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Contents

A Hospital-based Study of Stigmatisation and Well-being of Relatives of Mentally-ill in Ogun State, Nigeria

Abimbola Afolabi Ph.D
Department of Social Work, University of Ibadan, Nigeria.
08035627992 drafolabiabimbola@gmail.com

Abstract

The study was a hospital-based one that investigated stigmatisation and well-being of relatives of the mentally-ill in Ogun State. It adopted a correlational research design to study252 relatives of mentally-illusing purposive sampling technique. Self-administered structured questionnaire and in-depth interview guides served as instruments for data collection respectively. The data obtained were analysed at univariate and bivariate levels with the aid of the Statistical Package for Social Sciences. The finding revealed a weak negative correlation [r (250) = -.083, p>0.05] between stigmatisation and self-acceptance among relatives of mentally-ill. A weak negative correlation was also found [r (250) = -.167, p<0.05] to exist between stigmatisation and personal growth level of relatives of mentally-ill. Moreover, a weak positive correlation but not significant was found [r (250) = .081, p>0.05] between burden of care and care of mentally-ill. However, the contrast was the case with the qualitative finding. It was concluded that stigmatisation has many negative consequences on persons having mental illness, including their relatives' well-being in terms of self-acceptance, personal growth and burden of care of mentally-ill.

Key words: Stigmatisation; Self-acceptance; Personal growth; Mentally-ill.

Introduction

Mental illness is a temporary or permanent change in an individual's brain or mental processes, thereby altering thinking, mood or behaviour, which makes the person unable to function normally in daily life activities or adjust to distress and psychic functioning. For instance, when it involves schizophrenic type of mental illness, it is usually characterised by restlessness, hyperactivity, delusions, hallucinations and over-activeness (American Psychiatric Association, 1994). Mental illness is usually characterised by stigmatisation in many societies. Stigma, in mental illness is a serious social problem which has a multitude of consequences on the individual concerned, as well as his or her family (Nxumalo & Mchunu, 2017). In the 1950s, the public viewed mental illness as a stigmatised condition and displayed an unscientific understanding. Mental illness carries great social stigma, especially if linked with fear of unpredictable violent behaviour. In the Yoruba traditional society, people who suffer from mental disorders are called "Were", which is translated as "mad". It is believed that the pregnancies of such people were possessed by spirit pranksters most often referred to as "emere". Surviving children manifest various forms of mental illness ranging from manipulative, stereotyped, historic dissociative disorder to real schizophrenia (Ilechukwu, 2007).

Globally, the issue of mental disorders are commonly happening and often seriously impairing in several countries (Kessler, Aguilar-Gaxiola, Alonso, Chatterjie, Lee, OrmelUstun & Wang, 2009). Specifically, World Health Organisation estimated that mental health disorders were the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality as of 2002 (Buka, 2008). For example, it has been observed that Schizophrenia as a severe mental illness affects 29 million people globally (Chan, 2011). Consequently, caring for the mentally ill patients leaves much burden on the family institution. Mental illness is associated with an enormous global burden, consisting of both direct and indirect cost implications. The direct clinical cost encompasses hospitalisation, medication and therapy while the indirect cost reflects in reduced labour supply, loss of earnings and reduced or missed educational attainment among others (Farchione and Bullis, 2014). According to Canive, Sanz-Fuentenebro & Perez (1996), the major effects of caring for the mentally sick on family included community stigmatisation of caregivers, poor health of family members, disruptions to social, physical, leisure, domestic activities and by extension, reduction in household income.

