

EVALUATING PUBLIC STIGMA TOWARDS MENTAL ILLNESS IN  
WINDHOEK

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## **Abstract**

Public stigma towards mental illness is associated with various negative implications for those struggling with mental illness and plays a significant role in help seeking behaviour as well as treatment adherence. The aim of this study is to quantify the degree of public stigma that exists and to understand attitudes towards mentally ill people held by people residing in Windhoek, Namibia. Finally, it seeks to identify whether there are any demographic variables associated with higher degrees of public stigma towards people with mental illness. This study utilises a mixed method approach, utilising the Community Attitudes towards the Mentally Ill (CAMI) scale, surveying 150 participants through a non-probability sampling technique. Data from the surveys were analysed using the Statistical Package for Social Sciences (SSPS) (Version 24.0) with inferential statistics used to identify any variables that could contribute to higher degrees of public stigma. In addition, three focus-group discussions with groups drawn from three different socio-economic areas within the Windhoek district were conducted. Each group consisted of eight participants and views held by the group members around mental illness were discussed. These discussions were analysed to allow for the identification of themes present in the data. Findings from this study revealed an overall level of public stigma towards mental illness of 41% from the CAMI Scale. Older adults, men and people with lower levels of education appeared to possess higher levels of public stigma towards the mentally ill. In addition, results revealed that lower socioeconomic groups had more misconceptions and misinformation around mental illness than middle- and higher-socioeconomic groups. In addition to further research and development of mental health treatment services, strategies to address public stigma, namely contact, protest and education would appear to be applicable in the Namibian context.

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## LIST OF ABBREVIATIONS

PS	-	Public stigma
PSMI	-	Public stigma against mental illness
PWMI	-	People with mental illness
LSE	-	Lower socio-economic
MSE	-	Middle socio-economic
HSE	-	Higher socio-economic
CAMI	-	Community attitudes towards mental illness
AU	-	Authoritarianism
BE	-	Benevolence
SR	-	Social restrictiveness
CMHI	-	Community mental health ideology

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My family, my journey into mental health would never have happened without you.

Henning, for bringing the music back into my life.

## **DEDICATION**

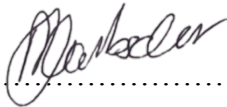
Dedicated to my father. There are so many words that could be strung together to provide an idea of how extraordinarily grateful I am for you as my father but they do not seem sufficient. You have inspired, motivated and challenged me. And I am who I am today because of you. Thank you, dad.

## DECLARATION

I, Marleen Laubscher, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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Marleen Laubscher.....		04/03/2020.....
Name of Student	Signature	Date

## **CHAPTER 1: INTRODUCTION**

### **1.1 Introduction**

This chapter will include a general overview of the purpose of this study. It will begin by providing a brief introduction and background of public stigma (PS) by briefly giving an idea of the current state of the stigma surrounding mental illness and its associated implications. Next it will discuss the objectives and significance of this study and what it hopes future findings would be able to contribute to. Lastly it will consider the limitations and delimitations of this study before concluding.

Mental illness refers to a significant disruption in the cognitive, behavioural and/or emotional aspects of an individual's functioning (Overton & Medina, 2008). Mental illness stigma is a global issue that is associated with various negative implications for people with mental illness (Michaels, López, Rüsçh, & Corrigan, 2012; Overton & Medina, 2008; Teh, King, Watson, & Liu, 2014; Reta, Tesfaye, Girma, Dehning, & Adorjan 2016). These negative implications include unemployment, lower income, less social support and social acceptance as well as a lowered self-esteem and increased risk of suicidality (Lai, Hong, & Chee, 2000; Michaels et al., 2012; Oexle, Waldmann, Staiger, Xu, & Rüsçh, 2018). Challenges related to mental illness often present themselves in a number of ways, ranging from absenteeism from work or school, delinquency, substance dependence, suicide, physical complaints and criminal behaviour (Ministry of Health and Social Services, 2005).

### **1.2 Background of the study**

The situation in Namibia is no different, with various forms of discrimination experienced by those struggling with mental illness (Kangootui, 2012). Stigma and misconceptions in Namibia around what mental illness is, has resulted in many

people struggling with mental illness being treated as outcasts in their communities and led to various forms of neglect and inappropriate forms of treatment (Kangootui, 2012). According to available data, those receiving appropriate treatment for mental illness in Namibia make up only a small percentage of the total number of people struggling with mental illness (Ministry of Health and Social Services, 2005).

The impact of public stigma around mental illness (PSMI) is far-reaching (Michaels et al., 2012). It can lead to the internalisation of negative stereotypes about ones disorder, affecting self-esteem and morale often leading to social withdrawal which can further exacerbate the impact of their disorders (Girma et al., 2013; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Reta et al., 2016). It can further influence help-seeking behaviour, treatment adherence and ultimately treatment outcomes (Rao, Feinglass, & Corrigan, 2007; McCann, Renzaho, Mugavin, & Lubman, 2017). Stigma is often based on unfounded generalisations or stereotypes which can be attributed to a lack of understanding and fear around those who are different from oneself (Girma et al., 2013). There is thus a need to better understand the degree of PSMI that potentially exists in a Namibian context as this understanding would allow for future improvements of the way in which society engages with those struggling with mental illness.

### **1.3 Statement of the problem**

Mental illness contributed to around 12% of the Global Burden of Disease in 2001 and this is expected to increase to 15% by 2020 (World Health Organization, 2001). In addition, mental disorders contributed to five of the ten leading causes of disability in the world, with depression expected to be the second leading cause of health disability in 2020 (World Health Organization, 2001). While there is no accurate data yet available in Namibia, conservative estimates suggests that



approximately 10% of the adult population are struggling with mental illness (Ministry of Health and Social Services, 2005).

Individuals who are struggling with mental illness are considered to be among the most stigmatised, disadvantaged and vulnerable (Overton & Medina, 2008). These individuals do not only have to deal with the symptomology of their respective disorders but also the impact of receiving such a diagnosis, which carries with it a negative label (Overton & Medina, 2008; Wu, Bathje, Kalibatseva, Sung, Leong, & Collins-Eaglin, 2017). It has also been found that community reactions towards the mentally ill are generally adverse (Overton & Medina, 2008; Sartorius, 2007). As mentioned above, the stigma associated with mental illness has been found to have a significant impact on treatment seeking, treatment adherence and has also been found to lead to early cessation of treatment (Michaels et al., 2012; McCann et al., 2017; Wu et al., 2017).

