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Stigmatization and Discrimination Experiences of Persons with Mental Illness: Insights from a Qualitative Study in Southern Ghana

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1 Introduction

Globally, stigmatization and discrimination against persons with mental illness is a matter of public health concern. This is due to the fact that many people with mental illness are challenged twice; on one hand, they struggle with the symptoms and disabilities that result from the disease and on the other, they are stereotyped and prejudiced due to misconceptions about mental illness (Corrigan &Watson, 2002). Persons with mental disorders represent a considerable proportion of the world's population (World Health Organization, WHO, 2010). It is estimated that about one million people die due to suicide every year (WHO, 2009) and one in four people worldwide will experience mental illness in her or his lifetime (WHO, 2010).

In Ghana for instance, the World Health Organization's report (2007) on mental health indicated that out of the 21.6 million people living in Ghana, 650,000 were suffering from severe mental disorders and 2,166, 000 were suffering from moderate to mild mental disorders. While the burden of mental health care is a public health concern worldwide (Prince et al., 2007), there is a significant gap between the level of mental health needs and the availability of quality services to aptly address these needs (Faydi et al., 2011). For low-income countries like Ghana, mental health is often given the lowest health priority by authorities (Ofori-Atta, Read & Lund, 2010) and this could deepen the stigma and discrimination faced by this population.

In both low-income and middle-income countries in Africa, it is estimated that between 76 percent and 99 percent of people with serious mental disorders do not have access to the treatment they need for their mental health problems (Faydi et al., 2011; World Health Organization, 2008). Some scholars (e.g., Forster, 1962; Read, Adiibokah & Nyame, 2009) have argued that political apathy towards mental health combined with widespread stigma, hinders the progress of mental health care in Ghana. The stigmatization of mental illness is a serious issue given that it adversely affects patients and their relatives as well as institutions and health care personnel working with persons with mental illness (Barke, Nyarko & Klecha, 2011). People who have or are perceived to have mental disorders may find it difficult to access services due to stigma and discrimination and these reactions obstruct prevention and treatment efforts and intensify the impact of the mental health disabilities.

Across the world, people with mental disorders, mental health services, mental health professionals and even the very concept of mental health receive negative publicity and are stigmatized and discriminated against in spite of growing evidence of the importance of mental health for development (Sadik, Bradley, Al-Hasoon & Jenkins, 2010). Mental health has an impact on varied development outcomes and is a basis for social stability because it serves as a key determinant of well-being and quality of life (WHO, 2010). Given that mental health is an important indicator of human development, issues regarding stigmatization and discrimination against persons with mental health disabilities cannot be ignored. The World Health Organization for instance, has linked the stigma and discrimination associated with mental illness to suffering, disability and poverty (Corrigan & Watson, 2002; Crabb et al., 2012)

In his seminal work on stigma, Goffman (1963) asserted that stigma is a feature that is deeply discrediting and makes the person experiencing it different from others and of a less pleasant kind. The unpleasant phenomenon is often accompanied by stereotyping, rejection, status loss and discrimination (Link & Phelan 2001). According to Byrne (2000) stigma is a sign of disgrace or dishonor, separates a person from others. It could arise from a number of factors such as superstition, ignorance, lack of knowledge, belief systems and the fear and exclusion of people who are perceived as different (Agbenyega, 2003; Avoke, 2002; Baffoe, 2013). Similarly, Crabb and colleagues (2012) assert that the experience of stigma is characterized by shame, blame, secrecy, labeling, isolation, social exclusion and discrimination. Since stigma is often rooted in social attitudes, persons with mental illness in Ghana are often disliked, rejected, shunned and could experience sanctions, harassment, and even violence.

Discrimination on the other hand, results from stigma and occurs when people are treated on the basis of belonging, or being perceived to belong to a particular group (Letamo, 2005). Goreczny, Bender, Caruso and Feinstein (2011) describe discrimination as the way persons are treated, intentionally or unintentionally, due to stigma. Discrimination may lead to societal exclusion, bullying, aggression, ridicule and devaluation of the self-worth of people and these could bring about oppression against such persons in all areas of life including the ability to obtain housing, maintain regular employment, access education, engage in meaningful relationships and enjoy quality of life (Baffoe, 2013).

Compared to stigma, discrimination can be recognized more often because it includes public restrictions and some forms of punishment (Busza, 1999). However, not all acts of discrimination are obvious because it may take a more subtle form, as in community members withholding care and support for ailing individuals (Collymore, 2002). Discrimination and stigma are devastating experiences for persons with mental health disabilities in Ghana because in most communities, people tend to have strong views about mental illness, which are often based on stereotypes and traditional beliefs.

