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Impact of the Stigma of Mental Illness: A Descriptive Exploratory Study of Outpatients in a Public Mental Health Hospital in Ghana

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ABSTRACT

Despite ongoing efforts, persons with mental illness (PWMI) continue to experience stigma and discrimination and with profound negative outcomes. This study examined the psychological and social impact of the stigma attached to mental illness as experienced by out-patients at a public mental health facility. We applied a descriptive exploratory method using a semi-structured interview guide to elicit subjective responses from 12 Outpatient Department members. Study participants described various ways the stigma of mental illness impacted them within the social space. Overall, five (5) themes emerged. These include devaluing, losing their partners, social exclusion, unemployment, and loss of self-esteem. Participants' account of their experiences with stigma so far depicts stigma as an everyday occurrence that adversely impacts their social standing. To effectively address stigma requires intentional efforts to bridge the gap created by deliberate acts of discrimination and lack of support for PWMI within our social framework.

1 | Introduction

“Stigma is the product of historically rooted public attitudes and behaviors (i.e., religiocultural and structural violence perspectives) that characterize labeling, stereotyping, prejudice, cognitive separation, status loss, and discrimination that lead to responses of stress and esteem-related appraisal of experienced, anticipated, perceived or personal endorsement of societal actions due to existing power relational differences” (Gyamfi 2022, 120).

The societal stigma associated with mental illness constitutes a formidable obstacle, diminishing the societal acceptance of individuals grappling with such conditions and impeding their

access to essential care (Knaak, Mantler, and Zeto 2017). The pervasive impact of stigma manifests in people with mental illnesses (PWMI) being hesitant to utilize healthcare services, often resorting to such services only when the condition has escalated to a chronic state. The deleterious consequences of stigma and discrimination on PWMI are manifold, encompassing adverse outcomes stemming from inadequate clinical care, infringements on human rights, deficient institutionalized care protocols, and a dearth of rehabilitative interventions (Gyamfi 2014; Yuksel, Bingol, and Oflaz 2013).

Current literature reports that PWMI continue to experience widespread stigma and discrimination in the community (Hao et al. 2023; Oexle et al. 2018; Subu et al. 2021), media (DuPont-

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Reyes et al. 2020; Ross et al. 2019; Smith 2015), and job search (Hampson, Watt, and Hicks 2020) with profound adverse outcomes. Some community members debarred PWMI from entering public places of socialization, including shops and pubs (Subu et al. 2021). These negative public attitudes and behaviors can lead to social anxiety (McDonagh, Lynch, and Hennessy 2022), insecurity (Pahwa et al. 2022) embarrassment, feelings of shame (Gerlinger et al. 2013; Hao et al. 2023; Mashiach-Eizenberg et al. 2013; Rössler 2016), guilt (Rössler 2016), and anger and aggression (Da Silva et al. 2020). In other jurisdictions, PWMI have lost their social relationships, have been disrespected, isolated, treated with hostility, and rejected by their family and close friends after the first episode of mental illness or contact with mental health care services (Gyamfi 2014; Gyamfi, Hegadoren, and Park 2018; Hao et al. 2023; Subu et al. 2021). Poor social support and networks contribute to adverse outcomes, including low empowerment and internalized stigma that results in low self-esteem and poor quality of life (Mashiach-Eizenberg et al. 2013; Rüscher et al. 2013), low self-efficacy, hopelessness, suicide, and related risks (Hu et al. 2023). These ongoing negative public attitudes and behaviors concerning stigma make most PWMI stay away from treatment, leading to treatment nonadherence and socialization (Parle 2012; Yuksel, Bingol, and Oflaz 2013). There have been reports of health professionals ignoring PWMI (Parle 2012; Subu et al. 2021), culminating in their refusal to seek treatment even when sick with physical ailments (Parle 2012; Radez et al. 2021; Subu et al. 2021).

Barke, Nyarko and Klecha (2011) conducted a pioneering quantitative study examining the attitudes of patients and the public towards mental illness in Ghana. Participants reported high levels of perceived stigma and secrecy/concealment alongside perceived discrimination and devaluation. The public also regarded PWMI as inferior. The public will not accept the PWMI as close friends and will not hire them due to perceptions that they were unintelligent and not trustworthy. Their opinions were also not taken seriously by the community. Since the groundbreaking stigma research by Barke and colleagues in Ghana, there has been a consistent advancement in this field. Despite the ongoing scholarly inquiry into stigma and mental illness, there remains a noticeable scarcity of qualitative research addressing the stigma associated with mental health and, specifically, its impact on outpatients in Ghana. To address this gap, the current study investigated the social and psychological repercussions of the stigma linked to mental illnesses, as encountered by outpatients in a public mental health facility in Southern Ghana.