Currently in Namibia, there is a lack of available information on the prevalence of PSMI that exists (Ministry of Health and Social Services, 2005). Accumulating data around the public stigma of mental illness within the Windhoek area would provide a platform for a better understanding of the implications associated with public stigma for PWMI (Ministry of Health and Social Services, 2005).

Knowledge around the current level of public stigma of mental illness within Windhoek would provide researchers and clinicians with valuable information that would allow for the improvement of future treatment services, as well as more targeted educational platforms to improve public understanding about mental illness in order to reduce public stigma and improve support for those struggling with mental illness (Overton & Medina, 2008; Sartorius, 2007).

#### **1.4 Objectives of the study**

Addressing PSMI requires an understanding of the public's views around mental illness and crucial to this understanding is the ability to accurately measure the various components associated with public stigma (Coolican, 2013). To date, no accurate data is available to the prevalence of mental illness stigma that exists in Namibia. This information would provide a future platform to better manage public stigma as well as the relevant targeted interventions (Boyd, Adler, Otilingam, & Peters, 2014).

The purpose of this study is thus to understand and also measure PSMI in Windhoek, therefore the objectives are:

1. To understand the attitudes people hold towards mentally ill people in Windhoek.
2. To quantify the prevalence of public stigma towards the mentally ill within Windhoek.
3. To assess whether there are any demographic variable differences in public stigma towards mental illness.

#### **1.5 Significance of the study**

Considering the various negative implications that PSMI has been noted to have on those struggling with mental illness it can be seen how a better understanding of PSMI could positively impact those struggling with mental illness. It is thus necessary to understand the levels of stigma that exist in Windhoek in order to better facilitate the way in which PSMI is approached in the future (Girma et al., 2013; Michaels et al., 2012). The results of this study could also serve as a platform for

future work in addressing the public stigma and associated negative impacts of mental illness.

Findings from this study would thus provide needed information for improved understanding of PSMI within Windhoek. Future studies could build on findings from this research, which could assist in building better anti-stigma initiatives, increasing life opportunities and improving health seeking and treatment outcomes for those struggling with mental illness (Corrigan & Shapiro, 2010; Teh et al., 2014; Wu et al., 2017). The findings of this study could also be used in the future development of more tailored education initiatives found to foster change and help reduce PSMI (Ministry of Health and Social Services, 2005; Teh et al., 2014).

This study aims to illustrate the challenge that developing countries such as Namibia have when dealing with public stigma towards mental illness and the ultimate negative implications associated with this stigma for those struggling with mental illness. Knowledge around the degree of public stigma that exists could be used in future initiatives to combat public stigma towards mental illness. Additionally, the general public could also benefit from this study as they will be better informed and have a better understanding of what mental illness is.

## **1.6 Limitations of study**

The quantitative data that will be used in this study will be collected with a self-reporting measure namely the Community Attitudes toward the Mentally Ill (CAMI). As a result, self-presentation bias could arise as participants' answers could be based on what they believe the preferred answers would be. Self-presentation bias, also known as social desirability bias, is related to a respondent providing answers that

are consistent with an acceptable social view even when it may not be representative of that respondents view (Neuman, 2014).

The language of the CAMI scale is English. Focus group interviews will also be conducted in English. This could mean that respondents who are not English literate would be unable to take part in the survey or that those who participate might not always understand the items of the measure. The study is also a cross-sectional study which means that data was collected from different samples at one moment in time (Coolican, 2013). Furthermore, the data will only be collected in Windhoek, so the results cannot be generalised to the rest of Namibia.

### **1.7 Delimitations of the study**

While there are various forms of stigma that have been noted in research, such as self-stigma, internalised stigma and stigma by association, this study will specifically focus on public stigma and the attitudes held by the community towards mental illness within Windhoek.

### **1.8 Conclusion**

This chapter provided an overview of the purpose of this study. It began by discussing mental illness and its associated implications. It then discussed the backgrounds of this study and more specifically that of the stigma associated with mental illness, before looking at the impact mental illness has not only towards the global burden of disease, but also to the individual's carrying such a diagnosis.

Ultimately, this study's objectives as outlined above seek to seek to understand and quantify PSMI as it exists in Windhoek with hopes that these findings could be used the future to improve how mental illness and the public stigma towards it is managed.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

This chapter will review the relevant literature related to this study. It begins by providing the theoretical framework which was utilised for this study. It then provides an overview of mental illness and stigma regarding mental illness. It then discusses the context of this study as it relates to Windhoek before moving on to look at the stigma processes involved in public stigma and finally discusses the effects of public stigma and ways in which public stigma can be addressed.

The study's aim was to understand opinions and attitudes held by the public within a Namibian context concerning mental illness. It also sought to determine the prevalence of public stigma of mental illness (PSMI) held by the community within Windhoek. In addition, it assessed whether any demographic differences existed in relation to the prevalence of PSMI. The basis of a literature review is to build support for a thesis by providing reliable data from past research in order to create a background that illustrates existing knowledge about the subject and create a rational argument for the conclusions it reaches (Machi & McEvoy, 2016).

This chapter begins by providing the theoretical framework which was utilised for this study. It then provides an overview of mental illness and stigma regarding mental illness. It then discusses the context of this study as it relates to Windhoek before moving on to look at the stigma processes involved in public stigma and finally discusses the effects of public stigma and ways in which public stigma can be addressed.

## **2.2 Theoretical framework**

Two primary sources were utilised as the theoretical framework in this study to provide an understanding and explanation of the various influencing components and processes involved in stigma, and more specifically, public stigma as it pertains to this study. The two main theories used to explain the processes of stigma and on which the theoretical framework of this study is based are firstly, Goffman's (1963) social identity, and secondly, Link and Phelan's (2001) components of stigma.

