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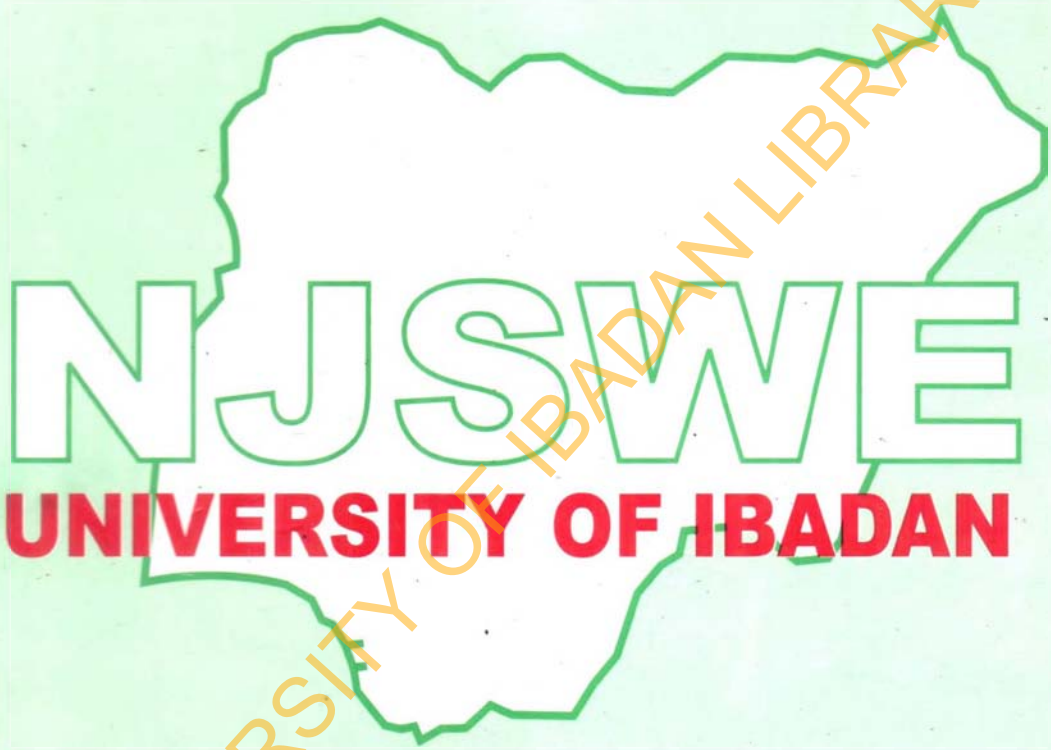

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REDUCING STIGMATIZATION AMONG PERSONS WITH MENTAL ILLNESS: CHALLENGES FOR THE PSYCHIATRIC SOCIAL WORKERS

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Abstract

The stigmatization of persons with mental illness has been found to have a negative impact on people with serious psychological problems. The literature reviewed 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. The negative consequences of this stigmatization require psychiatric social workers to embark on strategies towards reducing the stigma associated with persons having mental illness. A review of some relevant literature also revealed that mental health stigma has been found to have negative impact on an individual's opportunities for jobs and lodging, self esteem, environmental mastery, autonomy, self growth, unwillingness to seek professional and psychological help. Therefore, the paper examined the nature, types and treatment of mental illness. It also discussed the effects of stigma on persons having mental illness and the various ways by which it can be reduced. Such ways include: protestation, contact and education. The paper recommends that Government at all levels should plan and execute health education programmes. It is also recommended that community mental homes should be sited in all communities with a view to saving anybody with symptoms of mental illness prompt and adequate medical treatment.

Keywords: stigmatization, mental illness, persons with mental illness, social workers.

Introduction

Mental illness as a term collectively refers to all diagnosable mental disorders; health conditions that are characterised by alteration in thinking, mood or behaviour associated with distress and/or impaired functioning (American Psychiatric Association, 1994). Mental illness is a disease that affects millions of people each year. Experts estimate that one out of every five American suffers from a mental disorder in any six- month period and one of every three persons suffers from a mental disorder in his or her life time (Bourden, Rac, Locke, Narrow & Reiger, 1992). At a point in time of every year, 30% of the population worldwide is affected by a mental disorder and over two thirds of those affected do not receive care (Kessler, Dembler, Frank, Olfson, Pincus, & Walters, 2005; Chisholm, Flisher, Lund, Patel, Saxena, & Thornicroft, 2007;). Mental illness carries great social stigma, especially, those linked with fear of unpredictable and violent behaviours. In Yoruba culture, people who suffer from mental disorders are called "were", and they believe that the pregnancy 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). Most Nigerians believe that mental illnesses are afflictions caused by supernatural causes (Udoh, 2002). African society also has a peculiar attitude towards the mentally ill person and this is evident in the rejection, scornful disposition and a negative perception of the mentally sick individuals (Mohammed & Mohammed, 2008).