Since many people have little knowledge and understanding regarding mental health issues, they may not understand that mental illness is a form of disability that could affect anyone in society. Additionally, stigma research in general has been challenged for drawing on theories and concepts that are uninformed by the lived experiences of the people studied (Link & Phelan, 2001). In Ghana for example, persons experiencing mental conditions are one of the most highly stigmatized and vulnerable groups, for that reason they are usually seen by others in society as being violent, dangerous and unpredictable. Moreover, even though some studies have examined mental health issues in Ghana, a minimal number of empirical research studies have explored stigmatization and discrimination among persons with mental illness.

This study, which is part of a larger research, however goes beyond extant literature by exploring the stigmatization and discrimination experiences of persons with mental health disorders from their own voices and the perspectives of key informants. Understanding their experiences is important because stigmatization and discrimination experienced by persons with mental illness could lead to restrictions in their lives. Research has shown that persons with mental illness are usually prone to a vicious cycle of social isolation, poverty, unemployment and homelessness, among others. In this article the terms mental illness and mental disorder are used interchangeably. The objectives of this study were:

1. To find out how persons with mental illness are stigmatized and discriminated against by their family members.
2. To ascertain how persons with mental illness are stigmatized and discriminated against by the public (friends and neighbors).
3. To determine how persons with mental illness are stigmatized and discriminated against by their employers and work colleagues.

The family, public, and workplace were the focus of the study because as Alexander and Link (2003) asserted, they are qualitatively different in how personal the relationships are and how intentional the contacts may be. The relationship between persons with mental disorders and their family members is usually more personal than their relationship with friends, neighbors and work colleagues. Likewise, interaction between persons with mental illness and the public and those in the workplace are different in that public contact is not sought out, but work contact is chosen (Alexander & Link, 2003).

2 Methodology

2.1 Research Design

A qualitative research approach, specifically phenomenology was used to study the lived experiences of persons with mental health disorders. Generally, reflection on the lived experiences is recollective because it is a reflection on experience that had passed or lived through (van Manen, 1990). The context of this study involved questions about how social life was organized and ways in which individuals and groups made sense of their lived experiences within a their society (Miller & Dingwall, 1997; Baffoe, 2013). Phenomenology was useful for this study because it allowed participants to share their experiences regarding mental illness. As Schwandt (2000) opined, the main concern of phenomenological analysis is to understand how participants constitute their everyday, inter-subjective world.

2.2 Study Area

Ghana is a country located along the coast of West Africa and is a typical hot and humid tropical country. There are a lot of sub-cultures in the country because it consists of a large variety of ethnic groups (Ardayfio-Schandorf, 2005). This study was conducted in the Pantang community, which comprises of people with different ethnic backgrounds. It is a community in Accra, the capital city of the country. Pantang was deemed appropriate for the study because of the existence of a psychiatric hospital in the community. The Pantang Psychiatric Hospital is the largest of the three psychiatric hospitals in Ghana with patients from all over Ghana and other West African countries such as Togo, Benin, Nigeria, Burkina Faso, and Ivory Coast.

2.3 Participants

For this study, a purposive sampling method was used to recruit twenty respondents. This sampling method allowed the researchers to select individuals whose experiences were useful for the purpose of the study (Patton, 2002). The participants comprised of ten persons with mental illness, six relatives of persons with mental illness and four residents of the Pantang community. According to Marshall (1996), the number of participants for a qualitative study becomes clear when new categories, themes or explanations stop emerging from the data that are being collected. In this study, the researchers settled on the sample size of twenty when not much new information emerged from the data being gathered.

Persons with mental illness included in the study accessed psychiatric services at the out-patient department (OPD) of the Pantang hospital and the relatives were persons who were principal caretakers of the mentally ill persons. With assistance from officials of the Pantang Psychiatric Hospital, persons with mental illness were recruited from the OPD because they were medication compliant and functioning well in society. Additionally, the other key informants were included in the study due to their in-depth knowledge about the experiences of persons with mental health disabilities as a result of their direct and regular interactions with them.

The respondents were 18 years and above with an average age of thirty years. In relation to marital status, eight of the persons with mental illness had never married and the other two indicated that they were married prior to their illness but were divorcees at the time of the study. While many relatives of persons with mental disorders and persons in the community included in this study were self-employed, the participants with mental illness were unemployed. The majority of respondents was Christians and belonged to different ethnic groups.

