barger & Grandey, 2006; Pugh, 2001). Emotional reactions are a major factor in the stigma process (Link et al., 2004). For this reason, healthcare professionals who have associative stigma experiences might show their emotions, which may in the end affect the emotional state of their service users.

2.5 Related Literature

2.6 Experiences of Associative Stigma among Mental Health Professionals

Stigma as defined by Goffman, (1963) is an “attribute that is deeply discrediting” and that reduces the bearer from “a whole and usual person to a tainted, discounted one”. According to Goffman, stigma usually occurs as a result of a transformation of the body,
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flaw in a person’s character, or membership in a group that is not regarded. The relationship between an attribute and a stereotype is emphasized by Goffman. Goffman’s definition is further expanded by Chapple, (2004) who defines stigma as “stigma exists when a person is identified by a label that sets the person apart and links the person to undesirable stereotypes that result in unfair treatment and discrimination.”

According to Crawford, Brown, and Majomi, (2008), health care professionals, including nurses, despite receiving mental health education, still stigmatize the mentally ill, fear for their own safety, and report an associative stigma in relation to Mental Health Nurses. Crawford et al. conclude that nurses believed that the specialty of Mental Health Nursing is not ‘real’ nursing, citing its focus on mental health rather than physical health (2008). The specialty of mental health nursing holds negative connotations within the profession of nursing and in the general public, (Natan, Drori, & Hochman, 2015). Nurses who choose to help this subset of the population often are targets of stigma themselves.

Stigma by association as experienced by Mental Health Nurses is defined as discrimination as a result of a relationship with someone who is stigmatized (Larson, & Corrigan, 2008; Werner, et al., 2011). Mental Health Nurses are considered as “contaminated” because of the close relationship they have with mentally ill patients who are generally stigmatized (Goldstein, & Heinik, 2011). Based on a study by Ebsworth, and Foster, (2016) on public perception of Mental Health Professionals (MHPs), it was revealed that Mental Health Professionals appeared stigmatized by association with their clients.

Stigma occurs when people are perceived as having negative characteristics and are then looked down upon as an entire group for exhibiting these characteristics (Martensson, Jacobsson, & Engstrom, 2014). These characteristics are often
misunderstood, with people frequently believing they can be controlled with enough willpower or that they are punishments for moral failings. Individuals who then interact with stigmatized groups can also be stigmatized by association. This is the basis for associative stigma (Natan, et al., 2015). With regard to mental health nursing, in choosing to help patients who are stigmatized, Mental Health Nurses are subject to stigma themselves. Experiencing associative stigma is not limited to people outside the healthcare community; the stigma extended to nurses, families, and others who help persons with mental illness can also be perpetuated by people who work within the healthcare sector. When mental healthcare professionals are stigmatized not only by the general public but also by their colleague healthcare professionals, both stigmatization of the mentally ill and associative stigma of psychiatric nursing are perpetuated (Halter, 2008).

Associative stigma is the stigma of a group of people who are in close, frequent contact with a population that itself is negatively viewed and stereotyped by the general population (Halter, 2008). Associative stigma is as a result of association with a stigmatized population. Compared to other health professionals, researchers have consistently found that psychiatric and mental health nurses are the target of this associated stigma due to their contact with patients that are negatively perceived by society. This stigma may affect self-perception in Mental Health Nurses (Crawford, et al., 2008). Natan, et al., (2015) in a study found that nurses outside mental health nursing stigmatize nurses who care for people with mental illness. Similarly, Crawford et al., (2008) indicate that many psychiatric and mental health nurses reported feeling unappreciated and undervalued.

Stigmatization and discriminatory behavior are a key obstacle in psychiatric care. They are a major challenge in caring for people mental illness. Regrettably, some negative
attitudes have been record among mental health care staff (Ross, & Goldner, 2009; Hansson, Jormfeldt, Svedberg & Svensson, 2013). There is vague knowledge about the professional identity of psychiatric nurses, which has been associated to the unpopularity of the specialty and negative attitudes toward mental health nursing among nursing students in most societies (Happel, & Gaskin, 2013). Stigma seems to pose a threat for professionals who work in mental health care as their association with people who are mentally ill is seen as a discrediting attribute (Goffman, 1963). Stereotypes like being blameworthy, dangerous and unpredictable which are attributed to people who suffer from mental illness are passed onto the mental health nursing profession. This leads to the portrayal and perception of nurses in this field as neurotic, ineffective and unskilled (Gouthro, 2009; Halter, 2008). Therefore, psychiatric nurses face negative reactions and jokes when they inform people about their job (Verhaeghe, & Bracke, 2012).

Additionally, the general public has the wrong perception that Mental Health Nurses (MHN) behave just like their mental ill patients. This creates a challenge for caregivers in mental health service as their connection with the mentally ill leads to their stigmatization. Stigma that is experienced by psychiatric patients also affects MHN due to their frequent interactions with them. Similarly, Shrivastava, Johnston, Tharkar, Shrivastava, Sarkhel, Sunita and Parkar, (2011) in their study discovered their colleagues at the work place were mocked and disrespected and were teased because they were mentally unsound.

Likewise, according to a report on Nigeria and Ethiopia, stigma in relation to mental illness is widespread. A descriptive investigation based on a questionnaire developed for World Psychiatric Association’s Program to Decrease Stigma and Judgment was conducted in three Yoruba-speaking societies in Nigeria. The findings of the study
showed mainly negative perceptions of mental illness. Hence, stigma was spread evenly across all social strata and independent of sex or age. A high level of social distance was also discovered among the Yoruba society (Adewuya & Makanjuola, 2008).

Also, Sorsdahl, Stein, and Myers (2012) conducted a study in the Northern and Central suburbs of Cape Town using a descriptive quantitative methodology. A convenience sample of 868 members of the community was used to find out persons who used drugs as well as the gender of substance abusers. It was confirmed that high levels of public stigma and discrimination existed in all classes of the substance abusers.

In addition, Igbinomwanhia, James, and Omoaregba, (2013) examined the attitude of the clergy towards persons with mental illness using a cross sectional study of 107 Christians and Muslims in Nigeria. A total of 71.1% of the clergy believed that persons with mental illness must be treated like kids. More than 80% of the clergy were not happy staying in the same neighborhood as psychiatric patients. For others, they believed that psychiatric hospitals should be located at the outskirts of town. While more than 50% admitted that psychiatric hospitals looked more like prisons than hospitals; 46% was not comfortable with allowing women who had suffered from mental illness to cater for their children.

Also, Tawiah, Adongo and Aikins, (2015) discovered that mental disorder cuts across all ages, sex, education, ethnicity, employment, and marital status. More females were stigmatized than males at the work or employment and educational levels. Various forms of stigma were observed at the economic, psychological and social levels. Caregivers were also stigmatised and discriminated against. They concluded that, mentally ill patients and their relatives suffer from stigma and discrimination from people, family, at work, and school.
In addition, Parle, (2012) reviewed twelve (12) articles and found that discrimination was common among persons with mental illness. They were discriminated and ridiculed at their work places by their co-workers. They were also verbally and physically attacked. They were hurt, embarrassed and depressed as result of these experiences. Parle further indicated that this predisposed stigmatized people to respiratory problems, heart diseases and even shortened their life span.

Furthermore, families of mentally ill persons experienced what is termed ‘stigma by association’. Hence, they experience discriminatory and prejudicial behaviors. Stigma associated with mental illness usually brought shame to families and affected the marriage potential of other relatives. Consequently, families keep this type of illness as a secret and are normally hesitant to seek professional help. Family stigma takes the form of blame, shame, and contamination. Some public attitudes which blame family members for incompetence might lead to relapse of a person’s mental illness (Thornicroft, Rose & Mahta, 2010).

Discrimination on the other hand refers to any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Discrimination take two forms; direct and indirect. Direct discrimination takes place when a person is treated less favorably, as a result of their illness, than others in similar circumstances. On the other hand, indirect discrimination happens when a requirement or condition is applied which, although applied equally to all persons, it is such that a considerably smaller proportion of people with the disease can comply with it and it cannot be shown to be justifiable other than on health grounds (WHO, 2003).

It is well known that negative and stigmatizing attitudes towards people with mental illness are highly widespread in the general population (Ewalds-Kvist, Högberg, &
In recent decades, no improvements in these negative attitudes have been recorded (Schomerus, Schawahn, & Holzinger, 2012). Some studies have looked at associated factors (such as age, gender, marital status, educational level, and real-life experiences) and discovered that older people, males, and persons without personal experience of mental illness often have more negative attitudes (Ewalds-Kvist, et al., 2012). Experiencing stigma due to a stigmatizing health condition also leads to others treating the stigmatized individual differently. This treatment can include an increased physical distance between the individual and another person, awkward social interactions, and being advised to conceal their condition, which can lead to greater amounts of psychological distress compared to those who do not have a stigmatizing health condition (Stutterheim, Bos, Pryor, Brands, liebregts, & Schaalma, 2011). When individuals feel devalued due to their connection to someone with a stigmatizing condition, associated behavioral tendencies are exhibited.

Furthermore, Hamilton and Braithwaite, (2016) carried out a study in Australia to determine how the stigma attached to parents extended to discredit community workers who were supporting them. This resulted in stigma by association. Stigma by association was identified from interviews with nineteen (19) community workers from nine (9) different organizations. The workers reported being stereotyped as rejecting the principle of acting in the best interests of a child, treated in a discriminatory and hostile manner, robbed of status recognition, and undermined in their capacity to do their jobs. They also stated that community workers play a vital role in providing support services. Most of them showed a degree of resistance and managed to maintain their commitment to parents and families. Institutional failure to take advantage of the knowledge and experience of community workers, however, undermined the capacity of the child protection authority to
map out new pathways for family unification and safety for children (Hamilton & Braithwaite, 2016).

In an investigation of nurses in USA on the perceived characteristics of psychiatric nurses in relation to stigma, Halter, (2008) concentrated on the notion of stigma by association or the adverse effect associated to persons who are in close contact with individuals who are stigmatized. The findings of the study indicated that psychiatric nurses may similarly be affected by this stigma. Furthermore, 122 nurses designated psychiatric nursing as the least chosen specialty of 10 areas. Psychiatric nurses were less likely to be described as respected, logical, skilled, and dynamic. The outcomes proposed that psychiatric nursing may be stigmatized by association (Halter, 2008).

In the work of Ebsworth and Foster, (2016) on public perceptions of mental health professionals, it was revealed that mental health professionals (MHPs) were stigmatized based on their association with clients. Likewise, Sorsdahl, Sumaya, Stein, and, John, (2010), assessed the awareness and attitudes towards stigma associated with psychiatric disorders in South Africa. It was also revealed that participants believed that there was stigma associated with mental illness.

In Europe and North America, some authors (Brockington et al., 2011; Gerlinger, Hauser, Hert, Lacluyse, Wampers, and, Correll 2013), have concluded that, a child may be predisposed to bullying, teasing and high risk of psychological disturbance as a result of mental illness. The studies further reported high levels of stigma and discrimination from family and community members.

In Berlin, Gaebel, Zaske, Zielasek, Cleveland, samjeske, Stuart and jorge, (2015) also found that those who work as Mental Health Nurses were more stigmatized than general nurses. In addition, the stigmatization of psychiatrists and general practitioners in
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Berlin compared to the extent and correlation patterns of perceived stigma in psychiatrist and general practitioners. It was reported that psychiatrists had relatively high perceived stigma than general practitioners.

Also, Oleniuk, Duncan, and Tempier, (2013) examined 41 psychiatric patients in Canada and discovered that patients who attended psychiatric hospitals more frequently had a higher impact of stigma. Therefore, findings demonstrated that having frequent interactions with psychiatric patients also exposed Community Psychiatric Nurse (CPN) to some form of stigmatization.

