
PATIENTS' AND CARE PROVIDERS' EXPERIENCES OF STIGMA ASSOCIATED WITH BIPOLAR I DISORDER IN UGANDA

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ABSTRACT

Stigma is often associated with low levels of mental health literacy among members of the public and it is a significant barrier to care-seeking and utilisation of psychiatric care. Because little is known about the experience of stigma associated with psychiatric illness in Uganda, we investigated this phenomenon among patients diagnosed with bipolar I disorder and their care providers in western Uganda. A case study design and a qualitative approach were adopted. In-depth individual interviews were conducted with the participants and data were analysed using the thematic data analysis method. We found that stigma was expressed in the form of derogatory labels and social exclusion from public life. As a consequence, patients were inhibited from seeking and utilising psychiatric care while adherence and recovery were undermined. Our results suggest a need for interventions targeted at addressing stigma and its consequences to promote care-seeking, utilisation, adherence and recovery among people with psychiatric illness. Psychiatric care should thus be conceptualised broadly to include psychosocial interventions such as psycho-education and community sensitisation focused on patients, families and the broader community.

Keywords:

stigma, discrimination, patients, care providers, bipolar 1 disorder, Uganda

INTRODUCTION

Psychiatric illness and stigma are closely related (Sartorius, 2007; World Health Organization (WHO), 2001). Within the context of this study, a psychiatric illness refers to a mental health problem that is diagnosed by a psychiatric health worker. Stigma is enacted based on the labelling of everyday experiences within people's social and cultural contexts. The tendency by health workers to view psychological distress as a psychiatric illness is often a basis for stigma and discrimination (Rapley, Moncrieff and Dillon, 2011). Social stereotypes of psychiatric patients influence the ways they are perceived socially (Corrigan, Kerr and Knudsen, 2005). Moreover, labelling people with a psychiatric illness involves cognitive, emotional and behavioural processes that manifest in stereotypes, prejudices and discrimination. The stigmatisation of a psychiatric illness is a ubiquitous phenomenon, but may occur especially in contexts characterised by social, economic and political inequality (Littlewood, 1992). In this regard, persons who hold power usually label and stigmatise those who do not, such as individuals living with a psychiatric illness (Narayan, Chambers, Sha and Petesch, 2000).

Misconceptions about psychiatric illness often result in hostile social reactions to patients, thus exacerbating stigma. These include the belief that psychiatric illness leads to pity (Sorsdahl and Stein, 2010); is caused by spirit possession (Ssebunnya et al., 2009); and is associated with infectiousness, violence, incompetence and character weakness (Corrigan et al., 2005). Misconceptions about psychiatric illness have also been associated with low levels of mental health literacy (Helman, 2007).

Stigma can be disaggregated into public and self-stigma. On the one hand, public stigma manifests in social and personal reactions in the form of prejudice, stereotypes and discriminatory behaviours towards people with psychiatric illness (Rüsch, Angermeyer and Corrigan, 2005). It is common especially among authoritarian, paternalistic and, in isolated cases, benevolent relationships with people with psychiatric illness (Watson and Eack, 2011). For example, in Botswana, exclusionary behaviour manifests in relocation of people with psychiatric illness to slums, cattle posts and shrines of traditional healers (Moroka, 1998). Similarly, social exclusion rather than the loss of essential skills or poor job performance often leads to the marginalisation of persons with a psychiatric illness (Ssebunnya, Kigozi, Lund, Kizza and Okello, 2009). Public stigma is associated with poor quality housing and homelessness for persons with a psychiatric illness (Desjarlais, 2010). While psychiatric illness may undermine patients' capacity to live independently and safely, public stigma associated with the illness often aggravates the situation. For example, Orley (1970) reported that members of the Baganda community in Uganda secluded patients in deplorable dwelling places because they mistakenly associated psychiatric illness with violence and contagion.

On the other hand, self-stigma refers to the endorsement and internalisation by people with psychiatric illness of negative stereotypes and beliefs about the illness prevalent in specific cultural and social contexts (Rüsch et al., 2005; Sayre, 2000). Self-stigma is often a consequence experienced by the person with a psychiatric illness in interpersonal interactions, in the form of intentional and non-intentional exclusion in both the private and public institutions, and negative media images about psychiatric illness (Alonso, Buron, Rojas-Farreras, de Graaf, Haro, de Girolamo, Bruffaerts, Kovess, Matschinger, Vilagut and the ESEMEd/MHEDEA 2000 Investigators, 2009).

