International Journal of
Mental Health Nursing

International Journal of Mental Health Nursing (2018) 27, 368–377 doi: 10.1111/inm.12331

ORIGINAL ARTICLE

Individual factors that influence experiences and perceptions of stigma and discrimination towards people with mental illness in Ghana

***Sebastian Gyamfi,*[1] *Kathy Hegadoren*[2] *and Tanya Park*[2]**
[1]*School of Nursing, University of Ghana, Accra, Ghana, and* [2]*Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada*

ABSTRACT: *People with a mental illness often encounter stigma and discrimination from a variety of sources, reinforcing negative self-perceptions and influencing their health and well-being. Even though support systems and attitudes of the general public act as powerful sources of stigma, views and perceptions held by people with mental illness also influence their sensitivity to the experiences they encounter. The aim of the present qualitative study was to examine perceptions of stigma and discrimination and self-stigma in individuals diagnosed with a mental illness. This study adopted a narrative, descriptive method, using a semistructured interview guide to elicit participant perceptions regarding sources of stigma, discrimination, and personal factors that might influence their experiences. Twelve outpatients attending a clinic in Ghana were interviewed. Thematic content analysis was completed and augmented by field notes. Participants' perceptions about personal impacts of stigma were found to be influenced by self-stigma, anticipated stigma and discrimination, perceived discrimination, and their knowledge about their illness. For many participants, their views served to augment societal views, and thus reinforce negative self-perceptions and their future. However, for other participants, their views served as a buffer in the face of environmental situations that reflect stigma and discrimination. Stigma is a complex, socially-sanctioned phenomenon that can seriously affect the health of people with mental illness. As such, it requires coordinated strategies among public policy makers, governmental bodies, and health-care providers to address stigma on a societal level, and to address its potential impacts on broad health outcomes for individuals with mental illness.*

KEY WORDS: *discrimination, mental illness, stereotype, stigma.*

INTRODUCTION

The World Mental Health Surveys carried out in the Americas, Europe, Middle East, Africa, and Asia reported that up to 40% of individuals in developed countries and 80% in less developed countries receive no treatment, even for serious mental illnesses that are associated with substantial functional disability (Demyttenaere *et al.* 2004). In addition to scarcity of resources, stigma and discrimination contribute to these findings. Multiple government and non-governmental documents highlight that most people with a mental illness report experiencing stigma and discrimination (Mental Health Commission of Canada 2016; World Health Organization 2012). According to Goffman (1963), stigma is an attribute that deeply discredits and reduces the individual from a whole to a tainted person with low social rank. Stigma is often associated with mental illness, defines individuals in terms of distinctive features, and devalues them for such features

---

Correspondence: Tanya Park, Faculty of Nursing, Edmonton Clinic Health Academy, 11405-87 Avenue, Edmonton, AB, T6G 1C9, Canada. Email: tanya.park@ualberta.ca
Sebastian Gyamfi, RMN, Mphil.
Kathy Hegadoren, RN, PhD.
Tanya Park, RN, PhD.
Accepted February 13 2017.

(Dinos *et al.* 2004), thus creating barriers to accessing treatment and clinical improvements (Hinshaw 2007). The impacts of stigma are pervasive, including mood instability, increased hospitalizations, poorer physical and mental health outcomes, and lower psychosocial functioning (Ritsher & Phelan 2004; Shrivastava *et al.* 2011; Thomé *et al.* 2012; Oleniuk *et al.* 2011). These impacts are observed globally, but are more pronounced in developing countries with more traditional societal views on mental illness and low budgetary allocations to mental health services (Saxena *et al.* 2007; World Health Organization 2007, 2011; Dako-Gyeke & Asumang 2013).

Historically, research on stigma focussed on stigma and discrimination experienced by those with mental illness from family and others in the community and by health systems (Brohan *et al.* 2011; Crocker 1999; Rüsch *et al.* 2009b). Data from multiple African studies from Nigeria, Malawi, Zambia, and South Africa reflect similar sources of stigma and discrimination experienced by people with mental illness (Crabb *et al.* 2012; Gureje *et al.* 2005; Kapungwe *et al.* 2010; Sorsdahl & Stein 2010). Similar findings were also found in the one Ghanaian study in the literature (Barke *et al.* 2011). More recently, some of the focus has shifted to examining the influence of the individuals themselves, and how their own knowledge and perceptions can augment or buffer the negative impacts of stigma and discrimination. This has led to a growing body of literature regarding self-stigma or internalized stigma. The terms 'self-stigma' and 'internalized stigma' are used interchangeably. Self-stigma is defined as a personal response to perceived mental illness stigma (Corrigan & Watson 2002) and a transformative process, wherein the individual adopts a devalued view of themselves that reflects the dominant social perceptions towards people with mental illness (Yanos *et al.* 2015). Two African studies from Ethiopia and South Africa (Assefa *et al.* 2012; Sorsdahl *et al.* 2012) related to self-stigma have been published, but no data specific to Ghana were found. The aim of the present qualitative study was to examine perceptions of stigma, discrimination, and self-stigma in individuals who access outpatient psychiatric services in Ghana.