Parcesepe and Cabassa, (2012) in a study conducted in the United States of America, using a systematic review of 31 articles studying public stigma of mental illness, discovered that public stigma was widespread because both adult and even children felt that persons with mental illness and their caregivers were violent and dangerous.

Research was conducted on the factors that affect the career choice and retention of Community Mental Health Workers (CMHW) in Ghana and it was realized that in ascertaining the impact of stigma on the mental health workforce the degree to which they wanted to quit their profession was because of stigma (Agyapong, et al., 2015). 164 mental health workers from all the 10 regions of Ghana, involving 71 (43.3%) CPNs, 19 (11.6%) CPOs, and 74 (45.1%) CMHOs took part in this survey. The CMHWs had work experience ranging from 1 to 40 years in the field of mental health with a mean time of 4.7 years and a standard deviation (SD) of 6.98 years. 99.4 % of the CMHWs testified that there was stigma associated with working in mental institutions. In addition, they were asked if they had the intention of leaving the profession as a result of the stigma associated with it. The summary of the findings shows the percentages of CMHWs who communicated worries about the danger associated with working in mental health and
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those who had deliberately left the mental healthcare profession because of concerns of stigma. 60.6% CPNs stated that they had been harmfully impacted by the stigma in mental health hence they had to leave the profession entirely to other professions like anaesthesia, medical assistance and education. Furthermore, 16.2% of CMHOs, 5.3% CPO and 28.2% of CPNs indicated that they had deliberately left the mental health profession as a result of the stigma they experienced. However, only four (4) psychiatrists reported that because of stigma CMHWs wanted to quit the profession. Furthermore, 52.2% health policy coordinators were of the view that CMHWs were affected by stigma as 41.4% of them reported that they knew of some CMHWs who had considered leaving the mental health profession because of stigma (Agyapong, et al., 2015).

Moreover, Stevens, Browne, and Graham, (2013) carried out a longitudinal study on 150 students on career, which found that mental health was an unlikely career choice for nursing graduates. The purpose of the study was to find out about the attitudes of students at the postgraduate level in relation to psychiatric mental health clinical experiences; their readiness to care for people with mental illness; students’ perceived stigmas and stereotypes; and plans not to choose mental health nursing as a career (Stevens, et al., 2013). The findings showed that mental health nursing was one of the least career options for most nurses at the start of their course and remained the same as they got closer to graduation.

In Ghana, Opare, (2013) explored the experiences of community psychiatric nurses in the discharge of their duties using twelve participants in six districts of the Community Psychiatric Units in the Accra Metropolis of Ayawaso, Osu-Klottey, Ablekuma, Okai-Koi, LEKMA, and Ashiedu-Keteke. The major findings included difficulty locating the homes of patients due to poor home addresses and transportation, limited logistical support and
irregular supply of medications. The study affirmed the stigmatization of Community Psychiatric Nurses, assaults from patients and the negative attitudes of relatives of patients which led to relapses. Participants opined that risk allowances must be given in the event that they suffer any injury sustained while performing their duties.

Numerous coping strategies such as reducing stigma, religion, self-motivation and reduction in home visits were used to deal with the challenges. Established on these findings, recommendations were made to help deal with the challenges of community psychiatric nurses in the Accra Metropolis. Amid these were the employers and management of various health care facilities should provide community psychiatric nurses with transport to facilitate access to their clients in the community. There should be media involvement in educating the general public on mental health issues to reduce the stigma of mental health and mental illness.

2.7 Emotional Response to Stigma by Association among Mental Health Professional

In an exploratory cross sectional survey of 272 African Americans, it was discovered that those who worry more about stigma associated with mental illness suffer depression (Ward, Witshire, Detry & Brown, 2013). Another study in Germany revealed that anticipated stigma could result in reduced quality of life and depression (Vault et al., 2007). Sharaf, Ossman, and Lachine, (2012) specifically noted that internalized stigma was linked to depression. In a study by Mystakidou, Tsilika, Papra, Galanos, and Vlahos, (2007) revealed that caregivers’ feelings of hopelessness is dependent on the characteristics of their patients and a patient’s depression is linked to that of a caregiver.

Additionally, Zumrut and MSC, (2012) carried out a study in Turkey on the subject of “Loneliness, Depression, and Social Support of Patients and their Caregivers”. Studies
show that most caregivers of patients experience anxiety, depression, and burden. Their distress was connected to their care giving roles and had been shown to continue over time, and may be exacerbated by changes in a patient’s condition.

2.8 The Behavioral Pattern of Stigma by Association

Stigmatizing reactions have been shown to affect mental well-being, social life and social networks (Van der Sanden, Remko, Bos, Arjan, Stutterheim, Sarah; Pryor, John, and kok, 2014). One way individuals react to the experience of SBA is to conceal their relationship with the stigmatized person or avoid the stigmatized person and others.

Van der Sanden et al. used semi-structured interviews to examine the effects of SBA. Van der Sanden, et al., (2015) studied 23 immediate family members of people with mental illnesses. The stigmatized individuals had broad diagnoses including various mood disorders, personality disorders; attention deficit hyperactivity disorders (ADHD), dissociative disorder, autism spectrum disorders, schizophrenias, or addictions. SBA and perceived burdens were evaluated and examined the extent to which these factors affected participants’ experiences and well-being as well as how they coped with these challenges. With this modest sample, several immediate family members reported avoiding social events and reducing or breaking contact with family, friends, and acquaintances to avoid awkward questions and remarks about their family member. Family members also feared potential stigmatizing reactions and the loss of relationships and friendships of potential romantic partners due to their relationship with the stigmatized individual. Thus, family members of an individual with a mental illness were likely to avoid others.

Reasons for avoidance is further supported through qualitative reports in which family members indicated they were blamed for the onset or continuation of the mental illness by others (Van der Sanden, et al., 2015). The family member of an individual with
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a mental illness would explain the mental health condition to another individual, such as another family member and the individual would respond with comments stating that the associated family member was the cause of the mental health problem. Situations such as these are aversive interactions and lead to an avoidance of others as an escape from interactions where blame is put on the person experiencing SBA.

When people alienate themselves from others including the stigmatized person as well as other family, friends, and acquaintances to avoid association or further stigmatization, feelings of social exclusion arise. Van der Sanden, et al., (2015) found that family members received more negative treatments from others (including mental health professionals), as well as exclusion by others. In addition, they found decreased peer relationship quality and strained peer relationships among people affected by SBA.

People cope with stigma-induced identity threat in a variety of ways. Some coping efforts are primarily problem focused whereas others are primarily emotion focused. Coping strategies can also be characterized as engagement versus disengagement strategies. Engagement involves fighting the stigma-induced identity threat.

Furthermore, Yanos, West, and Smith, (2010) conducted a research in the United States of America to explore the coping strategies of 27 adults with mental illness. It was discovered that avoidant coping and neutral coping were the strategies adopted by some persons to cope with mental illness stigma. They used some neutral copings such as ignoring the stressor, relaxation strategies and religious activities. Anger, avoidance, violence and sleeping was used for avoidant coping. Yanos, et al., (2010) also mentioned that others manage stigma through violence, anger or by totally ignoring the source of stigma.
In addition, Yanos, Roe, Markus, and Lysaker, (2008) studied 102 mental patients suffering from schizophrenia in the United States. They found that avoidant coping was more determined by internalized stigma whiles Yanos, et al., (2010) opined that coping with mental illness stress stigma was avoidant coping mechanism. Later, Boardman, Griffith, Kokanovic, and Potiriadis, (2011) discovered that people coped with stigma through social support groups such as friends, family members and colleagues. They also noted that others withdraw to avoid being stigmatized. In the same vein, others reported that people coped through education and that in-group comparisons helped in dealing with stigma (Rusch, Corrigan, Wassel, Micheals, Olschewski, wilkiniss & Batia, 2009).

In another development, a research was also conducted in Belgium on how stigma influenced mental health nursing identities (Sercu, Ayala. & Brakes, 2015). The study focused on the meaning of stigma for nursing role identities in two Belgian Psychiatric Hospital. Finally, Secrcu, et al., (2015) recently underscored that the nursing role is made based on official labels, a major cause of stigma. Sercu, et al., (2015) focused on the changes which notify this complicated relation between stigma and mental health nursing identity. To them, stigma should be factored into the overall study of mental health nursing identity. The results suggested that confronting stigma was a predominantly significant peculiar motive for nurses to work in mental health care. It was, therefore, concluded that integration of stigma in mental health nursing identity research was very important. The emphasis on stigma may offer the chance to associate the contexts of illness and care, and nurses’ identity constructs (Sercu, et al., 2015).

One study found that education and exposure helped people decrease stigma (Bulanda, Bruhn, ByroJonhson & Zentmyer, 2014). When people are exposed to and interact with patients suffering from a mental illness who are successful members of
society or those associated with persons with mental illness, the exposure may decrease stigma. Education on mental illness, increasing a person’s understanding of the various disorders may also decrease the stigma towards persons with mental illness (Bulanda, et al., 2014).

These findings are in line with those revealed by van der Sanden, et al., (2014) who found that certain family members of people with mental illness used emotion focused coping to deal with the stigma they faced like denial, self-distraction, acceptance, venting and behavioral disengagement while other family members used problem focused coping mechanisms to deal with their stigma.

Similarly, Dalky, (2012) cited that family members usually used concealment of the illness, seeking spiritual support or silence as a means of coping with the stigma they faced in similar circumstances.

Individuals experiencing SBA tend to conceal their relationship with the stigmatized person or avoid the stigmatized person and others (Van der Sanden, et al., 2015).

Experiencing stigma due to a stigmatizing health condition also leads to others treating the stigmatized individual differently. This treatment can include an increased physical distance between the individual and another person, awkward social interactions, and being advised to conceal their condition, which can lead to greater amounts of psychological distress compared to those who do not have a stigmatizing health condition (Stutterheim, et al., 2009).

Social isolation and avoidance of others leave affiliated individuals susceptible to psychological symptoms and distress. Research has found that among affiliated
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individuals, those experiencing greater amounts of SBA have increased levels of anxiety, depression, suicidal thoughts and withdrawal (Van der Sanden, et al., 2009).
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discusses the research setting, the target population, research design as well as gives a description of the sample and sampling technique, data collection tool, and data collection procedure methodology used as well as the ethical issues observed.

3.1 Methodology

An explorative descriptive qualitative research method was used to describe the experience of the RMN in the Ashanti region of Ghana. There was limited literature available on the subject of stigma by association in relation to Mental Health Nurses.

3.2 Research design

An exploratory descriptive qualitative design was utilized to carry out this study. The reason for choosing this design is that very little has been done in this area in Ghana; this has motivated the research to analyze the experiences of registered mental nurses in the discharge of their duties. Qualitative inquiry is usually utilized to describe a phenomenon about which little is known in order to gain insights into them (data are gathered in the form of feelings, behaviors, thoughts, insights and actions rather than in the form of numbers) and to describe a process rather than an outcome (Mayan, 2001 p.5).

A qualitative approach allows researchers to use naturalistic methods. That is they place emphasis on understanding the human experience as it is lived, generally through careful collection and analysis of narrations. Researchers acquire information directly from those experiencing it (Polit & Hungler, 1995).
3.3 Research Setting

The Ashanti Region has five hundred and thirty (530) health facilities. One hundred and seventy (170) of these health facilities are operated by the Ghana Health Service; seventy-one (71) are considered as missions’ hospitals run by churches; two hundred and eighty-one (281) by private institutions; and eight (8) by quasi institutions (Ashanti Region Health Directorate, 2015). The study was carried out in the Ashanti Region of Ghana as the region was the sole setting for data collection. All the Registered Mental Health Nurses who participated in this study had worked in the psychiatric unit, general hospital or in the community as Community Psychiatric Nurse (CPN) for more than twelve months. The RMN in psychiatric units and CPN in the communities in Ashanti Region provide mental health services to mentally ill clients in the region. Also, the psychiatric units and the community were used as a channel through which participants were recruited.

