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MENTAL ILLNESS STIGMA: A CASE OF INGUTSHENI HOSPITAL'S OUTPATIENTS.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter was the introductory part of the research on the stigma of mental illness from the perspective of those experiencing it. Thus, this chapter covered the background to the study which gave a basic explanation of what motivated the researcher to do research focusing on the above-mentioned area. The chapter also covered the statement of the problem, purpose of the study, research questions, significance of the study, assumptions, delimitations of the study, limitations and definition of terms.

1.2 Background of the study

Mental illness has been in existence for some centuries but ironically, the levels of stigma attached to it were still unbelievably high. In most cases as soon as a person was given a diagnosis of any mental condition they earned themselves discriminatory names from the general public (Corrigan, 2004). The stigma of mental illness, although more often related to context than to person's experience, remained a powerful negative attribute in all social relations. The stigmatization of mental illness was a serious problem affecting patients and their relatives as well as institutions and healthcare personnel working with people with mental illness.

According to the WHO (2012), more than 450 million people across the globe suffer from mental illness. WHO (2007), estimated that about 40% of people attending outpatient clinics in Sub-saharian Africa had problems related to emotional or mental health. According to the Refugee Review Tribunal Australia (2009) the number of people suffering from mental illness in Zimbabwe had been increasing due to the tough economic and social environment (one in every four people in Zimbabwe suffers from a mental disorder). Thus, mental illness had been common across the world and so was the stigma attached to it. In the United Kingdom 70% of people affected by mental illness experienced stigma and discrimination, and discrimination was

believed to be worse in developing countries (WHO, 2012). The Refugee Review Tribunal Australia (2009) in the African context, specifically in Zimbabwe stigma was always associated with mental illness, but it was dependent upon the nature of the illness. For example, persons who were born with a mental disability "may not be treated in the most enlightened way" by some communities and these persons were avoided (Refugee Review Tribunal Australia, 2009)

According to the Immigration and Refugee Board of Canada (2000), in Southern Africa, prior to the advent of Western influences, mentally ill people were well tolerated by their societies and cared for by family members. The traditional view of all illness including psychiatric disturbance was that it was caused by external phenomena such as displeased ancestral spirits. As a result, this external locus of control meant that there was little stigma associated with being mentally ill (Immigration and Refugee Board of Canada, 2000). However, according to the Refugee Review Tribunal Australia (2009), at the time this research was conducted levels of stigma attached to mental illness had risen, hence there was the need to look into the causes and consequences of stigma mainly from the perspective of the patients themselves.

Some studies have pointed out to the bad state that most psychiatric institutions in Zimbabwe were in as a direct reflection of the stigmatization of mental illness (Immigration and Refugee Board of Canada, 2000). For example, there was a severe shortage of resources at the country's second largest psychiatric institution, Ngomahuru Hospital in Masvingo according to the Zimbabwe National Association for Mental Health (ZIMNAMH) newsletter (2009). The infrastructure was poor and there was a deficiency of hospital transport and basic clothing for patients, just to mention a few. Negative attitudes people hold regarding mental illness were reflected, for example in the media. An example was that reported in the Newsday (2011) where unscrupulous African leaders who are regarded as selfish were labelled as having the 'Ngomahuru syndrome'. This label depicted the stigmatizing attitude that the media had towards mental illness as people who were famous for bad deeds were given a name that had been coined from the name of a psychiatric institution. This showed that anything to do with mental illness was linked with evil.

According to Thompson and Thompson (1997), the term stigma is formally defined as the assignment of negative perceptions to an individual because of perceived difference from the population at large (in this case it was the assignment of negative perceptions to mentally ill individuals). As evidenced by stigmatized patients' struggle in recovering, it was unfortunate that patients with severe mental disorders had to contend not only with serious disruptive symptoms of their disease but also with the rampant social and self-stigma. Social stigma refers to the general discriminatory perceptions the society holds about the mentally ill (Lee et al 2005). According to Bathje and Pryor (2011), self-stigma occurs when individuals assimilate social stereotypes about themselves as persons with severe mental illness and incapable of doing anything by themselves.

The researcher worked for a solid ten months at Ingutsheni Central Hospital (which is the biggest psychiatric institution in Zimbabwe) during his work-related learning. He was in the department of psychology whose main areas of focus were assessing psychiatric patients, diagnosing them and helping them through psychotherapy to manage their symptoms and help restore them to their level of normal functioning. Thus, during this time the researcher grossly interacted with the mentally ill people. Basically, the researcher noted that some patients' recovery was progressive while they were hospitalized but once they were discharged to go home they quickly relapsed even if they were on medication. Hence the causative factor had to be something in the community or home environment. Despite other factors the researcher felt that stigma was the most deeply felt and a major stumbling block to the treatment course.

Research had shown that stigma has detrimental consequences. These included low self-esteem, depressive symptoms, suicidal ideation and reluctance to access health facilities that could otherwise be of help (Parle, 2012). Stigma was also said to lead to reduced life opportunities like employment, as evidenced by WHO (2012) statistics which have revealed that mental and psychosocial disabilities were associated with rates of unemployment as high as 90%. According to Wright, Gronfein and Owens (2000) the self-concept is damaged and this triggers defensive behaviours aimed at warding off others' rejection: concealing psychiatric treatment history,

educating others about mental illness and withdrawing from social interaction. Thus, negative and stigmatizing public attitudes towards mentally ill persons therefore had direct implications for the prevention, treatment, rehabilitation and quality of life of those affected.

The main cause of stigma was identified as the misconceptions that people hold about mental illness. This was further consolidated by the media, nature of social relationships and rejection of the mentally ill in employment. More had been done in research to explore the attitude of the perpetrators of stigma. There was need to look into the experiences of patients as regards stigma, their perception of it and how they coped in the face of stigma, and that was the rationale behind this study.

1.3 Statement of the problem

Mental illness stigma was identified as a serious issue of concern but in our society it had seemingly been taken for granted. It had detrimental consequences on patients facing it. Stigma grossly affected mentally ill individuals in their recovery and their lives at large.

1.4 Research questions

- ➢ What forms of stigma do mentally ill individuals face**?**
- ➢ In what ways do psychiatric patients handle stigma?
- ➢ What can be done to eradicate stigma?

1.5 Purpose of the study

The study was aimed at bringing out the intensity of stigma attached to mental illness from the perspective of those experiencing it. It explored and assessed the strategies that they employed to deal with it, and finally unravelled what could be done to alleviate stigma.

1.6 Assumptions of the study

- ❖ The general population had little or no insight into mental illness and this gave birth to stigma.
- ❖ Stigma was one of the major contributors to psychiatric patients' relapses and readmissions to hospital.
- ❖ Some patients were using maladaptive coping strategies in dealing with the stigma they face.

1.7 Significance of the study

Findings of the study were aimed at helping in the following ways:

Government: the research results were meant to influence the law makers to put in place certain legislation that would protect the rights of psychiatric patients. Punitive measures could be made stiffer for those who perpetrate stigma against the mentally ill. This could greatly reduce stigma levels.

Community: the research findings would bring more awareness and insight to the community about mental illness and this would help reduce stigma. The community would also learn more on how detrimental its stigmatizing attitudes to the mentally ill were to the psychological and mental health of these people.

Patients: patients got the much-needed opportunity to air their grievances and experiences as regards stigma. They also learnt more effective coping strategies that will help them handle the pressure of stigma in safe ways.

Researcher: the research boosted the researcher's knowledge base on mental illness stigma and on coping strategies that can be used to alleviate the impact of stigma in patients' lives. In case the researcher becomes a clinical psychologist, knowledge acquired from the research will come in handy as it will sharpen his skills of dealing with patients who face stigma.

Education: the research findings were to be used by scholars and students as a source of information. As previously stated, the area of focus of this research had only been narrowly

researched on in our context, thus the research findings would fill in the gaps that previous researchers on the topic had overlooked.

1.8 Delimitations of the study

The study focussed on psychiatric patients' experiences of stigma. The research was carried out at Ingutsheni Central Hospital and participants of the study were the outpatients who visit the institution. Thus, most of the participants were sourced from the Out-Patients Department (OPD) at the hospital.

1.9 Limitations

The researcher ran the risk of acquiring biased or false information from participants. This happened as some participants decided not to tell him the coping strategies that they use because they felt like these strategies were unacceptable. Some participants did not acknowledge the effects of stigma because they feared that this acknowledgement would be viewed as a sign of weakness. Furthermore, some participants were reluctant to take part in the study after they learnt that there were no monetary incentives or rewards they were going to gain from participating.

1.10 Definition of key terms

Mental illness→ any of various conditions characterized by impairment of an individual's cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic or other factors.

Stigma → a mark of disgrace associated with a particular circumstance, quality, or person.

Psychiatry→ the branch of medicine that deals with the diagnosis, treatment, and prevention of mental and emotional disorders.

Psychiatric→ related to or based on psychiatry.

Out-patient→ a patient who receives treatment at a hospital, especially in an emergency room, but is not admitted to stay overnight. Distinguished from in-patient, who is assigned to a room to reside there while being treated.

1.11 Summary

The chapter provided an overview of the scope of the research as it gave a clear background on which the research was based. The problem statement and the research questions were also presented to help give direction to the research. The chapter also covered areas like the significance of the study, its purpose, objectives, assumptions, delimitations, limitations and operational definitions of terms that were used in the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section basically looked at the available literature on the subject matter of the study. Scholarly views on the concept of stigma were outlined, mainly focussing on their conceptualization of the phenomenon and also the various theories that had been postulated to explain stigma as a concept. Similar studies that have been done in the past that can be linked to this research study were also outlined. The main purpose was to bring out the knowledge that had so far been governed on the phenomenon and ultimately, to identify the knowledge gap.