Background

Anticipated stigma and acts of discrimination experienced by people with mental illness have been widely reported (Quinn *et al.* 2015). Many studies reported discrimination in relation to the workplace, initiating an intimate relationship (Daumerie *et al.* 2012; Parle 2012; Struch *et al.* 2008) or to education (Thornicroft *et al.* 2009; Üçok *et al.* 2013), as well as avoidance from family members and members of the community (Kapungwe *et al.* 2010; Yuksel *et al.* 2013). Younger and more educated participants across multiple studies concealed their diagnoses in an effort to decrease the expected experiences of stigma and discrimination (Sanseeha *et al.* 2009; Üçok *et al.* 2013). The individual's beliefs about the root cause of their illness were also found to influence their perceptions surrounding stigma. Those that attributed their illness to supernatural powers, bad karma, or cultural circumstances felt discriminated by society (Sanseeha *et al.* 2009; Ward *et al.* 2013). An Indian study found a common belief that ignorance of the characteristics of the illness was the main cause for stigma and discrimination (Shrivastava *et al.* 2011). Interestingly, illicit drug-related causes did not play a significant role in perceptions of root causes of mental illness in the present study; however, a Malawi study found that 96% of participants attributed mental illness primarily to alcohol/illicit drug use (Crabb *et al.* 2012). Cultural and religious beliefs and values surrounding the use of alcohol could contribute to these differences.

Self-stigmatization exerts a powerful negative influence on an individual's health outcomes and well-being. Low levels of self-esteem and self-efficacy, levels of recovery orientation, as well as more severe psychiatric symptoms and increased risk of suicide are all linked to self-stigmatization (Assefa *et al.* 2012; Barke *et al.* 2011; Branka *et al.* 2010; Drapalski *et al.* 2012; Livingston & Boyd 2010). In some studies, those with bipolar disorder (Brohan *et al.* 2011), compared to those with unipolar depression and schizophrenia, had higher levels of self-stigmatization (Ben-Zeev *et al.* 2012; Ehirlic-Ben *et al.* 2013), while others found that people with schizophrenia were the most stigmatized (Sorsdahl & Stein 2010). However, it has been more challenging to extricate the relationship between an individual's perception of anticipated stigma, their experiences with stigma and discrimination, and the development of self-stigma. Quinn *et al.* (2015) found correlations between increased discrimination and increased anticipated social stigma and greater self-stigma. However, the underlying mechanisms and all potential contributors to the observed relationships remain elusive.

Various theoretical and conceptual models explain how internalized stigma develops. Common themes include stressor appraisal and adaptation, self-identification with those with a mental illness as a group, and the dominant ethnic and cultural perceptions surrounding mental illness. Major and O'Brien (2005) posited an 'identity threat model of stigma' to explain the internalizing of stigma. According to this model, stigma directly affects the stigmatized person via experiences of discrimination, expectancy confirmation (anticipated stigmatizing events occur), automatic stereotype activation (reinforcement of cultural stereotypes related to mental illness), and indirectly via threats to personal and social identity. The model also includes situational cues, collective representations of a person's stigma status, personal beliefs, and motives as key factors that combine to affect the cognitive appraisal of stigma-relevant situations. Subsequently, these outcomes largely depend on the interactive effect of individual and public perceptions. The stigmatized person might come to share and accept the public point of view about their position in society, including acknowledgement of being devalued and discriminated against. These influence the perception and subsequent appraisal of circumstances that the stigmatized person might encounter, even in the absence of activities that reflect discrimination (Crocker 1999; Major & O'Brien 2005). In similar work, Rüsch *et al.* (2009a) found that specific responses to cognitive appraisal regarding stigma (emotional stress reactions and dysfunctional coping) had a greater role in stigma stress appraisal among people with mental illness compared to other illnesses.

Multiple sociodemographic factors have been associated with the risk for self-stigma. Age plays a significant role (Branka *et al.* 2010), with most adolescents demonstrating uncertainty and confusion about the nature of their problems; however, only a minority of them reported self-stigmatization (Tally 2009). Other factors associated with self-stigma include marital status, employment status, perceived quality of life, social anxiety, and depression (Assefa *et al.* 2012; Gerlinger *et al.* 2013). Significant sex and age differences were found to exist within an African American population in terms of attitudes and preferred coping strategies related to mental illness (Ward *et al.* 2013). Low levels of anticipated discrimination and perceived illegitimacy of discrimination were associated with higher self-esteem and a greater sense of empowerment (Brohan *et al.* 2011; Rüsch *et al.* 2006). Individuals who held their group in high regard or rejected stigma as unfair were more resilient to stigma. It is important to note that national laws, health policies, and health spending decisions in essence reflect societal values, and thus can perpetuate stigma and discrimination. The political will to improve mental health policies and services varies across African countries. According to Maye *et al.* (2010), mental health policies in Ghana, South Africa, Uganda, and Zambia are weak. However, improvements in policy development alone might not be sufficient to address stigma and discrimination. Despite the passage of ACT 846: Mental Health Act, 2012 in Ghana, with its stated goals of access to basic mental health care in the community, early identification, and prompt community-based treatment of patients, the implementation of these broad changes has been slow (Read & Doku 2012).