2.4 Data Collection Procedures

Data for this study was collected from respondents through in-depth interviews using unstructured open-ended questions and a voice recorder. Permission to use the voice recorder was sought from respondents. The open-ended questions allowed respondents to express themselves freely and enabled the researchers and participants to discuss emerging issues in much more detail. Furthermore, the data collection method allowed the researchers to probe participants' responses for clarification and to explore key issues mentioned, which were useful for the study. The consent of respondents was sought before the interviews were conducted. Participation in the study was voluntary and respondents were assured of anonymity and confidentiality regarding information they provided.

2.5 Data Analysis

The interviews were recorded after participants' consent was sought. The interviews were played and listened to several times to accurately capture the data and then transcribed. The data gathered was analyzed inductively because it enabled dominant or significant themes to emerge devoid of the restraints imposed by structured methodologies (Thomas, 2003). The researchers analyzed specific statements and looked for possible ideas that made the information more meaningful (Creswell, 1998). Significant themes that emerged from the in-depth interviews were used in analyzing and understanding the study. The most illustrative quotations were extracted and discussed.

3 Findings and Discussions

The study aimed at exploring stigmatization and discrimination experienced by persons with mental illness. The findings revealed that in their daily lives, persons with mental illness who were medication complaint and functioning well in society experienced stigma and discrimination from various groups of people. The themes generated from the data were:

interaction with family members, association with friends and community members, contact with employers and work colleagues.

3.1 Interaction with Family Members

This theme centered on stigmatization and discrimination experiences of persons with mental illness regarding their interactions with family members. As Stier and Hinshaw (2007) asserted, stigma leads to poorer individual and family functioning. Most often, negative perceptions by family members of mental disorders result in stigmatization and discrimination against persons with mental illness. During the in-depth interviews some respondents said:

“. . . things have changed since I was discharged from the psychiatric hospital . . . we used to share things together as a family, we talk about issues . . . I shared the same bed with my brother, my sister and I had meals together and dined from the same plate but now I have been given a separate room, my own plate and drinking cup . . . don’t do things together anymore . . .”

> *“My ex- husband beat me up, accused me of being the cause of my illness and deserted me . . . it wasn’t my fault to be mentally ill”.*
>
> *“We were a happy family but things changed when I got sick, my husband deserted me and went for another woman accusing me of being a witch . . . he took our two children with him and I hardly see them . . . I don’t have a choice, do I?”*
>
> *“My son and I have been rejected by my relatives because of his illness but it is not my fault that he has mental illness . . .”*
>
> *“. . . he is unpredictable and violent sometimes so I have to protect my other children from danger; he is the cause of his own illness by associating with bad friends who use hard drugs”.*
>
> *“My father is no more living with us, I didn’t know why he left and my mother didn’t tell me either, he ignores my calls . . . didn’t understand why because we were very close . . . now I know it is because of my mental illness”.*
>
> *“. . . before I got ill, I used to be invited by the welfare committee of my family to deliberate on family issues but now I am no longer invited . . . when I attend family meetings and contribute to discussions some family members laugh at me whenever I talk . . .”*
>
> *“My ex-husband and his family members have neglected us since my daughter’s mental illness, they said the illness is from my family lineage but I don’t know or haven’t seen anyone in my family with mental illness”.*
>
> *“Sometimes, he becomes violent and usually doesn’t make sense in his conversations . . . issues that aren’t funny are funny to him and vice-versa so it is frustrating to have a meaningful conversation with him*”.

The above responses from participants of this study clearly indicate that persons with mental illness are stigmatized and discriminated against in various forms by their family members. Mental illness affected family relationships where family members distanced themselves from a relative who had experienced a mental disorder. Most people are likely to withdraw from personal relationships with people with mental illness such as living together (Bhugra, 1989; World Psychiatric Association, 2005). Consequently, people with mental illness face social isolation, social distance and low self-esteem (Al-Naggar, 2013; Barke et al., 2011).

Additionally, Al-Naggar (2013) argues that the multiple consequences that result from negative perceptions of mental illnesses could prevent persons with mental illness from fully living and could serve as a barrier to proper care. In this study, it was found that some family members perceived mental ill persons as dangerous and incapable of engaging in daily activities. Our finding corroborates research findings which suggest that people's attitudes towards persons with mental illness often include beliefs that they are dangerous and less capable when compared with the general population (Al-Naggar, 2013; Angermeyer & Matschinger, 2003; Coker, 2005; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). However, it is important to mention that there could be people in the general population who are dangerous and incapable though may not have been diagnosed with mental illness.