### **2.2.1 Goffman**

Goffman's (1963) work on stigma is widely used and has influenced much of the research around stigma (Ahmedani, 2011; Bos, Pryor, Reeder, & Stutterheim, 2013; Pescosolido, 2013; Gaebel, Rössler, & Sartorius, 2017). In addition, Goffman's (1963) work on stigma takes into account the social interactional process that is involved in stigma, and more specifically, public stigma, which is why it was utilised in this study (Chaudhury & Sahu, 2017). In other words, stigma in this theory considers how a specific characteristic, such as mental illness, is only perceived as negative when assigned with a negative value by the wider society an individual forms part of (Goffman, 1963).

Stigma is seen as a social process whereby an individual's identity is evaluated by the society they form part of and thus for the purposes of this study will be referred to as public stigma (PS) (Goffman, 1963; Link & Phelan, 2001). Goffman (1963) discusses the idea of individuals being assigned a specific social identity based on an evaluation placed on them by society. This evaluation places certain values on specific features or abilities, which differs from culture to culture (Goffman, 1963). An individual is thus viewed in a specific way depending on them possessing the

features or abilities as outlined by their society (Goffman, 1963). These attributes can be either negative or positive and ultimately result in the individual being either valued or devalued in their societies (Goffman, 1963). Once a society has deemed a specific trait as negative, any member of the society carrying this trait is seen as being stigmatized (Goffman, 1963). Thus, PS can be seen as an interaction between an attribute and a specific stereotype (Brohan, Slade, Clement, & Thornicroft, 2010). However, stigma is not merely a trait that an individual possesses, but rather, it is dependent on the interactional process between the individual and the society to which they belong (Pescosolido, 2013). This interactional process involves the larger society placing value on a trait and negatively evaluating that trait (Bos et al., 2013; Green, Davis, Karshmer, Marsh, & Straight, 2005). Thus while PS is based on a highlighted mark or label, it can only be given power through the interaction with it by a specific society or social engagement (Green et al., 2005; Pescosolido, 2013).

Personal identity becomes a focus point when considering PS, as in many cases the stigma associated with an individual forms part of their identity if they begin internalising this, which is known as self-stigma (Goffman, 1963; Teh et al., 2014). This personal identity is assigned through an interactional process with an individual's society and impacts the way in which a society organises itself (Goffman, 1963). In this process, the specific stigma that an individual carries, ultimately becomes assigned or fixed to them as part of their personal identity by the society they are a part of (Goffman, 1963).

### **2.2.2 Link and Phelan**

Link and Phelan (2001) draw from Goffman's (1963) work and go on to discuss the various components associated with the stigma process. Stigma is thus seen as being

a trait that is considered to discredit an individual and that has the ability to reduce them from a complete person to one that is marked or diminished in some way (Link & Phelan, 2001; Gaebel et al., 2017 ). Individuals who are stigmatised are thus seen as having a certain quality that is debased within their society (Link & Phelan, 2001).

Link and Phelan (2001) discuss the various components involved in creating PS and explain how each of these components is interconnected with one another. The first component involves the identification and labelling of human differences, the second involves the way in which culture then links labelled differences to unwanted characteristics which then connects to negative stereotypes (Link & Phelan, 2001). In the third component, individuals who are labelled are then placed in a different category from the rest of society, creating a sense of separation or othering between ‘them’ and ‘us’ (Link & Phelan, 2001). This created separation then leads to a status loss of the labelled individuals in the fourth component which finally leads to the creation of stereotypes and the associated discrimination, exclusion and rejection (Link & Phelan, 2001).

In their first component, Link and Phelan (2001) explain that while most human differences are considered unimportant, other differences are viewed as being more significant. The significance of human difference is culturally influenced and socially determined, and once a specific difference has been identified as significant, the individuals who possess the quality are then labelled (Link & Phelan, 2001).

The second component involves the process whereby human differences that have been labelled as significant are then seen as being negative traits which are then linked to stereotypes (Link & Phelan, 2001). It is with this component, where stigma



is seen to develop as it links specific undesirable traits to a label which then forms the stereotype (Link & Phelan, 2001).

The third component involves the separation process of dividing people into ‘us’ and ‘them’, whereby those labelled with undesirable qualities are removed or excluded from being part of ‘us’ to existing with ‘them’ (Link & Phelan, 2001). In this process, labelled individuals are considered to be significantly different from the accepted norm within that society and this difference is then linked to the stereotypes associated with their label (Link & Phelan, 2001).

The final component of the stigma process notes how labelled individuals go on to experience discrimination and status loss (Link & Phelan, 2001). When individuals are labelled, they are set apart and associated with certain negative traits, this leads them to being devalued and rejected from their society (Link & Phelan, 2001). Link and Phelan (2001) note that this often leads stigmatised individuals to being disadvantaged in various ways and can influence opportunities related to education, income, well-being, housing, status and medical treatment (Link & Phelan, 2001).

The use of Link and Phelan’s (2001) components of stigma theory in this study is based on how the theory is conceptualised to consider stigma as not merely being an individualised problem residing within a person, but is also concerned with the interactional process through which stigma and its associated responses develops within a social context.

### **2.3 Overview of Mental illness**

Mental health is seen as being a necessary component in ensuring overall health, thus an individual’s right to mental health care can also be seen as forming part of their basic human rights (Girma et al., 2013). Individuals facing the diagnosis of a mental

illness are confronted with various symptoms that they must find ways to manage (Michaels et al., 2012). Mental illness can be seen as relating to a range of thoughts, feelings, and ways of behaving that may impact an individual's social, personal and professional functioning (Overton & Medina, 2008). These disorders hugely impair the way in which an individual is able to successfully engage with various areas of their lives as well as impacting their physical health (Mascayano, Armijo, & Yang, 2015).

The diagnosis of mental illness is assigned when there is a behavioural deviation from the accepted norms existing within a culture resulting in mental illness being a concept that is dependent on a specific culture, which leads to various expressions of mental illness and its associated stigma (Rao et al., 2007). The way in which stigma is associated with mental illness has been noted to largely depend on the way in which mental illness is perceived within a specific culture (Teh et al., 2014). Thus the way in which mental illness is conceptualised within a culture can significantly impact the stigmatization process (Teh et al., 2014).