2.2 Stigma of mental illness

The term stigma is derived from the Greek for a mark branded on a slave or criminal (White, 1998). An all-encompassing definition of stigma was given by Kroska and Harkness (2011) who said it is a societal reaction which singles out certain attributes, evaluates them as undesirable and devalues the persons who possess them. Thus, mental illness stigma is the negative attitudes that people develop and behaviours that they enact towards the mentally ill.

The way in which the general public perceives people with mental disorders depends largely on their diagnosis. Crisp (2000) posits that disorders that carry the most stigma are schizophrenia, depression and drug induced disorders. That is, people with schizophrenia are seen as dangerous and unpredictable whilst those with drug-induced disorders are perceived as violent and they are also blamed for their addiction. Thornicroft (2006) states that people with depression are often seen as lazy and hard to talk to.

According to Corrigan and Watson (2002), stigma may be understood in terms of three basic components: stereotypes, prejudice and discrimination. Social psychologists view stereotypes as especially efficient, social knowledge structures that are learned by most members of a social group. Corrigan and Watson (2002) state that stereotypes are considered "social" because they represent collectively agreed upon notions of groups of persons. They are "efficient" because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group. The fact that most people have knowledge of a set of stereotypes does not imply that they agree with them. On the other hand, people who are prejudiced endorse these negative stereotypes and generate negative emotional reactions as a result. In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative (generally negative) component (Allport, 2000). Prejudice also yields emotional responses (for example, anger or fear) to stigmatized groups.

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction. Thus discrimination becomes the actual vilifying behavior and actions that people enact towards those who are mentally ill (Weiner, 1995). Prejudice that yields anger can lead to hostile behavior (for example, physically harming a minority group). In terms of mental illness, angry prejudice may lead to withholding help or replacing health care with services provided by the criminal justice system. Fear leads to avoidance; for example, employers do not want persons with mental illness nearby so they do not hire them. Alternatively, prejudice turned inward leads to self-discrimination. Research suggests self-stigma and fear of rejection by others lead many persons to not pursuing life opportunities for themselves (Corrigan & Watson, 2002).

2.3 Forms of stigma faced by mentally ill people

Stigma of mental illness is experienced by the mentally ill in different ways. Link and Phelan (2001) have posited three forms of stigma distinguishing them on the basis of their source, namely individual discrimination, structural discrimination and self-stigmatization. Individual discrimination consists in individual persons' negative behavior towards members of a

stigmatized group (Link & Phelan, 2001). According to Larson and Corrigan (2008), structural discrimination refers to the negative consequences of injustices inherent in social, political or legal structures or decisions. Self-stigmatization is the process by which mentally ill persons adopt the stereotypes about people with mental illness prevailing in the society and consequently come to perceive themselves as socially unacceptable (Schulze, 2007). Perceived stigma can result in a reluctance of the patient to seek help for mental illness.

Unlike Link and Phelan's tripartite conceptualization of stigma, the most widely accepted forms of stigma are public (or social) stigma and self-stigma (Bathje & Pryor, 2011).

Public stigma

Public stigma, also known as social stigma, refers to the general discriminatory perceptions the society holds about the mentally ill (Lee et al, 2005). It is evident in the day to day interactions between those who are mentally ill and those who are not as when others find out about someone's illness, he or she can experience discrimination in employment, housing, medical care and social relationships, and this negatively affects the quality of life for these individuals and their loved ones.

Self-stigma

Self-stigma, according to Bathje and Pryor (2011), occurs when individuals assimilate social stereotypes about themselves as persons with severe mental illness and incapable of doing anything by themselves. However, self-stigma has a paradox to it in the sense that it is not everyone who is stigmatized who internalizes such stereotypes. One might think that people with psychiatric disability, living in a society that widely endorses stigmatizing ideas, will internalize these ideas and believe that they are less valued because of their psychiatric disorder. However, research suggests that there are fundamentally three ways in which people respond to social stigmas (Chamberlin, 2006). That is, in the face of stigma the victims may internalize it and be diminished by it, or may become righteously angry and be motivated to act or they may just be indifferent.

Those who internalise the stigmatizing attitudes feel hopeless as they are low on self-esteem and other attributes. However, according to Chamberlin (2006) for some, instead of being diminished they become righteously angry because of the prejudice that they have experienced. This kind of reaction empowers people to change their roles in the mental health system, becoming more active participants in their treatment plan and often pushing for improvements in the quality of services. Low self-esteem versus righteous anger describes a fundamental paradox in self-stigma. Models that explain the experience of self-stigma need to account for some persons whose sense of self is harmed by social stigma versus others who are energized by, and forcefully react to, the injustice (Corrigan & Watson, 2002). There is also a third group to be considered when describing the impact of stigma on the self. According to Corrigan and Watson (2002) this is the group of those people with mental illness whose sense of self is neither hurt nor energized by social stigma, instead showing a seeming indifference to it altogether.

2.4 Sources of mental illness stigma

Discrimination and stigma have been linked to ignorance or simply, lack of insight into mental illness. According to Angermeyer and Matschinger (2005) studies show that the majority of the public have limited knowledge of mental illness and the knowledge they do have is often factually incorrect. For example, many people believe that having a mental illness reduces intelligence, which is not true. Mental illness is perceived as an indulgence, a sign of weakness. Angermeyer and Dietrich *(2006)* posit that people generally begin to learn and internalise negative attitudes to people with mental illness during playschool and endure into early adulthood. Negative attitudes are partly constructed in the language we use to describe mental illness. The mentally ill have been given such names as lunatics, schizos, nutters, mad persons, monsters and maniacs (Tudor, 1996).

The media

The media is one major source of gross stigma for the mentally ill. Serving as a central source of information, the mass media not only reflect public attitudes and values in relation to disabilities and illnesses, but also take part in shaping them, both unintentionally by means of news coverage

and entertainment shows, as well as intentionally, through advertising and information campaigns (Klin & Lemish, 2008). Parle (2012), states that the media have often been accused of sensationalism by portraying mental illness inaccurately in the quest to gain higher ratings. Selective coverage by journalists of attacks by persons with schizophrenia reinforces the connection between violence and schizophrenia that labels the entire mentally ill population as dangerous and unpredictable (Angermeyer & Matschinger, 2005). Distorted descriptions of the connection of schizophrenics to violence were found even in drug advertisements in medical journals (Klin & Lemish, 2008).

Indeed, mental disorders are among the causes for the rise in violence among children and youth. According to Angermeyer and Schulze (2001), the media do not make it clear to the public, however, that only less than 14% of those afflicted with mental disorders commit severe crimes and that the percentage of general violence associated with mental disorders is low. An additional distortion was found in descriptions of post-partum depression and related mood disturbances (Klin & Lemish, 2008). This distortion adopts the biomedical model of emotional disorders following childbirth and fails to provide accurate information regarding psychological aspects of this period. There is contradictory information regarding the phenomenon's definition and its frequency, onset, duration, causes, symptoms, and treatment. Similarly, direct-to-consumer advertising of antidepressants frames depression narrowly within a biomedical model of causation and privileges benefits over risks (Grow, Park & Han, 2006). Depictions of persons afflicted with mental disorders in television dramas or films as violent and unpredictable, as victims, or as incapable of holding down a job are a source of negative stereotypes.

Health professionals

Stigmatizing views about mental illness are not limited to uninformed members of the general public; even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness. Patients encounter discrimination when accessing health services. According to Lyons (2009), patients reported professionals as being dismissive or assuming that physical presentations were "all in the mind". This can result in reluctance to

return for further visits, which can have a detrimental effect on physical health. Just like patients are reluctant to admit to having depressive symptoms, physicians are also reluctant to assess them which further reveals their negative attitudes towards the mentally ill.

Employers

Many people with mental health problems experienced discrimination when applying for jobs. This included trying to explain gaps in their CV due to episodes of mental ill health. According to Parle (2012), they not only experienced stigma when applying for jobs, but also found that when returning to work colleagues treated them differently, with some experiencing bullying, ridicule and demotion. As a result of lack of knowledge about mental illnesses, some employers want to completely do away with psychiatric patients because they view them as incapable and a hindrance to productivity.

Social stigma and structural discrimination

Persons with mental illness are perceived by the public to be in control of their disabilities and responsible for causing them. For example, people with depression are seen as lazy to talk and are always told to 'just snap out of it' (Thornicroft, 2006). The mentally ill report social discrimination in the community, giving accounts of being physically and verbally attacked by strangers and neighbors, their property being vandalized, or being barred from shops and pubs; those with addictions or psychotic illness tended to experience this more than those with non-psychotic illness (Parle, 2012). Lyons (2009) states that reports also include examples of being spoken to as if they were stupid or like children, being patronizing and, in some instances, having questions addressed to those accompanying them rather than the patients themselves. The 1996 General Social Survey (GSS), found that more than a half of respondents are unwilling to: spend an evening socializing, work next to, or have a family member marry a person with mental illness (Corrigan and Watson, 2003). The poor quality of mental health services is perceived as the strongest form of structural discrimination.