2 | Methods and Materials

This paper reports on data that was part of a large study that examined the psychosocial impact of stigma among PWMI (Gyamfi 2014) and, therefore, reproduces some portions of information already presented in detail elsewhere.

2.1 | Design

We employed a descriptive-exploratory method, utilizing a semi-structured interview guide, to gather subjective data from outpatients at the Accra Psychiatric Hospital in Southern

Ghana. This method facilitated the participants in articulating their perspectives, enabling researchers to gain insights into individual experiences with stigma, including how participants perceive and interpret these encounters and their ensuing impact (Gyamfi 2014). The process of narrating their experiences imbued meaning into their human encounters with illness within the social context, a dimension that would have proven challenging to quantify through numerical measures.

2.2 | Research Setting

The present study was conducted within a public mental health hospital located in the Greater Accra Region of Ghana. The provision of care for individuals with mental illnesses (PWMI) in Ghana traces its origins to the enactment of a legislative instrument known as the Lunatic Asylum Ordinance cap (79) 1888, promulgated by the British Colonial government. Governor Sir Edward Griffiths endorsed the decree, authorizing the apprehension and confinement of individuals with mental disorders in a Lunatic Asylum in Accra (Gyamfi 2016). As reported by Gyamfi (2014, 2016), a significant proportion of patients admitted to mental health hospitals/units, including the Accra Psychiatric Hospital, have endured prolonged periods of mental illness and experienced abandonment by their relatives; highlighting the substantial impact that negative public attitudes have on PWMI.

2.3 | Target Population

The study focused on the outpatient population at the Accra Psychiatric Hospital.

2.3.1 | Inclusion Criteria

Qualified study participants comprised outpatients diagnosed by a certified healthcare professional, adhering to the diagnostic benchmarks outlined by the American Psychiatric Association (APA) Diagnostic criteria (APA 2013; Roy et al. 2019). Those individuals who provided informed consent fell within the age range of 18–65 and possessed the ability to express their perspectives and experiences related to the research question in the English language.

2.3.2 | Exclusion Criteria

Individuals experiencing a relapse, as well as first-time visitors to the Outpatient Department (OPD) with mental illness, were excluded from the study. Additionally, individuals below the age of 18 and those above 65 years were not recruited.

2.4 | Sampling Technique and Sample Size

The purposive sampling method was employed to select 12 participants from the OPD of the Accra Psychiatric Hospital. This technique facilitated the identification of individuals with

prior experiences of mental health challenges who were able to articulate their personal narratives.

2.5 | Data Collection

The principal investigator (SG) obtained permission from the relevant authorities at the Accra Psychiatric Hospital by submitting a formal letter seeking authorization. Additionally, ethical clearance was sought from the Noguchi Memorial Institute of Research (NMIR) and the Ghana Health Service (GHS) Research Ethics Board (REB). Upon receiving the necessary approvals, the study commenced in accordance with the hospital protocol.

The first author (SG) conducted interviews with 12 outpatients who were attending reviews. To ensure confidentiality and prevent external influences, one-to-one consultations were carried out, aiming to extract in-depth responses from participants. The interviews, conducted in English using a predefined guide, were facilitated by SG. All participants were proficient in English and their native language, therefore, there was no need for transcript translation. Interviews were scheduled at convenient times and locations agreed upon with each participant. In certain instances, repeat interviews were conducted after transcription to address gaps, clarify responses, and confirm issues raised by participants. Participants were encouraged to share their perspectives until it was evident that no new themes were emerging, aligning with the principle of reaching data saturation (Lobiondo-Wood and Haber 2013). The data collection and analysis process spanned 2 months to ensure sufficient time for acquiring comprehensive data. Interviews were recorded with participants' consent and subsequently transcribed manually. Field notes were also maintained during interviews to complement the study transcripts. On average, the interviews lasted approximately 40 min each.