Individuals struggling with mental illness are considered to be the individuals facing significantly high levels of stigmatisation and discrimination (Overton & Medina, 2008). According to Overton and Medina (2008), who conducted a literature review on mental illness and the stigma surrounding it, persons struggling with mental illness are also seen as being among the most vulnerable and disadvantaged members in the societies they form part of. The assumptions and beliefs associated with mental illness can be as damaging as the illness itself (Overton & Medina, 2008). In addition, studies have also found that not only do those struggling with mental illness experience discrimination, but also those associated with them, such as their families, caregivers and loved ones (Girma et al., 2014; Koschorke et al., 2017; Larson &

Corrigan, 2008). It is also necessary to understand the key role that stigma plays in the progression and outcome of mental illness for those who have been diagnosed (Overton & Medina, 2008). The symptoms of mental illness can impact an individual's life in various negative ways (Michaels et al., 2012). In addition to the various symptoms experienced by an individual with mental illness, this individual also faces the challenge of how the society of which they form part perceive their disorder (Michaels et al., 2012). In many instances these perceptions of what mental illness is, are based on misunderstandings, leading to discrimination and exclusion from one's community (Michaels et al., 2012).

It is estimated that around one in four people will have or experience a mental illness at some time during their life (Overton & Medina, 2008). Despite the evidence of efficacy for various treatments for specific disorders, research has found that many individuals struggling with mental illness never seek treatment and other individuals who may seek treatment do not completely adhere to the full treatment processes advised (Corrigan, 2004). Research has found stigmatization to be a primary factor in the inhibition of the utilisation of mental health services as well as treatment adherence (Vogel, Bitman, Hammer, & Wade, 2013).

Low- and middle- income countries such as Namibia are believed to contribute to 75 percent of the global mental illness load (Mascayano et al., 2015). Namibia has been noted as having restricted mental health services in spite of the increasing burden of mental illness within the country (Mutanga, 2017). The shortage of investment experienced in these developing countries towards treating mental illness has been associated not only with problems in funding but also with a lack of interest toward mental health and mental health services (Mascayano et al., 2015). The governments within these developing countries have also been noted as being the lowest

contributors to mental illness treatments services worldwide (Mascayano et al., 2015). Mental illness treatment would thus require an integrated approach that would incorporate all areas of government in addressing the needs associated with treating mental illness (Mutanga, 2017). An improved understanding around stigma and its impact on mental health is seen as a vital step in improving the services offered to those struggling with mental illness (Mascayano et al., 2015).

## **2.4 Overview of stigma**

Stigma involves a multi-layered construct that incorporates emotions, perceptions and behaviours (Overton & Medina, 2008; Gaebel et al., 2017). Stigma entails a lack of understanding, knowledge and fear around those who are different from the norm (Girma et al., 2013; Johnson, & Benson, 2017). Ultimately, it has been suggested, that the two fundamental features of stigma is an awareness of an existing difference and a devaluation that is linked to that difference (Bos et al., 2013). While mental illness stigma is considered a global phenomenon, it has been noted as being a stronger limitation to accessing treatment in low-income areas and especially with the members of a society who are considered to be more vulnerable (Mascayano et al., 2015). Research concerning stigma has led to the identification of different manifestations of stigma which are all interconnected (Bos et al., 2013). Pryor and Reeder (2011) developed a model to better illustrate current research on the types of stigma and how they are interconnected (see below). While the focus of this study is on public stigma of mental illness, it is regarded as useful to briefly view the different stigmas that have also been identified as they are all interrelated.

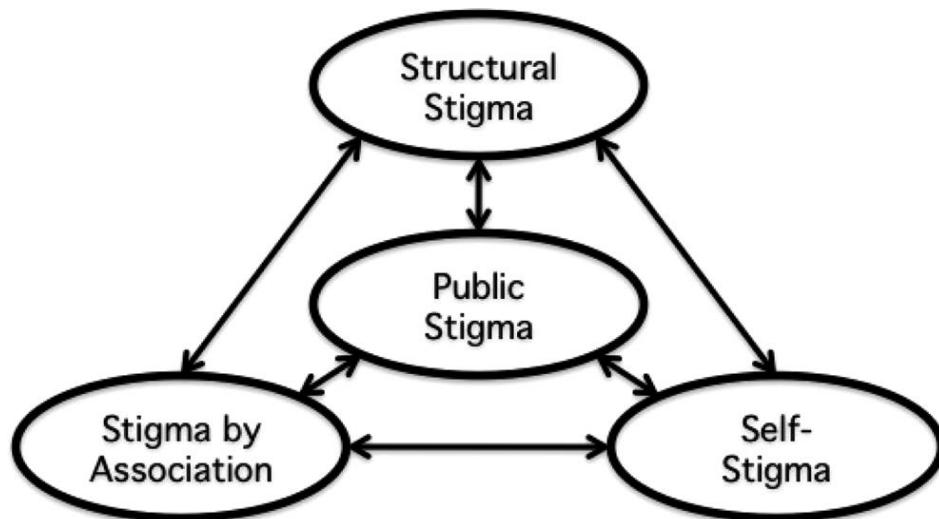


Figure 1: *Four types of stigma (based on Pryor & Reeder 2011. Pryor , J. B. , & Reeder , G. D. ( 2011 ). HIV-related stigma . In J. C. Hall , B. J. Hall & C. J. Cockerell (Eds.), HIV/AIDS in the Post-HAART Era: manifestations, treatment, and Epidemiology (pp. 790 – 806 ). Shelton , CT : PMPH-USA .)*

#### **2.4.1 Self-stigma**

Self-stigma is associated with an individual who possesses a feature that is stigmatised, such as mental illness, and who then accepts the devaluation placed on them and internalises the negative stereotypes associated with their respective stigmatised feature (Pescosolido, 2015; Vogel et al., 2013; Gaebel et al., 2017). Self-stigma also involves the various psychological and social implications that are associated with carrying a specific stigma which has been noted to lead to lower levels of self-esteem as well as self-efficacy (Bos et al., 2013; Vogel et al., 2013).