Mentally-ill people are not only stigmatised but their caregivers and family relatives also suffer the same fate of rejection and social isolation in many societies. The burden of care of mental patients

on family members is usually enormous, coupled with the challenge of self-acceptance and impaired personal growth among close relatives of the mentally-ill. Stigma originally dates back to ancient Greece where it was a mark made by a branding iron or tattoo on the skin of a slave, criminal, or traitor to identify that person as a degraded or immoral person that should be avoided (Crocker, Major & Steele, 1998; Bos et al., 2001). The way society sees and fights stigma is historically influenced by the way madness and mental illness have been conceptualised over time. Such conception, also observed in the nuclear family, is frequently based on myths of incapacity, dangerousness and the irreversible nature of severe mental illness. Till today, stigmatisation poses more or less conscious obstacles to the functional competency and recovery possibilities of the mentally-ill (Hinshaw, 2007). Misconceptions and reinforced stigmatisation about mental disorders could have negative consequences on familial relationships in the form of social isolation and exclusion (Kring, Johnson, Davidson & Neale, 2009).In the light of the foregoing, the study investigated a hospital-based study of stigmatisation and well-being of relatives of mentally-ill in Ogun State, Nigeria. However, the specific objectives were to: examine relationship between stigmatisation and self-acceptance; examine the association between stigmatisation and personal growth.

Review of Related Literature

Indeed, stigma may hinder both treatment-seeking and recovery of the mentally ill. The World Health Organization (WHO) has identified stigma as the main cause of discrimination and social exclusion, as it affects the person's self-esteem; limits social functioning; hinders the successful acquisition of a home and a job; and contributes to family dysfunction (WHO, 2005). Such discriminative behaviours become even stronger when individuals are faced with a diagnosis of schizophrenia, due to its typical symptoms, disruptive behaviours and the dangerousness commonly associated with the disorder (Leff & Warner, 2006).

Evidently, stigma is not merely a physical mark, but is often seen as a context-related attribute that leads to widespread social disapproval (Byrne, 2000; Stutterheim, 2011; Bos et al., 2013). As such, stigma does not reside in a person but occurs within a social context and more specifically in social interactions between people. Consequently, experiences constituted as stigmatising in on esocial context may not be perceived as stigmatising in others (Bos et al., 2013; Crocker, Major & Steele, 1998).

Basically, there are four types of interrelated stigma, namely: stigma by association, self-stigma, structural and public stigma. However, public stigma is at the centre of them and is considered to be the foundation for the three other manifestations. Some of the harmful effects of stigma can include: reluctance to seek help or treatment; lack of understanding by family, friends, co-workers or others you know; fewer opportunities for work, school or social activities or trouble finding housing; bullying, physical violence or harassment, health insurance that exclude mental illness treatment.

Stigmatisation and Psychological Well-Being

The relationship between stigmatisation and psychological well-being is a complex one. In the context of this study, six proxies of psychological well-being were considered, namely: self-acceptance, personal growth, environmental mastery, purpose in life, autonomy and positive relations with others. However, self-acceptance and personal growth were given prominent attention in this study.

Stigma diminishes self-esteem and robs people of social opportunities (Corrigan & Miller, 2004). This includes being denied opportunities such as employment or accommodation because of their illness. Self-discrimination or internalised discrimination is the process in which people with mental health problem turn the stereotype about mental illness adopted by the public towards themselves. They assume they will be rejected socially and so believe they are not valued (Livingstone & Boyd, 2010).

Literature suggested that the way in which the general public perceives people with mental health problems depends on their diagnosis. Those with schizophrenia are seen as dangerous and unpredictable (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). It is widely acknowledged that mental illness attracts stigma. The society's historical approach to those with mental illness played a

significant part in cloaking the subject with misunderstanding and fear. Caregivers play a vital role in supporting family members who are sick, infirm or disabled (Singleton, 2002).

Larson and Corrigan (2008), in their study, found that experiences of stigma by association have damaging effects on the lives of family members of people with mental illness. Specifically, it was noted that family members worried about being blamed and had strained relationships with others, lower self-esteem, and a diminished quality of life. Similarly, Struening, Perlick and Link (2001) reported that family members of mentally ill are devalued, thereby making them feel their lives are more difficult than those who do not have mentally ill relative. In extreme cases, stigmatisation has led to premature death of relatives of mentally ill through suicide. An almost immediate consequence of successful negative labelling and stereotyping was a general downward placement of a person in a status hierarchy. The person was connected to undesirable characteristics that reduced his or her status in the eye of the stigmatiser.