In general, stigma is a significant barrier to care-seeking and care utilisation (Saxena Thornicroft, Knapp and Whiteford, 2007). For example, people with psychiatric illness are usually reluctant to disclose their condition to others (Corrigan and Rao, 2012). Disclosure of psychiatric illness often involves weighing the likely benefits such as increased social support against the possible costs such as social exclusion and prejudice (Corrigan and Rao, 2012; Rüsç et al, 2005). Such hostility or sympathy may influence the likelihood of disclosure and vary widely in different cultural and social contexts (Kleinman, 1980). In addition, care seeking and utilisation often cause and aggravate self-stigma (Kranke, Floersch, Townsend and Munson, 2009). For example, American adolescents taking psychiatric medication reported internalising stereotypes associated with psychiatric illness, such as lack of self-control which made them feel ashamed of having a psychiatric diagnosis and taking medication (Kranke et al., 2009). They consequently became secretive about taking medication and limited their social interactions with peers. Taking medication, in particular, resulted in beliefs that they were different and thus inferior to other adolescents (Kranke et al., 2009).

This study derives from the social constructivism perspective which assumes that people create social realities which ultimately influence how they experience their created social realities (Teater, 2010). For example, whereas social institutions such as hospitals are created by people, they are subsequently experienced differently. For example, the hospitals could be experienced differently by psychiatric patients and care providers. This perspective recognises that contextual factors including the social, historical and cultural factors influence people's experiences of social reality. In particular, people's beliefs determine how they label, express and respond to distress (Helman, 2007). The processes of internalisation and externalisation of subjective experiences, facilitated by people's interaction and socialisation with other people are central tenets of the social constructivism perspective (Hardcastle, Powers and Wenocur, 2004).

Social constructivism perspective is also in keeping with Graham Scrambler's medical sociology theory of stigma and social exclusion (Whitehead, Carlisle, Watkins and Mason, 2001). Whitehead et al. reported that Scrambler analysed stigma within the contexts of health and illness by developing the idea of the sick role that was earlier proposed by Parsons, with regard to illness and deviance. Scrambler's theory identifies medical structures that result in social exclusion of patients on the basis of labelling conditions within medical and social contexts. Conditions that are often labelled and thus stigmatised include HIV and AIDS and epilepsy; they set apart sufferers as socially unacceptable or inferior from *normal* people (Whitehead et al., 2001). The theory also postulates that illness involves deviance and stigma at two levels: (i) an individual deviates from the social norm when he or she is labelled "a sick person", and (ii) an individual has a condition that is socially uncomfortable for other societal members. Deviance may manifest in either appearance or behaviour (Whitehead et al., 2001).

Although there is general consensus among researchers that people with psychiatric illness suffer from stigma, little is known about how the psychiatric patients and their care providers in Uganda think about and experience stigma. The present study examines the perspectives of the patients and their care providers regarding experiences of stigma among patients receiving psychiatric care in Western Uganda. Understanding experiences of stigma among patients and their care providers contributes to social workers' efforts to promote social development goals such as social solidarity, social inclusion, empowerment, moral renewal and social citizenship among psychiatric patients in Uganda.

METHOD

Research design

We adopted an exploratory case study design involving multiple cases of psychiatric patients and their care providers. A case study research design according to Yin (2003) facilitates researchers to study a contemporary phenomenon in depth and within its real life-context. The participants whom we enrolled as cases in this study were psychiatric patients seeking treatment for bipolar I disorder and their professional and lay care providers. We adopted a qualitative research approach to this study because it is effective in studying people's lived experiences regarding psychiatric illness (Holliday, 2010) and facilitates the learning from an emic perspective (Babbie, 2010). We triangulated multiple sources of evidence to describe holistically how stigma associated with having a psychiatric illness was experienced in western Uganda (Henning, van Rensburg and Smit, 2009).

Study setting

The study was conducted in the Greater Mbarara region, Western Uganda. The selection of the large public hospital and the Greater Mbarara region for this study was, to a great extent, influenced by the fact that one of the authors is fluent in the Rukiga-Runyanyakore, a language that is commonly spoken in the area. He is also familiar with the local culture. Interest in knowing the local culture is in keeping with the primary aim of qualitative research, namely to promote "thick descriptions" and understanding of actions and events from an emic perspective, in the actors' natural settings (Babbie and Mouton, 2001).