Limited knowledge of the causes, symptoms and treatment of mental illness often lead to common but erroneous beliefs that these conditions are caused by the individual themselves or by supernatural forces, possession by evil spirits, curse or punishment following the individual's family or part of family lineage (Mohit, 2001; Roberts, 2010; Aghukwa, 2010). Mental illnesses are caused by several factors such as damage to the central nervous system, body constitution, hereditary, preternatural and supernatural causes. The cause in some cases may be of unknown origin (Mojoyinola, 2002). Although the exact cause of mental illness is not known, it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological and environmental factors (Goldberg, 2014).

Biologically, some mental illnesses have been linked to abnormal functioning of nerve cell circuits or pathways that connect particular brain regions. Other biological factors that may be involved in the development of mental illness include genetics (hereditary), infections, brain defects or injury, prenatal damage, substance abuse, poor nutrition and exposure to toxins (Goldberg, 2014). Psychological factors that contribute to mental illness include: severe psychological trauma suffered as a child, early loss of a parent, neglect and poor ability to relate with others (Garno, Goldberg, Ramirez, & Ritzler, 2005). Environmental factors that contribute to mental illness are death and divorce, dysfunctional family life, social or cultural expectations and feelings of inadequacy. Different perspectives on the causes of psychological disorders arose including some that stated that psychological disorders are caused by specific abnormalities of the brain and nervous system and that is, in principle, they should be approached for treatment in the same way as physical illness (Carlson, & Neil, 2010).

Mental illnesses can be grouped into four: neuroses, psychoses, psychopathic states and psychosomatic disorders (Mojoyinola, 2002). Neuroses: are group of minor mental disorders where the developments of certain behaviour patterns that avoid rather than cope with problems occur. Psychoses are major mental disorders which involve serious disturbances of thoughts and behaviour. There are two main categories of psychoses which are organic psychoses. They result from damage to the nervous system and functional psychoses which are disorders that are presumed to be primarily psychological in origin. There may also be evidence of genetic contributions and environmental conditions.

Functional psychoses could be classified into affective psychoses and schizophrenia. In affective psychoses there is no evidence of a specific lesion in the nervous system to account for the grossly disturbed functioning, however, there is disturbance of mood. In this case, the affectively disturbed person may be severely depressed, manic or may alternate between periods of depression and elation. These mood changes are often so extreme that the individual may need to be hospitalised.

Affective psychoses, therefore, include: manic state, depressed state and manic depressive state.

Depressed state is a disorder of the mood where the mental and physical activities of the depressed individuals are much slower than normal. His self-esteem is usually at lower ebb. He may feel rejected and discouraged, hence, he is likely to attempt or commit suicide. In manic depressive psychoses, the victim alternates between manic and depressive states often with a period of normal behaviour in between. The depressive element in this type of psychoses is characterised by low spirit unaffected by environmental changes, characteristic pattern of sleep disturbance of early waking between 2am and 3am, ideas of unworthiness, loss of weight without physical causes, inability to concentrate and hypochondriac delusion. The manic element of the depressed psychosis is characterised by elevated mood which ranges from unmarked cheerfulness to wild hilarity, over activity, excessive talking flight of ideals, intense excitement.

Schizophrenia refers to a psychotic disorder characterised by distortion of reality, withdrawal from social interaction, disorganisation of thought, emotion and motor behaviour. Schizophrenia exists in different forms. Simple Schizophrenia commonly occurs at the age of puberty and is characterised by progressive deterioration of personality, sluggishness, apathy and affective dullness. This form of illness may not be immediately known as it is almost imperceptible. Hebephrenic schizophrenia also commonly begins at puberty but sometimes comes on after 20 years of age. It is more acute at the onset than the simple form and its initial episode often shows a complex neurotic symptom which proceeds to reaction resembling hysteria.