In Ghana, most people with a mental illness remain isolated and discriminated against by their families, close friends, co-workers, neighbours, and partners (Commonwealth Human Rights Initiative Africa 2008; Read & Doku 2012). Despite 2012 legislation aimed to bring mental health care to communities, large psychiatric hospitals provide the majority of services (Ofori-Atta *et al.* 2010). However, for economic reasons, most patients are treated as outpatients, including those with severe symptoms who would likely be hospitalized in other countries. Available pharmacotherapies include multiple classes of antidepressants, benzodiazepines, and both traditional and atypical antipsychotics; however, the choices are limited by patient affordability and regional availability. Adjunctive therapies include psychosocial therapy (client and family education), individual therapy, recreational therapy, therapeutic community, clinical counselling, and rehabilitation activities. To support longstanding beliefs and values, faith and traditional healers are legally able to offer care to people diagnosed with mental illness.

The lack of inpatient resources for those with severe symptoms or acute exacerbations of their long-term mental illness might serve to reinforce social stigma and increase discriminatory behaviours. In traditional Ghanaian society, mental illnesses are viewed within the context of spiritualism and 'juju' (somebody using spiritual powers to make another have a mental illness). These beliefs likely increase the risk for acts of discrimination and the development of self-stigma. Although some disavow these beliefs, many still hold onto these traditional views.

Although data are available about the environmental and social contextual sources of stigma and discrimination in Ghana, there remains a paucity of information about the contribution of individual factors to the perceptions and experiences of stigma and discrimination, and about the degree of self-stigma in those with a mental illness. The objectives of the present study were to fill that gap in our understanding by interviewing individuals with a mental illness, documenting their perceptions of stigma and their experiences of discrimination, and examining their narratives for evidence of self-stigma.

STUDY DESIGN AND METHODS

A descriptive, narrative method using a semistructured interview guide elicited perceptions about stigma and discrimination experienced by the participants, their views on the potential sources of such attitudes and behaviours from others, and evidence of self-stigma. The choice of the method was based on our desire to make the world of persons with a mental illness in Ghana visible through the interpretation of their narratives and the discovery of the meaning they attach to their spoken words (Lobiondo-Wood & Haber 2013).

Inclusion criteria for this convenience sample included: (i) age 18–65 years; (ii) attending an outpatient clinic for the treatment of a mental illness; (iii) able to speak English, Twi, or Ga (the languages spoken by the principal investigator); and (iv) the ability to articulate perceptions and experiences in response to open-ended questions. Exclusion criteria included first-time clinic attendees and relapsed patients coming back for acute treatment. The staff of the outpatient clinic sought permission from patients to forward their names to the research team. The research team contacted interested individuals, provided further information about the study, and if in agreement, obtained written consent. The University of Ghana Ethics Committee (Accra, Ghana) granted ethics approval.

A single investigator (SG) interviewed all participants, with data collection continuing until no new themes emerged during the interviews. Individual interviews ensured privacy, prevented influence from others, and generated a rich text of personal responses from each participant. All participants could speak English, and chose a private room at the clinic for interview. Topics covered included demographics (age, marital status, and diagnosis) employment history, living arrangements, perceptions about how one was treated within the home and within the community, how the perceived treatment affected them and their health, strategies used to deal with how one was treated, and suggestions to others about how to address stigma and discrimination. The interviews were audiotaped and transcribed verbatim, using pseudonyms to ensure confidentiality. Field notes regarding non-verbal observations were completed after each interview. Follow-up interviews with three participants, as a member-checking strategy (Sandelowski 1998), were possible and enabled the interviewer to affirm interpretation of the issues raised by the participants.

Thematic content analysis as conceptualized within grounded theory (Milliken & Schreiber 2012) was completed with the transcripts and field notes. The research team members each read all of the transcripts. The analytic process was iterative and involved manual coding of all key words, statements, or ideas from the transcripts, followed by grouping into common themes, categories, and subcategories. Emerging themes were summarized into narrative text, with key statements from the participants used to illustrate and support the main themes.

RESULTS

Demographic characteristics of the participants

Of the 25 individuals approached for interviews, 12 consented. The participants included nine males and three females, with a range of mental illnesses and durations of illness (Table 1). More women declined to participate when approached compared to men (9 women and 4 men). The majority of participants were single (8/12), unemployed (8/12), lived with family members or friends (10/12), and endorsed a Christian faith (10/12). The duration of treatment for their particular illness ranged from 8 months to 18 years (mean treatment duration = 4.7 years). Their ages ranged between 18 and 50 years (mean age = 29.8 years). All of the participants had some form of education, with two participants being university graduates. The participants represented four ethnic groups, with the majority being Akan, which is the largest ethnic group in Ghana. It is important to note that, in Ghana, a seizure disorder is considered a mental illness and treated within the psychiatric service system. In North America, these disorders are treated within neurology, which might partially explain why the three participants with seizure disorders in this study had very similar perceptions of stigma and experiences of discrimination to those of participants with diagnoses of schizophrenia or bipolar disorder.