#### **2.4.2 Stigma by association**

Stigma by association, which is also known as courtesy stigma, refers to negative reactions directed to individuals who are connected to a stigmatised individual (Bos et al., 2013). In this form of stigma, these individuals do not possess the devalued

feature or stigma, but are in some way associated or involved with a stigmatised individual and are commonly treated as contributing in some way to the behaviour that is stigmatised (Pescosolido, 2015). This in many cases relates to the friends and families of the stigmatised individual (Bos et al., 2013; Pescosolido, 2015).

### **2.4.3 Structural stigma**

Structural stigma, expands the negative reactions from an individual level to a wider organisational or institutional level (Bos et al., 2013; Pescosolido, 2015; Gaebel et al., 2017). Corrigan et al. (2004), explain that in this form of stigma, certain policies put forth by organisations, governments and/or institutions result in intentional as well as unintentional consequences and restrictions towards stigmatised individuals. For example, being permitted to vote or get married (Buechter, Pieper, Ueffing, & Zschorlich, 2013).

### **2.4.4 Public Stigma**

Public stigma, as will be discussed in this study, involves various socio-cultural processes, which results in a community assigning preconceived values on a labelled individual which devalues them and which lead to these individuals being discriminated against (Corrigan & Rao, 2012; Gaebel et al., 2017; Michaels et al., 2012). Community attitudes towards mental illness contribute significantly towards the mental health of a community as these attitudes can play a vital role in promoting the attainment of treatment and adherence to treatment (Girma et al., 2013; Johnson, & Benson 2017).

Public stigma relates to the perception held by the general public around specific stigmas associated with an individual seeking mental health services as being socially unacceptable (Vogel et al., 2013). Additionally, research has shown that

those who have made use of mental health services are viewed less favourably than those who have not (Vogel et al., 2013). Public stigma can be seen as consisting of stereotypes, prejudice and discrimination (Michaels et al., 2012). Stereotypes involve negative expectations of an individual with mental illness, prejudice involves the agreement with these stereotypes and the subsequent emotional response evoked by these stereotypes and finally, discrimination involves the withholding of certain opportunities based purely on their diagnosis (Michaels et al., 2012). Therefore, public stigma can pose a significant problem as societally held negative perceptions toward a specific group of people can result in these individuals being discriminated against (Vogel et al., 2013).

## **2.5 Previous findings on PSMI**

Previous studies that have looked at PSMI have found that older individuals, men, people with lower education and lower socio-economic status had higher levels of PSMI (Evans-Lacko, Henderson, & Thornicroft, 2013; Subramaniam et al., 2017; Yuan et al., 2016). Additionally, experience of contact, history of mental disorders were also found to impact levels of PSMI (Hartini, Fardana, Ariana, & Wardana, 2018). In addition, findings from previous studies also showed that individuals from rural areas as well as lower socio-economic areas showed increased levels of PSMI (Girma et al., 2013; Subramaniam et al., 2017; Yuan et al., 2016). Although stigma has been noted to be a global issue, it appears to present a more significant barrier in accessing treatment for lower-socioeconomic populations. (Mascayano et al., 2015)

## **2.6 Context for this study**

This study takes place within Namibia, and more specifically within the Windhoek municipal district. Therefore it is useful to create an understanding of the contextual

environment that currently exists, such as the composition and features of the population, the current atmosphere surrounding mental illness as well as the facilities that are available to treat mental illness.

### **2.6.1 Overview of Windhoek**

This study is focused within the Windhoek municipal district. Windhoek is the capital city of Namibia and is located in the Khomas region (Khomas Regional Council, 2015). According to the most recent survey, the Khomas region is made up of a population of approximately 415 780 (Namibia Statistics Agency, 2017).

According to the National Statistics Agency (2017) the gender composition of the population in the Khomas region was found to be composed of 49.6 percent male and 50.4 percent female. Age distribution in the Khomas region was primarily composed of 15-59 years of age (67.8%) (Namibia Statistics Agency, 2017). The ability to read and write with understanding is defined as literacy (Namibia Statistics Agency, 2017). Within the Khomas region, the literacy rate was found to be 96.7 % (Namibia Statistics Agency, 2017). While Namibia is classified as a higher middle income country, it has significant uneven distribution of income with approximately 70% of the gross domestic product (GDP) being controlled by about 5% of the Namibians (Central Bureau of Statistics National Planning Commission, 2008; Evaluation Office of the United Nations Development Programme, 2009).

### **2.6.2 Mental illness in Namibia**

Various factors can be considered when looking at the mental illness context within the Namibian population (Ministry of Health and Social Services, 2005). Namibia's history and that of an oppressive and racially discriminatory apartheid system in addition to the liberation struggle that followed can be seen as carrying with them



various emotional and cognitive stressors with future impacts on the population's mental health (Ministry of Health and Social Services, 2005). Additionally, the country faces challenges with high unemployment rates, substance abuse and substance dependency issues, domestic and sexual abuse, gender-based violence, high suicide rates, as well as psychological health challenges such as HIV/AIDS, tuberculosis and malaria posing on-going implications for mental health within the population (Alweendo, Andreas, & Rafla-yuan, 2018; Embula, 2018; Ikela, 2018; Kazembe & Neema, 2015; Ministry of Health and Social Services, 2005).

Individuals struggling with mental illness in Namibia encounter various challenges ("Mental illness alarmingly underestimated in Namibia," 2012). Due to myths or inaccurate beliefs around mental illness, many cases go unreported in Namibia, which often leave families with little support and inadequately prepared in how they cope, with many individuals receiving little support from their families ("Mental illness alarmingly underestimated in Namibia," 2012; Nhongo, 2016).

A significant factor influencing many cases going unreported in Namibia is due to the stigma associated with mental illness as a result of these inaccurate beliefs surrounding what it means to have a mental illness ("8 000 diagnosed with mental illness – Kavetuna," 2016). This stigma is noted as affecting not only the individual dealing with a mental illness, but also the family and loved ones involved ("8 000 diagnosed with mental illness – Kavetuna," 2016).