2.6 | Data Analysis

We conducted thematic content analysis following the framework proposed by Braun and Clarke (2006). This method, as outlined by Gyamfi (2014), enhances the contextual representation of verbal expressions, capturing essential ideas regardless of the data volume. The data analysis was conducted concurrently, commencing immediately after the initial interview. The analysis process involved familiarizing ourselves with the data, generating initial codes, identifying themes, reviewing, defining, and compiling a comprehensive write-up, in line with the approach advocated by Lynch and Boyle (2021).

The primary investigator (SG) transcribed the interview audiotapes verbatim after careful listening. SG engaged in reflective practices, repeatedly listening to the audiotapes while mentally visualizing each participant to comprehend and interpret the contextual nuances of their expressions (Gyamfi 2014). The transcribed data and audiotapes underwent review and validation by another team member (JA) to ensure alignment between audio contents and transcriptions.

Text coding was executed by assigning numerical identifiers to each line of the transcripts along the left margin. To address any gaps, the

research team thoroughly reviewed the initial transcripts, formulated additional questions where necessary, and re-engaged participants for further probing (Gyamfi 2014). The researchers then condensed the coded text by compiling keywords, statements, or ideas onto a separate sheet. Subsequently, they organized these codes into sub-categories and main categories representing significant themes. All audiotapes from subsequent interviews were transcribed using the same process applied to the initial interview, with follow-ups conducted as needed to fill in any gaps. Following coding, the emerging themes from all transcripts were amalgamated and summarized into a narrative text for interpretation. Additionally, critical statements from participants were incorporated to illustrate and substantiate the key ideas presented in the study report.

2.7 | Data Management

All study-related materials, encompassing transcripts, field notes, audiotapes, and other pertinent documents, were securely stored in a locker and safeguarded with a key (Gyamfi 2014). Access to these study documents was restricted to the researcher and the designated research team members.

2.8 | Rigor

In accordance with Mayan (2009), the concept of rigor in qualitative research involves the explicit demonstration of the reasons to accord special attention to the findings of a particular study. A qualitative study is considered rigorous when it meets the criteria of credibility, transferability, dependability, and confirmability, as outlined by Lincoln and Guba (1985) and Strawn and Littlepage (2021).

To ensure credibility, the researcher employed open-ended questions posed in various ways to elicit detailed descriptions of participants' perspectives. This approach not only facilitated triangulation, ensuring multiple sources of data collection but also enhanced the authenticity of the study. The research team, in reviewing initial transcripts, generated additional questions as needed and engaged participants in further probing, thereby deepening the discussion. For confirmation of trustworthiness, an independent coder, JA, was involved in the coding process, contributing to the validation of themes identified by SG. Field notes, derived from observations during interviews, were also systematically taken to enrich the comprehensive report reflecting discussions and study-related observations. These field notes, serving as an additional source of data collection, contributed to the study's overall validity. All study activities, including but not limited to field notes, audiotapes, transcriptions, and relevant materials, were diligently recorded and securely stored. This meticulous record-keeping allowed concerned stakeholders to trace the evidence leading to the study's conclusions, thereby ensuring transparency and accountability in the research process.

2.9 | Ethical Considerations

The study protocol was formally submitted to the Noguchi Memorial Institute of Research (NMIR) and the Ghana Health Service (GHS) for approval. Subsequently, explicit informed

consent was obtained from each participant, involving a detailed explanation of the research's purpose, study procedures, as well as the associated risks and benefits. Following this, participants were given the opportunity to pose questions about the study.

To ensure privacy and encourage optimal participation, mutually agreeable locations for each interview session were established with each participant. Participants were explicitly informed of their right to withdraw from the study at any point and were provided the option to answer or decline any questions posed to them. Additionally, assurances were given regarding the confidentiality of all information shared, emphasizing that their treatment at the OPD would remain unaffected, irrespective of their decisions. To safeguard participant identities, pseudonyms were also employed to represent everyone, including all expressions and comments related to them in this article.