While in most societies the family is regarded as a safe haven for family members, it is rather unfortunate that persons with mental illness in this study were stigmatized and discriminated against by close family members like parents and spouses. Such attitudes and behaviours are not surprising, given that the majority of Ghanaians have poor knowledge regarding causation of mental illness as well as the efficacy of orthodox psychiatric medications. Compounding this issue is that stigmatizing views about mental illness are not limited to uninformed members of the general public; some trained professionals from most mental health disciplines subscribe to stereotypes about mental illness as well (Corrigan & Watson, 2002; Lyons & Ziviani, 1995). In their study on attitudes towards mental illness in Malawi, Crabb et al (2012) found that their respondents were not willing to consent to a social intimacy with persons who had experienced mental illness. This finding according to Crabb and colleagues was influenced by respondents' belief that genetic factors were the cause of mental illness and therefore could be passed on to their future children.

Additionally, since the adverse impact of stigma of mental illness extends beyond individuals who have been with mental illness to their family members (Barke et al., 2011; Corrigan & Watson, 2002; Ohaeri & Fido, 2001; Stier & Hinshaw, 2007; Wahl, 1999; Wahl & Harman, 1989) family relations are likely to distance themselves from their relatives who are mentally ill. This could heighten the stigma and discrimination experienced by persons with mental disorders. Based on studies conducted in Ethiopia, Shibre and colleagues (2001) asserted that the experience of stigma by people with mental illness may be widespread since about three quarters of family members of individuals with mental disorders experience stigma, as well.

3.2 Association with Friends and Community Members

In view of the fact that persons with mental illness live in communities, it was vital to explore stigma and discrimination they experienced from friends and people in the Pantang community. Due misconceptions about mental illness, persons with mental illness are robbed of the opportunities that define quality life, which include affiliation with friends and community members (Corrigan & Watson, 2002). Below are some responses from participants:

> *"I have lost my friends after I was diagnosed with mental illness, we were hanging around most of the time but it is not the same anymore . . . ignore me these days . . ."*

> *". . . if a tragedy happens to you in life, you will know the true colours of your friends . . . my friends have distanced themselves from me since I was discharged from the psychiatric hospital".*

> *"My fiancée was my best friend, we dated for almost five years living together in an apartment, we had no secrets . . . he deserted me when I became mentally ill . . . made all efforts to contact him now that I am well but to no avail . . ."*

> *". . . people in our neighbourhood ridicule my daughter when we go out so I make sure she doesn't go out alone . . ."*

> *". . . my friends changed their attitudes towards me when they became aware of my son's mental illness, some have stopped visiting me for fear of being attacked by my son".*

> *". . . some neighbours, especially the teenagers ridicule and point fingers at me wheneverI go out, I don't like going out, I prefer being at home . . ."*

> *"Every time I come out of my room, people in my house look at me in a funny way . . . even their visitors do same, it is quite frustrating . . ."*

> *"I can't be a friend to someone who is crazy because you wouldn't know when he or she will strike, madness knows no friend . . ."*

> *"I will not be comfortable around someone who is crazy due to their unpredictable and violent behaviours . . ."*

> *". . . will consider friendship with someone with mental illness depending on the severity of the illness . . . be extremely careful in order not to be in danger of being harmed".*

> *"I am scared of someone whose brain does not function well or is crazy; it will be very difficult to establish friendship with such a person . . ."*

> *"I was a member of a keep fit club in my neighbourhood but they cancelled my membership when I became mentally ill, I am well now but they don't associate with me anymore . . ."*

> *"I was part of the neighbourhood watch committee but members don't care about me anymore, they have rejected me . . . no one comes to my house to visit me"*

> *"I was a member of a football team in my community . . . stopped playing because the team members treated me badly after I was diagnosed with mental illness . . ."*

As the responses indicate, due to their diagnosis, some persons with mental illness lost their friends and others were scoffed at by community members. Research studies on community attitudes have been done in West Africa and have showed widespread negative views towards mental illness and the belief that persons with mental illness are not suitable for normal social contact (Gureje et al., 2005). Similar perceptions were held by community members included in this study. These negative perceptions are likely to account for the social distancing and isolation that people with mental disorders experience and could also make people unfamiliar with the realities of sufferer's experiences and illness (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000).