Participants

The primary study participants comprised: (a) patients, (b) family members of patients, (c) psychiatric care providers, (d) religious healers, and (e) traditional healers. The latter four were all involved in the care of the patients. We adopted purposive and snow-ball sampling techniques to recruit participants because they allow researchers to identify a subset of subjects from the population who "do not fit into fairly regular patterns and behaviours" (Babbie, 2010:193). These sampling methods also enable theoretical sampling, which suggests that the "evolving theoretical understanding of the subject directs sampling in certain directions" (Babbie, 2010:193). Thus, we enrolled the care providers successively, based on the initial insights, information and consent given by the patients. For the purpose of comparing perspectives, we enrolled patients living with bipolar I disorder together with their care providers. We enrolled patients whom the psychiatric care providers had diagnosed with bipolar I disorder in accordance with the DSM-V criteria (American Psychiatric Association (APA), 2013).

Enrolment procedures for participants

The following participant groups were enrolled in the study: (a) seven psychiatric patients, (b) seven care providers from seven patients' families, (c) seven psychiatric care providers, (d) three religious healers, and (e) three traditional healers. Data were collected until a point of data saturation was attained (Babbie and Mouton, 2001).

(a) Enrolment of patients

We chose to conduct the study among outpatients rather than inpatients because inpatients were in more dependent relationships with their care providers and were likely to perform less capably in the interview process than outpatients. As a public hospital funded by the Ugandan Ministry of Health, the majority of its patients are expected to receive free general health care. Patients were enrolled if they: (a) had a psychiatric diagnosis of bipolar I disorder, (b) were treated as outpatients for at least 6 months, and (c) resided in the Greater Mbarara region. We publicised the study on notice boards at the Psychiatric Unit at the hospital inviting eligible and interested patients to participate. We also publicised the study at review sessions of patients at the Psychiatric Unit and at follow-up community visits.

(b) Enrolment of care providers from patients' families

Care providers from patients' families were enrolled if they were: (a) willing to participate in the study, (b) identified by the respective patients as their trusted confidants, and (c) were closely involved in the care of the patient for at least six months. For each patient interviewed, only one care provider from his or her family was enrolled. All enrolled patients provided verbal consent for us to approach their respective confidants (family members) to participate in the study. One of the researchers made direct telephone calls or conducted home visits to families to explain the study and request their participation.

(c) Enrolment of psychiatric care providers

Psychiatric care providers were enrolled at the hospital in the same way as the patients.

(d) Enrolment of religious healers, and (e) traditional healers

Religious and traditional healers were enrolled if they were identified by a patient as being involved in their care for at least six months and lived in the Greater Mbarara region. Patients provided the research team with the names and physical addresses of those religious and traditional healers who had provided or were currently providing them with care. Such care included spiritual healing, food, accommodation and health education.

After obtaining informed consent from each patient, we verified their respective psychiatric diagnoses of bipolar I disorder from hospital files and obtained confirmation from their attending psychiatrists that episodes of the disorder were in remission and that the respective patients were mentally stable for enrolment into this study. Only patients whose health care workers had given a diagnosis of bipolar I disorder were enrolled in this study.

Bipolar I disorder is a type of mood disorder characterised by one or more manic or mixed episodes, often accompanied by depressive episodes (APA, 2013). The following are some of the diagnostic features of a manic episode: (i) an unusually and persistently elevated, expansive or irritable mood lasting at least one week or less, for which hospitalisation is required, (ii) inflated self-esteem or grandiosity, (iii) decreased need for sleep, and (iv) accelerated speech and thought processes. In contrast with a manic episode, a mixed episode comprises symptoms that meet the diagnostic criteria for both a manic episode and a depressive episode (APA, 2013). The choice of bipolar I disorder as the focus of this study is influenced by the fact that this psychiatric illness is highly associated with

hospitalisation (APA, 2013) and is more impairing to patients than depression (Smith, 2011).

DATA COLLECTION INSTRUMENTS AND METHODS

We used individual in-depth interviews as the main method of data collection and triangulated the sources of the data to enhance validity of the results (Henning et al., 2009; Yin, 2011). Interviews were conducted at each participant's home or office, depending on the most convenient one. Some of the questions we asked participants included: (i) how severe is the health condition (bipolar I disorder)? and (ii) how does this condition (bipolar I disorder) affect your (the patient's) health in particular and life in general?