The self

Self-stigma is a clear indication that mentally ill people also have stigmatizing attitudes towards themselves. Self-stigma occurs when individuals assimilate social stereotypes about themselves as persons with severe mental illness and incapable of doing anything by themselves (Bathje & Pryor 2011). Self-stigmatization has been described, and there are numerous personal accounts of psychiatric illness, where shame overrides even the most extreme of symptoms. This worsens illness and leads to patients' reluctance to seek help.

2.5 Coping strategies used by psychiatric patients in handling stigma

Psychiatric patients attempt to handle stigma through using a variety of coping strategies. Coping strategies are defined as conscious, rational ways for dealing with the anxieties of life, and are often categorized into active (or approach) and passive (or avoidance) strategies (Bardwell, Ancoli-Israel & Dimsdale, 2001). Active strategies include confrontive coping, seeking social support, planned problem solving and positive reappraisal. Passive strategies include distancing, self-control, accepting responsibility, and escape or avoidance (Bardwell et al, 2001). However some coping strategies are unsafe, such as distancing and avoidance and can lead to anxiety or depressive symptoms.

With regards to the magnitude of the stigma attached to mental illness, and the myths surrounding it, it is not surprising that the most commonly used coping strategy for most stigmatized patients is secrecy (Barke, Nyarko & Klecha, 2010). Secrecy in this context refers to one's concealment of his mental illness from others. The person may choose to conceal their illness or treatment history from employers, relatives, or potential partners to avoid the possibility of rejection or opt for limiting social interaction altogether. Patients also usually encourage their family members to keep their illness a secret. Withdrawal is another strategy that stigmatized patients use. A majority of patients preempt rejection by avoiding people if they think someone thinks less of them because they have been in psychiatric treatment or someone

held negative opinions about psychiatric patients in general. Barke et al (2010) state that in terms of general social contact, some patients think that it is generally better, easier or less stressful for persons with mental illness to socialize among themselves. Thus most patients agree with the view that places of work should be organized in such a way as to allow people who have experienced mental illness to work together.

It is also important to take note of gender differences in coping strategies. According to Bardwell et al (2009) women are more likely to use more passive, emotional and avoiding coping styles than men. These differences in coping styles may contribute to gender differences in reactions and attitudes to people with mental illness.

2.6 Ways of eradicating mental illness stigma

The lack of language to describe the discourse of stigma has served to delay its passing, for example there are terms used to refer other prejudicial beliefs like racism, fatism, ageism, religious bigotry, sexism and homophobia. One possible remedy to this would be the introduction of the term "psychophobic" to describe any individual who continues to hold prejudicial attitudes about mental illness regardless of rational contrary evidence (Thompson & Thompson, 1997). There is a dearth or deficiency of psychiatric research on stigma and discrimination. Widening and increasing the frequency of stigma studies may be the starting point to eliminating stigma of mental illness.

According to Schulze and Angermeyer (2003), inasmuch as the media perpetuates stigma, it can also be a powerful vehicle for changing stigmatizing representations of mental illness. Practitioners in the media sector should be challenged in order to counteract negative media coverage of mental illness. Clearly, in order to maximize the use of mass media with the goal of reducing stigmatization, we should enrich our knowledge on the topic. To this end, it is important, initially, to define explicitly what is included in the term mental disorder. This will

help reduce inaccurate overgeneralizations about mental disorders and thereby creating insight among media practitioners and the general population at large.

Change strategies for public stigma have been grouped into three approaches: protest, education, and contact (Corrigan & Watson, 2002). Groups may protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. Anecdotal evidence suggests that protest campaigns have been effective in getting stigmatizing images of mental illness withdrawn. There is, however, little empirical research on the psychological impact of protest campaigns on stigma and discrimination, suggesting an important direction for future research. Protest is a reactive strategy; it attempts to diminish negative attitudes about mental illness, but fails to promote more positive attitudes that are supported by facts. Education provides information so that the public can make more informed decisions about mental illness (Corrigan & Watson, 2002). Education is very effective as the strategic provision of information about mental illness and this seems to lessen negative stereotypes. Education programs are effective for a wide variety of participants, including college undergraduates, graduate students, adolescents, community residents, and persons with mental illness (Corrigan & Watson, 2002).

Stigma is further diminished when members of the general public meet persons with mental illness who are able to hold down jobs or live as good neighbors in the community. Research has shown an inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma (Corrigan, Edwards & Green, 2001). Hence, opportunities for the public to meet persons with severe mental illness may discount stigma. Interpersonal contact is further enhanced when the general public is able to regularly interact with people with mental illness as peers.

Tartakovsky (2011) asserts that to combat self-stigma, explore therapy can be used as it helps one reframe their life experience, improve their self-image and replace negative self-talk with

more positive language. She further says patients can also practice strategic disclosure whereby one tells their story to a peer or person with a realistic view of their illness.

Importance of eradicating mental illness stigma

Without stigma, people with mental illness will be accepted and feel comfortable reaching out for help. With early intervention, treatment may be more effective. The mentally ill are bound to reach out for help if they; understand their symptoms, do not feel embarrassed and know they can recover. All this will go a long way in assisting mental health care givers and practitioners as it will make their workload easier by reducing patient relapses and making treatment progressive. It may decrease levels of social isolation among those afflicted thereby reducing their susceptibility to anxiety and depressive symptoms.

2.7 Theoretical Framework of stigma

This section explains the existing theories of stigma in the context of mental illness. In this study the following theories will be looked at: the social interactionist theory and the labelling theory.

Social interactionist theory

It was propounded by Goffman (1963). He theorized stigma as more of a social construct, wherein he concentrates on social interaction patterns and the fashion in which stigma operates within those social settings. He states that the stigmatized self arises when there is an undesirable discrepancy between one's virtual social identity (what society expects of him or her in a given situation at a given point in time) and actual identity (what the person actually is). Thus, the stigma makes the person less desirable and different from the ones who are 'normal'. In short, stigma arises when there is a feeling of inferiority, which arises from the failings versus social expectations that the person carrying stigma has. This feeling thus raises a question of acceptance of the stigmatized person by the 'normal'.

Goffman states that mixed social contacts produce anxiety among both normal and stigmatized people- anxiety on the part of the normal on how to avoid the stigmatized person and anxiety on the latter of how to deal with rejection, so that he or she can be accepted by the normal. According to Goffman stigma operates in relation to what the others view about the person; although the feelings of being stigmatized may happen in the absence of others, it is more associated with feelings based on social interactions with others (mixed social contacts) or anticipation of such social interactions (Lewis, 1998). Therefore, stigma is a public mark, significantly marked by social interactions.

Labelling theory – an attempt to understand deviance

The labelling process is a process of stigmatization in which those who do not comply with accepted behaviours are marked out for avoidance and ostracism. The most explicit theory for viewing mental illness from a labelling perspective is studied by Thomas Scheff (1966). According to him, society has perceptions about people with mental illness, and everyone in society learns the stereotyped imagery of mental disorder through ordinary social interaction. From childhood, people learn to use terms like 'crazy', 'looney', 'nuts' and associate them with disturbed behaviours. The media also contributes to this bias against the mentally ill by associating them with violent crimes. Scheff (1966) believes that mental illness is a label given to a person who has behaviour which is away from the social norms and behaviours, so it is treated as deviant. The symptoms and deviant behaviours associated with mental illness are actually deviation from the social norms rather than just psychopathology.

According to this theory, once a person is given the label of 'mental illness', he or she receives a set of uniform responses from the society, which are generally negative in nature. These responses from the society compel the person to take on the role of 'mentally ill' as he or she starts internalising them. Scheff (1966), further states that hospitalisation of a mentally ill person further reinforces this social role and forces him or her to take this role as part of his or her self-perception. Once the person is institutionalized for a mental disorder, he or she has been publicly labelled 'crazy' and forced to become a member of a deviant social group. It then becomes

difficult for the deviant to return to his or her former level of functioning as the status of 'patient' causes unfavourable evaluations by self and by others.

2.8 Previous studies

A study was conducted in Ghana (Barke et al, 2010) aimed at assessing public attitudes towards mental illness. Since no data are available regarding the question whether, and if so, how much, stigma is experienced by Ghanaians with mental illness, their perceptions were also included in the present study. The study drew a convenience sample of 403 participants (210 men, mean age 32.4 ± 12.3 years) from urban regions in Accra, Cape Coast and Pantang, who filled in the Community Attitudes towards the Mentally Ill (CAMI) questionnaire. In addition, 105 patients (75 men, mean age 35.9 ± 11.0 years) of Ghana's three psychiatric hospitals (Accra Psychiatry Hospital, Ankaful Hospital, Pantang Hospital) answered the Perceived Stigma and Discrimination Scale.

Findings of the study on the population revealed that with regard to the causes and nature of mental illness negative views prevailed. Although the majority of respondents thought that nobody had the right to exclude mentally ill persons from their neighborhood, they also felt that their presence might pose a risk and many people would not want to live next to a person with mental illness. Mental health services in the community by contrast were seen in a more positive light. This apparent discrepancy might perhaps be related to the scarcity of resources and the presence of a treatment gap of 98% with regard to mental illness.

In general, the participants felt that mentally ill persons deserve sympathy, should not be denied their individual rights and have for too long been the subject of ridicule. The society ought to adopt a more tolerant attitude and although a majority judged that the mentally ill are a burden on society, the responsibility to provide the best possible care for the mentally ill was widely acknowledged (80.3%). Dividing the participants in two groups, basic and secondary education differences were found indicating that persons with secondary education tended to hold more

positive views on persons with mental illness than those with only basic education. They also expressed more benevolent views than the less educated participants.