3 | Results

3.1 | Participants Demographic Characteristics

Out of the 12 individuals who provided consent to participate in the study, nine (9) were male, and three (3) were female. The participants presented with various diagnoses, including schizophrenia (6), alcoholism (1), epilepsy (3), and bipolar disorder (2). Despite having recovered from severe symptoms, these individuals continued to attend routine outpatient reviews following their discharge from the hospital. Psychiatric treatment had been administered to all participants over a span ranging from 12 months to 18 years, with a mean treatment duration of 4.7 years. The participants' ages varied between 18 and 50 years, with an average age of 29.8 years. All participants had received some level of education, ranging from junior secondary school to university levels. Most participants were unemployed, unmarried, and resided with their parents or other family members. Seven participants identified with the Akan ethnicity, specifically Fante, Ashanti, and Kwahu. The predominant religious affiliation among participants was Christianity, aligning with the demographic pattern in Ghana, where more than 75% of the population is Christian (Ghana Statistical Service GSS and ICF, 2023). Only two participants identified as Muslims.

3.2 | Themes

Analysis of the transcribed data uncovered a range of impacts on participants concerning their experiences over the years. Five (5) overarching themes were identified. These include devaluing, partner loss, social exclusion, unemployment, and diminished self-esteem. The following excerpts from collected participant data are presented to substantiate the identified themes and offer evidence of participants' experiences. A common narrative among participants highlighted shifts in societal attitudes following the onset of their illnesses. Despite their efforts to adapt, the pervasive effects of stigma proved to be formidable challenges for them.

3.3 | Devaluing

Participants who were already employed before their challenging circumstances discussed their difficulties with employers and colleagues. Consequently, some individuals faced demotion, while others experienced alterations in their job responsibilities and salary reductions, all attributable to their pre-existing mental health issues.

Kumi recounted:

...He [my boss] cut down my salary... I was just managing because I couldn't just go home and do nothing. I was just trying to cope with the situation...at my workplace, I was very competent with the job I was doing, but because I had just fallen sick, when I came back I was taken from that field to a different side which doesn't even fit my qualification.

Another participant too reported:

I went for fitting. When I completed, I was working for my master as work and pay. When I was treated and I came back, the amount of money that I was supposed to earn at the end of the month became less than that of my colleagues, and even my juniors whom I have taught... I was given 104 Ghana cedis. When I asked, he [my master] told me business is not as good as it used to be formerly. But when I asked my juniors, they were still receiving 200 Ghana every month. (Nana)

3.4 | Loss of Partner

Adverse public attitudes/behaviors, including gossip and mockery, had detrimental effects on the PWMI. Their personal relationships were significantly strained due to their mental health conditions. Participants encountered disrespect and rejection from community members who were aware of their illnesses, resulting in the breakdown of intimate relationships with their partners or loved ones.

Korankye shared his experience:

I have tried to be in relationships, but most times people come around to tell whoever I am with that I have suffered a condition before, and because of that the ladies shun away from me. Some also accept the relationship but later when they get to know, they also run away from me... out of these 5 relationships, have ended nothing.

Kwamena recounted:

I'm not married. Previously I was having but due to my condition, I broke up. The lady broke up with me. So now I am not having. She was with me, before this illness and after I had this problem, she was not coming to me, so I found out why, and she was saying people have been mocking her with my condition, that I'm not correct, I'm

crazy. She felt bad and she thought not moving with me again. I even personally went to her to see how things would be better but I wasn't able to convince her, so she left.

Ama also disclosed:

I was [married] but now am single. The man just woke up some morning, and asked me we can't go on again so we have to break up... I asked him but he did not give me any good answer... I've been asking myself, I don't know anything about it.

3.5 | Social Exclusion

Some participants recounted instances where friends and colleagues excluded them from specific group activities and marginalized them in decision-making processes. As expressed by the participants, these distressing encounters led to feelings of embarrassment, prompting them to self-isolate (withdrawing from social engagements) to cope with the predicament.

Korankye hinted:

Sometimes when someone brings a fault and I try to share my idea about it, they ignore me. Sometimes they even go on to tell the person that he shouldn't mind me, and that I have a problem with my head. My master is part and some of the workers at the place too. Some of the people don't normally want to come close to me, and sometimes if they say something and I want to come in, they just ignore me and move on...I feel rejected, neglected, and sometimes don't even want to talk to anybody.

Kumi too said:

I had friends earlier but now I don't have a best friend. They don't come to me again...it is like they don't want to move with me anymore or come closer to me like they used to do. This started after I was brought back from the Hospital. They don't come to me now.