In the region, the Komfo Anokye Teaching Hospital is the largest provider of mental health services. They provide both inpatient and outpatient mental health care. The mental health team comprises of psychiatric/mental health nurses, psychiatrist/physician assistants (psychiatry), clinical psychologists, pharmacists, social workers and other paramedical staff such as health aids and biomedical scientists. The hospital provides services to patients with various mental disorders including schizophrenia, epilepsy, bipolar affective disorder, anxiety disorder and substance use disorders or drug addiction. There are seventy-nine (80) psychiatric clinics in the region. There are twenty-five (26) Community Psychiatric Units in the district hospitals, twenty-four (24) in the Health Centers, twenty (20) in the Christian Health Association of Ghana, two (2) private clinics two, (2) quasi institutions, two (2) private hospitals, one (1)Teaching Hospital and three
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(3) rehabilitation centers. All these clinics are manned by trained registered psychiatric nurses.

3.4 Target Population

A target population was the entire collection of cases which could be generalized in relation to the objectives of the study (Polite, Beck & Hungler, 2001). For this study, the target population was all Registered Mental Nurses, Community Psychiatric Nurses who were working in psychiatric units and CPN working in the communities in the region.

3.5 Accessible Population

The target population which the researcher had access to was fifteen (15) Registered Mental Nurses from the Tafo Government Hospital’s Psychiatric Unit and Komfo Anokye Teaching Hospital Psychiatric unit all in Kumasi; New Edubiase Government Hospital’s Psychiatric Unit in New Edubiase, Obuasi Government Hospital’s Psychiatric Unit in Obuasi, Bekwai Municipal Hospital Psychiatric unit and the Nurses’ and Midwifery Training School, Fomena-Adansi all in the Ashanti Region of Ghana.

3.6 Sampling Technique

The probability purposive cluster sampling methodology was utilized to carry out this study. Cluster sampling is a technique in which clusters of participants that represent the population are identified and included in the sample, Jackson (2011). Botma et al., (2010) posit that during purposive sampling, a certain person is selected due to the fact that he/she exhibits a characteristic that is relevant to a study. Purposive and snowball sampling techniques were utilized. The purposive cluster sampling technique was utilized because this study targets a population that has unique characteristics or experiences. Cluster sampling involves identification of cluster of participants representing the population and their inclusion in the sample group. The main aim of cluster sampling is to
reduce cost and increasing the levels of efficiency of sampling. The advantage is that of time-efficient and cost-efficient probability design for large geographical areas. This method is easy to be used and can be used for larger sample size due to increased level of accessibility of perspective sample group members. Its disadvantage includes it requires group-level information to be known. It also has higher sampling error than other sampling techniques. Cluster sampling will reflect the diversity in the sampling frame. Participants in the study were registered mental health nurses who had worked in a psychiatrist unit, hospital or in a community for twelve month or more as RMNs within the Ashanti region of Ghana.

The following formula was used to select the unit. $Z = \frac{N}{n}$

All the psychiatric units were given numbers up to 80 e.g. 1, 2, 3, 4, 5, 6 up to 80. Determine the sample interval which is $Z = \frac{N}{n}$. Where $Z$ is the random start or number to choose from, $N$ is the population, $n$ is the sample size to be selected. The random number to start with (random start) random start is the first number of first member of the sample chosen at random ($Z$).

In this case it $80/15=16$. A dice was tossed and it fell on 16 and every 16th member of the unit was selected till the 5 unit were selected. After this the researcher used simple random sampling method to select the respondents from the selected units.

3.7 Sample Size

The sample size for the study was fifteen (15). This sample size was determined by saturation by the fifteenth (15th) participant saturation (Dworkin, 2012), when no new themes emerge during the interview because the content and themes of the interviews becomes the same.
3.8 Inclusion Criteria

All Registered Mental Nurses who work in psychiatric hospitals/units as Mental Heal Nurses, or in the community as community psychiatric nurses and had been at post for a minimum of twelve (12) months. This is because Mental Health Nurses with work experience of at least one year might have experienced stigma by association. Also, participants who were articulate and were willing to share their experiences of stigma by association in a logical and coherent manner were selected for the study.

3.9 Exclusion Criteria

Any Registered Mental Health Nurse who had not practiced Mental Health Nursing for a minimum of twelve months in a ward, unit or in a community was not considered for the study. Also, rotation Registered Mental Nurses who were on rotation at the medical surgical wards were excluded. This is because they may not have experienced stigma.

3.10 Tools for Data Collection

An interview guide was used for the data collection to elicit for in-depth responses from participants. The interview guide helped to guide the interview process. The interview guide consisted of two main sections; the demographic information of participants and questions tailored based on the purpose of the study. The questions were formulated taking into account the specific objectives of the study. Probing questions were formulated to elicit in-depth explanation and understanding of a concept. The interview guide was piloted at the Assin Praso Presbyterian Hospital’s Psychiatric Unit with two (2) participants who met the inclusion criteria for the study. Piloting of the interview guide was to enable the researcher to test the appropriateness of the questions to adequately provide answers for the research questions set and to determine the length of the interview.
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An audio tape recorder was utilized to record the voice/data of interviewees during the interview session.

3.11 Data Collection Procedure

An introductory letter was taken from the School of Nursing, University of Ghana and submitted to the Regional Director of Health Service in Kumasi together with an ethical clearance certificate from the Institutional Review Board of Noguchi Memorial Institute of Medical Research (NMIMR-IRB) to introduce the researcher to healthcare workers in the region. The research was then introduced to the Coordinator of Community Psychiatric nurses in the region. Also an introductory letter was also sent to the District Directors of Health Service and then various Medical Superintendents of the hospitals and staff of the hospitals selected for the study.

Contact details of participants who had agreed to take part in the study were collected and they were later interviewed in order to collect data for the study. A convenient place as well as a time suitable for participants was set to ensure the privacy and confidentiality of the participants. Also, consent procedures were explained to participants of the study. These procedures included explaining the purpose of the study, voluntariness to participate, risk and benefits of participation, assurance of privacy and confidentiality. In addition, participants were informed that the interview will be recorded using an audiotape recorder. Consent forms were made available to the participants to read. Participants were allowed time to ask questions for clarification of any ambiguity. The services of an interpreter and a witness were not engaged as all participants were able to speak, read and write English. All the interviews were conducted in English. The average length of interview duration was between 30-90 minutes. Data was collected using an audiotape recorder to record the voice of the participants.
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As earlier stated participants were booked for interviews and during the interview sessions an audio tape recorder was turned on as the interview began. The interview began with participants providing their demographic information. However, so as to ensure anonymity of participants their names were not recorded. This was followed by grand tour questions. A grand tour question is open-ended questions which allow discussion. This allowed participants to begin to answer questions from any angle they preferred (Mayan, 2016). This was followed by other probing questions. The probing questions helped the participants to provide in-depth explanation for concepts/ ideas. Also, they gave in-depth understanding of concepts/ideas. Participants were given ample time to express their thoughts in relation to their experiences to ensure clarity until no new theme emerged (LoBiondo-Wood & Haber, 2013).

Participants were also observed for non-verbal cues that hinged onto their verbal expressions. Non-verbal cues were very important because they helped to elicit information that could not have been obtained through verbal means. Observations were done prior, during and after the interview. Areas which were observed included non-verbal cues expressed by mental health nurses during the interview. Observing participants and the environment of the participants in the study was useful in providing information that the interview session could not elicit. Therefore, this complemented the data gathered through interviews. After the interview, observations made on the participants were documented in the form of a field note. The recorded audiotapes were later transcribed to reflect the exact phrases and statements made by the participants. The transcribed data were cross-checked to ensure that the transcribed data was the exact reflection of the audio recording obtained from participants during the interview. The audio recording and the transcribed data were done under the supervision of the research supervisor. This ensured that the appropriate themes that answer the research questions were identified. The field
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Motes taken after observing the participants during the interview session were also included in the transcribed data.

3.12 Field Note

Field notes were taken by observing the interviewees to form a full report that reflected the discussion as well as other observations made during the study. This ensured that several sources of data collection which enhanced the validity of the study.

3.13 Data Management

All soft copies of audio recordings, field notes (time, place and date) and all other relevant materials about the study were secured in a locker. In essence, the data was kept under lock and key, hence, only the researcher and the project supervisors had access to the data collected (Makulilo, 2012). The institution supports that it should be kept under lock and key for five years.

3.14 Data Analysis and Management

Thematic content analysis was used to analysis all aspects of the data with the field notes. Thematic content analysis is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts. It is a form of pattern recognition within the data, where emerging themes become the categories for analysis (Fereday and Muir-Cochrane, 2006). Thematic content analysis enhances the representation of verbal expression in a contextual form while maintaining the main ideas irrespective of the volume of data involved. It also involves the process of identifying codes and categorizations of primary patterns found in the data collected. All the interviews were conducted in English and audio recordings were transcribed with precision.
Analysis of data commenced after the first interview was conducted. The audio recording of the interview was repeatedly analyzed in order to understand and interpret the data obtained. Coding was done by numbering each line of the transcript on the margin of each page. The initial transcripts were analyzed in order to formulate more questions where necessary, and participants were contacted for further questioning when the need arose. This helped to further address the gaps in 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 audio tape and its transcript were presented to supervisor of the study for validation. All audiotapes from the subsequent interviews were transcribed just as the first interview with appropriate follow ups where necessary so as to fill in the gaps until saturation was reached (Dworkin, 2012). After this, the emerging common themes from transcripts were integrated, and summarized into a narrative text for interpretation. The key statements from the respondents were used to illustrate and support the main ideas and these were quoted in the report.

3.15 Methodological Rigor

This was demonstrated by using trustworthiness criteria as suggested by Mayan, (2009). A laborious qualitative study should comprise of credibility, transferability, dependability and confirmability in a qualitative research. Credibility was ensured by asking open ended questions, by repeating phrases and asking participants questions in multiple ways to confirm what they say. Dependability depicts how consistent the findings were and if it can be repeated by other researchers and confirmability was established through an audit trail where all information could be clarified and presented as it was. The researcher is responsible for providing adequate information accordingly so that another researcher who reads the study would arrive at similar decision (Speziale, Streubert, and
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Carpenter, 2011). This was ensured by not adding any extra information to the data (unadulterated) collected, the written notes and audiotapes recorded for the study. All the data collected were kept in their raw states so they can be accessed by other researchers to confirm the findings of this study.

Transferability was also ensured by creating narration which when read by another researcher can be applied in other contexts (Speziale, et al, 2011).

3.16 Ethical Considerations:

Ethical clearance was sought from the Noguchi Memorial Institute for Medical Research’s Institutional Review Board to obtain an ethical clearance certificate to conduct the research (Appendix pg 98). An introductory letter from the School of Nursing and Midwifery, University of Ghana (Appendix pg 103) was then taken from the school and submitted to the Regional Director of Health Service and the Regional Community Psychiatric units Coordinator. Furthermore, it an introductory letter was sent to district directors and medical superintendents in healthcare institutions in the region which provided services to people with mental disorders to seek permission for the study. An information sheet was given to participants. The participants were asked to indicate their consent to participate in the study by signing a consent form they were given. The participants were informed that they could opt out of the study anytime they wished even though they had signed the consent form (Appendix pg 99). No form of force or coercion was used to attract or retain participants.