The major symptoms of this illness include association disturbance, philosophizing, abundance of neologism, hoarding of rubbish, arguing at length on any occasion without cause, making grimaces, assuming majestic poses, gesticulating, sometimes performing a complete ceremony of welcome or parting, making intricate body movements, solemn bows or courtesies and hallucinations especially the bodily ones.

Catatonic schizophrenia commonly develops between the ages of 29 and 30 years. However, it can also occur at a later age such as menopausal age. It has rapid onset and the symptoms which characterise the initial stage seem more of a clear-cut with growing anxiety, fear and objectionable auditory hallucinations of threat or command. Catatonic Schizophrenia has two dimensions which are catatonic excitement and stupor. Catatonic excitement is characterised by motor excitement which at first, consists of orderly actions which later transform into stereotype, monitory and senseless actions. Thus, some of the patients' behaviour in this condition includes: verbal excitement with broken and often incomplete and incoherent speech, pathological obedience, obstinacy, meaningless initiation of actions (echopraxia) or repetition of phrase heard (echolalia). Catatonic excitement is not infrequently followed by complete or partial catatonic stupor within a few days. In complete stupor, the patient is totally immobile and stiffened in some often inconvenient posture and there may also be complete or partial inhibition of speech.

Paranoid schizophrenia is characterized by gradual onset. The paranoid schizophrenic experiences difficulty in the way he views the world and the people in it. He trusts nobody and is constantly watchful. The combinations of grandiose-paranoid delusion of persecution as well as that of the emotion

and mental disorganisation always make the paranoid seek redress. In the later period of illness, the delusion becomes illogical, disrupted and absurd.

Involution psychoses (melancholia) are an affective or emotional psychosis characterised by worry, anxiety, guilty feeling, agitation and insomnia. The onset of the disorder is at middle age and often due to an awareness that the end of life is approaching. Its incidence is twice as high among women as among men. It consists of depressive moods and it is distinguished from depressive psychosis largely by the fact that it occurs at a middle age. An involutional psychotic is more agitated and experiences greater anxiety.

Other classifications as reviewed by Goldberg 2014, documented the following as the types of mental illness: anxiety disorders, mood disorders, psychotic disorders, eating disorders, impulse control and addiction disorders, personality disorders, obsessive-compulsive disorders, post traumatic stress disorder, stress response syndrome, dissociative disorders, factitious disorders, sexual and gender disorders and somatic symptoms.

The treatment of mental disorders can be traced back to medieval times when attempts were made to drive them away with flogging or by drilling a hole in the skull in order to release the evil spirits. Until the 16th century, treatment techniques were cruel and sometimes tortuous. All these treatment were aimed at balancing the mind and the body. The advent of psychotropic medications in 1950s and deinstitutionalization in 1960s has each had a large impact on the lives of the mentally ill patients and their relatives. It is estimated that approximately 65% of discharged mentally ill return home to live with their families (Goldman, 1982).

A common form of treatment for many mental disorders is psychotherapy. Psychotherapy is an inter-personal intervention, usually provided by a mental health professional such as clinical psychologist who employs any or a range of specific psychological techniques. There are several main types. Cognitive behaviour therapy (CBT) is used for a wide variety of disorders, based on modifying the patterns of thought and behaviour associated with a particular disorder. Psychoanalysis which addresses underlying psychic conflicts and defenses has been a dominant school of psychotherapy and is still in use. Systemic therapy or family therapy is sometimes used, addressing a network of relationships as well as individuals themselves. Psychotherapy is based on humanistic approach.

Stigmatization of persons with mental illness.

Stigma is universally experienced. It isolates people and delays treatment of mental illness, which in turn causes great social and economic burden. Stigma is something that detracts from the character of a person or group, indicating that something is not considered normal or standard. Stigma is also viewed in terms of a deeply discrediting undesirable attributes that disqualify one from full social acceptance. This motivates efforts by the stigmatized individual to hide the mark. Link, Struening, Neese-Todd, Asmussen, and Phelan, (2001) opined that stigma exists when elements of labelling, separating, status loss and discrimination jointly occur in a situation that allows these processes unfold. Stigma is also an attribute that is significantly discrediting; sets the affected person or groups from the normalized social order. Stigma can be a barrier to seeking early treatment; it causes relapse and hinders recovery (Parle, 2012).