Six major thematic foci arose from the transcripts: (i) perceptions about stigma and experiences of discrimination; (ii) establishing causality for one's problems; (iii) responses to discrimination; (iv) self-stigma; (v) role of self-esteem and faith; and (vi) potential strategies to address social stigma. Of note, the participants did not discriminate between stigma and discrimination, so we have reported them under one overarching theme.

TABLE 1: *Demographic data of participants*

Name	Age (years)	Diagnosis	Treatment duration (years)	Education	Living with	Marital status	Occupation	Religion
Joe	33	Schizophrenia	4	Graduate	Wife	Married	Teacher	Muslim
Nana	48	Alcoholism	2	MSLC	Family	Married	Unemployed	Christian
Adwoa	19	Epilepsy	3	SSSCE	Family	Single	Unemployed	Muslim
Sampson	20	Epilepsy	2	NVTI	Family	Single	Unemployed	Christian
Addae	31	Schizophrenia	6	JSS	Brother	Single	Corn miller	Christian
Owusu	45	Schizophrenia	>15	MSLC	Mother	Single	Unemployed	Christian
Dan	23	Bipolar disorder	6	Graduate	Aunt	Single	Service personnel	Christian
Evelyn	20	Bipolar disorder	2	SSSCE	Mother	Single	Student	Christian
Alex	38	Schizophrenia	4	HND	Alone	Separated	Unemployed	Christian
Ama	25	Epilepsy	8	JSS	Family	Divorced	Unemployed	Christian
Korankye	32	Schizophrenia	5	JSS	Friend	Single	Unemployed	Christian
Kumi	23	Schizophrenia	3	SSSCE	Family	Single	Unemployed	Christian

HND, Higher National Diploma; JSS, junior secondary school; MSLC, Middle School Leaving Certificate; NVTI, National Vocational Technical Institute; SSSCE, Senior Secondary School Certificate of Education.

Perceptions about stigma and experiences of discrimination

All of the participants gave examples of being stigmatized and experiencing acts of discrimination. Two participants spoke about the loss of an intimate relationship and felt that their illness underpinned the loss:

> I'm sure it's because of this problem that my wife left me…when I came home, my wife's reaction towards me suddenly changed…she left me after I had been discharged from the hospital. (Alex)

> I think it's because of my illness that's why he (my boyfriend) is no more interested in me. I feel rejected and discriminated against. (Evelyn)

Common experiences included the loss of previous close social relationships, opinions discounted or decisions made for them, and loss of occupational status. Korankye commented that it was 'as if you don't exist…like they are isolating me as not being human beings anymore'. Dan commented about the importance of occupational status:

> When you have something to defend yourself, like you have a job, you have income, you know family and friends, you will be able to defend yourself.

Alex spoke of his experience of workplace discrimination:

> When I was discharged, I was changed. I was taken to a different (work) site, which doesn't fit my qualifications. He (my boss) indirectly made some statements, making me know I'm no more competent for my work because of my condition. They cut down my salary.

Establishing causality for one's problems

Initially, the majority of participants considered or were told that the problem was a spiritual one, although many comments reflected both Christian and traditional thinking around spirituality. Many sought help from their Christian church members or pastor. Those who strongly held the more traditional view of being cursed or being invaded by evil spirits paid community healers to rid them of the curse or evil spirit. Eventually all sought hospital care, either on the advice of their mother or the church. A few attributed their illness to specific events, such as a breakup of an intimate relationship or God's punishment for previous poor behaviour:

> I was sick. I got up and I was in a hospital. I didn't know what was going on…my mother said there was something (like foam) on my mouth, but I didn't (understand) why all this was going on….I've done something (bad) and the person went to juju man and did something. I was also thinking the same way my mother and father were thinking. Because the time I was born I wasn't like this, but…I've not done anything to anyone. (Sampson)

> When it (the illness) started, people were saying it's not real, so I'd been going to church, from one church to another….The doctor said that I'm sick, but he didn't tell me the particular sickness, but he said he can help….At that time, I didn't know it was a

> sickness. I thought maybe someone was doing me. I sometimes feel bad. (Ama)

> People around me (were) telling me that it seems all was not well with me. I also saw that I wasn't behaving normally…they told me that it can be spiritual, so they took me to a church for people to pray for me, and because of that we were only resorting to church. (Korankye)

Personal responses to discrimination

The predominant subthemes included the importance of secrecy, anticipation of stigma and discrimination by self or those they lived with, social withdrawal, and self-isolation. All spoke about the value of hiding one's illness as a way to avoid discrimination, and some added that this strategy also helped to avoid others using the spirits against them. The desire for secrecy led many to undertake multiple moves from various communities to avoid those who knew about their illness and to quit work, not because they could not do the work, but rather, they described feeling unable to manage their co-workers' discriminating behaviours. Many spoke of increasing their time spent praying and reading the bible:

> Sometimes I feel uneasy, especially when I'm out; I'll be looking around hoping not to see anyone I know…maybe the person might tell other people about my condition and the people will also get to know. That's what I fear most. (Alex)

> So I go to my room, I switch on my television….Sometimes too if I'm really angry, I will exchange words with other people…so that they know I am also a human being…and I pray too and tell God to help me….My mother said because of my condition she will not like me to go out and do anything for people to treat me bad. (Kumi)

Korankye expressed anticipatory discrimination and his typical response:

> Already most of the time when I see (old friends), I try to dodge. I want to be alone so that no one will point fingers at me anymore or say anything that will hurt me again…when it gets too much, I just stay in my room watch television and listen to gospel music.