### **2.6.3 Public health facilities in Windhoek**

Reported cases of mental illness have shown a noticeable increase in Namibia, which is in line with findings from the World Health Organisation indicating a rise in mental health disorders worldwide ("8 000 diagnosed with mental illness –

Kavetuna,” 2016; Mutanga, 2017; World Health Organization, 2001). However, the “facilities and resources” available in Namibia are failing to meet the reported needs of those struggling with mental illness (Mutanga, 2017; Nhongo, 2016; World Health Organization, 2011). In addition, public “understanding” and “education” has also been significantly impaired, thus limiting improvement in available services for those needing them (Nhongo, 2016).

## **2.7 The stages in stigma development**

Patrick Corrigan (2004) in his work with stigma, noted that there are certain stages involved in stigma development and highlights four socio-cognitive processes that are involved, namely, cues, stereotypes, prejudices and discrimination. The first stage involved in stigma development relates to cues in which the public associates mental illness with specific psychiatric symptoms, deficits in social-skills, different physical appearance and peculiar labels (Corrigan, 2004; Gaebel et al., 2017 ). These cues are often based on severe mental illnesses which may have resulted in extreme bizarre behaviour (Overton & Medina, 2008).

The second stage suggests that it is out of these cues that specific stereotypes are evoked (Ben-Zeev, Young, & Corrigan, 2010). These stereotypes which are seen as ways of organising various social groups are based on ideas and expectations around a specific group of people (Corrigan, 2004). Stereotypes around people with mental illness include ideas about them being violent, incompetent and having a weak character (Overton & Medina, 2008).

Prejudice, the third stage in stigma development, involves the endorsement of negative stereotypes leading to negative reactions and ultimately to discrimination through behavioural reactions (Corrigan, 2004). This discrimination is thus seen as

the fourth stage involved in stigma which elicits specific behavioural reactions towards the stigmatised individual. These reactions are often based on fear created from incorrect stereotypes which often leads to avoidance of those carrying the stigma (Ben-Zeev et al., 2010; Overton & Medina, 2008; Gaebel et al., 2017).

## **2.8 Effects of public stigma**

Research regarding public stigma concerning mental illness has resulted in the development of new awareness of what can be done to address it (Corrigan & Shapiro, 2010). Public stigma of mental illness has also been found to impact treatment seeking and treatment adherence and has been associated with early cessation of treatment (Michaels et al., 2012). Public stigma of mental illness has also been noted to impact recovery, thus affecting an individual's ability to cope with challenges related to mental illness negatively (Michaels et al., 2012; Vogel et al., 2013).

The discrimination, stereotypes and prejudices that are associated with mental illness, limit individuals' life opportunities (Corrigan, 2004). Stigma has been found to impact an individual's employment opportunities as well as their social acceptability (Lai et al., 2000). Public stigma of mental illness has been noted to impact an individual's ability to obtain work and housing (Michaels et al., 2012). Stigma has also been found to potentially impact an individual's self-esteem, relationships and psychological well-being negatively (Lai et al., 2000; Teh et al., 2014). Mental illness stigma has also been linked to increased risk of suicidality (Oexle et al., 2018).

Due to the noted impacts of stigma on help seeking behaviour, there is an evidenced need to improve understanding of the various elements associated with the stigma

process and how it develops so as to create improved interventions that reduce stigma and increase help seeking behaviour in PWMI (Vogel et al., 2013). Stigma is one of the reasons why people do not access mental health care as there are various reasons that motivate them to avoid labels around mental illness associated with seeking these services (Corrigan, 2004).

## **2.9 Addressing stigma**

When considering the processes involved in public stigma of mental illness it is also necessary to consider the ways in which stigma has been addressed or challenged. Most notably Corrigan and Shapiro (2010) have recommended three strategies that have been used to challenge stigma and found to have some impact. These are protest, education and contact (Corrigan & Shapiro, 2010).

Protest is described as the process in which the discriminatory treatment of PWMI is brought to attention and challenged (Corrigan, Morris, Rüsçh, Michaels, & Rafacz, 2012; Corrigan & Shapiro, 2010). In this way, the negative behaviours adopted by the general public towards PWMI are highlighted, questioned and confronted (Gronholm, Henderson, Deb, & Thornicroft, 2017). This method of protest has been done through challenging stereotyped behaviour of mentally ill people, as depicted in media or in judicial instances where they have been discriminated against (Gronholm et al., 2017).

The second strategy noted as being used in challenging public stigma of mental illness is education (Finkelstein, Lapshin, & Wasserman, 2008). This approach involves addressing incorrect assumptions and stereotypes that are held around mental illness and instead providing accurate information (Gronholm et al., 2017). In

this way the general public is educated in terms of their understanding and misconceptions of mental illness (Corrigan et al., 2012).

The third strategy utilised in addressing stigma is known as contact (Corrigan & Shapiro, 2010). This approach is based on members of the population interacting and engaging with PWMI and through these interactions are able to gain a more realistic understanding of mental illness through first-hand experience (Buechter et al., 2013).

While more research has been recommended to further verify the effectiveness of each of these strategies, it is useful to be aware of possible ways in which public stigma of mental illness can be improved and how these strategies can be utilised in the context of this study (Corrigan et al., 2012; Corrigan & Shapiro, 2010; Gronholm et al., 2017).

## **2.10 Conclusion**

The literature reviewed in this chapter indicates the various processes involved in the construction of public stigma, the impact it has on PWMI as well as the role that public stigma plays in effectively addressing mental illness. Although the literature that was reviewed identified the various impacts of public stigma, it did not provide an indication of the level of public stigma that exists within a Namibian context such as Windhoek or whether any demographics within this context may result in higher levels of public stigma. This study then aims to identify the level of public stigma that exists in Windhoek as well as the perceptions and understandings held towards mental illness within this context.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1 Introduction**

This chapter focuses on the methods utilised in this study for the collection and analysis of data. It will look at the research design used for the study, the population and sampling as well as sampling methods. This chapter will also discuss the research instruments, the procedures for collecting data as well as data analysis methods that were used. Ethical considerations for this study will also be discussed.