In many African countries, including Ghana, people's attitudes towards mental illness are influenced strongly by social and traditional norms that are in turn informed by historical, cultural and symbolic practices such as beliefs in supernatural causes (Gureje & Alem, 2000; Read et al., 2009). Many Ghanaians view persons with mental illness as dangerous, violent and unpredictable because the majority of persons with mental health problems do not use formal health institutions, are labeled with derogatory language such as crazy or lunatics and are often seen roaming the streets of urban centers begging for food or money, sometimes chasing pedestrians and either naked or wearing torn dirty clothes. This is usually due to one or a combination of the following factors; inadequate mental health resources, lack of money and stigma associated with mental illness and psychiatric treatment (Barke et al., 2011; Asenso-Okyere, 1998; Roberts, 2001; Rosenberg, 2002).

Although the majority of persons with mental illness in the Pantang community functioned well on psychiatric medications, as the findings of this study showed, community members still had negative perceptions and attitudes towards them. The findings are consistent with that of Schulze and Angermeyer's (2003) study in Germany. They found that as soon as contact with mental health services became known to their social environment, most people with mental illness experienced negative reactions, which included reduction of their person to being crazy, not trusted, carefully watched over, and every detail of their behavior ascribed to the illness. Kapungwe et al (2010) noted that the stigmatization and discrimination against persons suffering from mental disorders hinders their ability to integrate into society and recover from the illness, due to frequent personal harassment, isolation and exclusion they experience.

Moreover, many Ghanaians do not have confidence in orthodox psychiatric services since they are more familiar with unorthodox medication and services (herbal preparations and spiritual incantations and invocations) offered by traditional and spiritual healers. Most often, in order to get rid of the supposed demons causing the mental illness, individuals are chained, flogged, or incarcerated in shrines or spiritual prayer camps (Fournier, 2011; Commonwealth Human Rights Initiative Africa, 2008; Read et al., 2009). This maltreatment of persons with mental disorders is sometimes exposed through the media and often leads to unhelpful or health-damaging reactions to mental illness (Gureje & Alem, 2000). Once people perceive that mental illness is caused by demons, they have a tendency to believe that it can only be treated spiritually and therefore cannot be cured by orthodox psychiatric medications.

3.3 Contact with Employers and Work Colleagues

The stigmatization and discrimination experiences of persons with mental disorders were explored with regard to their contact with employers and work colleagues. If people, especially employers perceive mental disorders as stable, permanent conditions that are unresponsive to treatment (Stier & Hinshaw, 2007), it is likely they would not offer persons with mental illness jobs. Commenting on this issue, respondents disclosed the following:

> *". . . before I was diagnosed with mental illness, I was in the building construction business with my own workers, now they are all gone because of my illness. . . I do not get jobs anymore"*

> *"When I came home from the psychiatric hospital, I went back to my workplace but my manager said I was sick and that he cannot afford to lose customers because of me . . ."*

> *"I went back to my job after I was discharged from the psychiatric hospital but most of my colleagues started behaving funny towards me, I wasn't feeling comfortable so I left and has since not looked for a job".*

> *"I was a driver before my mental illness, I went back to the car owner after I was discharged from the psychiatric hospital, but she refused to offer me a job on grounds that I was ill and cannot drive well . . . I have tried to convince her on several occasions without success . . . tried other car owners but none of them is willing to offer me a job".*

> *"I was a fisherman but have lost my job after my mental illness, my fishing colleagues refused to have me on board although I am feeling better now, they told me they cannot guarantee my safety because I am not fit to go for fishing on the high seas . . ."*

> *"I knew from the time he became ill that he will lose his job because of the way we treat people with mental illness in our society. . ."*

> *"I will never be comfortable working with someone suffering from mental illness or with a history of mental illness, I will always be nervous".*

> *". . . it would be a waste of time and resources to employ persons with mental illness, how will they function effectively on the job? . . . cannot guarantee the safety of other workers and customers . . ."*

> *"It is rather unfortunate she was not given a second chance to continue her work, she is functioning very well on medication but here we are in a society where even the normal people are not getting jobs so how much more those regarded as crazy . . "*

> *"I was working in a bakery prior the mental illness, although I am feeling better on medication, my manager fired me because most of the workers threatened to quit because of me . . ."*

> *"I am a dressmaker but have stopped sewing . . . lost my customers after was diagnosed with mental illness . . . opened my shop a couple of times but nobody came around, even my apprentices refused to come to work".*

> *"It was a disturbing issue for me when she was diagnosed with the mental illness, Ghanaians refer to people with mental illness as crazy and because of that people are not willing to offer a job to a person with mental illness . . ."*

The findings showed that persons with mental disorders were unemployed since they were unable to find or keep their jobs although they were functioning well on psychiatric medications. Some employers shunned persons with mental disorders because they perceived them as incapable of working and other employers felt they would lose customers if they hired persons with mental illness. In the seminal study of Farina and Felner (1973), it was found that employers were significantly less likely to offer jobs to individuals believed to have a mental illness. As a result, in most work places, people who have been labeled with mental illness report a wide range of discriminatory experiences in occupational settings such as being turned down for jobs for which they are qualified (Alexander & Link, 2003). Consequently, people with mental illness are deprived of opportunities to earn income, which adversely affects total national output (Corrigan & Watson, 2002; Fournier, 2011).