One strand of sociological research on social hierarchies stated 'tradition' is particularly relevant to the study of stigma and status loss (Driskell, 1990). The research conducted showed the external status like race and gender within small group of unacquainted persons. Those findings are important because they showed how having a status that is devalued in the wider society can lead to very concrete forms of inequality in context of social interaction within small groups. Nxumalo and Mchunu (2017) carried out a study to explore the stigma-induced experiences of family members of persons with mental illness in a selected community in the ILembe District of KwaZulu-Natal (KZN), in order to develop recommendations to help families cope with such stigma. Findings showed that participants reported experiencing stigma from the community in the form of isolation, blame and exploitation, community neglect, as well as labelling and stereotyping. Meanwhile, the majority of the participants reported using emotion-focused coping mechanisms to deal with the stigma they faced.

There appears to be a bi-directional relationship between the mentally ill and their relatives. It is such that mental health afflictions place a great demand of care on family members and relatives. Conversely, the socio-economic conditions of family members and relatives of the mentally-ill determine the quality of care that the mentally sick persons receive per time. Families not only provide practical help and personal care but also give emotional support to their relative with a mental disorder. Therefore, the affected person is dependent on the care and their well-being is directly related to the nature and quality of care provided by the care giver. Caring for a mentally ill can raise difficult and personal issues about duty, responsibility, adequacy and guilt (Oyebode, 2005). In a study by Link et al. (1987), stigma was demonstrated to have negative impacts on social interaction, employment opportunities, emotional well-being, psychological well-being and self-perception. Similarly, mental illness is often associated with a range of psychosocial risk factors such as poverty, isolation, unemployment, substance use and domestic violence, all of which can impact on the children (Nadia, Fortiha, Soumia & Driss, 2004).

Furthermore, it was observed that the children of mentally-ill were exposed to socioeconomic and socio-cultural risk factors such as poverty, inadequate housing, marginal social status and cultural discrimination of the family. They were also exposed to low educational and occupational status of the parents including possible unemployment (Ihle, Esser, Martin, Blanz, Reis & Meyer – Probst, 2001). Also, the mentally ill and their relatives were said to have had limited vocational, recreational and social opportunities caused by factors such as stigma and segmentation (Robert, 2002).

Methodology

The study adopted a correlational research design to investigate stigmatisation and well-being of relatives of the mentally-ill. At the expanded level, the design was used to establish the associations between stigmatisation and self-acceptance; stigmatisation and personal growth; stigmatisation and burden of care of the mentally-ill. Meanwhile, the study setting was Neuro Psychiatric Hospital, Aro in Abeokuta, Ogun State. The study population consisted of a relative of each mentally-ill patient who attended the out-patient department of the hospital. The calculated population was therefore, based on a relative each of the incidence of mentally-ill in the outpatient department between January, 2013 and December, 2013 which is one thousand, one hundred and eighty-two (1,182) according to unpublished medical records of the hospital.

Minimum sample size from the population then was 296 relatives of mentally-ill persons. Assuming a 10% attrition rate, the final sample size was calculated thus:

Attrition rate = 10/100 ×296=29.6+ 30 attrition rate=326. Hence the final sample size is 326. In the course of analysis, 252 respondents with complete, accurate and reliable responses were considered. Others were voided for incomplete filling of questionnaire and unreturned ones.

Furthermore, purposive sampling technique was used to select the individual respondent. This was done by enquiring of the exact relationship that exists between the mentally-ill and the person who accompanied the patient to the hospital. Only those who were nuclear family members of the mentally- ill were included in the study sample. The relative that owned up to be closer or closest to the mentally-ill was selected out of those that had more than one person in the patient's company. An adapted and well-validated questionnaire (Robitschek, 1998; Corrigan, Watson & Miller, 2004) and an In-depth interview guides were instruments used to collect the data for the study. However, the questionnaire was self-administered with some research assistants. Both the researcher and the assistants also informed and explained what the research is all about to the respondents in line with ethical principles governing human subject research. Similarly, 50 relatives were selected for in-depth interview. Moreover, the quantitative data obtained were analysed at univariate and bivariate levels with the aid of Statistical Package for Social Sciences (SPSS) software version 18 while the qualitative data were content-analysed.