Stigmatization has been described by numerous personal accounts of psychiatric illness, to show that shame override even the most extreme of symptoms. In two identical UK public opinion surveys, little difference in their outcome was recorded over 10 years, with over 80% endorsing the statement that "most people are embarrassed by mentally ill people", and about 30% agreeing " I am embarrassed by mentally ill persons" (Huxley, 1993).

Due to stigma, the typical reaction encountered by someone with a mental illness and his or her family members is fear and rejection. Some have been denied adequate housing, loans, health insurance and jobs due to their history of mental illness. Due to the stigma associated with the illness, many people have found that they lose their self-esteem and have difficulty making friends. Specifically, mental health stigma has been found to negatively impact an individual opportunities for jobs and lodging (Corrigan & Miller (2004), one's self-esteem (Corrigan, 1998; Corrigan, Markowitz, & Watson, (2004); Link & Phelan (2001), and one's attitudes toward and willingness to seek professional psychological help (Ben-Porath, 2002; Corrigan, Markowitz, & Watson, (2004); Vogel, Wade, & Ascheman, 2009; Vogel, Wade, & Haake, 2006). Around 9% of the European population experience depressive disorders every year, while the most severe psychotic disorders are much less common with a twelve month prevalence rate of 2.6% (Winchen, & Jacobi, 2005).

Traditionally, communities looked after the mentally sick since they are part of the community and their possible traditional therapeutic regimens to bring them to a relative state of normality (Jegede, 1981; Adebowale & Ogunlesi, 1999; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). However, in Nigeria, the situation is not different as mentally ill individuals are socially stigmatized even after they have been cured of the illness (Jegede, 2005). Family members are often reluctant to discuss their mentally ill member with their friends because they do not know how people will react due to myths and misconception that surround mental illness.

The literature reviewed 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). In a Swedish multi-centre study, 162 relatives of patients in acute psychiatric wards following both voluntary and compulsory admissions were interviewed concerning psychological factors related to stigma. A majority of the relatives experienced psychological factors of stigma by association. Eighteen percent (18%) of the relatives had at times thought that the patient would be better off dead and ten percent (10%) had experienced suicidal thoughts. Interventions are thereby needed to reduce the negative effects of Psychological factors related to stigma by association in relatives of people with mental illnesses (Ostman & Kjellin, 2012).

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 the mentally ill can raise difficult and personal issues about duty, responsibility, adequacy and guilt (Oyebode, 2005). The stigma, myths and misconceptions surrounding mental illness

contribute to much of the discrimination and human rights violations experienced by people with mental illness (Ndetei, Khusakhala, Kingori, Oginga & Raja, 2007).

In a study, that was conducted to look into the stigma impact on Moroccan families of patients with schizophrenia, Nadia, Fortiha, Soumia and Driss (2004) found that a total of 86.7% reported psychological suffering, sleep and relationship disturbances and poor quality of life. A total of 7% of family members were divorced, 2% were ejected from a rent house and 6% of fathers left the family, leaving the mother to care for the patients alone. One study showed family shame was 40 times more prevalent in families with mental illness compared to families who have member with cancer (Ohaeri, & Abdullahi, 2001).

Crisp et al, (2005) in their social handicaps and distress that relatives of people with mental illness experience as a result of prejudice or stigmatization, surveyed 1737 adults with 65% response and concluded that respondents commonly perceived relatives of people with mental illness as unpredictable thereby, promoting negative opinion which contributed to the relatives' social isolation, distress and difficulties in employment. Large proportions of students had been actively discouraged by their medical school teachers, family members, friends and fellow students from going into psychiatry (El-Gilany, Amr, & Igbal, 2010).

Studies have consistently shown that at least one-third of caring relatives have elevated levels of anxiety or depression connected with the caring role and some researchers have found up to 60% of caregivers feeling very anxious and depressed (De Silva & De Silva, (2001). Mentally ill and their relatives assume they will be rejected socially and so believe they are not valued (Livingstone & Boyd, 2010). Many people believe having a mental illness reduces intelligence and the ability to make decisions (Angermeyer & Matschinger, 2005). Based on the literature reviewed above, it is imperative that stigma associated with mental illness and labels given to persons having mental illness should be reduced to make them recover quickly and prevent them from relapse.