Emotionally, participants spoke of a loss of trust in others, feeling rejected, neglected, powerless, and anxious about their future:

> I fear for the future. I think when this sickness comes back, people will know more that I'm sick and the stigmatization will increase. I feel disturbed. (Evelyn)

However, some participants maintained personal relationships with others, which helped them remain positive about their lives. Others felt they had specific strategies to ward against the impact of acts of discrimination:

> I've come to the conclusion that you are what you think you are; nobody can think who you are for you…what people say about you doesn't have to be what you say about yourself. (Dan)

Evidence of self-stigma

No participant used the terms 'self-stigma' or 'internalizing stigma' in their narrative; however, some comments and behaviours were obviously reflective of stigma internalization, while other descriptions were subtler. For example, acceptance of social rejection and rejection of group membership might underlie the abundant use of self-isolation and hiding one's diagnosis as responses to stigma and discrimination, but could also represent internalization of stigma:

> I also thought it good that I shouldn't go (out in) public…I can see that they don't want me to be with them again, so I thought it wise that I will not go there. (Korankye)

Nana felt: 'I have become somebody different', and Ama stated: 'I don't think I can marry again because of the way the thing is going on'. Evelyn reflected:

> I thought I knew who I was till I was diagnosed with bipolar, but now I'm struggling with identifying with my personality, with being somebody who has this illness, because I tend to see people with this illness and it deteriorates their well-being, their life, and everything.

Ama recounted that:

> She (her friend) said 'Ooh…one of our friends said when we go out with you, you'll go and fall and things', so that's why we didn't call you, and I said 'Oooh okay, it's a good idea too'. I feel sad, it pains me, because this is the time I need them, and they said no! They don't need me, so I have to leave them.

A few participants rejected passive acceptance of discriminatory behaviours and described how friends or church leaders helped them attenuate the distress over such behaviours by others. Owusu spoke of attending bible studies as a way of dealing with his illness and others' reactions:

> I usually chat with my friends with whom I attend the discussion. They give me encouragement.

Role of self-esteem and faith

Many participants expressed guarded optimism that medical treatment and/or their faith in God would make their symptoms disappear and they would recover. Quotes from several participants provide examples of self-esteem boosting:

> For what I know is that, for illness, everybody can get sick, and it is not me alone that I have fallen sick. (Joe)

> The cause was a reaction to a drug, not a mental illness. (Adwoa)

> This is not my permanent state. This is what I believe. (Addae)

Dan defined self-esteem, but at the same time expressed a common subtheme of uncertainty:

> (Self-esteem) comes with a sense of being valued by family, friends, or a group of people…also comes with knowing who you are deeply. I thought I knew who I was till I was diagnosed with bipolar, but now I'm struggling with identifying with my personality. I struggle to see the positive aspects.

Evelyn also expressed guarded optimism:

> I think my self-confidence has been shut down ever since I was diagnosed with this illness, so it will take some time for it to build back. My self-esteem comes with physical value; a sense of being valued by family, friends, or a group of people also come with knowing who you are deeply.

Potential strategies to address stigma and discrimination

Most participants expressed views that the government should fund various types of support, including financial support to start one's own business, increase funding for drug therapies, support to display the gifts/talents of those affected by mental illness, and group homes for those abandoned by their families. Other commonly-held views included increasing multimedia public messaging/educational programming on how to interact those with mental illness, on seeking medical treatment at onset of symptoms, and on focussing on strengths rather than limitations. Several participants expressed views that those who displayed stigma or discriminated against those with mental illness should go to court, be sued, or jailed:

> People should be educated to accept us…something on the radio or television…so that we'll also be considered as part of society and not isolated from society. (Korankye)

> When it starts, she or he must go to the hospital first to hear what the doctor will say, but when the doctor said there is nothing wrong with him or her, then she can start going to church and things….not listen about what the people will say. (Ama)