Employers do not want persons with mental illness nearby so they do not hire them (Corrigan & Penn, 1999; Manning & White, 1995). Even if hired, people who have been patients of psychiatric hospitals are likely to be underemployed and earn less income compared to people with similar psychiatric problems who have not been labeled as mentally sick (Link, 1987). In addition to employers, persons with mental disorders in this study experienced stigma and discrimination from their colleagues at work. As indicated in the responses, some employers and work colleagues were not comfortable working with persons with mental illness due to the likely occurrence of the disease while on the job. Stier and Hinshaw (2007) have argued that using potential future episodes of mental illness as a hiring practice is discriminatory, which is similar to employers' avoidance of hiring females because they might become pregnant and be less productive.

Of more concern is the likelihood that persons with mental illness may not disclose their disease to employers and work colleagues due to fear of not being hired or losing their jobs. Thara and Srinivasan (2000) found in their study in India that the need to conceal mental illness from others was stigmatizing. Thus, concealment of mental illness in order to procure a job cannot be overlooked (Loganathan & Murthy, 2008) because it has implications for the health of sufferers as well as productivity. For fear of being ridiculed or fired from their jobs, persons with mental illness may not access mental health services and this could adversely affect their job performance and interactions with people in the work environment.

4 Conclusions and Implications

While globally, persons with mental illness face a plethora of challenges in their daily lives, issues relating to stigmatization and discrimination cannot be over emphasized. This is due to the fact that a growing number of voices including this study are recognizing the negative effects of stigma and discrimination on persons with mental illness, their families, communities and nations (Corrigan & Kleinlen, 2005; Hinshaw, 2006; Link & Phelan, 2001; Stier & Hinshaw, 2007). Clearly, the findings of this study provide a picture of the prevailing stigma and discrimination perpetuated by family, friends, work colleagues and neighbors towards persons suffering from mental illnesses in the Pantang community.

Certainly, the findings suggest the need for societies to take a critical look at the ways of seeing and interacting with persons with mental illness and how they could support and empathize with these persons. In order to reduce the stigma and discrimination experienced by persons with mental disorders, it is suggested that societies join and develop a multilevel response to the phenomenon. Given that in many countries in Africa, including Ghana, the family remains an important resource for the support and care of patients with mental disorders (Giel et al., 1983; Gureje & Alem, 2000), family members need to be supported financially and counseled to understand the causes, effects, and medical responses to mental illness. This is essential because family members must often cope with burdens related to care giving, stigmatization and discrimination (Corrigan & Miller, 2004; Martens & Addington, 2001; Stier & Hinshaw, 2007).

Without assistance, it is likely family members would become overwhelmed and distance themselves from their mentally ill relatives. This could worsen the plight of persons with mental disorders who need love, care and support from family should the public abandon them. As found in this study, the majority of persons with mental disorders lost their friends and jobs when their mental illness became publicly known. Once people associate disclosing mental illness with negative consequences, they are likely to conceal their mental illness from people, which could have an adverse effect on their professional help seeking behavior and ultimately affect their health and positive adjustment in society. As argued by Stier and Hinshaw (2007), attempting to hide one's illness may come at the cost of intimacy, friendship, support, and likeability, which may further increase the symptoms a person with mental disorder is trying to conceal.

Stigma and discrimination against persons with mental illness are often fueled by societal attitudes and practices, discriminatory policies, tendencies toward concealment and silence, and structural processes that hinder the seeking or funding of adequate treatment (Corrigan, 2005; Hinshaw, 2006; Stier & Hinshaw, 2007). It is therefore important for mental health professionals such as clinical social workers and psychologists to understand the stigma and discrimination against persons with mental illness. Based on their understanding, they should be funded by governmental and non-governmental organizations to develop and provide appropriate mental health awareness campaigns in communities to improve people's knowledge about and acceptability of the illness.

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