Participants were informed that each interview session would be audio recorded and that they would be free to choose which questions to answer. Informed consent was taken from each participant recruited for the study after the purpose of the study had been explained to them; assurance of privacy and confidentiality as well as a description of
the risks and benefits of the study were also explained to each participant. Participants were given sufficient time to ask questions for clarification.

Ensuring the privacy and confidentiality of all participants in this study were significant. With regard to convenience, the locations chosen by the participants were used for the interview. The names of the participants were not recorded. In addition to the above, participants were informed that they could choose not to participate, withdraw from the study or choose to remain silent or refuse to answer certain questions asked during the interview process. Participants were also informed that a second interview may be done where necessary. The demographic data about participants was matched with other data on the consent forms. This was to ensure the privacy and confidentiality of the participants. Consent forms were kept separately from the transcribed data in a different locker. This was to ensure privacy, confidentiality and anonymity of the participants. In addition, the audio recordings were transcribed without the names of the participants. Data were labeled with initials. All the documents in the study were put under lock and key and were only accessible to the research supervisor on request. These documents included recorded audiotapes, transcribed data, field notes and consent forms. Electronic data on the computer and other storage form/devices were secured with a password.

### 3.17 Expected Outcome/Results

The findings from this study may generate information that could be used to review policies and guidelines, especially when with regard to the enactment of the Mental Health Bill which favors the patients but not psychiatric nurses who take care of patients both in the communities and in the hospitals. This is because the main aim of this bill is to de-institutionalize the patient. The findings will help to inform further research as far as stigma by association experienced by registered mental health nurses is concerned. The study will assist health professionals in both mental and general practice as well as policy
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makers to understand and appreciate the depth of stigma by association experienced by those who care for mental patients in psychiatric hospitals, units and in communities, and how this affects the sufferer. Findings about the extent to which stigma by association affects family members, care givers and other professionals who cater for the mentally ill and people diagnosed with mentally illness could assist in sensitizing all stakeholders into strategically planning activities that will help meet the needs of the mentally ill so as to enhance their quality of life. This study of stigma by association in the Ghanaian context will add further knowledge on stigma and its impact as perceived by mental health nurses and the meanings that they attach to their experiences. Getting closely involved with participants and allowing their voice to be heard could enhance their self-esteem and urge them to stand up and confront stigma by association wherever they find themselves.
CHAPTER FOUR

RESULTS/FINDINGS

4.0 Introduction

This chapter presents the findings obtained from the data gathered on the experience of Mental Health Nurses as far as stigma is concerned. The findings of the study were based on in-depth face-to-face interviews with Mental Health Nurses within the Ashanti Region of Ghana. Data was collected from 15 participants using an audio recorder. Also, notes were taken on the field during interview sessions with the participants which served as additional information. The interview sessions started on 1st March 2018 and ended on 31st May 2018. The data collected were manually transcribed and edited through reading, rereading and listening to the recorded audio several times and then thematic content analysis was applied to analyze the data. The analysis was based on the construct and themes of the identity threat model of stigma by Yanos, (2018). Other subcategories that emerged from the data were analyzed using content analysis. In describing the experiences of the participants, initials were used to protect participant’s identity. These initials were AA, AAF, AW, CA, DA, EAF, EAM, PPF, SO, PMA, WA, KAR, EM, EB, and EAO.

4.1 Demographic Characteristics of Participants

The demographic data of the participants included age, sex, marital status, religion, place of work, years or duration of work, Nurses’ Training School attended, tertiary level and availability of psychiatric units in their hospital of work. Their age range was between twenty-five to forty (25-40) years. They were made up of eight (8) males and seven (7) females. Out of the fifteen (15) participants seven (7) had tertiary level education while the other eight (8) had Diploma in Mental Health Nursing. Out of the fifteen (15) participants,
six (6) were married and nine (9) were single. Fourteen (14) of the participants were Christians and one (1) Muslim. Their work experience ranged from between one to eleven (1-11) years. Nine (9) of them had attended Nurses’ Training College in Cape Coast while six (6) attended Nurses’ Training schools in Accra.

4.2. Themes and Categorization

During analysis of the transcribed data collected from the participants, three (3) major themes were covered; forms of stigma, emotional response to stigma and the behavioral patterns of stigma. There were additional nine (9) categories or sub-themes (label, mockery, discrimination, stereotype, anger/fury, depression, ignoring, distancing and confrontation) emerged. The major themes and their sub-themes were forms of stigma (label, mockery, discrimination, stereotype), emotional response (anger/fury and depression), and behavioral patterns of stigma (ignoring, distancing and confrontation). Samples from the data collected were labeled to provide evidence of participants’ experiences and to support the themes identified. Most of the participants cited the experiences they had had with the general public as well as other healthcare professionals. The behavioral pattern cited mostly by respondents was that they were ignored; people distanced themselves from them and sometimes confrontation.
Table 1: Themes and Sub-themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td>Experiences with forms of stigma</td>
<td>1. Labeling/association</td>
</tr>
<tr>
<td></td>
<td>2. Mockery</td>
</tr>
<tr>
<td></td>
<td>3. Discrimination</td>
</tr>
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<td></td>
<td>4. Stereotype</td>
</tr>
<tr>
<td>Emotional responses to being stigmatized</td>
<td>1. Anger/fury</td>
</tr>
<tr>
<td></td>
<td>2. Depression</td>
</tr>
<tr>
<td>Behavioral responses to stigmatization</td>
<td>1. Ignoring</td>
</tr>
<tr>
<td></td>
<td>2. Distancing</td>
</tr>
<tr>
<td></td>
<td>3. Confrontation</td>
</tr>
</tbody>
</table>

Summary of themes and sub themes

4.3. Responses to Forms of Stigma Experienced by Mental Health Nurses

The participants expressed their views about the stigma that Mental Health Nurses experience as healthcare professionals, which included general public tagging them as mentally sick because they provide services to people with mental disorders. People assume that they act and behave like their clients. This form of stigma is expressed through labeling and discrimination while others were genuinely concerned with the poor image of psychiatric nursing. This stigma and discrimination extend to the offices of Community Psychiatric Units (CPU).
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The first objective of the study was to explore the experiences associated with stigma by association among mental health nurses. This associative stigma has been extended to the whole psychiatric unit including the nurses. Psychiatric units were viewed as a different entity from other units in the hospital.

4.3.1. Labeling/Association

The first sub-theme described by participants was labels or association. A label is used to describe characteristics or qualities of people, activities or things usually in a way that is unfair. Association is marks put on someone by virtue of being a family member or caring for a person with a stigmatized condition. Labels/associations are prejudiced tags ascribed to someone or a minor group because of their close association with a stigmatized person or group.

The participants noted that they were called “abodamfoa nurse” which is transliterated as “mad people’s nurse” by their immediate relatives. This was when they were asked about the forms of stigma they go through.

It’s just because we take care of the mentally ill people that is why we are labeled like that. This even prevails among healthcare professionals, it is not easy. Within this facility, they call us “abodamfoa” “mad people’s nurses” even the unit is called “abodam” that is “mad” clinic. More so when a client reports to the OPD, they send someone to come and call the “abodamfoa nurses” (“mad people’s nurses”) to come for their client (EM).

I was called to come to a see a patient in a ward managed by a medical officer, when I got there he was treating the client like a psychiatric patient, but the case was a surgical case. When I wanted to suggest to him that this case was a surgical case, he said to me, ”What do you know; you are just a mental nurse! “abodamfoa” “mad people’s nurse”. What do you know? Immediately I kept quite (AW).

I am comfortable I don’t think about them, when I was in my first year and when I came home during holidays, my auntie and mum used to call me “abodam nurse” that is “mad nurse” (AA).
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Yes, they do accept me; I have a cordial relationship with others. But some call me by my name while others call me “abodamfoa nurse” “mad people nurse” (AAF).

Also, some of the community members address me as “abodanfoa nurse” (“mad people” nurse) instead of calling me by my name (AW).

Yes, I have been called severally as abdamfoa nurse,” mad people nurse” even here in the hospital sometimes when you go to your friends in the other ward, they call you “abodamfoa nurse” you have come here, there are no clients here for you, or they would introduce you to their friends as “abodamfoa nurse” (AW).

Another respondent said the mental health nurses are stigmatised everyday by labeling them “abodamfoa nurse” “mad people nurse” even by health professionals in the hospital.

We are stigmatised everyday even here at the hospital by the other healthcare professionals and the stigma is too high. They know your name but they will call you “abodamfoa nurse” (KAR).

I actually experienced some form of stigma when I was a student nurse, an in-charge used to call us that is those from Ankaful Nursing Training School, as “abodam nurses no wohen?” or “Ankaful nurses no wohen?” (Where are the mad people’s nurses? Where are the Ankaful nurses?) Although we worked equally as hard as our counterparts from other schools, we were always tagged with that name (PMA).

Another participant said he was stared and that they saw psychiatric nurses as weird (strange) people.

They see psychiatric nursing as a unique profession; they see psychiatric patients to be weird, aggressive and unfriendly people and psychiatric nurses act like their patients. So to be a PN you need to very special among all nurses (EA).

One participant stated that even when she makes unintentional remarks or crack jokes her colleague nurses in other departments would say that her illness is coming.

At a point in time I made some unintentional remarks and cracked a joke but my peers told me that my mental illness was coming and I’m exhibiting the symptoms (EM).

According to another participant,

One day, I came to the unit and a rotation nurse was sent to call the psychiatric nurse on duty but when she came to our unit she said she had been sent to call the “abodamfoa nurse” (“mad people’s nurse”) to come to the emergency unit. I
asked her who had asked her to say “abodamfoa nurse”. She responded that the nurse in-charge had asked her to call the mad people’s nurse. When I went to the ward to ask for the person who wanted a PN, the in-charge not knowing I am the PN repeated that I should call the “abondamfoa nurse” for her. I told her that we don’t have “abodamfoa nurses” here (AA).

She further said

She had been introduced as “abodamfoa nurse” during general ward rounds (AA)

4.3.2 Mockery

Mockery is teasing and making scornful remarks or behaviour which is directed to a particular person or thing. The sub-theme mocking was described by the participants as the way they were ridiculed and disrespected consciously and unconsciously as they were teased in the hospital by other healthcare professional and outside the hospital.

Still on the forms of stigma the psychiatric nurse goes through some of the participants said people giggled and looked at them strangely, made unpleasant comments, teased or laughed at them for being mental health nurses.

In the community if you are asked the category of nursing profession you belong to and you mention that you’re a mental health nurse, they will tell you that they thought you were a proper nurse, not knowing that you were taking care of the mentally ill (WA).

A participant said he was once introduced as a psychiatric nurse in the church and all his peers were teasing and laughing at him

I was introduced as “abodamfoa nurse” and all my peers laughed and told me to add that I was mad (AW)

Besides CA added that;

Yes, they call me “abodamfoa nurse” but not often and they introduce you as such. When they do that people turn and look at you and then laugh, some look at you in a certain way (CA)
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One respondent said that when she mentioned her professional category her colleagues would start to laugh.

*I was once invited by a fellow nurse from a different category to deliver a health talk at a church, when we were done people were happy. I talked about teenage pregnancy, after I had finished everyone clapped their hands for me, most of the people who attended the fellowship came to me to request for my telephone number. All of a sudden my fellow nurse said; “You see! She is a psychiatric nurse, these psychiatric people if you give them the whole day they can talk; they are all mad (EM).*

Also EB states that even in the hospital where he works they call and tease him as “abodamfoa” nurse

*And in the hospital his peers called him “abodamfoa” nurse (EB).*

Furthermore, the participants noted that,

*When people ask you for your professional affiliation, immediately you mention PN they laugh and ask why mental nurse? (AW).*

Another participant PAM indicated that people do not see the need for RMN.