DISCUSSION

The aim of the present study was to examine perceptions of stigma, discrimination, and self- stigma with outpatients from a psychiatric clinic in Ghana. The participants in this study identified common experiences of stigma and discrimination, including anticipated stigma, perceived discrimination, and various understandings about their illness. The experiences they described were mostly negative in their interactions with others. They described how they came to share and accept the public point of view about their position in society. They felt sad as a result, and looked down on themselves. These findings are consistent with the identity threat model of stigma (Major & O'Brien 2005), and with Üçok *et al.*'s (2013) findings, where the majority of their participants did not apply for work, training, or education, and concealed their diagnosis because of anticipated discrimination. Our findings are similar to those of other African studies. People with mental illness experience common feelings of guilt, concealment, isolation, and segregation; are perceived as incompetent; relate their symptoms to supernatural or spiritual sources; describe families as significant sources of stigma and discrimination; and encounter co-workers who refuse to work with them (Crabb *et al.* 2012; Gureje *et al.* 2005; Kapungwe *et al.* 2010; Sorsdahl & Stein 2010). These qualitative data also provide added depth and support for Barke *et al.*'s (2011) quantitative study in Ghana, where the majority of respondents endorsed socially-restrictive roles; however, some held more benevolent attitudes, despite describing unfair treatment from partners, family members, friends, employers, and the public. This might reflect self-stigma. Perhaps only direct open discriminatory behaviours are considered discrimination, whereas subtler expressions of unfairness are expected based on societal standards, and thus to some degree are acceptable. Our finding that secrecy about having a mental illness was the dominant coping strategy also mirrored Barke *et al.*'s (2011) work.

There was evidence that many of the participants had internalized stigma or expressed some personal acceptance of societal views about people with mental illness. Their narratives support the results of Assefa *et al.* (2012), who found that social withdrawal, perceived discrimination, alienation, and stereotype endorsement explained 70% of the variance in scores on the Internalized Stigma of Mental Illness scale. Although Sorsdahl *et al.* (2012) did not find similar high levels of self-stigma in their study in South Africa, the discrepancy could be due to their focus on a population with depression and anxiety disorders.

Previous studies report that families who have a family member with a mental illness also experience stigma and discrimination within their community (Gureje *et al.* 2005; Kadri *et al.* 2004); however, none of the participants in this study spoke of this. This could be due to interviewing only the family member with the mental illness, rather than multiple family members. Participants also did not perceive that others thought them as dangerous, which differs from the findings of other African studies (Gureje *et al.* 2005; Kapungwe *et al.* 2010). In addition, the degree of perceived stigma and discrimination appeared independent of diagnosis, which differs from the results of Sorsdahl & Stein 2010, who found that those with a diagnosis of schizophrenia were the most stigmatized. Previous African studies did not address government responsibilities or legal strategies to address stigma and discriminatory behaviours, as the aims of these studies focussed on public views towards mental illness and individual experiences of perceived stigma and discrimination.

Lastly, these data support other African studies that health professionals are not immune to public beliefs about mental illness, and as such, might perpetuate stigma and discriminatory behaviours overtly and covertly in their interactions with individuals and their families (Kapungwe *et al.* 2010). Health-care providers' beliefs and care can affirm the patient's self-stigma, and thus affect clinical outcomes (Fournier 2011; Gureje & Alem 2000).

Limitations

The findings of the present study must be viewed in the context of Ghana, and thus might not be generalizable to other countries. However, from our review of the literature related to this project, it seems that stigma and acts of discrimination towards people with mental illness are global phenomena. What might differ are specific types of discriminatory behaviours and legislated policies and laws that prevent overt discrimination in the workplace or other aspects of individuals' lives.

CONCLUSION

The stigmatization of individuals living with a mental illness continues to be an issue worldwide. The participants in the present study each shared their experiences of stigma and discrimination that were widespread and persistent in all facets of their life. Their narratives also reflected significant self-stigma, which carries with it multiple negative impacts on clinical outcomes and on quality of life. However, eliminating the experience of stigma and discrimination requires a multifaceted approach by health-care providers, policy makers, government, and the person with the mental illness and their family.

Relevance for clinical practice

Attribution is a key element to perception. Further research could address whether self-stigma and comments and behaviours by others feed on each other to increase a sense of powerlessness and hopelessness, leading to increased self-stigma. Would addressing self-stigma with patients provide nurses with opportunities to decrease self-reinforcing stigmatizing thoughts? Several participants rejected the predominant societal beliefs and expressed a more positive outlook, felt more in control, and understood the value of social relationships. A more in-depth study specific to how those with mental illness in Ghana who have been able to define themselves beyond their illness could shed light on developing targeted interventions to reduce self-stigma. A recent review highlighted common elements to intervention approaches that have been developed to address self-stigma (psychoeducation to counter myths; cognitive components to provide opportunities to identify and combat self-stigmatizing thoughts and beliefs; an emphasis on narration to make sense of, and meaning to, experiences and strategies to increase hope, empowerment, and motivation) (Yanos *et al.* 2015). These elements could be useful in developing novel nursing interventions specific to the context of Ghanaian families and communities.

It is important to emphasize that interventions aimed at the individual would in no way absolve all levels of government and public service agencies from ongoing effort to stem societal stigma and discrimination against people with mental illness. As patient advocates, nurses also need to evaluate their educational programmes in terms of addressing stigma and avoiding perpetuation of societal beliefs regarding people with mental illness. Positive media portrayal of people diagnosed with mental illness would also go a long way in reducing their negative expectations of themselves, and replace them with personal strength and hope.