Barke et al (2010) assert that if one compares the attitudes they observed in Ghana with attitudes among the German population reported by Angermeyer and colleagues (2003), the Ghanaian participants held more authoritarian and socially restrictive views, were less benevolent towards persons with mental illness and also less supportive of the community mental health ideology. The result of this comparison agrees with the findings of previous studies in African societies compared with Western societies and reflects the more general observation that stigma tended to be higher in developing than in developed countries.

The research on the patients revealed that they perceived extensive stigma. They felt devalued, experienced large social distance and expected to be discriminated against when looking for work. Consequently, concealment of one's illness was a major concern of the respondents and secrecy a universally employed coping mechanism. In addition, withdrawal from social contacts, particularly those where a negative attitude was suspected, was practised by the majority of the persons interviewed.

The majority of the patients were men (72.8%). This does not reflect a sampling bias, but the proportion of men among the patients at the time of the survey. The fact that in sub-Saharan Africa men are overrepresented in psychiatric hospitals has been described repeatedly (Franklin, Sarr, Gueye and Sylla, 1996). Franklin et al (1996) discussed possible reasons for the high proportion of men and concluded that they lie in sex differences with regard to service utilization rather than differing prevalence of mental disorders. The high level of perceived stigma found in the present study is in line with the scant data from other sub-Saharan countries like a South African study which will be outlined below.

Botha, Koen and Niehaus (2006) conducted a study in South Africa wherein they sought to investigate stigma as experienced by patients with schizophrenia. They administered the

Internalized Stigma of Mental Illness Scale (ISMI) on 100 patients. The results indicated a high overall level of stigma with 65% of the participants agreeing to the statement that they were discriminated against due to their psychiatric illness. Of the patients, 58% reported verbal abuse (name calling) and 39% had even experienced physical abuse because of their illness (Botha et al, 2006).

Another study was conducted by Indiana University and Columbia University (Pedersen, 2010). The study, funded by the National Institute of Mental Health, examined whether American attitudes toward mental illness changed during a 10-year period — from 1996 to 2006 — a decade with numerous efforts focused on making Americans aware of the medical and genetic explanations for depression, schizophrenia and substance abuse. For the surveys, participants listened to a hypothetical scenario of a person with major depression, schizophrenia or alcohol dependency, and then answered a series of questions.

According to Pederson (2010) the study reveals that 67 percent of the public in 2006 attributed major depression to neurobiological causes, compared with 54 percent in 1996. Also, a higher percentage of respondents were more supportive of professional treatment as the years went on, especially treatment from a psychiatrist, for treatment of alcohol dependence (79 percent in 2006 compared to 61 percent in 1996) and major depression (85 percent in 2006 compared to 75 percent in 1996). However, the results show that although believing in neurobiological causes for these disorders increased support for professional treatment, it did nothing to alleviate stigma. The results show that, in fact, the effect increased community rejection of the person described in the vignettes. Thus, stigma for mental illness has changed just a little bit, if at all, over the past years. According to Pederson (2010), the researchers suggest that stigma reduction efforts should focus on the person rather than on the disease, and should emphasize the abilities and competencies of people with mental health problems.

2.9 Knowledge gap

For an in-depth understanding of mental illness stigma, there was need to also explore the personal experiences of those experiencing it, learn how they coped with it and what they thought could be done to eradicate it. Despite some research having been done on mental illness stigma, less research had been done that tackles the issue from the perspective of the patients. The few studies available could not be generalized to the Zimbabwean context because they were done using participants from other countries, hence there was a need to carry out such a study in a Zimbabwean setting.

2.10 Summary

This chapter clearly brought out the concept of stigma through reviewing the literature available on the concept. The various forms of mental illness were looked at, the perpetrators of stigma, the ways in which psychiatric patients cope with stigma and also various strategies that can be adopted in dealing with the stigma. Theories that explain stigma were also brought and this enhances one's understanding of how stigma functions. Previous research studies on mental illness stigma were also outlined and these helped to identify the knowledge gap, which is basically the rationale behind carrying out this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Generally defined, research methodology is the section of the research study that describes the methods and procedures that will be used to carry out the research project. Therefore, this section covered the following areas: research design, target population, sampling methods, research instruments, data collection procedures, data analysis and ethical considerations.

3.2 Research Approach

A qualitative approach to the research was adopted. According to Weathington, Cunningham and Pittenger, (2010), qualitative psychological research is where the research findings are not arrived at by statistical or other quantitative procedures. Its goal is to understand behaviour in a natural setting. This approach is essential because it understands a phenomenon from the perspective of the research participant and also aims at understanding the meanings people give to their experience. Kvale (1996) asserted that this type of methodological approach is very sensitive to human situation and involves emphatic dialogue with studied subjects.

3.3 Research Design

Research design specifies the methods and plans that were used in conducting the research. Cohen and Manion (1991), stated that its importance is that it minimizes the danger of collecting haphazard data. The case study was used as the research design. Generally defined, a case study is a descriptive or explanatory analysis of a person, group or event (Yin, 2009). Ingutsheni Central Hospital was appropriate for a case study because it is an institution that houses and treats psychiatric patients. Cases of stigma among out-patients were the focus of this study.

The Case study

Thomas (2011) defines case studies as analysis of persons, events, decisions, policies, institutions, or other systems that are studied holistically by one or more methods. A case study was used because it allows for a much more detailed conclusive research as data collection is relatively easy (Yin, 2009). Case studies may be prospective (in which criteria are established and cases fitting the criteria are included as they become available) or retrospective (in which criteria are established for selecting cases from historical records for inclusion in the study). Case study research relies on multiple sources of evidence, and benefits from the prior development of theoretical propositions. The advantage of a case study is that it is an inquiry method that investigates a phenomenon within its real-life context unlike other methods like experiments that create artificial settings to study phenomena. A case study also allows for an in-depth study of a case and addressing of important factors in a non-superficial way. The focus of the case study was to look at cases of psychiatric outpatients of Ingutsheni Central Hospital who were faced with stigma.

3.4 Target population

According to Brink (1996) the target population is the total set of people, items, entities or cases to which the research findings can be generalized. It represents the sampling frame from which the sample is drawn. Hence, in this research study the target population was the entire population of outpatients at Ingutsheni Central Hospital. From these, a sample was drawn that comprised participants of this study. The researcher chose out-patients only because they were the most affected by stigma as they grossly interacted with the general public as compared to in-patients who spent most of their time within the hospital premises. Statistics collected directly from the outpatients department at Ingutsheni Hospital showed that an average of about 320 patients per week were attended to by the out-patients department. That made it roughly 64 patients per day in a week of five working days. The statistics were calculated using figures obtained from January to May 2013.

3.5 Sample

Bailey (2004) defines a sample as a sub-set or portion of the total population. That is, a sample comprises of carefully selected individuals from the target population that should be representative of it. Since interviews were used to collect data, it would have been difficult, if not impossible, to include a large population sample. Twelve out-patients participated in the study. As a result of the study being qualitative in nature, the size of the sample was not predetermined. Sample size highly depended on the saturation of information. Thus after the twelve participants had been interviewed, no new information came up.

3.6 Sampling method

According to Morgan and King (1986), sampling is a process of selecting a set of individuals or measurement from a large population of possible individuals or measurements. Thus, to select the most suitable participants, this particular research utilised the purposive sampling method. According to Battaglia (2008) purposive sampling involves the application of the researcher's judgment or expert knowledge to decide which members of the population should be taken into the sample. The selection of a purposive sample is often accomplished by applying expert knowledge of the population to select in a nonrandom manner a sample of elements that represents a cross-section of the population (Battaglia, 2008). The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable you to answer your research questions. To aid in the sampling procedure, the researcher compiled and used a stigma assessment checklist that compromised five questions. This helped identify the most suitable participants for the study, as those that answered at least three questions with a 'yes' were considered suitable.

One advantage of purposive sampling is that it can provide researchers with the justification to make generalizations from the sample that is being studied, whether such generalizations are theoretical, analytic and/or logical in nature. A disadvantage of this sampling method is that

another expert likely would come up with a different sample when identifying important characteristics and picking typical elements to be in the sample (Battaglia, 2008).

3.7 Research instruments

Research tools are the tools that are used to collect information from participants. In this study, the researcher used interviews. An interview is a conversation between two or more people where questions are asked by the interviewer to elicit facts or statements from the interviewee (Kvale, 1996). Interviews are an effective tool because they allow the researcher to note some important details about the participant, for example, facial expressions to questions, and these can be useful in interpreting data. Semi-structured interviews were used. Merits of such interviews were that they allowed for flexibility and they were tailor-made to meet the different experiences of participants. The interviews were tape-recorded to provide a rich source of information for data analysis.

3.8 Data collection procedure

Data collection is any process of preparing and collecting data, for a project or research study. The researcher first obtained a letter of approval from the Midlands State University that proved that he was a student at the institution and was requesting permission to carry out his research study there. He then took the letter to the Chief Executive Officer of Ingutsheni Hospital. He was granted the permission to carry out his research, so he then commenced and set up to meet potential participants.

3.9 Data Analysis

Data analysis is a process of inspecting, cleaning, transforming, and modelling data with the goal of highlighting useful information, suggesting conclusions, and supporting decision making (Wikipedia, 2008).In this study the thematic analysis approach was adopted. According to Braun

and Clarke (2006), thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data. Inductive analysis will be used in coding data obtained from interviews. Inductive analysis is a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. The research analysis procedure followed Braun and Clarke's (2006) guide to the 6 phases of conducting thematic analysis.