*Some of them see our profession not to be important and they say all sorts of things about mental illness and some of them call us “abodamfoa” “mad people” nurses and the rest sometimes laugh at us and some of us sometimes laugh with them (PMA).*

This nurse said that sometimes they use it to crack jokes with her by calling her “maame abodamfoa” “mother of mad people nurse” but others mean what they say PMA.

*Sometimes they use it as fun, I also know that some of them deep down they see our profession as not important. I actually had a friend who would always introduce me as “eyi oye abodam nurse oo” that is “This is mad people’s nurse” (PMA).*

*When you tell them the type of work you are doing they will tell you I feel pity for you. You are doing a dangerous work; they can hurt you (SO).*

At times they mock psychiatric nurses;

*They mock at us with the word “abodamfoa” nurses (AA).*
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They have been using this word “abodamfoa” in relation to us, even other staff nurses jokingly say that we behave like our patients. Some people say “abodamfoa” nurse for fun while others mean what they say (SO).

4.3.3. Discrimination

The third sub-theme under forms of stigma experienced by the RMN is discrimination. Discrimination is when a person/people are treated unfairly because of who they are or because they possess certain characteristics. The participants stated that during workshops and in-service training as well as when items and logistics were shared, they were left out because there is the assumption that psychiatric units do not need further training or logistics. In one of the hospitals, doctors and nurses did not want to enter the psychiatric unit. Also, psychiatric nurses were not allowed to perform procedures both at the general ward and maternity ward.

On how they were discriminate at the work place this is what some of the participant said,

As you see me if I don’t tell you that I am a psychiatric nurse you won’t know, but immediately you disclose yourself they turn to look down on you. They don’t want to socialize with you as though psychiatric nursing was contaminated (DA).

Madam PMA narrated her personal experience;

I had a personal experience when my uncle told me that “se metee se oko ye Psychiatric Nursing aaa enka maa mano anko” that is “If I knew she was going to pursue mental health nursing I wouldn’t have allowed her to go”. This is someone who is in the medical profession who should know better. He asked me why I didn’t go for midwifery or general nursing (PMA).

Mr. KAR said he does not understand why they call us “abodamfoa” nurse instead of mental health nurse;

I don’t understand why they call us “abodamfoa” nurse, what is it? If you call me a mental health nurse I like it better than “abodamfoa” nurse. Immediately you say “abodamfoa” nurse the people around you turn to look at you with different looks. (KAR)
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Another participant indicated that doctors and nurses do not want to enter the psychiatric ward.

Even the doctors and nurses when they come around, they don’t want to enter the ward. They think when they enter they will be injured. They enter if they have a relative on admission, even with that they don’t feel comfortable. (EA)

Mr. WA is of the opinion that all the other healthcare professionals stigmatize RMNs;

All categories of healthcare professional stigmatize us, but the professionals who stigmatize us most are doctors and other categories of nurses. They don’t see our relevance. Receiving us into the ward is a problem. When a patient is on admission, they don’t want to see the need to support him or her; even receiving your patient into the ward is a problem. (WA)

The participants indicate that they were discriminated against at various wards;

Yes, as a psychiatric nurse, when you are in the labor ward you are not allowed to perform procedures and they will ask, “What do we need a psychiatric nurse for? (AA)

Yes, recently the municipal director was looking for nurse who had served for two years and had experience to be trained as a prescriber to man a CHPS compound. I went to the Municipal director and told him that I was interested. He told me that, psychiatric nurses are not part. He said “What do you know as a psychiatric nurse, this opportunity is for general nurses. I tried to reason with him but he said no, you don’t know anything. (WA)

Hmmm, very bad, because of discrimination, they see you to be mentally ill. Recently, I had an encounter with an in-charge of the male ward; I wanted to sedate a client at the male ward. They looked on although I needed support from the other healthcare professionals, preferable the nurses who had studied courses related to psychiatric to assist me. When I asked the nurses to assist me, they did not as a result; I had to rely on laborers to assist me. All the nurses replied that the client was too violent. (AAF)

Last year after peer review [performance review], all the units were given awards and unit heads were awarded but staffs from this unit were left out. Meanwhile all units and individuals were awarded. Why leave out the psychiatric unit even though we were peer reviewed? (EB)

Sometimes when an important information is given from the hospital administration it does not get to this unit, like promotional interviews and workshops; by the time you hear of it, it is past and gone. It is very bad. (EA)
In relation to programs and in-service training, participant responded that;

When it comes to psychiatric nurses we have been more or less abandoned, we don’t get programs such as in-service training for staff. (CA)

We have written letters to Christ the King Secondary school to give health education on mental illness, not just once, but thrice but they didn’t give us audience, but other units such as public health nurses are allowed so why not psychiatric nurses. (AAF)

Also, every psychiatric patient should have free access to essential psychotropic drugs from psychiatric hospitals or units. In addition, funds must be made available to nurses to be used as their transportation fare or to buy fuel for unit motor bikes for home visits. They should also be provided with sufficient office accommodation for both staff and clients. The CPUs are under resourced which is affecting the smooth management of psychiatric units and their patients. The participants stated that in relation to funding, they were not given money to run the unit. They sometimes had to contribute money personally to pay for their transportation when they visit clients in their homes.

We don’t get any money from anybody. Sometimes the staff use their own pocket money for home visits. If some of the patients don’t have money to buy drugs the staff contribute to help them buy the drugs. (AW)

Others observed that there was no money provided for outreach programs and that the staff had to contribute monies from their own pockets to support such programs;

We don’t have funds to run our outreach programs, meanwhile other units get funds from the Ministry of Health. (CA)

We get some funds from the hospital administration and from the district director, but the majority of our funds come from the staff or we use our own money to go for home visits. (EA)

It is a big challenge, we are not comfortable working here. We are trying to cope with situations because there are certain activities we need to do but because we don’t have money we can’t do them especially outreach programs and durbars at schools and churches. (EB)

With regard to medication, a participant said;
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No drugs, the patients buy from drugstores after consultation. Even if we buy drugs to sell, they don’t have money. Mostly we go to home visits without drugs. It is even just recently that we were given transport for our visits by the hospital (AAF).

The things we need to run this unit are not available especially drugs, you have to write a prescription for clients to buy from the open market. As you know psychiatric drugs are not easily available in every drug store (AW).

4.4.4. Stereotype

The fourth sub-theme, stereotype, was categorized under the main theme of forms of stigma. A stereotype is an over-generalized belief about a particular category of people. It was discovered that the participants’ Registered Mental Nursing (RMN) certificates were rejected when they were presented or were used to apply for a ‘locum’ or part-time employment in other private hospitals. They were told that the hospital did not need such caliber of staff. Also, other respondents were told that they act like their clients or behaved like them. This was evident by the following interview;

On the question of stereotyping this is what they said

*There are times I ask myself if I am really in the right profession because of the way I sometimes get treated by other professionals who should know better. Sometimes, they look at you differently.* (PMA).

*Working in the hospital as a psychiatric nurse is sometimes very unbearable because health workers see you to be weird and mentally unstable. This is the image the public and other professionals have of us.* (AW).

*They deal with you like a mental patient. I think the public has a poor image of psychiatric nursing, I was once introduced at church as a psychiatric nurse; all my peers there started laughing at me and asked me why I had done psychiatric nurse. I don’t think it is their fault; it is the nation’s fault. There is a perception that when you work as psychiatric nurses for a long time you tend to behave like your patients.* (CA)

*People see PNs as mentally ill nurses because ‘we act like our patients’; I don’t know where they had that perception from.* (DA)

In the same vein, PPF remarked that,
We once attended a workshop and when a PN introduced herself, everybody laughed and teased her. When it got to my turn I said that I was a staff nurse. They tag you with your patient. They look at you like you are not a nurse, so sometimes I just tell people that I am a staff nurse. (PPF)

For now people do not know much about psychiatric nursing. When they see you they think you are like your patient. (EA)

They see us to be like our patients and to behave like them. They don’t even see you to be a nurse; at times they introduce you to the general public as “abodamfoa” nurse. (KAR)

The word abodam means madness, it then creates an impression that you are mad. Whenever you do anything in which is not in line with what they want, they tag you as mad. Even sometimes when you speak, they think that what you are saying is out of place. They just see all your actions to be abnormal. (SO)

I quite remember when I was in school, back home I had recalled an event in my mind and so I was smiling. When my mother saw me smiling, she called me and asked if I was ok. This was just because I was studying at Pantang Nurses Training school a well-known mental health training institute. (EM)

They have already created their impression of you; they see you as your client and they call me “abodam” nurse. (SO)

Mr. CA notes that he was stereotyped when he applied to a private hospital with his RMN certificate.

We are stigmatized especially when we apply for locum with a RMN certificate. They usually respond that they do not need r mental health nurses. We are not interested in RMN. (CA)

During a workshop I introduced myself as a mental health nurse, as soon as I ended my statement like heaven had broken loose, everybody shouted “abodam,” and they started to laugh. (EM)

4.4. Emotional Respond to being Stigmatized as a Psychiatric Nurses

The second theme covered was emotional response to stigma. This had two sub-categories, which are anger/fury and depression. Emotional respond is reacting to a certain intra-psychic feeling or feelings that are accompanied by physiological changes which might not be physically visible but provoke or precipitate some actions or behavioral
response. The participants cited various emotional responses such as anger, fury and depression; others included sadness, dejection, fury, and anger.

4.4.1 Anger/Fury

Anger is the first sub-theme under the main theme of emotional response to stigma. Anger is a strong feeling of annoyance, displeasure, or hostility. The participants expressed anger and fury when they were called “abodamfoa” (“mad people”) nurse.

On the question on how they were responding to the forms of stigma, some mentioned depression, other feel sad while others become furious. This is what one said

One Friday I was called from the hospital after I had closed from work and had just reached home. I was called to return to the hospital to administer a drug. I directed the nurse who had called me to where to find the key to our office and where to locate the drug in the office. The nurse told me that she won’t enter our office. Therefore, I had to return to the hospital even though I have to board two (2) cars before I get there. Before I got to the hospital I was angry and bored. (AAF)

Others also said

It is very bad when this stigma is directed at us; even nurses in other departments of the nursing profession call me “abodam nurse”. (PMA)

At times I become emotional and furious. (AW)

Sometimes, some of my colleagues become angry and I feel very bad, angry and at times I feel pain. When an in-charge called me “abodamfoa” nurse I felt bad and very embarrassed. I don’t think she would have called a general nurse like that, why me? (AA)

Yes, but at times I feel bad and bitter. It dampens your spirit and you feel very low. (AA)

I feel pain in me. I feel bad for being a psychiatric nurse. (CA)

In fact I was emotionally disturbed and very upset. I was really angry and I had verbal exchanges with her. (EA)

Similarly, Mr. AW said it was annoying when he is referred to as ‘mad people’s nurse’;
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The most annoying thing is that when a patient is on PRN medication, they won’t serve him/her but rather ask you to serve the drug. I am having second thoughts as I’m thinking of leaving psychiatric nursing. (WA)

4.4.2 Depression

Depression is the second sub-theme under emotional response to stigma. Depression is a feeling of sadness, tearfulness, emptiness or hopelessness. Even though they are Mental Health Nurses and have been taught how to handle traumatic situations so as not to break down, most of the participants still stated that they could not help but feel sad, bad, unstable, hopeless and depressed because of the treatment they received from other health professionals and the general public, and even from their relatives.

Further question on emotional responses, Miss. AA said that,

It dampens my spirit; I feel too low and miserable to be a psychiatric nurse. Sometimes I blame myself for being a psychiatric nurse. (AA)

AA added that she felt sorry for clients with inadequate drug supply.