REFERENCES

Assefa, D., Shibre, T., Asher, L. & Fekadu, A. (2012). Internalized stigma among patients with schizophrenia in Ethiopia: A cross-sectional facility-based study. *Biomed Central Psychiatry*, *12*, 239.

Barke, A., Nyarko, S. & Klecha, D. (2011). The stigma of mental illness in Southern Ghana: Attitudes of the urban population and patients' views. *Social Psychiatry and Psychiatric Epidemiology*, *46*, 1191–1202.

Ben-Zeev, D., Frounfelker, R., Morris, B. S. & Corrigan, P. W. (2012). Predictors of self-stigma in schizophrenia: New insights using mobile technologies. *Journal of Dual Diagnosis*, *8*, 305–314.

Branka, M. A., Jakovljević, M., Ivanec, D., Margetić, B. & Tošić, G. (2010). Relations of internalized stigma with temperament and character in patients with schizophrenia. *Comprehensive Psychiatry*, *51*, 603–606.

Brohan, E., Gauci, D., Sartorius, N. & Thornicroft, G. (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN–Europe study. *Journal of Affective Disorders*, *129*, 56–63.

Commonwealth Human Rights Initiative Africa (2008). *Human rights violations in prayer camps and access to mental health in Ghana*. [Cited 15 October 2016]. Available from http://lifestyle.myjoyonline.com/pages/health/200905/29497.php

Corrigan, P. W. & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science & Practice*, *9*, 35–53.

Crabb, J., Stewart, R. C., Kokota, D., Masson, N., Chabunya, S. & Krishnadas, R. (2012). Attitudes towards mental illness in Malawi: A cross-sectional survey. *BMC Public Health*, *12*, 541.

Crocker, J. (1999). Social stigma and self-esteem: Situational construction of self worth. *Journal of Experimental Social Psychology*, *35*, 89–107.

Dako-Gyeke, M. & Asumang, S. E. (2013). Stigmatization and discrimination experiences of persons with mental illness: Insights from a qualitative study in Southern Ghana. *Social Work and Society International online Journal*, *11*, 1–14.

Daumerie, N., Vasseur, B. S., Giordana, J. Y., Bourdais, M. C., Caria, A. & Roelandt, J. L. (2012). Discrimination perceived by people with a diagnosis of schizophrenic disorders: International study of Discrimination and stigma Outcomes (INDIGO). *Encephale*, *38*, 224–231.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P. & WHO World Mental Health Survey Consortium (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization: World Mental Health Surveys. *Journal of the American Medical Association*, *291*, 2581–2590.

Dinos, S., Stevens, S., Serfaty, M., Weich, S. & King, M. (2004). Stigma: The feelings and experiences of 46 people with mental illness: Qualitative study. *British Journal of Psychiatry*, *184*, 176–181.

Drapalski, L. A., Lucksted, A., Perrin, B. P. *et al.* (2012). A Model of internalized stigma and its effects on people with mental illness. *Psychiatric Services*, *64*, 264–269.

Ehirlic-Ben, O. S., Ohayon, I., Feingold, D. *et al.* (2013). Meaning in life: Insight and self-stigma among people with severe mental illness. *Comprehensive Psychiatry*, *54*, 195–200.

Fournier, O. A. (2011). The status of mental health care in Ghana, West-Africa and signs of progress in the greater Accra region. *Berkeley Undergraduate Journal*, *24*, 9–34.

Gerlinger, G., Hauser, M., Hert, M. D., Lacluyse, K., Wampers, M. & Correll, C. U. (2013). Personal stigma in schizophrenia spectrum disorders: A systematic review of rates, correlates, impact and interventions. *World Psychiatry*, *12*, 155–164.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Prentice Hall.

Gureje, O. & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization*, *78*, 475–482.

Gureje, O., Lasebikan, O. V., Ephraim-Oluwanuga, O., Olley, O. B. & Lola, K. (2005). Community study of knowledge and attitude to mental illness in Nigeria. *British Journal of Psychiatry*, *186*, 436–441.

Hinshaw, S. P. (2007). *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change*. Oxford: Oxford University Press.

Kadri, N., Manoudi, F., Berrada, S. & Moussaoui, D. (2004). Stigma impact on Moroccan families of patients with schizophrenia. *Canadian Journal of Psychiatry*, *49*, 625–629.

Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R. & Mental Health and Poverty Research Program Consortium (2010). Mental illness stigma and discrimination in Zambia. *African Journal of Psychiatry*, *13*, 192–203.

Livingston, D. J. & Boyd, E. J. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*, 2150–2161.

Lobiondo-Wood, G. & Haber, J. (2013). *Nursing Research in Canada; Methods, Critical Appraisal and Utilization*, 3rd edn. Canada: Elsevier.

Major, B. & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology*, *56*, 393–421.

Maye, O. A., Green, T. A., Bird, K. P., Mirzoev, T., Flisher, J. A., Kigozi, F. & Mental Health and Poverty Research Program Consortium (2010). Mental health policy process: A comparative study of Ghana, South Africa, Uganda, and Zambia. *International Journal of Mental Health Systems*, *4*, 24–34.