Alex shared this:

I was appointed as one of the leaders in the men's fellowship. But after the incident, someone else was put in my place to take over my duties. Sometimes too you will raise your hand [at a meeting] you want to say something, they won't call you. Even if they call you and you make any statement, they will just have that face like you don't have anything better to say so let's continue. So, I had to leave.

3.6 | Unemployment

Support systems and prevailing public attitudes served as origins of stigma, leading to the participants being

dismissed, perceived as incompetent, and deemed incapable of leading independent lives or sustaining employment. This pervasive disregard left them feeling undervalued and disrespected. Despite a genuine eagerness to work, many participants encountered challenges securing employment, as potential employers were reluctant to accept them. In some cases, individuals resigned from their jobs due to the impact of stigma and discrimination. Self-employed participants faced the necessity of closing their businesses due to the repercussions of their mental health conditions. The participants' observations collectively suggest dissatisfaction with how society treats people with mental health problems.

For instance, this participant stated:

I don't have any meaningful job...This issue of job, when I came to Accra I had a cleaning job for one year. I worked for a contractor. It was a contract for one year. After the contract ended, I've not had a job again. If I get the job I'll do, just that I don't get it. I have been asking. I even went to [company name] to search for job. But I was told my strength cannot march up for the job. I don't know why they said so. I didn't ask them. I am seriously searching for a job. I have even asked my friends to help me find one. So far I've not found one yet. (Owusu)

Another participant also disclosed:

I started my own business and it collapsed and since then I haven't been able to set it up. Before, I have been taking some video coverage and as at now, it's not moving like before. It's not like every week they would come and call you that come and take my funeral or birthday shots, it's not happening. It's only my wife who is supporting me. (Nana)

3.7 | Low Self Esteem

Certain participants revealed a shift in their self-perception, expressing a diminished sense of personal value compared to their pre-illness state. They conveyed that their illness had eroded the respect they once commanded. This self-devaluation adversely affected participants' self-esteem, self-efficacy, well-being, and overall assertiveness.

Dan shared this view:

...I feel I should be more outspoken about family issues at this age but still very reserved. You see the illness makes me withdrawn, sort of. I just feel like I'm not being of myself most of the time when I'm with my family or friends.

Ama also hinted: "...I don't think I can marry again. I don't think any man or any boy will like to marry someone who is sick, I don't think..."

4 | Discussion

The researchers aimed to delineate the psychological and social ramifications of the stigma associated with mental illness as experienced by outpatients at a public mental health facility in Southern Ghana. The participants underwent diverse impacts stemming from their encounters, encompassing devaluation, partner loss, social withdrawal, exclusion, unemployment, and diminished self-esteem.

The profound influence of stigma and discrimination significantly affected the outpatients, particularly those who were employed before their mental health diagnoses. These individuals discussed their challenges with employers and colleagues, resulting in reduced salaries and reassignment to departments perceived as incongruent with their qualifications. This aligns with findings from previous studies, including those by Corrigan and Rao (2012), Goffman (1963), Lin et al. (2022), and Subu et al. (2021). Stigmatization characterizes individuals based on distinctive features, ultimately devaluing them (Goffman 1963). Parle (2012) also identified instances where the public treated individuals with mental illness as if they were children or lacked intelligence. Individuals whose mental health conditions were publicly known encountered more underemployment and underpayment than those with similar psychological issues who had not undergone official assessment and diagnosis (Bathje and Pryor, 2011). This adverse impact may contribute to individuals concealing their mental health status to protect their standing at work and in the community, potentially leading to complications such as frequent relapses, absenteeism, inefficiency, job loss, or demotion. To foster social integration, self-esteem, adherence to treatment regimens, and recovery among PWMI, support from the general population, including families, health professionals, employers, and employees, is crucial. In cases where individuals need to be transferred to different work departments for valid reasons, counseling should precede such actions, demonstrating mutual respect, acceptance, and support between employers and employees (Gyamfi 2014).