I feel sorry for clients. (AA)

Another said,

At times I’m very worried but I can’t do anything.(EB)

Likewise, others responded that,

Very bad, I become ashamed, at times I walk away but within me I feel pain.(KAR)

Very bad, ashamed, shy and it reduces my morale which makes me ashamed to practice PN. (WA)

In fact I become emotionally disturbed, sad and I feel like crying.(EA)

In fact I feel very bad, aside from the fact that I have the passion for the work, when I am in my office or when a colleague nurse makes certain degrading comments about my profession. Where did I go wrong, is it because I am psychiatric nurse? You feel very bad as it brings your spirit down. In fact if you don’t take care, you will be depressed. It’s like I don’t care but it gets to me and it

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demoralizes me and causes me to sometimes get angry. Honestly, sometimes I get depressed; I feel very bad. (AW)

Miss AAF said;

So sometimes it affects me emotionally and I get unstable at times, but sometimes I work myself out of it. (AAF)

4.5 Behavioral responses to Stigmatization

The behavioral pattern of stigma was the third theme. It has three sub-themes. These were ignoring, distancing and confronting/report. Behavior is an observable response to stimulus within the individual environment.

4.5.1 Ignoring

Ignoring was the first sub-category of the behavioral pattern of stigma. Ignoring is to refuse to take notice of or acknowledge the presence of something or someone; it is also disregarding stimulus in the environment.

When a question was put in relation to the behavioral pattern they use to deal or cope with the stigma most of the respondents said the behavioral pattern they adopted to avoid stigma was to ignore it existence. Some of the respondents said choosing to ignore, silence and avoid helped them to deal with the stigma they were facing.

Almost all the participants stated that by choosing to ignore and avoid the bad attitudes people exhibit towards them, they were helped to deal with stigma.

Formally I felt very bad; I become worried and disturbed as it was as though we were not part of the hospital. But now I have stopped because no matter what I do they won’t change. (EA)

Very bad, sometimes I feel ashamed. I avoid them by walking away but within me I feel pain. At time I ignore them and also avoid them. Sometimes I’m very worried but I can’t do anything. With time I don’t feel the need to respond to them when they call me. I have adjusted. When I was in school I was told this was how they would call me. (KAR)
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Over the years I have seen those people as people who do not know what they are talking about, so often I don’t mind them. I am sure other psychiatric nurses do ignore them, and then I end up being the one to correct them and tell them they rather need help (PMA)

I sometimes don’t mind them. Other times I tell them they are rather sick. They don’t understand what they are doing. (AAF)

I use silence, acceptance and mingle with them I have adapted and adjusted to it so it is now normal to me. You will become worried when you don’t accept that you are a psychiatric nurse. When you understand these things people no longer get to you. I am a psychiatric nurse, trained to handle stress and manage stress. I have also learned about behaviors and defense mechanisms. Because of this I don’t mind people when they talk. I accept them after all I am a psychiatric nurse, I can’t change my status. We must adjust and adapt. As a Psychiatric Nurse, I try to mingle with them, it’s part of the work. (EA)

I use the defense mechanism I learned at school to keep quiet. (KAR)

Miss SO stated that she has accepted every behavior;

Psychiatric nursing is a nice profession among all the categories of the nursing profession. I accept every behavior and every behavior is meaningful to me. As a psychiatric nurse you have to express yourself freely and you are free to go. So I am proud to be a psychiatric nurse. (SO)

4.5.2 Distancing

Distancing was the second sub-category under the behavioral pattern of stigma.

On the question of dealing with stigma, some of the participant used distancing as a means of behavioral pattern.

Sometimes I’m very worried but I can’t do anything. Therefore, I don’t mind them if they call me names. I have adjusted. When I was in school I was told that I would be called ‘mad people’s nurse’. (EB)

I need not be angry; it’s normal that is their behavior I have to adapt to it. I have adapted and adjusted to what they are saying, you have to prepare your mind for such things, since mental illness is not accepted in communities. (AW)

Mr. DA said he use dissociation to deal with the situation;

feel bad, worried sometimes and disappointed; you feel like quitting work and isolating yourself. At times I don’t mind them. And I tell them they don’t understand what they are doing I used to bother about it, but now I no more think
or bother about it. At first it was a bother but now, I rather laugh over it. Sometimes I tell them they need help. (DA)

4.5.3. Confronting

To confront is to face a situation that makes you uncomfortable or to say something to someone about something they have done that bothers you. The third sub-theme under behavioral pattern of stigma is confrontation. Some of the participants objectively handled matters right when they were ridiculed or teased while others reported the matter to the hospital authorities.

Still on the question on behavioral pattern used to deal with stigma one of the participants said he usually replied that they were rather sick or reported them to the in-charge.

At times I tell them they are rather sick and then report them to the in-charge of the hospital. (AA)

Another one said she uses fury and anger to deal with the stigma

I was once called “abodamfoa” nurse at the outpatient department, I become angry and furious. The led to verbal exchanges, I didn’t like it at all. I confronted her and reported her to the in-charge as well as the hospital matron. (EAO)

Madam EB said she uses confrontation

I don’t mind them. I confront them and tell them they are also mad. I tell them my piece of mind. (EB)

Mr. WA stated that,

I confronted my Municipal Director of Health on some occasions and told him that they were not treating us fairly. (WA)

Sometimes I will tell them straight in their face that I don’t like that. (CA)

4.6 Summary

To sum up, this study used the identity threat model of stigma by Yanos, 2018, to explore experiences of stigma by association encountered by Registered Mental Health Nurses in
the Ashanti Region of Ghana. The results of the study show that Mental Health Nurses were indeed stigmatized by the general public and other healthcare professionals in the hospital setting because they provide services to mentally ill patients. The participants mentioned mockery and label/associative discrimination as forms of stigma. This resulted in emotional responses such as anger, fury and depression from registered mental health nurse in relation to stigma. The behavioral patterns used were avoiding and ignoring the source, distancing and isolating themselves from them, and also confronting and reporting them to unit heads.
CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter presents a discussion of the findings presented in the previous chapter. The study focused on stigma by association in relation to the experiences of Mental Health Nurses in the Ashanti Region of Ghana. Critical analysis and comparison of the findings of this study with available literature from previous studies have been carried out in this chapter. Three specific objectives were formed from Yanos’ associative stigma model of 2018.

These were to:

1. Explore the experiences of Mental Health Nurses with regard to Stigma by Association in Ashanti Region of Ghana.

2. Explore the emotional response to stigma by association among Mental Health Nurses in the Ashanti Region of Ghana.

3. To assess the behavioral responses to stigma by association among Mental Health Nurses in Ashanti Region of Ghana.

5.1. Demographic Characteristics of Participants

The demographic characteristics of respondents comprised the age, sex, marital status, religion, educational level, institution of training and place of work. Per this study more males (8) than female (7) were recruited for the study. The mean age of the participants was 32.5. On marital status the non married (9) were more than the married (6). On education the Diploma holders (8) were more than the degree holders (7). Also on religion the Christians were 14 while, Moslem was 1. On institution of training Nurses Training College, Cape Coast were 9, while, 6 attended Nurses Training College, Accra.
On education the diplomats (8) were more than the tertiary (7), while place of work the district hospitals were 10, while the regional capital Kumasi had 5. It was discovered that, stigma by association was observed at the work place and extended to spouses of Mental Health Nurses in the community.

Tawiah, Adongo and Aikins, (2015), discovered that mental disorder cuts across all ages, sex, education, ethnicity, employment, and marital status. More females are stigmatized than males at the work or employment and educational levels. Various forms of stigma were observed at the economic, psychological and social levels. Caregivers were also stigmatised and discriminated against. They concluded that, mentally ill patients and their relatives suffer from stigma and discrimination from people, family, at work, and school.

Also, Regehr & Glancy, (2014) mental illness affects people of different backgrounds and culture, irrespective of age, gender, race, education, religion, or socio-economic status. They also indicated that individuals diagnosed with mental illness find themselves stigmatized by family, society, and the community at large. A large majority of individuals with mental illness find themselves been discriminated against due to society’s perception of mental illness (Regehr & Glancy, 2014).

5.2. Experiences with Forms of Stigma by Association of the Psychiatric Nurses

There are four kinds of stigma based on Pryor and Reeder’s 2011 model which include Self-Stigma, Association Stigma, Enacted stigma and Felt stigma. Despite the four different types of stigma, it was realized from the findings that the types of stigma experienced by Mental Health Nurses was stigma by association. Stigma by Association is defined as a process through which friends, companions, caregivers, and family members of stigmatized people are discredited and discriminated as a result of their
connection with stigmatized person (Bos et al., 2013; Pryor et al., 2012; Stutterheim, et al., 2011). The first sub-theme reviewed was label or association. Other health professionals call Mental Health Nurses as “Abodamfoa nurses” that is “mad people’s nurses”. Other healthcare workers refuse to enter the wards of psychiatric units.

Additionally, Mental Health Nurses are not allowed to perform procedures both at general wards and the maternity ward. Therefore, stigmatization of Mental Health Nurses as a result of their provision of services to patients with mental disorders exists. This is consistent with the findings of a similar study carried out by Australian researchers (Hamilton & Brainwaite, 2016). They indicate that stigma attached to parents extend to discredit community workers who were supported them. This resulted in stigma by association. Furthermore, they note that stigma by association was seen as the rejection of the principle of acting in the best interests of someone who is treated in a discriminatory and hostile manner, robbed of status recognition, and undermined in their capacity to do their jobs.

Also, Ross, and Goldner, (2009) and Hansson, et al., (2013) indicate that other health professionals show negative attitudes toward mental health-care staff. This is consistent with findings that indicate that stigmatized behaviors are believed to be more common among mental health professionals (Horsfall, et al., 2010).

Furthermore, the second sub-theme discussed was mockery. The participants revealed that they were mocked, labeled, stereotyped and discriminated against as psychiatric nurses. At the same time, however, some people were concerned about their welfare and safety although they had a poor image of Mental Health Nursing. Some MHNs reported that they were consciously and unconsciously ridiculed and belittled through teasing, funny comments and giggling in the hospital as well as outside the
hospital by other health professionals. The participants admitted that they found it very humiliating when they were teased especially in the hospital. This finding is consistent with another study carried out on the subject under discussion (Brockington, et al, 2011). That study identified that because of parental illness, children might be exposed to teasing, intimidation and shunning. In addition, the respondents noted that parents also suffer from stigma, which could result in social isolation that aggravates the hardships of their children.

Similarly, Shrivastava, et al., (2011) in a study discovered that colleagues at the workplace were mocked, disrespected and had funny comments passed about them because they were mentally unsound. This had become normal in Ghana because of the way mental patients and their caregivers are viewed. Similarly, Oleniuk et al., (2011) identified certain individuals who were mocked because of mental illness.

Also, Parcesepe and Cabassa, (2012) posit that public stigma was widespread because both adults and even children felt that persons with mental illness were violent and dangerous. Moreover, other scholars (Kapungwe et al., 2010; Oleniuk et al., 2011; Igbinomwanhia et al., 2013) have obtained similar results in their study of public stigma. In a similar study in Northern and Central Suburbs of Cape Town, Sordsdal et al., (2012) used descriptive quantities analysis and confirmed that high levels of public stigma existed in relation to mentally ill people and their caregivers.

Furthermore, participants expressed how they were labeled and discriminated against in various ways. This was the third sub-theme, discrimination. The actions and inactions of other health professionals which included tagging and name calling were cited by most participants as discriminatory and this hurt them a lot. This was consistent with the findings of some studies demonstrate that the family members of persons who suffer
from mental illness are frequently humiliated and degraded because of their relationship with that mentally ill individual (Bos et al., 2013; Hebl & Mannix, 2003; Pryor et al., 2012). The undesirable characteristics ascribed to stigmatized people and the negative assessments of this individual are transferred to the previously non-stigmatized companion. This makes their companions feel tainted, degraded or inferior (Kulik et al., 2008; Pryor et al., 2012). Opinions on stigma by association have been discovered to be linked to experiences of low self-esteem and psychological distress by persons who have a connection with stigmatized people (Mak & Kwok, 2010).