Mental Health Commission of Canada (2016). *Advancing the Mental Health Strategy for Canada: A Framework for Action (2017–2022)*. Ottawa, ON: Mental Health Commission of Canada.

Milliken, P. J. & Schreiber, R. (2012). Examining the nexus between grounded theory and symbolic interactionism. *International Journal of Qualitative Methods*, *11*, 684–696.

Ofori-Atta, A., Read, U. M. & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry*, *13*, 99–108.

Oleniuk, A., Duncan, C. R. & Tempier, R. (2011). The impact of stigma of mental illness in a Canadian community: A survey of patient experiences. *Community Mental Health Journal*, *49*, 127–132.

Parle, S. (2012). How does stigma affect people with mental illness? *Nursing Times*, *108*, 12–14.

Quinn, D. M., Williams, M. K. & Weisz, B. M. (2015). From discrimination to internalized mental illness stigma: The mediating roles of anticipatory discrimination and anticipated stigma. *Psychiatric Rehabilitation Journal*, *38*, 103–108.

Ralph, N., Birks, M. & Chapman, Y. (2015). The methodological dynamism of grounded theory. *International Journal of Qualitative Methods*, 1–6.

Read, U. M. & Doku, V. C. K. (2012). Mental health research in Ghana: A literature review. *Ghana Medical Journal*, *46* (2 Suppl), 29–38.

Ritsher, J. B. & Phelan, J. C. (2004). Internalized stigma predicts erosion of morale among psychiatric out patients. *Psychiatric Research*, *129*, 257–265.

Rüsch, N., Lieb, K., Bohus, M. & Corrigan, P. W. (2006). Self stigma, empowerment and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services*, *57*, 399–402.

Rüsch, N., Corrigan, P. W., Wassel, A. *et al.* (2009a). A stress-coping model of mental illness stigma: I. Predictors of cognitive stress appraisal. *Schizophrenia Research*, *110*, 59–64.

Rüsch, N., Corrigan, P. W., Wassel, A. *et al.* (2009b). In-group perception and responses to stigma among persons with mental illness. *Acta Psychiatrica Scandinavia*, *120*, 320–328.

Sandelowski, M. (1998). The call to experts in qualitative research. *Research in Nursing & Health*, *21*, 467–471.

Sanseeha, L., Chontawan, R., Sethabouppha, H., Disayavanish, C. & Turale, S. (2009). Illness perspectives of Thais diagnosed with schizophrenia. *Nursing and Health Science*, *11*, 306–311.

Saxena, S., Thornicroft, G., Knapp, M. & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity and inefficiency. *The Lancet*, *370*, 878–889.

Shrivastava, A., Johnston, M. E., Thakar, M. *et al.* (2011). Origin and impact of stigma and discrimination in schizophrenia–Patients' perception: Mumbai study. *Stigma Research and Action*, *1*, 67–72.

Sorsdahl, K. & Stein, D. J. (2010). Knowledge of and stigma associated with mental disorders in a South African community. *The Journal of Nervous and Mental Disease*, *198*, 742–747.

Sorsdahl, K. R., Ritsuko, K., Wilson, Z. & Stein, D. J. (2012). The internalized stigma experienced by members of a mental health advocacy group in South Africa. *International Journal of Social Psychiatry*, *58*, 55–61.

Struch, N., Levav, I., Shereshevsky, Y. *et al.* (2008). Stigma experienced by persons under psychiatric care. *Israeli Journal of Psychiatry and Relational Science*, *45*, 210–218.

Tally, M. (2009). Self-labeling and its effects among adolescents diagnosed with mental disorders. *Social Science & Medicine*, *68*, 570–578.

Thomé, E. S., Dargél, A. A., Migliavacca, F. M. *et al.* (2012). Stigma experiences in bipolar patients: The impact upon functioning. *Journal of Psychiatric and Mental Health Nursing*, *19*, 665–671.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., Leese, M. & INDIGO Study Group (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *The Lancet*, *373*, 408–415.

Üçok, A., Karaday, G., Emiroğlu, B. & Sartorius, N. (2013). Anticipated discrimination is related to symptom severity, functionality and quality of life in schizophrenia. *Psychiatry Research*, *209*, 333–339.

Ward, E. C., Wiltshire, J. C., Detry, M. A. & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma and preferred coping behaviors. *Nursing Research*, *62*, 185–194.

World Health Organization. (2007). *Ghana: A Very Progressive Mental Health Law, the Country Summary Series*; WHO, Geneva. [Cited 13 January 2013]. Available from: URL: http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.pdf?ua=1

World Health Organization. (2012). *Fourth meeting of the WHO Mental Health Gap Action Program (mhGAP) forum*. [Cited 27 April 2013]. Available from: URL: http://www.who.int/mental_health/mhgap/en/

Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D. & Lysaker, P. (2015). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal*, *38*, 171–178.

Yuksel, C., Bingol, F. & Oflaz, F. (2013). Stigma: The cul-de-sac of the double bind' the perspective of Turkey; A phenomenological study. *Journal of Psychiatric and Mental Health Nursing*, *21*, 667–678.