### **3.2 Research design**

This study's aim was to measure the prevalence of PSMI for the general public in Windhoek, Namibia, and seek to understand public attitudes towards mentally ill people and therefore a mixed method approach was utilised (Coolican, 2013). A mixed methods approach is research that incorporates both a qualitative and quantitative approach to collecting and analysing data within a single study (Leech & Onwuegbuzie, 2009). A descriptive design utilising a cross-sectional survey method was used for this study which sought to quantify PSMI that exists in Windhoek. A descriptive design aims to provide information about behaviours, relationships, attitudes or processes of a specific group while also looking at possible correlations between certain variables (Neuman, 2014). The method used to collect data for the quantitative section of the study was in the form of a research questionnaire which allowed for a larger sample size to be used, limited expenses and ultimately produced quantitative data that was statistically analysed (Coolican, 2013). The aim of the quantitative section was to find data for the prevalence of PSMI. In addition, focus group discussions were held as a way of collecting qualitative data regarding the attitudes of community members towards mentally ill people.

### 3.3 Population

Coolican (2013) defines a population as consisting of a specific group of people from which a sample will be gathered. The population of this study consisted of people currently living in the Windhoek municipal area which consists of approximately 325 858 people (Khomas Regional Council, 2015) . For this study, inclusion criteria for the population from where the sample was drawn included any individual living in the Windhoek municipal area from the age of 18 years and older. The exclusion criterion was citizens younger than 18 years, or people diagnosed with a mental illness as well as people who were not English literate.

### 3.4 Sample

A sample can be defined as consisting of a smaller number of cases from which generalizations can be made to the larger population from which they were drawn (Neuman, 2014). The sampling method utilised for the quantitative part of this study was a non-probability sampling method which is defined as a method of sampling that does not utilise a random selection approach for the participants used (Coolican, 2013). More specifically, the type of non-probability sampling utilised was that of convenience sampling, which allows for participants to be utilised based on availability allowing for quicker and less expensive research to be conducted which was best suited for this study as it had a limited timeframe in which it needed to be complete (Elfil & Negida, 2017). The sample of the quantitative section of the study consisted of 150 people. The sample size was determined based on the population size (N) of 325 858, using a confidence level of 95%, a margin of error (MOE) of 8% and a sample proportion (p) of 50%. The size of the sample was calculated using the

following equation  $n = \frac{N * X}{(X + N - 1)}$ , where,  $X = Z_{\alpha/2}^2 * p * (1-p) / MOE^2$ . (Daniel &

Cross, 2013). Potential participants were approached within the city centre and requested to complete a questionnaire namely, the Community Attitudes towards Mental Illness (CAMI) scale.

The sample for the qualitative section of the study was collected through the use of a self-selecting sampling method in which the participants themselves elected to be part of the research (Colman, 2015). Similarly to convenience sampling, self-selecting sampling reduces the time required for collecting participants for the research to be conducted allowing for data to be collected in the allotted timeframe (Sharma, 2017). Additionally, it has also been found that participants are more likely to remain committed to taking part in the research as well as being more willing to contribute more deeply into the topic being researched (Sharma, 2017). Participants were found through word of mouth from three different socio-economic areas within Windhoek. The areas that were used were Ludwigsdorf (high socio-economic area), Pioneerspark (middle socio-economic area) and Otjomuise (low socio-economic). Ludwigsdorf is part of the Windhoek East constituency and lies within the eastern part of Windhoek, Pioneerspark is part of the Windhoek West constituency in the southern part of Windhoek and Otjomuise is part of the Khomasdal constituency in the north western part of Windhoek (<http://www.khomasrc.gov.na/constituencies>). These three areas in Windhoek were utilised as a way of representing participants from higher- to lower- socio economic areas, as one of the potential variables considered to possibly impact public stigma of mental illness in this study was the impact of socio-economic status on PSMI (Girma et al., 2013). One focus group consisting of eight participants was conducted within each area. Focus group discussions followed an interview guide that aimed to understand views held towards mental illness and stigma.



### **3.5 Research instruments**

The study made use of two research instruments, namely the CAMI questionnaire for collecting quantitative data regarding the prevalence of PSMI and an interview guide for collecting qualitative data from community members within the Windhoek area regarding attitudes towards mentally ill people. Demographic information such as age, sex and level of education was also gathered from participants in the quantitative part of the study at the beginning of the CAMI scale. Participants in the qualitative part of the study were also asked to provide demographic information such as age and sex, in addition to the socioeconomic area in which they lived.

#### **3.5.1 Community Attitudes towards Mental Illness scale**

This study utilised the Community Attitudes towards Mental Illness (CAMI) scale (Taylor & Dear, 1981). The scale consists of 40 items and utilises a 5-point Likert scale with 1 indicating strongly agree and 5 indicating strongly disagree. It has four subscales, with each sub-scale having 10 items: Authoritarianism (AU), Benevolence (BE), social Restrictiveness (SR), and Community Mental Health Ideology (CMHI) (Taylor & Dear, 1981). AU relates to the belief that PWMI are inferior and in need of supervision. BE indicates the degree of understanding towards PWMI. SR relates to the idea that PWMI pose a danger to society. CMHI indicates the degree to which services provided for mental health and people with mental illness are accepted into a community. High scores on the scale indicate higher levels of stigma towards people with mental illness. Five of the 10 items within each subscale are negatively worded and thus the scoring of these negative items is reversed. The items that were reversed within each of the sub-scales were as follows: Authoritarianism= 1, 9, 17, 25, 33; Benevolence= 2, 10, 18, 26, 34; Social Restrictiveness= 3, 11, 19, 27, 35;

Community Mental Health Ideology= 4, 12, 20, 28, 36 (Taylor & Dear, 1981). The measure has good reliability and Cronbach's alpha for the subscale scores are as follows: Authoritarianism = .68; Benevolence = .76; Social Restrictiveness= .80; Community Mental Health Ideology = .88 (Gamst, Liang, & Der-Karabetian, 2011; Taylor & Dear, 1981). Criterion validity has been demonstrated and known-group validity provided, however, the CAMI has not been correlated with other measures (Gamst, Liang, & Der-Karabetian, 2011; Taylor & Dear, 1981). While this scale has not been validated within a Namibian context, it has been used in other African studies, such as Ghana, South Africa and Nigeria (Barke, Nyarko, & Klecha, 2011; Sorsdahl & Stein, 2010; Ukpong & Abasiubong, 2010).