Results

Table 1: Demographic Characteristics of the Respondents

Demographic Characteristics	Options	Frequency	Percentage
Sex	Male	146	57.9
	Female	106	42.1
Age	18-25 years	63	25.0
	26-30 years	46	18.3
	31-35 years	74	29.4
	36-40 years	18	7.1
	Above 41 years	51	20.2
Religion	Christianity	138	54.8
	Muslim	107	42.5
	Traditional	7	2.8
Marital status	Single	95	37.7
	Married	148	58.7
	Widow	2	.8
	Widowed	1	.4
	Divorce	5	2.0
	Separated	1	.4
Level of education	No formal education	10	4.0
	Primary education	14	5.6
	Secondary education	73	29.0
	Tertiary education	155	61.5
Occupation	Self employed	88	34.9
	Civil service	77	30.6
	Studying	55	21.8
	Unemployed	16	6.3
	Others	16	6.3
What is your Income per Annum?	Less than N24,000	59	23.4
	N25,000-N50,000	20	7.9
	N51,000-N100,000	11	4.4
	N101,000-N150,000	55	21.8
	N151,000-N200,000	23	9.1
	Above N201,000	84	33.3

The majority (58%) of the relatives that accompanied their mentally-ill persons in Table 1 above are males compared to their female counterparts. The respondents who fall within the age range of 31 and 35 years constituted the highest percentage. The largest population (54.8%) of the respondents were Christians as against the muslims that accounted for 42.5%. The result also showed that married respondents,were the highest group (59%) of the relatives of people living with mental illness.

The respondents with no formal education (4%) formed the lowest group of people in the study. More than half (62%) of the respondents had attained tertiary education. Less than half (35%) of the respondents were self-employed constituted. In terms of income distribution, those whose income level was the highest in naira currency term constituted 53% while the least made up of 4%. It could be inferred that the highest income earners were likely to cope better with the burden of care of their mentally-ill persons.

Table 2: Relationship between Stigmatisation and Self-acceptance

Correlations			
		Stigmatisation of Relatives	Relatives Self -Acceptance
Stigmatization of Relatives	Pearson Correlation	1	-.083
	Sig. (2-tailed)		.191
	N	252	252
Relatives Self-Acceptance	Pearson Correlation	-.083	1
	Sig. (2-tailed)	.191	
	N	252	252
**Correlation is significant at the 0.05level (2-tailed).			

A Pearson correlation coefficient was calculated for the relationship between stigmatization and self-acceptance of relatives of mentally ill as shown in Table 2. A weak negative correlation that was not significant was found [r (250) = -.083, p>0.05]. At 0.05 test level of significance, a p-value of .191 indicates an insignificant relationship. The negative correlation implies an inverse relationship, which means that an increase in stigmatisation will reduce relative self-acceptance, and vice versa. The qualitative findings revealed that majority of the relatives expressed that, with increased stigmatisation, there was reduced self-acceptance. This was noted in the following submission by one of the mentally-ill:

> ...not easy at all. I most times withdraw to my shell in social gatherings. I don't get to talk when others do for fear of being labelled...**(IDI/ Female/Aro / 2017).**

Attesting to the withdrawal feelings as above, another relative expressed thus:

> I don't like people to know I am at home even where I live, not to talk of attending social gatherings... I actually don't like myself because of my mentally ill-relative **(IDI/ Male/ Aro/ 2017).**

However, the contrast was the case with another relative of the mentally-ill who was able to adjust better in managing her self-acceptance crisis. The excerpt presented thus capture the view:

> I usually feel free in social gatherings. I believe it could happen to any other person... So, I don't let the mental illness of my family member bother me to thelevel of not enjoying myself... **(IDI/ Female/ Aro/ 2017).**

In response to questioning one's worth or not, this relative has this submission:

> I sometimes wonder if I have any worth because of my mentally ill relative. I feel my worth is low since I don't really get appreciated or praised for anything I do **(IDI/ Male Aro/2017).**

Contrary to what other relatives have stated about their self-worth, this relative has this to say:

> The fact that my family member has

mental illness does not influence my elf-worth in as much as I don't write it on my forehead and I don't react to people negatively because of it. I still have my dignity **(IDI/ Female/ Aro/ 2017).**

On feeling ashamed or not, another relative of people living with mental illness has this to say:

I am ashamed to relate openly with my family members having mental illness because of how other people around view me.