Ethical clearance for the study was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences at Stellenbosch University and from the Uganda National Council for Science and Technology. We also sought approval from the relevant authorities before enrolling individual participants into this study. These authorities included (a) the President's Office, Republic of Uganda; (b) the District Health Officer, Mbarara district; (c) the Executive Director of the large public hospital; and (d) heads of the families. Seeking permission from heads of families of the selected patients is consistent with the cultural competence agenda that requires care providers and researchers to be respectful and understanding to the beliefs, norms, values and practices of their patients and research participants (Erlen, 1998). We used pseudonyms throughout the study to ensure participants' privacy and confidentiality of information they shared with us. Additionally, we sought written informed consent from all the participants after explaining to them what this study was all about. We also explained to all eligible people that participation in the study was entirely voluntary; only individuals who responded to our study advert were considered for enrolment.

Data analysis

We analysed the data for patterns and themes using the thematic analysis method (Braun and Clarke, 2006). Thematic analysis is a flexible method of analysing qualitative data that may be carried out within both essentialist and constructionist paradigms. We conducted thematic analysis within the social constructivism perspective (Teater, 2010), thereby identifying latent themes across all the individual data sets. The data were coded to identify themes using a computer software programme known as Atlasti 6.2 (Friese, 2012). The coding process involved open coding, in vivo coding, axial coding and selective coding (Saldana, 2009). Data analysis involved inductive, deductive and iterative processes (Bradley, Curry and Devers 2007). To accurately identify themes, the verbal transcripts were read for evidence suggesting processes, actions, assumptions and consequences (Strauss and Corbin, 2008). We also identified metaphors, repetitions across the interviews and shifts in content that suggested relevant themes (Agar and Hobbs, 1985).

RESULTS AND DISCUSSION

We identified three main themes concerning experiences of stigma and discrimination among patients with bipolar I disorder in western Uganda. These themes are (a) stereotyping psychiatric patients, (b) excluding psychiatric patients socially, and (c) endorsing stereotypes by psychiatric patients.

Stereotyping psychiatric patients

Psychiatric patients and care providers reported that family members stereotyped psychiatric patients because of the latter's health problems. For example, Ninshaba, the 45 year old mother of Dorcus, a 28-year-old female patient, stated:

"She has young sisters who are fond of teasing her. You hear them saying eeh, eeh, (mocking laughter) her things (madness) have come back mummy; they (madness) are back. They say mummy that eeh, eeh, she has again become Omugwiraro (a mad person) now that she is conducting herself like that. Then she stays there, accusing her siblings of disturbance and things like that."

Dorcus herself similarly stated in this regard: *"When I became mentally ill my young siblings started addressing me as omugwiraro (a mad person). Calling me by this tag makes me angry for a long time."* These quotations indicate that family members can and do identify the tell-tale signs associated with relapse among psychiatric patients. However, instead of communicating their concerns, some family members ridicule the presenting symptoms of mood disorders. They also blame psychiatric patients for reacting angrily to such mistreatment. Labelling patients with a derogatory term, for example, *omugwiraro* (mad person) shows undue concern with patient's psychiatric disability.

Researchers have in the past similarly found psychiatric illness to be associated with various stereotypes and misconceptions (Corrigan et al., 2005; Rüsçh et al., 2005). For example, Watson and Eack (2011) report that because it is associated with various negative stereotypes, psychiatric illness is one of the most discrediting labels that can be attached to a person. Moreover, Watson and Eack (2011) report that members of the public often believe people with psychiatric illness to be dangerous, unpredictable, incompetent, irresponsible, at fault for their illness and unlikely to recover. Sartorius (2007) similarly reports that hostile societal reactions, such as shackling persons suffering from psychiatric illness, are due to misconceptions about the nature, causes, consequences and management of psychiatric illness. Such misconceptions include the belief that people with psychiatric illness are dangerous (Sorsdahl and Stein, 2010), possessed by malevolent spirits (Ssebunnya et al., 2009); and that psychiatric illness is infectiousness, and leads to violence, incompetence and weakening of one's character (Corrigan et al., 2005).

In addition, participants associated stigma with the use of mechanical metaphors (for example, *wires* in their heads) to refer to psychiatric patients. For example, Mrs. Ntare, the 36 year old wife of Ntare, a 35-year-old male patient, stated: *"There are times when he (the patient) comes home after his wires have gone off. I am now aware of his mental status; he usually comes when he is irritable."*

Mulokole, a 37-year-old female religious healer, similarly stated:

"When you know this person is always introverted and then you notice that the same person is becoming talkative and doing this and that; is actually out of his usual moods; that is how you come to know that there is a wire in his head, which has loosened."