3.10 Ethical considerations

Research procedures commenced only after institutional approval had been granted by the Chief Executive Officer of Ingutsheni Central Hospital. The researcher emphasized the voluntary nature of the exercise, and prior to participation, all participants provided verbal consent. They were guaranteed of safety and that during the exercise everything was going to be done to protect them from harm or discomfort. Participants were also informed of their right to withdraw from the exercise at any point in time. Since there was need for the research results to be published, the ethical principle of anonymity was observed. That is, it was guaranteed that a participant's identity would never be revealed when data are published. Participants were notified of their right to privacy, that is, where procedure is potentially intimate, embarrassing or sensitive they were told they had the right to withhold the information.

3.11 Summary

This chapter presented the practical methodological procedures that were followed in conducting the study. That is, the research approach, design, target population and the population sample were presented. This chapter also presented the research procedure that was followed in collecting the data and the instruments that were used to collect the data. Finally, the method of analyzing the data that was used was also outlined in this chapter.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter presented the research findings, giving an analysis of them and their interpretations. The research findings were presented in light of the research questions which guided the study which are: (a) what forms of sigma do mentally ill individual face? (b) in what ways do psychiatric patients handle stigma? (c) what can be done to eradicate stigma? Thematic issues were drawn from the data acquired and these were illustrated by participants' responses, which were presented verbatim to ensure genuineness and also to avoid distortion of meaning.

4.2 Characteristics of respondents

A total number of 12 outpatients participated in the study, 5 males and 7 females. The youngest participant was 16 years old and the oldest 60 years old. 60% of the participants were in their 30s. The researcher conducted semi-structured interviews with the participants. To ensure confidentiality, the true identities of participants were not revealed, they were named in the order in which they were interviewed, that is, participant 1, 2, 3 up to 12.

Table 4.2.1 Summary of participants' demographic information

Participant	Age	Gender	Occupation
1	38	M	Sample prep at a mine
2	32	F	None
3	44	F	Self-employed
4	16	M	Student
5	30	F	Teacher
6	38	F	Bedroom hand at a hotel

7	60	F	None
8	54	M	Pensioner
9	34	M	Hospital Hand
10	50	F	Clerk at a school
11	30	F	Vendor
12	35	M	Teacher

4.3.1 Forms of stigma faced by mentally ill people

Mentally ill patients reported discriminatory attitudes from the society they live in and also from within themselves. Information acquired from the participants revealed that there is social as well as self- stigma. People with mental illness reported that they face social isolation, loss of friends, violence, ridicule and discriminatory names, exploitation and ill-treatment, rejection in romantic relationships, negative attitudes in the media, low self-esteem and self-efficacy and also being objects of ridicule and belittlement. Some however reported feels of righteous anger and motivation to prove people wrong, and also others reporting an indifferent attitude towards stigmatization. These thematic issues that arose were highlighted below and they served to illustrate and enhance understanding of the forms of stigma that the psychiatric outpatients experienced.

Social isolation

Upon being given a diagnosis of any mental condition, psychiatric patients experienced isolation from various members of society. People avoided being around the mentally ill because they lacked insight into metal illness. Some viewed the mentally ill as having a greater potential to perform violent acts so they thought it is safe to keep their distance from them. Participants

reported that some members of society treated them as outcasts and did not want to involve them in societal activities or informal social interactions.

> *Before I commenced treatment at Ingutsheni my neighbours viewed and treated me like everyone else, but after they learnt that I am receiving treatment here they started to avoid me. I guess they did not want to have any association of any sort with me. Now even when even there residents meetings they do not notify me just because I'm mentally ill (Participant 7).*

Loss of friends

Loss of friends was an experience that many patients had lived. They reported that friends started to treat them differently after they learned that he or she was receiving psychiatric treatment. This is another instance of social stigma as it showed that even friends of the mentally ill did not want to be associated with them. Participants reported that friends no longer visited them and when they were going out they would no longer invite him or her.

> *My friends, I don't blame them, they don't know anything about mental illness. My relationship with them has changed. We no longer go out together. They say they fear I will get drunk and relapse. Every time I invite them over to my place all I get is excuses from them. I don't even know whether they are my friends or what (Participant 12).*

Some participants reported betrayal and deception they got from their friends. Friends pretended to love and care about them whilst back-mouthing them. When there was a quarrel with friends, most of the time other friends connived and took the side of the person who was quarrelling with the patient regardless of who was right.

> *When I'm with them, my friends pretend to care and understand me but later they talk ill about me when they are with other people. When I probably have an*

argument with one of them, they always assume I'm the one who is wrong because I'm mentally ill, even when I'm right (Participant 6).

Violence

Violence was used by people towards the mentally ill and this was a sign of discrimination against them. They reported being beaten up or chained because they were viewed as dangerous to other people. This showed that the mentally ill are treated as sub-humans. Some members of society resorted to violence as the only punitive measure as they believed that the mentally ill should be punished so that they could change their behaviour.

> *At one point when I relapsed (at the workplace) people started throwing stones at me say 'you mad woman' ……………… I remember there are numerous times when I was chained up and locked up in my room for hours (Participant 5).*
>
> *I usually hear other kids' grandmothers encouraging them to hit me with stones because they say I'm problematic…………... even my uncle thinks I'm not ill but I'm pretending so he goes to the extent of spanking me (Participant 4).*

Ridicule and discriminatory names

Psychiatric patients were a laughing stalk to some people and they were usually called humiliating names. This was also an instance of social stigma. Participants reported that every now and then they were made fun of because they were mentally ill. They were even called thieves as some people believed that they had stolen from someone who then bewitched them, thereby causing their illness. People laughed at them calling them discriminatory names which evoked feelings of irritation and anger.

> *We relapse in society with everyone watching, hence they usually laugh at us (Participant 5).*

> *I was laughed at by our neighbours when I got discharged from hospital (Participant 1).*

> *People laugh at me calling me 'uhlanya' (mad person). (Participant 4).*

Exploitation and ill-treatment

Exploitation of the mentally ill took place at home, at work and in social relationships with others. Exploitation was caused by the fact that these people could not make informed decisions sometimes especially when they were not stable, so other people merely took advantage of this. Some patients noted that they were being exploited but they fell like there is nothing that they could do about it.

> *My young brother takes advantage of me and gives me too much work (Participant 4).*

> *I came to a point when I realized that men have been taking advantage of me because they know I give in easily to their request for sex (Participant 5).*

> *I got fired from my advisory position in the finance committee because I had been hospitalized…… even family; my relatives were withdrawing my money from the bank without my consent while I was hospitalised (Participant 10).*

Rejection in romantic relationships

When in a relationship with someone everything seemed to be alright up until the partner of the patient discovered about the patient's mental condition. Patients reported that they usually faced rejection by their lovers when they learned of their mental illness and sometimes this made them feel hopeless as they thought they might never get married to anyone.

> *My boyfriend left me when I told him I receive treatment at Ingutsheni. The worst part was that I was pregnant with his child but that didn't stop him (crying) (Participant 5).*

Being objects of despise and belittlement

As a result of the misconceptions that other people held about mental illness, they viewed the afflicted as completely unable to do anything or even to take care of themselves. Participants reported that they were looked down upon by some members of society and even close family. Family members were sometimes overprotective and excessively caring as they felt it was appropriate because patients could not do much by themselves.

> *The advice I give people sometimes is taken lightly because they believe I cant say anything sensible (Participant 9).*

> *Sometimes I feel like my parents are over-involved in my life: they always tell me to take my medication even when it is unnecessary, they always want to know where I am, with who, doing what every second, can you imagine! (Participant 1).*

Negative attitudes in the media

The media was reported to be broadcasting content that was strongly discriminatory against mental illness. The media served as both a source of stigma and also as an agent that helped to maintain the negative attitudes about mental illness held by the society at large. Participants felt that the media should entertain the public and also help to eradicate the stigma attached to mental illness instead of strengthening it.

> *I was listening to Star-fm the other day and heard djs ridiculing mental health practitioners and patients saying 'they have even come up with names like hallucinations and delusions to refer to their weird experiences' (Participant 5).*

This showed that the media strengtheneds stigmatizing attitudes towards mental illness.

Loss of self-esteem and low self-efficacy

Due to the internalization of the negative attitudes and beliefs the society held and expressed about mental illness, some mentally ill people lost self-esteem and self-efficacy. They tended to

perceive themselves as incapable and worthy of the discrimination. This was clear evidence of self-stigma amongst patients. Participants reported feelings of helplessness and hopelessness.

> *What people say about me is true after all, because look at me, I never finished school, I don't have friends, I'm not working, I just eat and sit at home, I am just not able to lead a normal life like everyone else (Participant 2).*

> *One minute I'm ok, the next I'm depressed, the next I'm hyper. I just can't do anything, that's why I'm self-employed (Participant 11)*

Indifferent attitude towards stigma

A portion of patients reported indifference towards the negative attitudes the society held about the mentally ill. These patients neither lost self-esteem because of stigma nor felt righteous anger, they were just neutral. This supported the paradox of self-stigma which is based on the notion that there is no one single way in which psychiatric patients respond to the negative societal attitudes about the mentally ill. That is, their sense of self is neither hurt nor energized by social stigma.