Those who know me with my mentally-ill relative always look at me suspiciously as if I am dangerous to them **(IDI/ Female/Aro/ 2017).**

On the contrary, a relative of a mentally-challenged person held a different view that there was nothing to be ashamed of due to the condition of the metal health affliction of one's family member. The view was captured thus:

I am not ashamed at all about my relative's mental illness. It can be anybody and life continues despite the relative's mental illness. I go about my duties normally and attend all activities including social and religious as at when due at the usual places.

I don't get carried away with relative's mental illness. **IDI/Male/ Aro/ Nov, 2017.**

Table 3: Association between Stigmatisation and Personal Growth

Correlations			
		Stigmatisation of Relatives	Personal Growth of Relatives
Stigmatization of Relatives	Pearson Correlation	1	-.167**
	Sig. (2-tailed)		.008
	N	252	252
Personal Growth of Relatives	Pearson Correlation	-.167**	1
	Sig. (2-tailed)	.008	
	N	252	252
**. Correlation is significant at the 0.05 level (2-tailed).			

A Pearson correlation coefficient was calculated for the relationship between stigmatization and personal growth of relatives of mentally ill as shown in table 11. A weak negative correlation that was significant was found [r (250) = -.167, p<0.05]. At 0.05 test level of significance, a p-value of .008 indicates a significant relationship. The negative correlation implies an inverse relationship which means that an increase in stigmatization will definitely reduce personal growth of relatives of mentally ill, and vice versa.

The qualitative findings revealed that majority of the relatives submitted that with increase stigmatisation, there is reduced personal growth. This can also be observed in the reported interview below. In considering the relationship between care of the mentally-ill and career progression, a male family care-giver stated that his career was not affected negatively as result of giving care to the mentally-challenged relative. However, it could be that other relatives might be responsible for the physical care while the man in question provides the financial support. The excerpt below gives the submission of the male relative:

I am a lecturer in one of the higher institutions in Nigeria…

I am a senior lecturer today despite my family member living with mental illness. This is to tell you that having a family member living with mental illness does not have any negative effect on my career **(IDI/ Male Relative /37/ Aro/ Nov, 2017).**

In contrast, a female relative of a person with mental illness narrated how she had to stay with the patient on medical admission in the hospital. Consequently, she became inconsistent in school to the extent that her academic programme was

affected. This was because she was the only daughter of the mentally-ill mother. The excerpt below represents the view of the family care-giver:

> ...my mother who has mental illness has affected my schooling...
> I happen to be her only daughter so I don't have a choice than to be available whenever she is down. There are times I miss tests and examinations. I have also had to repeat a class because I had to stay with my mother on hospital admission **(IDI/ Male/ Aro/ 2017).**

A meat seller whose wife has been living with mental illness for almost a decade narrated how the care of the woman has slowed down his business due to lack of time. It was so bad that those he entrusted the business to defrauded him due to lack of time for proper monitoring. The experience is captured thus:

> My wife has been living with mental illness for eight years and I most times follow her to the hospital...
> I actually leave my businessfor my apprentices whenever I am to follow her to hospital... **(IDI/ Male/ Aro/ 2017).**

However, a respondent expressed that the care of the mentally-ill relative did not impede her level of life achievements. The vie is presented below:

> Despite being a relative of a mentally ill individual I have achieved so well because I did not allow the mental illness to be an issue to me to the level of it jeopardising my steps towards great or tremendous achievements **(IDI/ Female/ Aro/ 2017).**

The view of another relative was further elicited on tremendous achievements and the excerpt is presented below:

> I am a trained carpenter from a technical school and my wife has mental illness...
> This illness has disturbed my achievement because I spend my savings and the time I would have used for other things on her...**(IDI/ Male/ Aro/ 2017).**