How to reduce stigmatization among persons with mental illness

In order to reduce stigmatization among persons living with mental illness, five approaches will be considered. These are: protestation, education, person centred, social inclusion and contact.

Protestation: a way of reducing stigmatization among persons with mental illness

Protest here is a way of telling somebody or the public to stop believing negative views about mental illness. This strategy works on conveying messages to report negative and inaccurate representations of mental illness. Advocacy activities, educational support groups and patient empowerment groups are examples of interventions within the protest strategy. An examination was conducted by Pen and Corrigan, (2002) to examine the idea of protest with psychiatric stigma. Participants were instructed to either suppress or not to suppress their stereotypes of persons with mental illness and evaluation of the effects on stigma related attitudes and behaviours. The result showed that suppression instructions did reduce negative attitudes towards the mentally ill patients.

Education: a way of providing information about an idea

This originates from the belief that stigma is related to poor factual knowledge about mental illness and seeks to inform the general public and health professionals by replacing inaccurate and false assumption of mental illness with facts and accurate conceptions about the illness (Corrigan, River, Lundin, et al. 2001; Rusch, Angermeyer, & Corrigan, 2005). Providing information about mental illness in particular regarding dangerousness would reduce stigmatization. There is evidence that individuals who possess more information about mental illness are less stigmatizing than individuals who are misinformed or did not have knowledge about mental illness. Factual information on psychiatric stigma was attenuated when subjects had to rate their reactions to actual persons with mental illness. Thus, factual information regarding mental illness may be more effective in reducing stigma towards persons with mental illness in general than towards individuals.

Contact: an approach that has to do with direct interactions

According to the re-categorisation theory, contact with and out-group member results in changes in out-group member classification to relationships (Gaerther, Mann & Dovidio, 1989). Direct and face-to-face interactions are examples of contact interventions (Van der Meij & Heijinders, 2014). The idea of contact seems to be the most promising strategy for reducing stigma (Corrigan, & Penn, 1999) especially when contact is one on one and when people are seen as having equal status, working harmoniously than unhealthy competitive manner. However, reducing stigma through contact is time-consuming and may not be cost efficient (Cathoor, De Hert & Penskens, 2003). The efficacy of the strategy depends on the context and the nature of the contact (Kolodziej & Johnson, 1996). It has been established that increased contact with persons with mental illness is associated with lower stigma.

Social inclusion: everyone having a right to take an equal part in the society

In some countries, it is against the law for employers and people who provide services to discriminate against people with mental health and substance use problems. Denying people access to things such as jobs, housing and health care which the rest of us take for granted violates human rights. As a result of stigmatization, mentally ill persons are considered not fit enough to cope with the society and as a result they are being ostracised.

Person centred: treating people with mental health problems with dignity and respect

Those affected with mental illness are to be seen as having their positive values. They make valuable contributions to the society and it should be seen that their health problem is just part of who they are. These mentally ill individuals are at the centre of care so they should be supported and encouraged so that their conditions can be improved.

Challenges for Psychiatric Social Workers

Psychiatric social workers have many responsibilities to perform in reducing negative views about mental illness and those having it. Such responsibilities are not limited to the hospital setting but also outside the hospital setting. The psychiatric social workers have the responsibility to give factual education to individuals, groups and community on mental illness, types, causes

and how to care for the mentally ill individual. They are to liaise with their agency to provide public health education which will give factual information about how to maintain positive mental health, prevent mental breakdown, drug abuse and chronic alcoholism. They have to organize series of health campaigns aimed at people in the community and media personnel to demystify mental illness and reduce the portrayal of offensive stereotypes against people with mental illness.

The psychiatric social workers have the responsibility to promote and advocate for community mental homes where discharged mentally ill persons will live within the community. They have to encourage members of the communities to interact and relate freely with the residents of this community mental home, who could assist them whenever they perceive symptoms of mental illness or other people having them. Also, the psychiatric social workers have the responsibilities of contacting the employer of the mentally sick notifying him or her of the illness and also informing the employer when the patient is fit medically to resume work.

The psychiatric social worker should ensure the treated mentally ill is not denied accommodation after discharge. To this end, they should ensure that the discharged patients are adequately supported at home and if possible, ensure they are employed or do menial jobs to become independent and cater for their daily needs. Both the relatives and health workers should see the mentally ill as themselves, thereby reacting to the mentally ill as they would want others to react to them positively.