> *What people say about me does not move me, I just don't care because I know that it is because of lack of knowledge that they say bad things about me as someone who is a patient (Participant 1).*

> *I am not worried at all, mental illness is just a misfortune, I am not responsible for it, we don't choose to be mentally ill you know?(Participant 6).*

4.3.2 Coping strategies used by psychiatric patients in handling stigma

Living in a society that so strongly endorsed stigmatizing attitudes against mental illness, those affected by it adopted various behavioral strategies as a way of dealing with it. Some strategies were safe and helpful whilst others were unsafe and had negative consequences. The coping strategies that the mentally ill reported to be using were avoidance and isolation, violence,

secrecy, prayer, crying, seeking social support, drinking beer and listening to music. These thematic issues that depicted the coping strategies they adopt were presented below.

Avoidance and isolation

Psychiatric patients reported that they chose to isolate themselves as a way of handling the stigma they usually face. They reduced the frequency of meeting up with members of society and spent most of the time alone. Some patients completely avoided social interactions, and others avoided situations that they perceived as having the potential of them experiencing stigma. Some, especially children, had a tendency of running away from home if they were staying with people who treated them badly because they were mentally ill.

> *I usually choose to lock myself up in my room and be alone because when I try to mix and mingle with people they make me feel unwelcome (Participant 3).*

> *I run away from home because my uncle always insults me and beats me up because he thinks I'm just pretending to be ill (Participant 4).*

Violence

Aggressive behavior was also used by psychiatric patients who faced stigma, as a way of coping. They say it afforded them the opportunity to vent out their anger and frustration evoked by stigma, and once they did that they felt a sense of relief. However, some reported feelings of regret afterwards as they continuously blamed themselves as to why they became violent in the first place. Violence was an unsafe way of coping with stigma as it might have caused harm to other individuals and property.

> *Sometimes I lose it and become very violent. I remember I once slapped a child who called me 'uhlanya' (mad person), it really pains you know? But my problem is that sometimes I blame myself after hitting someone because I think it is not a good thing (Participant 12).*

Secrecy

Secrecy was a passive coping strategy adopted by patients to handle stigma. It entailed them intentionally avoiding telling others that they were mentally ill and keeping it a secret. Participants reported that they did this in order to save themselves the embarrassment that came with some people knowing that one is mentally ill.

> *My workmates do not know that I'm receiving psychiatric treatment and I don't intend telling them because I fear they will start treating me differently and isolating me (Participant 6).*

> *I used to good-heartedly tell people about my illness but now I don't because I realized that they look down upon me once I tell them (Participant 9).*

Although secrecy may have seemed to be fruitful in helping patients cope with stigma, it had its shortcomings. It was not everyone who stigmatized against the mentally ill, some people were actually well-informed and could be of greater assistance to the patient. This was also noted in one participant's account who reported having disclosed her illness and was treated favorably.

> *Sometimes notifying your superiors about your illness helps, for example, when I went for interviews at the United College of Education, I disclosed my mental condition and guess what… they did not deny me a place and also this helped me as they became sympathetic and lenient towards me when I relapsed and got hospitalized during school term (Participant 5).*

Prayer

A number of participants reported that they resorted to prayer when they were discriminated against. Participants who reported that they pray were all Christians. They felts rejected and not loved by anyone and they would then place their hopes on God to intervene in their situation because they believed He is the source of love, peace and hope. They believe He is the Almighty who has the power to seize them out of their misfortune.

I pray and put everything in God's hand. In prayer I find protection and hope (Participant 5).

I pray that God may take this illness away so that I can live like anyone else and be accepted by other people (Participant 4)

However, there was a section of patients who reported that they had given up on prayer because they believed it had not changed their situation for a long time. They reported that their prayers had not been answered ever since.

I used to pray but not anymore because nothing seems to be changing, you know I have been trapped in this situation for years now. There are times when I even blame God about why He allows this to happen to me. I continuously ask myself 'why me?' (sighs) (Participant 11).

Righteous anger and motivation to prove people wrong

Some mentally ill people were responded to stigma through righteous anger and motivation to act. This was their way of coping with stigma. They felt they were not responsible for their illness and that society was treating them unfairly. This motivated them to act and show people that they could lead a normal life. Such people were usually the voice of the rest of psychiatric patients. They strongly believed that mental handicap does not mean inability.

People are stupid! They don't know anything about this disease. What they say is not true, I, for example, am a member of the neighborhood watch committee, I worked in South Africa as a security guard. Now I plough the fields and produce food, I'm just able and I have yet to prove that to them (shouting and banging fist in the desk) (Participant 8)

Crying

Some patients reported that when they felt too emotional about the discrimination they faced they cried, as a way of coping with the feeling. Several participants reported locking themselves

up in their rooms and crying until they felt better. Patients said they resorted to crying because it helped them vent out their emotional frustration and it generally gave them a sense of relief.

> *I lock myself in my room and cry for hours when I am pained by what some people say it makes me feel like there is a lump that was in my throat and has been taken away (Participant 11).*

Another participant stated that she cried herself to sleep. Sleep also helped them in coping. After some time of sleep they reported feeling renewed when they wake up because they felt like they had escaped this cruel world for a little while.

Seeking social support

Mentally ill people sought social support when they were faced with stigma. They talked to someone who was close and understanding and non-judgmental. They also reported that talking to someone who was also receiving psychiatric treatment helped. It helped them understand their illness better and also gave them hope as they felt like they were not alone in this predicament. Participants stated that generally, talking to someone made them feel like their burden has been lifted off them.

> *Talking to other people helped me hear what they think about mental illness and I also got advice, for example, my aunt who had the same disorder instilled hope in me and also made me feel accepted and loved, which is quite a rare experience for me (Participant 2).*

Drinking alcohol

Taking alcohol and getting drunk was also used by patients as a means of coping with stigma. They claimed that when they got drunk they temporarily forgot their worries (negative effects of stigma included).

When I feel trampled down by what people say about me I sometimes binge on beer. It makes me feel relaxed and I don't feel any stress at all (Participant 1).

Bingeing on food

Another participant reported that she binged on food when she was stressed out because of people's negative judgments about her as someone who is mentally ill. However this would have had some serious negative health implications.

I have a tendency of eating too much just like what people with depression do when they are feeling down. It helps as it improves my mood, but sometimes I fear obesity (Participant 5).

Listening to music

Music is said to be therapeutic and psychiatric patients also reported that they listened to music when feeling bad about the stigma they faced. Listening to music helped improve mood. Participants reported that when they listened to their favorite type of music they somehow forgot the negative things people said about them and they felt relaxed psychologically and emotionally.

I listen to lots and lots of music just to forget about what these crazy people think and say about me. I make sure I adjust the volume to full blast so I can feel the beat running through my veins (laughing) (Participant 9).

4.3.3 Ways of eradicating stigma

In light of the vast negative consequences of stigma, there are certain measures that psychiatric patients felt can be put in place in order to eradicate stigma or at least reduce stigma levels. Most of the measures that the participants felt should be put in place were targeted towards social (public) stigma and a few aimed at eradicating self-stigma. Thematic issues related to the eradication of stigma that surface in the study include education, reforming the media,

involvement of patients in occupational therapy, advocacy for and protection of the rights of the mentally ill, patients being made aware of their rights, helping patients gain insight into their illness and building confidence in them, and provision of adequate treatment to patients.

Education

Education as a strategy for eradicating the stigma attached to mental illness was widely expressed by participants. Hence various educational approaches that could be adopted came up. Some participants felt that studies on mental illness should be included in the school curriculum so that knowledge would be imparted formally and people get to begin understanding mental illness at a tender age at school. They believed that this was going to go a long way in addressing stigma because people were bound to respect and accept views that they acquire from academics.

Patients also suggested that education can be offered through awareness campaigns. Participants said the frequency of awareness campaigns needed to be increased so that they would have a resounding impact on the attitudes of the general populace towards mental illness. The aim of awareness campaigns would be to educate society about the causes and nature of mental illness and to deconstruct the negative preconceptions held about it. Patients feel that society should be told that mental illness was not by choice but it could happen to anyone at any time and thus those afflicted should not be discriminated because it was not their fault.

> *More and more awareness campaigns should be conducted by the Ministry of Health so that people learn the truth about mental illness and they stop laughing at us because we did not choose to be like this (Participant 10).*
>
> *Campaigns should be done to let society know that they should not blame us because we did not choose to be ill, this can happen to anyone, u know? (Participant 5).*
>
> *I think it would be good to educate the general public about mental illness just as it is done with HIV/AIDS (Participant 12).*

Mental health practitioners and professionals should also educate both patients and their relatives and caregivers. For example, it came up that psychologists should give insight to and inform relatives of patients that some bizzare behaviors they exhibited were due to illness, they were not deliberate. Participants said that psychologists should also educate family members and caregivers about the dire consequences of stigmatizing patients, for example, suicidal ideation and anxiety.

> *We need learned people who are experts in mental health to give education to our relatives so that they understand us and our behavior and refrain from treating us with disdain (Participant 10).*

Reforming the media

Patients were not happy with the presentation of mental illness in the media hence they called for changes in the content of broadcast messages pertaining to mental illness. They suggested that the media should stop the hate-speech about mental illness and present it favorably. They said the truth about mental illness should be broadcast. Participants felt that this was going to be helpful as the media was more accessible to the majority of the population.