Similarly, when other category of nurses were compared to Mental Health Nurses, it was found that Mental Health Nurses were more stigmatized by the general public than their colleague nurses in other departments. This was consistent with the findings of Gaebel et al., (2015). According to them, psychiatrists reported significantly higher perceived stigma and experiences than general practitioners. Findings further indicate that mental health patients and their family members are stigmatized and discriminated against by other people, extended family members, employers, educators and even healthcare workers. Most of the Mental Health Nurses stated how they had been discriminated against even in the district hospitals were assigned to. This resulted in officials forgetting to include them when they were distributing or sharing logistics or important information. The participants recounted how they had been unfairly treated by various people including their friends, community members, some family members of patients who visit and more especially other healthcare professionals in the hospitals they work in. This finding is similar to the findings of Kapungwe et al., (2010) which indicate that there is stigma and discrimination among mental health patients and their health professional caregivers. However, this finding is contrary to the findings of Brohan et al., (2010) which discovered that discrimination is as a result of self-stigma. However, participants stated that even
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other healthcare workers did not want to associate with them which is consistent with earlier results obtained by Adewuya and Oguntade, (2007). Adewuya and Oguntade discovered that persons with mental illness were also discriminated against to the extent that people did not want to have a close relationship with their family members, caregiver or friends.

Meanwhile, Igbionomwanhia et al., (2013) also discovered that clergies were not happy to stay in the same neighborhood with psychiatric patients. This is troubling as clergies are highly respected persons in society whose actions can impact others. Some clergies were of the view that psychiatric hospitals should be located at the outskirts of communities. In Igbionomwanhia study more than 50% of the clergy said that psychiatric hospitals look more like prisons than hospitals while 46% were not comfortable with women who had suffered from mental illness catering for their children. Other studies (for instance, Brohan et al., 2010; Gerlinger et al., 2013) have also reported higher levels of stigma and discrimination from family members and community members. The findings of this present study are in line with Parle’s, (2012) which discovered that discrimination was common among persons with mental illness and their caregivers. They were discriminated and ridiculed at their work places by co-workers. They were also verbally and physically attacked because of discrimination.

However, some of health professionals have shown genuine concern and given encouragement and reassurance to some psychiatric nurses which have helped them. Some of the participants opined that some people have shown genuine concern about their safety in relation to taking care of mentally ill patients. This finding is consistent with that of a study conducted by Lund et al., (2010) which found that people were concerned about psychiatric nurses. Consequently, weak policies were addressed to ensure planned services and redress the present inequalities in the mental healthcare system, the continued
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dominance of mental hospitals as a mode of service provision and to assist with mental health care.

Furthermore, the findings of this study are consistent with to that of Agyapong et al., (2015). Their findings indicate that in Ghana, virtually all community mental health workers (CMHWs) have reported that they believed there was stigma associated with working in a mental institution. This finding is also affirmed by other studies (for instance, Halter, 2008; Ebsworth & Foster, 2016; Sorsdahl & Stein, 2010).

5.3 Emotional Respond to Being Stigmatized as a Psychiatric Nurse

The second theme discussed was emotional response to stigma. These were anger/fury and depression. Under emotional response, most of participants indicated that anger was one of their responses to stigma. This was consistent with Avasthi’s, (2010) study, which cites anger as one of the emotional response to stigma. Similarly, Barke et al.’s, (2011) assessment on stigma in relation to mental illness in Southern Ghana discovered that most Mental Health Nurses suffer from embarrassment, disappointment, ruined lives and discrimination which result in social withdrawal from social life, low self-esteem and low self-efficacy. However, anger is not the right response to stigma rather education and group discussion could be better used to resolve stigma.

The second emotional respond was depression. Most of the participants said they could not help but feel sad, bad, unstable, hopeless and depressed because of the way they were treated by other healthcare professionals and the general public which is consistent with the results obtained by Mystakidou, et al., (2007). They found that the hopelessness experienced by caregivers was determined or predicted by characteristics of a patient. Also, they posit that a patient’s depression is connected to that of the caregiver.
Likewise, Zumrut and MSC’s, (2012), study indicated that the caregivers of mentally ill patients might just be as prone to experience loneliness or depression after a diagnosis. Similarly, Ward et al., (2013) who demonstrate that those who worry more about stigma associated with mental illness suffer depression. Another study conducted in Germany by Vauth, et al., (2007) discovered that anticipated stigma could lead to the reduction of an affected person’s quality of life and depression. On the other hand, Sharaf, et al., (2012) have found specifically that internalized stigma is linked to depression.

5.4 Behavioral Responses to Stigma by Association

With regard to the behavioral pattern of stigma; ignoring, distancing and confronting were discussed as sub-themes. Participants described several behavioral patterns when asked. They noted that they responded to stigma by exhibiting unpleasant feelings which included avoiding and ignoring the source of stigma, confronting, group discussion, or education.

Almost all of the participants responded that what helped them to deal with stigma was ignoring and avoiding the bad attitudes people show towards them. They did this in order to prevent themselves from being hurt. This was consistent with the findings from other studies such as Yanos, et al., (2010) and Levav, et al., (2009). They discussed people whose coping mechanism was avoiding and ignoring people who teased and ridiculed others. Although, Yanos, et al., (2010) hold that some people manage stigma by totally ignoring the source of stigma and withdrawing to avoid being stigmatized, yet they do not hold that avoiding and ignoring the source of stigma was as a result of self-stigma. This study came out with ignoring, distancing and confronting were used to avoid bad attitudes other health professionals show them.
The other sub-theme under the main theme of behavioral pattern was confrontation. Some of the participants objectively handled matters when they were ridiculed or teased. Similarly, according to Sercu, et al., (2015) confronting stigma was a predominantly significant and peculiar course of action nurses took to enable them work in mental health care institutions.

Some of the participants noted that when they discussed issues among themselves such as the unpleasant experiences they go through they advised each other it helped them cope with stigma. They were strengthened by sharing experiences with each other. This affirmed the findings of Rusch, et al., (2009), that reported that people are able to withstand and deal with stigmatization as a result of group interactions. Also, Boardman, et al., (2011), found that people coped with stigma through social support groups such as friends, family members and colleagues.

Furthermore, most of the participants in this present study cited that they believed that people discriminated against them as Mental Health Nurses because they did not understand what Mental Health Nurses do. Hence, they used health education strategy as a coping mechanism and addressed unhealthy comments. This was consistent with the findings of Corrigan, et al., (2012), which indicated that education of the public about mental illness and contacts with people who have mental illness were effective.

5.5 Conclusion

The content of this chapter showed that RMNs are indeed stigmatized because of their close association with mental ill patients, particularly in visiting their various homes. The effects of this are low productivity, depression and anger. The coping mechanisms used by PNs are avoiding and ignoring the source of stigma, confrontation, group discussion with other health professionals and continuous education.
CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.0 Introduction

This chapter presents the summary of the research and the conclusions drawn from the findings of the study. The implications of the findings for the nursing practice, education and research have been outlined. Limitation and recommendations have also been included.

6.1 Summary of the study

The stigmatization of Mental Health Nurses as a result of their provision of services to mentally ill patients has been a major cause of concern because very little is known from published literature on the attitude of other healthcare professionals and the society towards psychiatric nurses in Ghana. An even more unstable situation prevails when it comes to published data about the stigma of Mental Health Nurses in Ghana (Barke, et al., 2011). The consequence of stigma is devastating for Mental Health Nurses. A lot of Mental Health Nurses have left to pursue other healthcare professions such as anaesthesia, medical assistance, critical care, and education (to teach in nursing training colleges) because of stigmatization. Low self-worth, social withdrawal and emotional instability are also present. There are diminished enthusiasms which result in low work output. It affects career progression in the field as Mental Health Nurses tend to divert into other fields. Globally, mental health problems affect approximately 450 million people (WHO, 2003). Hence, the stigmatization of CPNs is a public issue engaged in by both men and women from all social classes and of all ages because of association with mental patients (Arthur, Michael, Eileen, & Howard, 2005).
An exploratory descriptive qualitative design was used in the study to explore the experiences of Mental Health Nurses as far as stigma was concerned in three municipals hospitals one districts hospital, a Teaching hospital and a Nurses and Midwifery Training School, in the Ashanti Region. The Identity Threat Model of Stigma was employed to guide the research. Fifteen (15) Mental Health Nurses of both sexes between the ages of 25-40 years participated. The participants were made up of 7 females and 8 male Mental Health Nurses. The objectives of the study were to explore the experiences associated with stigma by association among Mental Health Nurses, explore their emotional response to stigma and to describe the behavioral pattern of stigma by association. Purposive sampling method was used to select participants with more than one (1) year working experience in the hospital/Community Psychiatric Unit. A one-on-one interview guide was used for data collection to ensure privacy and to also prevent influence of others in order to elicit in-depth responses from participants. The interviews were conducted in the offices of the Community Psychiatric Units of the selected health facilities. The interviews were tape-recorded and later, manually transcribed. It was conducted in English and thematic content analysis was used to analyze the data.

After the transcribed data from the participants were analyzed, three (3) major themes (forms of stigma, emotional response to stigma and behavioral pattern to stigma) and nine (9) sub-themes (labeling /associative, Mocking, discrimination, and stereotype, anger/fury and depression; and ignoring and distancing the source of stigma, and confrontation) emerged. The major themes and their sub-themes were grouped as follows; forms of stigma (labeling/associative, mockery, discrimination and stereotype); emotional response to stigma (anger/fury and depression); and behavioral pattern of stigma (confronting, ignoring and distancing from the source of stigma). Most of the participants acknowledged the fact that the public and other healthcare professionals’ attitude towards
them changed when they discovered that they were PNs. They coped mostly by ignoring, distancing and/or confronting the source of stigma.

**Implication for Nursing Practice Policy, Education and Research**

**Nursing Practice:** The participants believed that they were looked down upon, demeaned, discriminated, mocked, and sidelined because the public and other healthcare professionals were ignorant. Therefore, there is the need to intensify public education especially among nurses in other specialty areas. Mental Health Nurses should collaborate with the media to intensify health talks so that the general public could be educated.

It was detected during the study that PNs were left out of professional development workshops and therefore, an avenue should be found for them to upgrade their knowledge or they should be included in the various workshops conducted in their districts in order to enable them have the technical-how to handle current health conditions and issues.

**Policy:** The Mental Health Authority should implement the policy on stigma that would help minimize if not totally eliminate the stigmatization of Mental Health Nurses in the Ashanti Region and the nation at large. The media should be involved in the education of the general public. Policies should be put in place or enforce to ensure provision of logistics such as transport to the psychiatric nurses to be used for home visiting and home tracing of clients which will help decrease relapses.

Furthermore, in order to reduce the work load of CPNs, key stakeholders as well as NGOs, significant institutions and groups in the society should assist in the care and rehabilitation of the mentally ill in communities.

**Nursing Education:** The Mental Health Authority should urge the Nursing and Midwifery Council to index and register more Mental Health Nurses including CPNs to
help with community care of patients in the various districts to prevent frequent relapse and to assist CPNs in the discharge of their duties as well as enable a lot of public education programs which will help reduce the stigmatization of Mental Health Nurses.