Study participants also conveyed that their intimate relationships faltered due to their mental illnesses. Some explained that their partners ended the relationship because people ridiculed them, labeling them as sick or mentally unstable. The partners, feeling stigmatized, decided to leave, causing profound social and psychological repercussions. This observation aligns with previous research findings by Hao et al. (2023), Parle (2012), and Subu et al. (2021), indicating that individuals grappling with mental illness may be particularly responsive to rejection in relationships, heightening susceptibility to additional stigma and stress responses. The portrayed scenario appears to be a prevailing theme in Ghanaian society, as highlighted by Gyamfi (2014). The extended family system in Ghana facilitates the sharing of challenges a relative may face, both in terms of family stigma and stigma by association. When the partner is initially reluctant to end the relationship, familial pressure often becomes a decisive factor leading to separation. Ghana's deeply ingrained cultural, traditional, and religious beliefs govern family structures, with families traditionally taking active roles in ensuring unions' success. Consequently, families commonly conduct background checks on potential in-laws, aiming to exclude any potential illnesses and ensure the health of future offspring. Unfortunately,

society tends to stigmatize PWMI, viewing them as societal "outcasts" and harboring misconceptions about the incurability of mental illnesses. Partners may abandon individuals with mental illness due to family influences and negative societal perceptions associated with mental health. Partners may conform to prevailing public prejudices or fear the consequences of being associated with stigma, leading them to terminate their relationships. Implementing purposeful and transformative educational initiatives in schools and communities, with an emphasis on direct social interactions with PWMI, holds the potential to dispel negative myths surrounding mental illnesses, fostering improved social inclusion.

Participants also recounted instances where friends and colleagues excluded them from specific group activities, and their peers overlooked them in decision-making processes. According to the participants, these distressing experiences caused embarrassment, prompting them to distance themselves from various social activities. This finding aligns with Parle, (2012) systematic review of 12 articles, which highlighted discrimination faced by many PWMI in job searches, leading to demotion, bullying, and ridicule in the workplace. Consistent with our study, other research by Gerlinger et al. (2013) and Mashiach-Eizenberg et al. (2013) supported these findings.

Our study further revealed that inadequate social networks contributed to the stigma faced by PWMI, leading to disempowerment and heightened stigma that adversely impacted their quality of life. Despite the strong family bonds in Ghana, individuals with mental illness still experience discrimination from their family and friends, particularly from members of the public and certain extended family members. Notably, instances of unfair treatment toward a sibling with mental illness were rare among siblings who shared the same maternal and paternal parents. This robust social relationship is likely due to the close connection between siblings and immediate family members.

PWMI tend to face victimization when perceived as incompetent, violent, dangerous, unintelligent, or cursed. Lack of knowledge and ignorance about mental illness can significantly impact public perceptions, hindering effective socialization with PWMI. Some members of society may refuse to engage or collaborate with individuals with a history of mental illness. Social rejection experienced by PWMI contributes significantly to the stress associated with mental illness, affecting their recovery, quality of life, and overall well-being. These exclusionary incidents also exacerbate feelings of self-devaluation, heightened depression, low self-esteem, and withdrawal (self-isolation) from public spaces.

The majority of participants encountered challenges in securing employment, and some even experienced job loss due to reluctance from certain members of the public to collaborate with them. This outcome aligns with earlier studies that identified discrimination as a significant factor contributing to the unemployment of PWMI (Brohan et al. 2014; Parle 2012; Subu et al. 2021). According to Hampson, Watt, and Hicks (2020), PWMI face notably unfavorable employment prospects, encountering difficulties securing jobs and social support due to pervasive discriminatory attitudes and negative societal perceptions regarding their competence and trustworthiness (Hampson, Hicks, and Watt 2016).

In the context of Ghana, both social and governmental support for PWMI is insufficient. Unemployed individuals lack access to social assistance, which is currently nonexistent and not part of government policy. Consequently, many PWMI have resorted to becoming vagrants or resorting to begging on the streets for survival. Unemployment not only leads to poverty but also results in a poor quality of life, contributing to low self-esteem, depression, and frequent relapses.

Certain participants revealed a perceived decline in their sense of personal value, emphasizing the loss of respect within their social spheres. Some experienced a reduction in confidence in public settings, while others found it challenging to initiate new relationships due to the reluctance of others to engage with them because of their mental illness. This observation aligns with earlier research findings, such as those presented by Rüsche et al. (2013), indicating that one's sense of empowerment is intricately linked to the levels of stigma and self-contempt they encounter. Elevated self-stigma and diminished empowerment levels are associated with a lower quality of life and reduced self-esteem. Drapalski et al. (2013) and Oexle et al. (2018) similarly demonstrated that heightened internalized stigma correlates with low self-esteem, diminished self-efficacy, severe psychiatric symptoms, and limited recovery levels.