> *Television and radio should stop presenting us as useless people (Participant 9).*

> *The media can be very effective in changing the way society views us just because it is through the media that they learn to discriminate against us (Participant 10).*

Involvement of patients in occupational therapy

Patients thought that their involvement in occupational therapeutic activities would help them view themselves in positive light. Despite the widely expressed negative views the society held about the mentally ill, if they themselves realized that they were able to perform some tasks, they were bound to view themselves like other humans do. This would thus go a long way in curbing self-stigma. Some participants had been through occupational therapy and they reported that it helped them change their self-concept into a positive one.

If patients are involved in occupational therapy it helps them discover certain skills they might have thought they do not possess. When I did occupational therapy I felt important just because I could work alongside people who were not patients and even do better than them in some cases (Participant 9).

Advocacy and protection of the rights of the mentally ill

Psychiatric patients believed that stigma of mental illness could be overcome if their rights were advocated for and protected. They said it should be made clear that they had a right to education, employment and to access health facilities like any other person. They also wanted to be given the right to make their own choices independently.

We need a voice to stand for us out there in the community. We need representation, we have rights too (Participant 12).

We need protection because we are not always violent but our violent behavior is triggered by people who call us names. The legal system must do something! (Participant 12).

Patients should be made aware of their rights

Some participants expressed concern that some patients were not aware of their rights. Hence they suggested that making patients to be conscious of their rights was going to contribute to eradicating stigma. They would be able to stand for themselves and would know how to use their rights as a privilege to impede stigma.

The problem is that some of us do not know our rights, if we do it will help us reduce discrimination and negative attitudes , for example, patients should know that they can sue someone for defamation of character if they present them unfavorably publicly (Participant 5)

Helping patients gain insight into their illness and building confidence in them

Participants believed that if patients were helped to gain complete insight into their condition they would have a better understanding of themselves, hence what people said or thought would not matter that much to them. This would greatly help to eradicate self-stigma. Participants also said that mental health personnel should cultivate confidence and build self-esteem in patients, making them understand that it is not their fault that they are mentally ill. This would go a long way in helping patients overcome self-stigma.

> *Institutions of mental health should help patients gain confidence in themselves so that their perceptions of themselves is not influenced by what people say. Patients should also be helped to understand their condition so that they do not blame themselves for the illness and also that they dont view themselves as failures (Participant 10).*

Provision of adequate treatment to patients

Psychiatric patients said that stigma could be reduced by removing patients who were on the streets and treating them. Participants claimed that those patients on the streets were a source of stigma as they exhibited bizzare behaviors in front of everyone and these behaviors were then generalized by on-lookers to mean that every mentally ill person is like that.

> *Please collect all the psychiatric patients who wander around the streets and give them adequate treatment because what they do endorses stigmatizing attitudes of the society towards mental illness as a whole (Participant 7).*

4.4 Summary

The chapter presented, analyzed and interpreted the data that was acquired from participants. Responses of participants were briefly explained and themes drawn. The data gathered revealed beyond doubt that psychiatric patients are grossly stigmatized in society and they also stigmatize themselves. It also brought to light the various strategies that these patients adopt in order to cope with the stigma. It is also evident in the data that there are certain measure which when put in place can help eradicate the stigma of mental illness.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives a discussion of the research findings wherein the findings are analyzed and checked whether they have any link and consistency with previously conducted studies on the subject of the stigma of mental illness. Conclusions from the research will also be drawn in this chapter. Finally, certain measures will be recommended that could help in solving the problem at hand.

5.2 Discussion of results

The research study was focused on bringing out the stigma of mental illness as experienced by psychiatric outpatients. This discussion was a synthesis of the three basic aspects of mental illness stigma which are; the forms of stigma experienced, the ways of coping with it adopted and the ways through which stigma can be eradicated.

The research findings indicated a conceptualization of stigma which is congruent with Goffman's (1963) social interactionist theory of stigma. The theory stated that stigma is a social construct, and the stigmatized self arises when there is an undesirable discrepancy between one's virtual social identity (what society expects of him or her in a given situation at a given point in time) and actual identity (what the person actually is) (Goffman, 1963). This was evident in the research findings as participants reported being stigmatized by society on the basis of the behaviour that they sometimes exhibited which members of society saw as unacceptable and not normal.

5.2.1 Forms of stigma faced by mentally ill people

In the research findings, there were recurrences of social and self-stigma as reported in the experiences of participants. Social stigma was evident in participants' accounts where they talked about members of society giving them negative attitudes because of their illness. Participants reported social isolation and ill-treatment by some members of society and the family who had learnt that they are mentally ill. Self-stigma was seen as some participants viewed themselves as complete failures in life after they had believed the negative perceptions that society expressed about them. This was in line with previous research literature which identified two types of mental illness stigma which are social stigma and self-stigma (Bathje & Pryor, 2011).

The research found that mentally ill people faced isolation and loss of friends because of their illness. This was in line with the results of a study that was conducted in Ghana (Barke et al, 2010). In the study participants reported that they experienced large social distance because they were mentally ill. They further said that they faced rejection by friends because friends seemed to fear being associated with someone who had a mental health condition. In the same study, members of the neighborhood reportedly felt that the presence of a mentally ill person in the neighborhood might pose a risk and many people did not want to live next to a person with mental illness.

The results of this study showed that the mentally ill were ridiculed and called discriminatory names. This treatment of the mentally was congruent with the findings of Tudor (1996), who sated that negative attitudes are partly constructed in the language we use to describe mental illness. The mentally ill have been given such names as lunatics, schizos, nutters, mad persons, monsters and maniacs (Tudor, 1996). This was also well supported and explained in the labelling theory of stigma wherein it was said that from childhood, people learn to use terms like 'crazy', 'looney', 'nuts' and associate them with disturbed behaviours(Scheff, 1966). Another study (in South Africa) had 58% of its participating reporting verbal abuse (name calling) (Botha et al, 2006).

A discriminatory behavior towards the mentally ill also discovered in the study was violence. Participants reported having been physically abused by members of society either because they were seen as having the potential to be violent or as punishment for their behaviors. This finding was in line with what was reported by Parle (2012), that the mentally ill reported social discrimination in the community, giving accounts of being physically attacked by strangers and neighbors and their property being vandalized.

The mentally ill were also despised and belittled, as per the findings of this study. They reported being seen as people of no value who just could do anything by themselves. Previous research findings also echoed the same sentiments as Lyons (2009) stated that psychiatric patients reported being spoken to as if they were stupid or like children, being patronized and, in some instances, having questions addressed to those accompanying them rather than the patients themselves. This shows that they are seen as sub-humans.

Results of this study showed that the mentally ill faced exploitation at home and at work where they are taken advantage of. However in the literature reviewed exploitation of patients at home was not evident but exploitation at work was widely reported. According to Parle (2012), the mentally ill not only experienced stigma when applying for jobs, but also when returning to work where colleagues treated them differently, with some experiencing bullying, ridicule and demotion.

The findings of the current research study indicated that the media grossly stigmatized against mental illness. This was also supported by previous research findings. Klin and Lemish (2008) report distorted descriptions of the connection of schizophrenics to violence found even in drug advertisements in medical journals. According to Angermeyer and Schulze (2001), there were depictions of persons afflicted with mental disorders in television dramas or films as violent and unpredictable, as victims, or as incapable of holding down a job and these were a source of negative stereotypes.

The study also unraveled feelings of low self-esteem and self-efficacy as resulting from stigma. This was an indication of self-stigma. Similarly, as shown by previous research findings, some patients were low on self-efficacy and self-esteem. Wright et al (2000) posited that earlier studies indicated that expecting and fearing rejection can have serious consequences such as impaired self-esteem. Wright et al (2000) also states that negative social attitudes towards the mentally ill were harmful to their self-esteem and self-efficacy as they lowered it and made them feel worthless.

The findings of this research also indicated that there were some people who felt righteously angry about social stigma and were motivated to act in ways that proved that they were capable human beings. This was supported by Watson and Corrigan (2002) who stated that some of the afflicted were not diminished by social stigma but they were motivated to protest and advocate for the rights of the mentally and also such people were bound to stand up and effect changes within the mental health sector. This alluded to the paradox of stigma as stated by Chamberlin (2006), which constitutes that patients will not respond to social stigma in the same manner. The current research also reported that some participants had an indifferent attitude towards social stigma and this was still in line with the paradox of self-stigma.

5.2.2 Coping strategies used by psychiatric patients in handling stigma

This research study managed to identify a number coping strategies used by patients in coping with stigma. The strategies identified seemed to fall under the two categories that were theorized in previous studies which were passive and active coping strategies (Bardwell, Ancoli-Israel & Dimsdale, 2001). The researcher just noted, as in previous studies, that some of the coping strategies that patients used were unsafe.

Secrecy was one way of coping that was reported in the current research study. This tallied with previous research as there is evidence of secrecy being used in coping, for example a Ghanaian study whose findings indicated that in light of the extensive stigma perceived by patients,

concealment of one's illness was a major concern of the respondents and secrecy a universally employed coping mechanism (Barke et al, 2010).

Findings of this research study showed that avoidance and isolation were used as a way of coping with stigma. Those experiencing stigma usually avoided social settings just to save themselves the embarrassment. Similarly, according to Barke et al (2010), the study on coping styles of patients facing stigma in Ghana had many patients reporting that they withdrew from social contacts where a negative attitude is suspected, thus they preferred to isolate themselves.