These quotations indicate that participants perceived patients as having poor physical conditions that are compared to a low quality or malfunctioning machine. Osherson and AmaraSingham (1981) explain mechanical metaphors in terms of unique events, such as

increased technological sophistication, which flourished in the West at the time of the Enlightenment (1700s) (Beck, 2004; Cooke, Irby, Sullivan and Ludmerer, 2006). The use of mechanical metaphors by psychiatric patients and care providers to describe the patients' distress is in keeping with the view that because of their superior social status, care providers greatly influence the explanatory models of the former. Moreover, Osherson and AmaraSingham (1981) argue that because care providers such as clinicians are able to identify objective markers of disease, for example, neuron transmitters in the brain as a result of technological advancements, psychiatric illness is conceptualised as a specific and localised entity. The concern with objective markers, dominant in biological psychiatry, also marks a shift in the doctor-patient relationship, namely shifting from doctors being dependent on the patient for information to using machines to find the objective signs of illness (Helman, 2007). The unintended consequences of such technological advancements in medicine include stigmatisation of the psychiatric patient's body, perceived in this framework as a machine rather than a human being. However, such narrow conceptualisation of psychiatric illness also suggests that patients, rather than their social contexts, are often blamed for the psychological distress they experience.

Excluding psychiatric patients socially

Participants reported that members of the public socially excluded psychiatric patients from participating in public life. For example, Dorcus, a 28-year-old female patient, stated:

“When I was sick, all my friends abandoned me. They were asking themselves ‘what is the use befriending this Mugwiraro (mad person)?’ They were ashamed of me.”

Dr. Mungu, a 50-year-old male traditional healer, similarly informed:

“People on earth like to associate with those who are well-off. When you become mad, the relationships end there, people start avoiding you. For instance, people like other people who have something to offer, whom they can converse with and they get constructive advice.”

The belief among members of the public that psychiatric patients are of no substantial benefit to persons in their social constellation undermines investment in such social relationships. Dorcus demonstrated insight into the dynamics of why her friends abandoned her during period of florid psychosis.

Participants also stated that family stigma exacerbates patients' social exclusion. For example, Mrs. Ntare, the 36-year-old wife of Ntare, a 35-year-old male patient with bipolar I disorder stated:

“Most people do not know that he suffers from mental illness. One reason as to why I took him to the village was to ensure that people in Mbarara town do not know that he was suffering from mental illness.”

This quotation suggests that Mrs. Ntare sought to prevent the public from knowing about Ntare's psychiatric illness, resulting in seclusion from other people. Relocation involved further expenses such as transport costs, which meant less money for psychiatric care, which was available in Mbarara town.

Participants also reported that bipolar I disorder leads to disinheritance among patients. For example, John, a 50-year-old male religious healer, stated:

“A mad person may be considered as a dead person. Some people will wish to see him die so that they can inherit whatever belongs to him. If a person can grab a normal person’s property, including their relatives, what about cheating a mad person?”

This quotation suggests that some members of the public are interested in grabbing psychiatric patients’ property because they believe that psychiatric illness is chronic. Because of the belief that mental illness is chronic, some families may have neglected psychiatric patients. Besides, grabbing the patients’ property might have worsened the psychiatric illness.

Participants reported that families and communities exclude psychiatric patients from decision-making in personal matters such as care-seeking. For example, Dr. Nuwagaba, a 50-year-old male clinical officer, observed: *“Because of mental illness, partners are overlooked in decision-making. Their spouses think that the mental patients can no longer make good decisions regarding family matters. They are overlooked by the family and the community members.”*

Similarly, Friday, the 30-year-old daughter-in-law of Mwijakare, a 64-year-old female psychiatric patient, stated:

“In fact it’s a big problem because when she is in a meeting and in church deliberating, other people overlook her suggestions on the grounds that she is a mad person. Even if what she is saying is right, usually it is rejected on the ground that she is mad and that she does not know what she says.”

These quotations indicate that family members and the public overlook the agency and personal volition of psychiatric patients regarding decision-making on personal and public matters. Authoritarian and paternalistic decision-making in the family and community imply that the interests of psychiatric patients are either ignored or misrepresented.