Contrastingly, some studies have noted that despite the stigma and alienation faced by some PWMI, they exhibit elevated levels of empowerment and self-efficacy, accompanied by lower levels of stereotype endorsement (Sorsdahl et al. 2012). Furthermore, some individuals with mental illness reject the legitimacy of public stigma while maintaining low levels of perceived stigma and discrimination (Brohan et al. 2010). Research by Rüsche et al. (2009) corroborated that PWMI who hold their social group in high regard or reject stigma as unjust tend to be more resilient to stigma. The study also highlighted that high group identification predicts positive reactions among stigmatized individuals. These variations are likely influenced by personality traits, cultural and belief systems prevailing in specific geographical areas, previous experiences with stigma, personal insights, and the level of understanding about the causes of one's illness and public reactions.

When PWMI encounter negative feedback during interactions with the public, they are prone to respond with negative emotive behaviors such as anger, isolation, despair, self-blame, shame, and violent behaviors. This can create a cycle of negative events leading to increased stigma and worsened outcomes (Gyamfi 2014). Additionally, when individuals recognize their inability to change negative public perceptions, they internalize these unfavorable attitudes, resulting in self-stigma and concealment. This internalization often leads them to discontinue treatment, ultimately culminating in severe symptoms and frequent relapses.

5 | Implications of the Study

This study will provide valuable insights for health professionals in both mental and general practice, as well as policymakers, enabling a comprehensive understanding of the

profound impact of stigma associated with mental illness and its implications for individuals affected. The examination of public stigma's extent on PWMI serves as a crucial foundation for raising awareness among all stakeholders and informing strategic planning initiatives aimed at improving the quality of life for PWMI. This investigation, conducted within the Ghanaian context, contributes additional knowledge concerning stigma, shedding light on how patients perceive and interpret their experiences related to the stigma phenomenon. Engaging with participants in this study has proven empowering, allowing their voices to be heard and fostering an environment where they can express themselves. This process has enhanced their self-esteem and encouraged them to stand up and confront stigma wherever they encounter it. It is a recognition that PWMI are individuals with inherent rights to lead independent and fulfilling lives just like any other person.

5.1 | Limitations of the Study

Participants' reluctance to participate stemmed from individuals' concerns about divulging personal issues to fellow community members. Notably, the study focused exclusively on individuals undergoing outpatient treatment, thereby excluding perspectives from those on the streets and those currently admitted. The selected participants exhibited relatively higher levels of functioning, having sufficiently recovered to engage in interview responses. Consequently, the study intentionally excluded individuals deemed not yet stable regarding their symptoms. Future studies could benefit from a more inclusive sample, encompassing diverse groups, to comprehensively capture the perspectives of PWMI within the Ghanaian context.

6 | Conclusion

The pervasive and enduring stigmatization of individuals coping with mental illnesses is evident across various aspects of their lives. The participants' narratives detailing their experiences with stigma underscore its profound influence on their recovery and ability to navigate daily existence. Recognizing their perspectives in decision-making processes is crucial for comprehending and providing support to PWMI. It is noteworthy that, despite societal labels, these individuals harbor aspirations for independent living, encompassing vocational training for quality employment, equitable remuneration, active participation in community social activities, secure housing, and access to effective and affordable healthcare.

Consequently, comprehensive support is essential from various sectors, including governmental entities like the Ministry of Health and its subsidiary, the Ghana Health Service, to address stigma and its far-reaching impact. The participants' expressions collectively suggest discontent with how society perceives and treats PWMI in Ghana. Addressing this issue requires intentional efforts to bridge the gap created by deliberate acts of discrimination and the lack of support for certain individuals within our social framework.

Author Contributions

Sebastian Gyamfi is the project lead and was involved in the project conceptualization, design, overall responsibility for the project implementation, data collection and analysis, original draft preparation, and publication. Mark Fordjour Owusu review and validation of analysis, manuscript preparation, editing, and review. Joseph Adu was involved in data validation, review of findings, manuscript preparation, editing, and review. Isaac Amankwaa review and validation of analysis, manuscript preparation, and review. Ebenezer Martin-Yeboah review and validation of analysis, manuscript preparation, editing, and review.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The datasets analyzed during the current study are not publicly available. Participants of this study did not agree for their data to be shared publicly, so supporting data is unavailable.

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