This research reported crying as a coping strategy used by some patients to handle stigma. This was supported by a South African study by Botha and colleagues (2006) wherein a number of participants reported that when they are called bad names they isolate themselves and cry for hours on end.

Results of this study showed that some patients adopted the active coping skill of seeking social support. They found someone understanding and accepting of them to talk to and that helped them emotionally and psychologically. Seeking social support as a way of coping was also reported in study conducted by Indiana University and Columbia University (Pederson, 2010). Participants reported talking to someone about their illness and they also mentioned talking to another mentally ill person as helpful.

However, there are some coping strategies that came up in this study for which evidence in previous literature was not found. These strategies are listening to music, prayer, violence and drinking alcohol. This might, in part, be attributed to differences in cultural beliefs and practices, for example, praying. Some people do not have any religious affiliations or might be practicing other religions which do not involve prayer. The rampant use of violence in coping in our society compared to others could be indicative of the fact that stigma levels are very high in our society

as to driving the stigmatized to dangerous extremes in coping. This is supported by the fact discrimination is believed to be worse in developing countries as stated by WHO (2012).

5.2.3 Ways of eradicating stigma

The findings of this study included various measures which participants believed if put in place would help eradicate the stigma of mental illness. Participants strongly believed that not much was being done to eliminate the stigma.

Results of this research identified education as a tool that could be used to eradicate stigma or at least reduce its levels. Participants believed that the general public held stigmatizing attitudes because of its lack of knowledge about mental illness, hence educating people about mental illness could help. This was congruent with previous research findings, for example, Corrigan and Watson (2002) asserted that education is very effective as the strategic provision of information about mental illness and this seemed to lessen negative stereotypes. Education programs were effective for a wide variety of participants, including college undergraduates, graduate students, adolescents, community residents, and persons with mental illness. (Corrigan & Watson, 2002).

Findings of this research also called for reforms in the media as a measure that would go a long way to eliminate stigma. Participants' views concurred with those of previous researchers who postulated that the media presented mental illness in bad light as a way of conforming to social norms and gaining higher ratings. Participants felt that mental illness content in the media should be reviewed and changed. Previous research findings also echoed the same sentiments. Schulze and Angermeyer (2003) asserted that practitioners in the media sector had to be challenged in order to counteract negative media coverage of mental illness. They said that it was important, initially, to define explicitly what is included in the term mental disorder. This would help reduce

inaccurate overgeneralizations about mental disorders and thereby creating insight among media practitioners and the general population at large.

The research findings also indicated that there was need for the rights of the mentally ill to be advocated for and protected. The mentally ill have the right to education and housing. This was also evident in the literature acquired as Tartakovsky (2011) stated that more often the rights of the mentally ill were infringed as they were denied housing in some situations just because they were receiving psychiatric treatment.

However, some of the strategies and measures for eradicating stigma that some participants came up with seemed to be original in themselves as they did not appear in literature about mental illness stigma. For example, one participant suggested the use of occupational therapy; he was mainly talking from his personal experiences in occupational therapy. Other stigma eradication measures that came up that seem not to have any bearing from previous literature were helping patients gain insight and provision of adequate treatment to patients. This made the study unique and fruitful and more significant than other previous studies that had been conducted before.

5.3 Conclusions

From the study the following conclusions were drawn:

The stigma of mental illness was gross in our society and had been taken for granted by its perpetrators. The main reason behind the stigmatization of mental illness was the lack of knowledge about it as many people viewed it as debilitating and as a condition that reduced a human being to nothing. Thus they viewed people who were afflicted as such. In addition to the stigma that patients face from the public (social stigma) they themselves in some cases also stigmatized against themselves (self-stigma). This was detrimental as it resulted in a decline in self-related variables such as self-esteem and self-efficacy.

The paradox of self-stigma gives hope that stigma can be dealt with safely or eliminated. The fact that other patients facing the same stigma could either be indifferent to it or be motivated by it implies that those who internalize it can learn to do the same. However, at the same time it should be born in mind that these people could be reacting to stigma in different ways probably due some biological predispositional factors and hence greater precaution should be taken when trying to influence those that internalize stigma to copy those who do not.

There was diversity in the coping strategies that patients facing stigma used. Although some of the strategies like seeking social support were more effective, some were only effective in the short term, for example taking alcohol and bingeing on food. The most used coping strategies were secrecy and avoidance. However these are detrimental to the patient's health as they may lead to social isolation which in turn makes them more susceptible to anxiety, depression and even suicidal tendencies. Secrecy and avoidance also resulted in the patients' reluctance to access health services which could actually be of greater help to them.

In eradicating stigma education seemed to be the most effective strategy to adopt. There was need for education on the part of the general society at large and also on the part of those that were mentally ill and facing stigma. This would help to curb social stigma and self-stigma. One problem is that some stigmatized patients believed that eradicating stigma lies solely in the hands of other people and not themselves, hence they were reluctant to play their part. For example, to successfully eliminate self-stigma, the person experiencing it should actively take part. The media could be an effective tool in deconstructing the general public's negative attitudes towards mental illness because it is a faster way of disseminating information and it also has a general tendency to influence people's thoughts, attitudes and behavior (Klin & Lemish, 2008).

5.4 Recommendations

For successfully dealing with the problem of the stigma attached to mental illness, there is need for a collective effort from all sectors of the community. From the findings of the current research, the researcher makes the following recommendations:

- Decentralization of mental health services. There is need for mental health services to be offered at the level of primary health care. This will help people access services because they fear the stigma which is associated with large mental institutions which at the moment are the only service providers in Zimbabwe.

- The first port of call in eliminating stigma should be the social stigma and then self-stigma. This is because self-stigma is a product of social stigma so if the latter is dealt away with, self-stigma is automatically eliminated.

- There is need for those that are facing stigma to be taught effective and safe ways of coping with it. This will help them maintain psychological, mental and emotional wellbeing. It will also reduce stigmatized patients' instances of hurting members of society, for example, when they use violence as a way of coping.

- Awareness campaigns should be done every now and then so as to educate the public and constantly remind them of the dire consequences of stigmatizing against the mentally ill.

- People can also be taught healthy ways of living that will help them not end up suffering from mental conditions. This will reduce cases of mental illness thereby reducing the stigma attached to it.

- The paradox of self-stigma can be used as a starting point. Those stigmatized patients who do not internalize society's negative views can be used as role models to those who do. This will help in coping with stigma and also in eradicating self-stigma.

- Attractive monetary incentives can be offered to media practitioners in exchange for them to publish, broadcast and/or advertise mental illness accurately. This will be an effective strategy of using the media to help reduce stigma.

5.5 Summary

This chapter gave a discussion of the results of the research study. These findings of the research were compared with the findings of previous researches on the subject matter. The discussion showed some issues that came up which are unique to this study as they are not evident in previous researches. Conclusions of the research study were also drawn in this chapter and revealed the intensity of stigma, the nature of coping strategies used to cope with it and ways of eradicating stigma. Finally, recommendations were made that have implications to the stigma of mental illness as to how it can be prevented or reduced or eliminated.

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STIGMA ASSESSMENT CHECKLIST FOR PURPOSIVE SAMPLING

My name is Gift Nkomo and I am a student in the Department of Psychology at the Midlands State University studying for a Bachelor of Science Honors Degree in Psychology. I am carrying out a study on *'mental illness stigma: a case of Ingutsheni Hospital's outpatients'.* I am kindly asking you to assist me in carrying out my research by taking a few minutes of your time to respond to the following questions as frankly as you can. Your responses will be treated with confidentiality and will **ONLY** be used for the purposes of this study.

- Answer all questions by ticking on the answer you think is the most appropriate for you.

QUESTION	ANSWER	
	Y	N
Have you avoided telling others outside of your immediate family that you have received psychiatric treatment?		
Have you been turned down for a job, for which you were qualified, when it was learned you received psychiatric treatment?		
Were friends understanding and supportive after learning that you receive psychiatric treatment?		
Have you been shunned or avoided by others when they learned you received psychiatric treatment?		
Have you been excluded from volunteer or social activities outside the mental health field when it was known you had received psychiatric treatment?		

INTERVIEW GUIDE FOR PARTICIPANTS

My name is Gift Nkomo and I am a student in the Department of Psychology at the Midlands State University studying for a Bachelor of Science Honors Degree in Psychology. I am carrying out a study on *'mental illness stigma: a case of Ingutsheni Hospital's outpatients'.* I am kindly asking you to assist me in carrying out my research by taking a few minutes of your time to respond to the following questions as frankly as you can. Your responses will be treated with confidentiality and will **ONLY** be used for the purposes of this study. **I deeply appreciate your cooperation and support. Without you, I would not be able to conduct this research.**

Biographical Data

Age   :

Gender   :

Occupation   :

1. What forms of stigma do mentally ill individuals face?

1. What are the society's attitudes towards you as a mentally ill person?

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2. How are friends and relatives treating you ever since they learnt that you have been given a psychiatric diagnosis

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3. How do people's negative attitudes towards the mentally ill make you feel?

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2. In what ways do psychiatric patients handle stigma?

1. What strategies do you use to handle stigma?

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2. How do these strategies help you?

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3. What can be done to eradicate stigma?

1. What do you think can be done to eliminate the stigma attached to mental illness

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APPENDIX B

MIDLANDS STATE UNIVERSITY

SUPERVISOR-STUDENT AUDIT SHEET   Gift Nkomo R101045E

Date	Item submitted	Date returned	Comment	Student's signature	Supervisor's signature