Conclusion and Recommendations

There is no gain saying the fact that stigma has a lot of negative consequences on persons having mental illness. It affects patients' mental health and recovery negatively. It also contributes to high rate of relapse among the mentally ill. As a result of these, the paper discussed the various ways by which stigma of mental illness can be reduced. Such ways of reducing stigmatization against people living with mental illness include: protestation, contact and education. The paper recommends that government at all levels should plan and execute health education programmes such could help in reducing negative views about mental illness and labels given victims of mental illness. The paper concluded that if adequate information or education is given to members of the communities about mental illness and how to care for persons suffering from mental illness, many of these people will recover quickly and be prevented from having several relapses,

REFERENCES

Adebowale, T. O. & Ogunlesi A.O. (1999). Beliefs and knowledge about aetiology of mental illness patients and their relatives. *African Journal Medical. Sciences, 28:35-41.*

Aghukwa, C. (2010). Medical students' beliefs and attitudes towards mental illness: Effects of a psychiatric education. *Academic Psychiatry*, 34:67-70

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th edn) (DSM-iv).* Washington DC: APA

Angermeyer, M., & Matschinger, H. (2005). The stigma of mental illness in Germany: A trend analysis. *International Journal of Social Psychiatry, 51(3), 276-284.*

Ben-Noun, L., (1996). Characterization of

patients refusing professional psychiatric treatment in a primary care clinic. *The Israel journal of psychiatry and related sciences. 33, 167-74*

Ben-Porath, D. D. (2002). Stigmatization of individuals who receive psychotherapy: An interaction between help-seeking behaviour and the presence of depression. *Journal of Social & Clinical Psychology, 21, 400-413.*

Carlson, N. R. (2010). *Psychology: The Science of Behaviour*, 7th Edition.

Cathoor M., De Hert & Penskens, (2003). Stigma and schizophrenia, a review Tijdschrift Voor Psychiatric, vlo. 45 no 2,pp 87-95

Chisholm, D, Flisher, A.J., Lund, C.,Patel, V., Saxena, S. & Thornicroft, G., (2007). Scale up services for mental disorders. A call for action. *Lancet.* 370(9594):1241-1252.

Corrigan P., & Miller F. (2004) Shame, blame and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health.* 13, 537-548

Corrigan, P. Markowitz, F., & Watson, A. (2004). Structural levels of mental illness stigma and discrimination. Schizophrenia Bulletin, 30, 481-491

Corrigan, P. W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioural Practice, 5, 201-222.*

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59, 614-625.*

Corrigan, P. W. & Penn, D. L., (1999). Prejudice, Social Distance and Familiarity with Mental Illness. Downloaded from http//schizophrenia bulletin.oxfordjournals.org-January, 2016.

Corrigan, P. W., River L. P., Lundin R. K., Penn D. L., Uphoff – Wasowski K, & Campion J, et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophr Bull, 27: 187-95*

Crisp, A. H. Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatization of people with mental illnesses. *The British Journal of Psychiatry, 177:4 –7.*

Crisp, A., Gelder, M. & Meltzer, H. (2005) stigmatization of people with mental illness: a follow up study with the changing minds campaign of the royal college of psychiatrists. *World psychiatry,* 4:106-113

De Silva, D. & De Silva, S. (2001). A preliminary study of the impact of long term psychotic disorder on patients' families. *The Ceylon Medical Journal 46(4): 121-3. Psychologist, 48, 621-628.*

El-Gilany, A., Amr, M. & Igbal, R., (2010). Students attitudes towards psychiatry at Al-Hassa medical college, Saudi Arabia. *Academic Psychiatry.* 34: 71-74

Gaertner, S.L., Mann, J., Murell, A. & Dovido , J. F., (1989).Reducing intergroup bias: The benefits of recategorization. Journal of Personality, 57(2), 239-249.

Garno, J.L., Goldberg, J.F., Ramirez, P.M. & Ritzler, (2005) Impact of abuse on the clinical course of bipolar

disorder. *British Journal of Psychiatry*,186:121-5

Goldberg, C., (2014). A Phrase To Renounce For 2014: *The Mentally Ill. Common Health Reform and Reality.*

Goldman, H. (1982). Mental illness and family burden: a public health perspective. *Hospital and Community Psychiatry*, 33,557-560.