In eliciting the view on the difference in the level of achievement before and after the development of mental illness of the affected family member, a relative has this submission:

> As for me, I will say I have better achievement before my brother developed mental illness than after. Since he developed the mental illness, there has been a slow pace in the rate of achievement **(IDI/Female/ Aro/ 2017).**

A relative of a family member with mental illness has the following to say on level of achievement before and after development of mental illness:

> There has actually being a better achievement before the development of the mental illness of my family member. I had achieved so much before the illness that I have even had to dispose some of those things to take care of my relative with mental illness **(IDI/ Female/ Aro/ 2017).**

Moreover, the relatives of people living with mental illness were asked if they were fulfilled. One of them expressed the following opinion:

> How possible do you think I can be fulfilled with the lorry load of things I have to do for my mentally ill relative. The fact that I am not fully on my own makes me unfulfilled. **IDI/ Female/ Aro/2017.**

One other relative of family member living with mental illness has the following response on being fulfilled or not:

> Being a relative of someone with mental illness does not in any way make me unfulfilled. I have had to work extra hard to have my achievements despite the mentally ill family member. I also don't let my relative's mental illness affect my focus. **(IDI/ Male/ Aro/ 2017).**

Based on the liminal conditions of relatives of people with mental health afflictions, it could be deduced that their individual personal growth level in terms of educational pursuit, business and career has been badly affected as a result of caring and supporting the mental patients.

Discussion

It is noted in Table 2that stigmatisation had a weak negative correlation with the mentally-ill's relatives' level of self-acceptance as it was not significant. The negative correlation implies an inverse relationship which means that an increase in stigmatisation will (not significantly) reduce relatives' level of self-acceptance and vice versa. However, the finding was inconsistent with a couple of previous studies (Larson & Corrigan, 2008; Struening, Perlick & Link, 2001, *Nxumalo & Mchunu, 2017*). Although an excerpt from the qualitative finding contrasted with the aforementioned studies.

The analysis in Table 4showed that stigmatisation has an association with personal growth in the study. A weak negative correlation that was significant was found. The negative correlation implies an inverse relationship which means that an increase in stigmatisation will definitely (significantly) reduce personal growth of relatives of mentally ill, and vice versa. This result finding was in tandem with a study that identified some negative effects of stigmatisation to on social interaction, employment opportunities, emotional well-being and among others (Link et al., 1997). It also reinforced the view of Nadia et al. (2004) who noted that relatives of the mentally-ill were likely to be exposed to poverty, isolation, unemployment, substance use and domestic violence. Directly or remotely, the personal growth level of the relatives will be truncated or slowed down. Other studies (Ihle et al., 2001; Robert, 2002) carried out by sustain the current finding bordering on stigmatisation of relatives of mentally-ill and their level of personal growth. The qualitative finding equally corroborated that increased stigmatisation leads to reduced personal growth.

Conclusion

It is not an exaggeration that stigma has many negative consequences on persons having mental illness, including their relatives' well-being in terms of self-acceptance and personal growth. Stigmatisation affects the relatives of these mentally-ill in their various facets of life. Empirical finding from this study suggested that an increase in stigmatisation reduced relatives' level of self-acceptance and vice versa. It was also noted that an increase in stigmatisation impaired personal growth of relatives of mentally-ill in terms of business and career.

Recommendations

Arising from the study findings, the following recommendations were made, namely:

Health care providers, including social workers and policy makers should organise periodic public enlightenment programmes to foster community acceptance of family members of mentally-ill in Ogun State. This will go a long way to reduce or eradicate stigmatisation of mental illness.

Mental health care providers should educate family members of mentally-ill so as to enable them cope with any likely form of stigmatisation. Social workers should plan and execute educative programmes for health personnel on how to care for the mentally ill and relate with family members of mentally the ill.

The society should have re-orientation and attitudinal change in order to desist from stigmatising family members of mentally-ill. This will help rehabilitation and reintegration of both the mentally ill and their relatives.

Government should incorporate stigma prevention programmes into mental health care with a view to reducing or eradicating stigmatisation of people living with mental illness and their family members. This will enhance good mental health of the citizens of the country.

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