**Nursing Research:** The findings in this study show that PNs are indeed stigmatized because of the fact that they care for mental patients in the hospital and in the community. Even though it has been established through this research that Mental Health Nurses are stigmatized, further research needs to be conducted to find out why other healthcare professionals and the general public stigmatize Mental Health Nurses and to ascertain who is more stigmatized that is whether the male or female Mental Health Nurses using quantitative methods as this may help influence recruitment strategy.

6.2 Limitations

The principal investigator is also a Mental Health Nurses and might conduct the study from his personal standpoint. The fact that the principal investigator has a Mental Health Nursing background could have affected the research process despite the fact that enough measures were taken to minimize it. The participants were selected from only three (3) municipal Community Psychiatric Units, one (1) district hospital community psychiatric unit, the Teaching Hospital and a Nurses’ Midwifery Training School in the Ashanti Region and not from all the hospitals that has community psychiatric units in the country participated.

6.3 Insight Gained/Field Experiences

Even though the researcher encountered some few challenges, the experience gained in the process cannot be quantified in any way. The researcher had to reschedule appointments with some of the Mental Health Nurses for about four times as some of them received emergency calls from their clients on those occasions while others had sudden
calls from certain organizations to give health talks. The researcher has therefore realized
the need to book appointment with participants far ahead of time to avoid any
disappointments.

6.4 Recommendation

The following recommendations have been made based on the findings of the study to
combat associative stigma in Ashanti Region and Ghana as a whole.

6.4.1 To Ministry of Health (MOH)

1. The government should develop and implement community level policy on mental
   health care needs to reduce stigma

2. The Ministry of Health in collaboration with other stakeholders should recognised
   Community Psychiatric Nurses by offering formal training and certification of
   CPNs in country.

3. The Mental Health Authority should organize regular refresher courses for other
   health professionals on anti-stigma activities to help reduce the stigmatization of
   Mental Health Nurse.

4. The government should build more community base treatment centers in the
   country to be managed by qualified Mental Health Nurses

5. The Ministry of Health should put together funds that will intensify CPNs house
   tracing and home visits to prevent relapse of mental patients in the community.

6. The Ministry of Health should ensure regular supply of potent psychotropic drugs
   to the Mental Health Nurses so as to meet the demands of the patients and to
   prevent relapses.
6.4.2. Mental Health Authority

1. The Mental Health Authority should organize regular refresher courses for other health professionals on anti-stigma activities to help reduce the stigmatization of Mental Health Nurses.

2. The Mental Health Authority should enact a policy on stigma that would be punishable by law to help minimize if not totally eliminate the stigmatization.

3. Mental Health Nurses/CPN’s should be adequately motivated to reduce the feelings of frustration.

4. The Mental Health Authority as well as relevant NGOs, supportive institutions and groups in the society should assist in the care and rehabilitation of the mentally ill in communities.

6.4.3 Hospital Management

1. Health education needs to be intensified and to include care givers on the activities of mental health workers to help minimize these stigma and discrimination to the barest degree to ensure the best output to help restored dignity for patients.

2. The hospital management should organize regular refresher courses for other health professionals on anti-stigma activities to help reduce the stigmatization of Mental Health Nurses.

3. Also Mental Health Nurses should be involved in decision making in the various ward/community.

4. Management should pave way for Mental Health Nurses to upgrade their knowledge professionally by including them in the various workshops conducted.
EXPERIENCES OF MENTAL HEALTH NURSES

in the districts in order to enable them update their technical-how to handle current health conditions and issues.

6.4.2 The Media

1) The media should be involved in educating the general public on mental health issues to reduce the stigma of illness.

2) There is the need for the media to sensitize and enlighten the general public on the essence of the work of Mental Health Nurses in the community.

6.5 Conclusion

In conclusion, stigma by association is conceptualized as experience resulting from a relationship with someone who is stigmatized. Mental Health Nurses are considered “contaminated” because of the close relationship they have with the mentally ill persons. The purpose of this study was to explore the experiences of stigma by association among Mental Health Nurses. Stigma and discrimination make mentally ill persons not to seek early treatment and denial their illness.

This study concluded that, participants were indeed stigmatized and feels hurt daily from other health professionals’ comments and attitudes. The effect of by stigma by association on participants included low self-esteem, depression, fury and anger. The coping mechanisms used to overcome this associative stigma was avoiding, ignoring, and confronting the source of stigma.

The Mental Health Nurses need more support from both the Mental Health Authority, Ministry of Health as well as the Ghanaian Media to enable them intensify health education on associative stigma to void been stigmatized.
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REFERENCES


EXPERIENCES OF MENTAL HEALTH NURSES


EXPERIENCES OF MENTAL HEALTH NURSES


EXPERIENCES OF MENTAL HEALTH NURSES


EXPERIENCES OF MENTAL HEALTH NURSES


Holloway, I., & Galvin, K. (2016). Qualitative Research in Nursing and Healthcare. John Wiley&Sons


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EXPERIENCES OF MENTAL HEALTH NURSES


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Van der Sanden, R. L. M., Stutterheim, S. E., Pryor, J. B., Kok, G., & Bos, A. E. R. (2014). Coping with stigma by association and family burden among family members of
EXPERIENCES OF MENTAL HEALTH NURSES

people with mental illness. *Journal of Nervous and Mental Disease*, 202(10), 1–9. DOI: 10.1097/NMD.0000000000000189.


World Health Organization (2012). Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. Executive Board EB130/9, 130th session, Provisional agenda item 6.2.


Yap, M. B, Mackinnon, A., Reavely, N., & Jorm, A. F. (2014). The measurement properties of stigmatizing attitudes towards mental disorders. results from two
EXPERIENCES OF MENTAL HEALTH NURSES

APPENDICES

Appendix A: Demographic Data of Participants

<table>
<thead>
<tr>
<th>No</th>
<th>Initials of participants</th>
<th>Age (Years)</th>
<th>Gender</th>
<th>Marital status</th>
<th>Level of education</th>
<th>Religion</th>
<th>Years of practice as RMN</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
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<tr>
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<td>EAM</td>
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</tr>
<tr>
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### Summary of Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences with forms of stigma</td>
<td>5. Labeling/association</td>
</tr>
<tr>
<td></td>
<td>6. Mockery</td>
</tr>
<tr>
<td></td>
<td>7. Discrimination</td>
</tr>
<tr>
<td></td>
<td>8. Stereotype</td>
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<tr>
<td>Emotional response to being stigmatized</td>
<td>3. Anger/fury</td>
</tr>
<tr>
<td></td>
<td>4. Depression</td>
</tr>
<tr>
<td>Behavioral responses to stigmatization</td>
<td>4. Ignoring</td>
</tr>
<tr>
<td></td>
<td>5. Distancing</td>
</tr>
<tr>
<td></td>
<td>6. Confrontation</td>
</tr>
</tbody>
</table>
EXPERIENCES OF MENTAL HEALTH NURSES
CONSENT FORM

Title: Stigma by Association: Exploring the Experience of Registered Mental Health nurses’ in Ashanti Region of Ghana.

Principal Investigator: Peter Roger Kuntanaah

Address:
Community Health Nurses’ Training School,
Post office Box 1,
Fomena-Adansi.
Tel: 0208167011/0269491920
e-mail rpunktanaah@yahoo.com

General Information about Research

Registered Mental Nurse (RMN) are few and migrate to other discipline because of stigmatisation. This study is being conducted to look into the psychiatric nurse view toward you, explore the psychiatric nurse’s view and to explore the psychiatric nurse perception toward stigma by association, explore the effect of stigma by association, and to describe their coping mechanism in relationship to stigma by association. The purpose of the study is to describe your experiences as far as stigma by association is concern in the Ashanti Region of Ghana. I will ask you questions that will last between 60-90 minutes. You are free to ask any question concerning the research. Privacy and confidentiality will be ensure by holding all information provided confidential. It is entirely voluntary. All data including audiotape recordings, field notes of all interviews and other relevant materials will be kept safely under lock for five years and then discarded when there is no use for it. Only the researcher and supervisor will have access to the raw data. Your names will be not used; instead fake names will be in order to ensure anonymity.

Possible Risks and Discomforts

It is not expected that you will face any risk and discomfort by participating in this study. However, you may experience some emotional pain due to some questions I may ask you. In case you experience emotional pain during the questioning time a clinical psychologist, who is also a psychiatric nurse will be called upon to help you.
Possible Benefits

A potential benefit of you participating is that it will bring out views on stigma by association of your profession. Taking part in the study will directly benefit Registered Mental Nurse. It is hoped that the knowledge gained from talking to you will help policy makers’ make decisions that will enhance your work.

Confidentiality

The interview will take place at a location of your choice and convenient to you such that no one will hear about what you say. 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 only the researcher will be able to know your identity. Everything you say will be kept under lock and keyed in the researchers office for five years so that only the researcher and supervisor will have access to the raw data and latter destroyed when not needed. A copy of the report will be given to policy makers for decisions to be taken. A copy of the report will also be giving to you if you want these reports will however not have your names in any of them.

Compensation

There will be no compensation in cash, but by providing food, soft drink of your choice and biscuit after the interview section.

Additional Cost

There will be no additional cost to you, during or after the research.

Voluntary Participation and Right to Leave the Research

The research is voluntary and you can withdraw without penalty at anytime, even after signing the consent form.
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,
School of Nursing and Midwifery, University of Ghana,
P. O. Box LG 43, Legon.
Tel. 0278066255
E-mail: aatiogbeg@yahoo.com

Dr. Patience Aneteye,
School of Nursing and Midwifery, University of Ghana,
P. O. Box LG 43, Legon.
Tel. 0244681352

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Scientific Research (NMIMR-IRB). If you have any question 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
VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title \textit{(stigma By Association: exploring the experience of Registered Mental Nurse on Ashanti Region)} 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

\textbf{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

\textbf{VALID UNTIL}

06 Mar 2019

APPROVED DOCUMENT
The Regional Director
Ghana Health Service
Kumasi

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Peter Roger Kuntanaah, M.Phil Year II student of the School of Nursing and Midwifery, University of Ghana, Legon. As part of the M.Phil programme, he is conducting a research on “Stigma by Association: Exploring the Experiences of Mental Health Nurses in Ashanti Region of Ghana”. Your outfit has been chosen as his data collection outlet.

I would be grateful if you could kindly offer him the necessary assistance needed to enable him collect data for his thesis.

Thank you.

Yours faithfully,

Rev. Alexander Attigbe
SUPERVISOR

Cc: Municipal District Director
    Medical Superintendent

COLLEGE OF HEALTH SCIENCES

* Tel: +233 (5) 302 512 250 / 0289 531 213 * Email: sonn@chs.ug.edu.gh
* Website: www.nursing.ug.edu.gh
Stigma by Association: Exploring The Experiences of Mental Health Nurse’s in Ashanti Region of Ghana.

Semi-structure interview guide

SECTION A

DEMOGRAPHIC DATA
1. Age…………………………
2. Sex…………………………
3. Marital status……………..
4. Religion……………………
5. Level of education………..
6. Where were you trained as a psychiatric nurse………………
7. Place of work………………

SECTION B
1. How is your day?
2. How long have you been working in this hospital?
3. Could you kindly tell me what it is to be practising as a nurse or your experiences?
4. Is there a psychiatric unit here?
5. How comfortable are you working as a psychiatric nurse?
6. How do you see your professional status in term of the general public image compare to other professional nurses
7. In what way do you feel stigmatised?
8. Do you think you are treated differently from other professional nurses? Why?
9. How do your colleagues medical professional behave towards your profession?
10. Are you confident to tell your colleagues about your professional affiliation?
11. In what way are you stigmatised?
12. In what way have you ever been discriminated?
13. How does this affect your work in anyway?
14. As a psychiatric nurse, how do you handle or cope with the way you are stigmatised?
15. What can be done to reduce the stigma associate with the psychiatric nurse?
16. Do you have anything else to share with me?