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

Huxley, P., (1993). Location and stigma: A survey of community attitudes to mental illness. *Journal of Mental Health.*

Ilechukwu, S. T. C. (2007). Cross cultural Psychiatry on Mental Health. *Region and Culture, Vol. 10; 3:239.*

Jegede, A. S. (2005). The notion of 'were' in Yoruba conception of mental illness. *Nordic Journal of African Studies, 3(2): 5-9.*

Jegede, R. O., (1981). A study of the role of socio-cultural factors in the treatment of mental illness in Nigeria. *Social Science Medicine (15A) 49-54.*

Kessler, R., Dembler, O. Frank, R., Olfson, M., Pincus, H & Walters, E., (2005). Prevalence and treatment of mental disorders, 1910-2003. *New England Journal of Medicine.* 352(24): 2515-2523.

Kolodziej M.E & Johnson B.T, (1996). Interpersonal contact and acceptance of persons with psychiatric disorders, a research synthesis. *Journal of Consulting and Clinical Psychology, 64:387-396.)*

Link, B. G. & Phelan J. C., (2001). Conceptualizing Stigma. *Annual Review of Sociology,* 27(1):363-385.

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services, 52,1621-1626.*

Livingstone, J. D., & Boyd, J. (2010). Correlates and consequences of internalized stigma for people living with mental Illness: A Systematic review and meta-analysis. *Social Science and Medicine; 7: 2150-2161.*

Mohammed, S., & Mohammed, S. K., (2008). Attitudes towards mental illness in a Malay Army Battalion. *Medical Journal of Asia, 7(2): 21-32.*

Mohit, A., (2001). Mental health and psychiatry in the Middle East: Historical development. *Eastern Mediterranean Health Journal.* 7:336-347

Mojoyinola, J. K. (2002). *Introduction to dynamics of health and illness.* Ibadan: The Gift Communication.

Nadia, K., Fatiha, M., Soumia, B. & Driss, M., (2004). Stigma impact on Moroccan Families of Patients with Schizophrenia. *The Canadian Journal of Psychiatry.*

Ndetei, D., Khusakhala, L., Kingori, Oginga A & Raja S., (2007). The mental health situation in Kangemi informal settlement. Nairobi. Downloaded from http//www.basicneeds. org.uk.

20 December, 2015.

Ohaeri, J. U. & Abdullahi, A. F. (2001). The opinion of caregivers on aspects of schizophrenia and major affective disorders in a Nigeria setting. *Social Psychiatry and Psychiatric Epidemiology, 36: 493-499.*

Östman, M. & Hansson, L. (2000) Family burden and care participation. A test—retest reliability study of an interview instrument concerning families with a severely mentally ill family member. *Nordic Journal of Psychiatry, 54, 327 -332.*

Ostman, M. & Kjellin, L. (2002). Stigma by association: Psychological factors in relatives of people with mental illness. *British Journal of Psychiatry,* 181:494-8

Oyebode, J. R. (2005). Careers as partners in mental health services for older people advances in psychiatric treatment. *Journal of General Psychology, 128, 279-314.*

Parle, S. (2012). How does discrimination affect people with mental illness? *Nursing Times, 108:28, 12-14.*

Penn, D. L. & Corrigan, P. W., (2002). The effects of stereotype suppression on psychiatric stigma. *Schizophrenia Research.* 1, 55(3), 269-76.

Roberts, L. W. (2010). Stigma, hope and challenge in Psychiatry: Trainee perspectives from five countries on four continents. *Academic Psychiatry.* 34: 1-4

Rusch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20, 529-539.*

Udoh, C. O. (2002). *Health and illness behaviour.* Ibadan. Chris-Rose, pp. 29-48.

Vogel, D. L., Wade, N.G. & Ascherman, P. L., (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counselling Psychology,* 53, 325-337

Van Der Meij, S. & Heijinders, M, (2014). The Fight Against Stigma: An Overview Of Stigma – Reduction Strategies And Interventions. *Psychology, Health & Medicine,* 11.3: 353-363

Vogel ,D. L., Wade, N. G, & Haake, S. (2006). Measuring self-stigma associated with seeking psychological help. *Journal of Counselling Psychology, 53: 325-337*

Winchen, H.U. & Jacobi, F., (2005). Size and burden of mental disorders in Europe - a critical review and appraisal of 27 studies. *Neuropsychopharmacology,* 15(4): 357-76.