Social exclusion of people with psychiatric illness has been found to be common in low- and middle-income countries (Corrigan et al., 2005; Ssebunnya et al., 2009; Desjarlais, 2010). The earliest report of social exclusion in Uganda was documented by Orley (1970), who showed that members of the Baganda community frequently secluded relatives with psychiatric illness at the Butabika mental hospital. In this study, families showed extreme reluctance at receiving them back home, even when clinicians at the hospital succeeded in managing the patients’ symptoms. However, according to Orley (1970), seclusion of such patients was an improvement in care because many people in Buganda at the time kept relatives with mental illness in stocks until they either recovered or died from neglect. Contrary to expectations, deplorable housing conditions for patients, attributed to the stigma of psychiatric have similarly been found in high-income countries such as the United States (Desjarlais, 2010).

Social exclusion experienced by psychiatric patients is viewed among poor people in countries such as Malawi and Ethiopia as “ill-being” (Narayan et al., 2000:31). Narayan et al. (2000) describe ill-being as the experience and feeling of being isolated, excluded, looked down upon, alienated, pushed aside and ignored by mainstream socio-cultural and

political processes. In contrast to this pessimistic view, the social development perspective suggests that psychiatric patients be viewed as having the potential to recover recovery fully from the illness (Caplan, 2010). Recovery in the context of psychiatric illness implies facilitating psychiatric patients to have hope, develop social relationships, exercise self-determination, participate in meaningful work and to acquire education and empowerment. Recovery is also facilitated by the opportunity for improving the quality of psychiatric patients' lives as suggested by the social investment approach to social work practice. In particular, social workers are required to develop social capital and promote social solidarity, social inclusion and human rights among psychiatric patients (Caplan, 2010).

Social exclusion unfortunately undermines the basic tenets of the social development perspective by postulating that psychiatric illness, by and large leads to dire consequences (Gould, 2010). Such consequences include social withdrawal, unemployment, homelessness, worsening mental health, loss of social networks, debt (Gould, 2010). Social exclusion also suggests a vicious cycle of homelessness as a cause and consequence of psychiatric illness (Gould, 2010). Ill-being is thus linked to structural barriers to social and economic inclusion and participation, including lack of access to resources such as land and livestock, information, employment opportunities, and decision-making power (Narayan et al., 2000). Poverty is also associated with other clusters of disadvantage, for example, powerlessness, inaccessibility and ill-health, which aggravate the experience of alienation among the poor (Chambers, 1997).

The experience of poverty associated with psychiatric illness may be regarded as a form of oppression that manifests in relations of domination; the latter which divide people into dominant or superior groups and subordinate or inferior ones (Dominelli, 2002). The demarcationist theory of oppression postulates that people tend to view the world as hierarchical. As a consequence of this perception, dominant groups of people devise means and actions to exclusively keep power to dominate inferior groups of people. For example, dominant groups of people label people they exclude as "them" or "they" and those the people they include as "us" in a hierarchical ordering of social relations (Dominelli, 2002:14).

Conceptualising distress as a psychosocial experience is consistent with "psychobiology", a critical psychiatric theory proposed by Adolf Meyer (1856–1950) (Double, 2005:56). Double (2005) reported that Meyer regarded psychiatry of the time as mechanistic due to its over emphasis on the biological basis of illness and that such psychiatry did not fully assess patients as persons. The basic assumptions of the psychobiology theory of psychiatry were: (i) sufficient trauma was a possible cause of psychiatric illness, (ii) the boundary between people with a psychiatric illness and those who were healthy was fluid, and (iii) a combination of a harmful environment and psychic conflict caused psychiatric illness (Double, 2005).

Endorsing of stereotypes by patients

Participants reported that patients often enacted the stereotypes of the psychiatric illness they are experiencing. For example, Rutaremwa, a 48-year-old male patient with bipolar I disorder, stated:

"My own family believes that because of my health condition, I cannot do anything developmental; indeed, you have heard about the years I have spent renting my business

premises. When I work (workshop business) and get to somewhere, everything collapses because of relapse and I have to start all over again.”

Kamba, the 60-year-old father of Bebe, a 20-year-old male patient with bipolar I disorder, similarly stated: *“He (the patient) believes that he is not like other people because he did not go to school and does not have his own house. Generally, he is different from his age mates, which makes him feel unhappy.”*

Participants stated that patients were generally unsuccessful in their lives because they did not achieve common measures of success, such as running a business or having a house. In the context of this study, Rutaremwa considered continued payment of rental fees and his inability to own personal business premises as a sign of being an unsuccessful businessman. In addition, emotional reactions of family members and other care providers worsen self-stigma among psychiatric patients. For example, psychiatric patients may lose self-confidence if they believe their families doubt their abilities for social and economic advancement because of their psychiatric illness.

Participants reflected on the fact that some psychiatric patients were unaware that their behaviour was antisocial. For example, Dr. Mungu, a 50-year-old female traditional healer, stated:

“Mental patients are usually not aware of the wrong things such as raping women that they do. When the patient is informed that ‘you did wrong when you were mentally ill’, he develops self-hatred. The patient will ask you; ‘how did I do that?’”

This quotation suggests that patients are also often accused of criminal misconduct, such as rape, which they are not aware of having committed. Such accusations according to Dr. Mungu perpetuated feelings of self-stigma among the patients.

Researchers have in the past similarly found psychiatric illness to be associated with self-stigma. Rüsç et al. (2005) describe self-stigma as the enactment of negative societal stereotypes and beliefs about that may be prevalent in specific cultural and social contexts. However, Alonso et al. (2009) argue that self-stigmatisation is due to the discrimination psychiatric patients experience in interpersonal interactions, social exclusion in private and public institutions, and as a consequence of negative images that abound in the media. Additionally, Okello and Ekblad (2006) report psychiatric illness to be possibly associated with social withdrawal; consequently, the loss of employment, social networks and support. These consequences may, in turn, lead to feelings of low self-esteem and the experience of low self-efficacy (Watson and Eack, 2011). Among some psychiatric patients, however, the lack of insight into subtle stigmatising stereotypes may, on the one hand, protect against self-stigma during acute episodes of mental illness. On the other hand, insight into one’s psychiatric illness and awareness of its associated stereotypes may actually lead to self-stigma among psychiatric patients (Rüsç et al., 2005). Additionally, Narayan et al. (2000) report that self-stigma among the poor, including those with psychiatric illness, is often due to social adversity. Adverse social and economic conditions, such as homelessness and unemployment, lead to poor people becoming more introspective and introverted, which, in turn, lead to self-exclusion from community interaction. The risk of self-exclusion also includes linguistic disadvantages and lower literacy skills among such persons. The humiliation associated with poverty and neglect from members of the community exacerbate feelings of inferiority and alienation among the poor (Narayan et al., 2000).

Study implications

There is a need to prioritise raising awareness and improving literacy regarding psychiatric illness to overcome its associated myths and misconceptions. Such an intervention should, for example, focus on consequences and management of psychiatric illness as well as safeguarding the rights of patients and promoting utilisation and adherence to psychiatric care. Psychiatric interventions such as psycho-education should target individual patients, families and the community that stigmatise patients. Individualised interventions such as medication should also be complemented by social interventions such as community sensitisation because patients are invariably affected by social forces such as stigma that occur within community settings. Finally, further research should be conducted on stigma, for example, to determine its impact on patients' adherence and satisfaction with psychiatric care. Intervention research should also target psychiatric patients and members of the public to promote positive attitudes as towards patients as well as care-seeking and care utilisation. Psychiatric patients should also be empowered, for example, with the knowledge and skills to address stigma and its consequences.

STUDY LIMITATIONS

We enrolled all participants from the Greater Mbarara of western Uganda. The results of the current study are highly nuanced by the Banyankore and Bakiga cultures of this region; therefore, they may have limited relevance to other regions and cultures of Uganda. However, we triangulated perspectives of patients, patients' families, psychiatric care providers, religious and traditional healers; the key stakeholders in mental health. To promote cross-cultural communication in mental health, it is also important to discover cultural specifics alongside universals so that professionals can better contextualise knowledge in practice and research. Some psychiatric patients may also have felt compromised to participate in the study because our research assistant held a position of authority at the hospital. Because she was a familiar individual at the hospital, active involvement of our research assistant may have boosted confidence and encouraged her colleagues and psychiatric patients to participate in the current study. However, providing research assistance could have taken off her limited time and energy that were required to provide care to psychiatric patients in a generally resource-constrained health facility. We also informed participants about the scope and purpose as well as reassured them of the ethics involved. We trained our research assistant in research ethics and data collection and supervised her to ensure ethical conduct throughout study.

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