### **3.5.2 Focus group discussions**

The focus group discussions for the qualitative section of the study utilised an interview guide. An interview guide consists of a list of topics that a researcher aims to cover during a semi-structured interview with participants (Coolican, 2013). The interview guide used for the qualitative section of this study aimed to collect data that would provide an indication of community members' perceptions, understanding and attitudes towards mental illness and stigma. The interview guide was developed with the specific aim of seeking to understand views held towards mental illness by community members from different socio-economic areas.

### **3.6 Procedure**

Upon receiving ethical clearance from UNAM (clearance number: FHSS/346/2017) the CAMI questionnaire for the quantitative section of this study was distributed. The researcher approached people at various points in the city centre and provided them with a consent form and a short debriefing of the nature of the study. When the

prospective participant agreed to participate in the study and signed the consent form, the CAMI questionnaire was provided to the participant, which took between five and 10 minutes to complete. This process was repeated until 150 questionnaires had been collected.

The focus group discussions were conducted at a neutral venue, namely a private office space at the Aus Hills Centre in Windhoek. Participants for the focus groups were gathered through word of mouth within their communities. Through previous community engagement projects, the researcher had established relationships with certain community members of the three areas within Windhoek. These community members were able to put the researcher in touch with individuals who were willing to take part in the focus groups. One focus group discussion was held for each area and the duration for each session was 60 minutes on average. A debriefing was conducted with each of the focus groups, after which each participant signed the consent form.

Transport was arranged to and from the venue for participants who had difficulties arranging their own transport. The researcher was in contact with a transport company who was able to provide this service free of charge. Refreshments were provided by the researcher for respondents upon arrival in an attempt to create a calm environment before the focus group discussion commenced.

Overall, the focus group discussions proceeded as planned, all participants who agreed to participate in the focus group discussions did attend. A recording device was utilised in addition to comprehensive notes taken by the researcher throughout the discussions to ensure comprehensive data collection during the focus group discussions.

### **3.7 Data analysis**

The quantitative data collected for the study via the CAMI questionnaire was analysed by using the Statistical Package for Social Sciences (SSPS 25). Inferential statistics, more specifically, Spearman's rank order correlation and multiple regression analysis were used in order to identify whether any variables possibly contributed to higher degrees of public stigma as they allow for certain inferences to be made between the sample that was surveyed and the population of the study (Neuman, 2014). As the study made use of continuous and ordinal variables, Spearman's correlation was utilised to measure both the strength of associations between age, sex and level of education in relation to stigma, as well as the direction of these associations (Schober, Boer, & Schwarte, 2018). Multiple regression analysis utilises multiple independent variables to predict a continuous dependent variable (Cohen, Cohen, West, & Aiken, 2003). For this study, age, sex and level of education were the independent variables which were utilised to assess whether they had any influence on PS, which was the dependent variable in this study. These statistical methods were used in order to assess whether any correlations between the different variables could be drawn and whether there were statistically significant differences in the results that would indicate which, if any, of the variables predicted a higher level of PS.

Data gathered from the focus group discussions for the qualitative section of the study were analysed using content analysis which allowed for specific themes in the interviews to be identified (Neuman, 2014).

### **3.8 Ethical considerations**

Upon receiving ethical clearance from the University of Namibia, the researcher began collecting data. Participants for the quantitative section of the study were provided with a consent letter and the expectations for taking part in the study were discussed. Once the contents of the letter and purpose of the study were clearly discussed, those who provided their consent then took the CAMI questionnaire.

Participants were only approached if they were alone and the researcher frequently moved to different locations within the city centre in order to preserve confidentiality and anonymity. Participants for the focus group discussions were also provided with consent letters and the purpose and expectations of the group discussions were clearly discussed. Voice recordings were used in the group discussions with clear permissions given by each group member and no identifying information was requested from the group members. Participants were informed of their right to withdraw from the study at any point and assured that no negative consequences would prevail if they decided to withdraw from the study. Data collected from the study was stored electronically under password protection and will be kept for five years after which it will be deleted. Questionnaires were scanned to electronic format and saved digitally under a password protected file, with the hard copies being secured in locked safe where they will be destroyed after five years.

### **3.9 Conclusion**

This chapter outlined the research methodology for this study. It discussed the use of a mixed methods approach and defined the population and sample that will be used in for the study. It then specified the research instruments used in both the qualitative and quantitative parts of the study before elaborating on the procedures used for

collecting and analysing the data. Finally, ethical considerations were discussed and clarified.

## CHAPTER 4: RESULTS

### 4.1 Introduction

The data for this study was collected and analysed as discussed in Chapter 1 utilising a mixed methods approach. This chapter will therefore present the data for both the qualitative and quantitative sections of the study. It will begin by discussing the biographical information of the participants from both sections, specifically their age, sex, educational level. Participant socioeconomic status will be indicated for the participants of the qualitative section. Results from the CAMI will then be discussed by looking at the overall level of stigma that was measured by the survey. Additionally, possible correlations will be examined between level of stigma and age, sex and educational level of participants to examine whether these demographical characteristics of the participants may have an influence on the level of PS. Results from the focus group discussions will be discussed and comparisons will be made between the responses provided within the three different socioeconomic groups.

### 4.2 Descriptive statistics

Participants who took part in the quantitative section of this study were also asked to indicate their sex, age and highest level of education obtained. The results are presented below.

Table 1: *Characteristics of the Participants (n = 150)*

Item	Category	Percentage
Gender	Male	51
	Female	49
Age	18-24	19
	25-34	33
	35-44	25

	45-54	13
	55-64	6
	65+	4
Qualifications	No schooling completed	7
	Some schooling, not completed	9
	Some high school, no diploma	36
	High school graduate	17
	Some college credit, no degree	9
	Trade, technical or vocational course	6
	Bachelor's Degree	12
	Master's Degree	4
	Doctoral Degree	0

#### **4.2.1 Sex of participants**

The participants surveyed for the quantitative section of this study were asked to indicate their sex. Of the 150 participants surveyed for the quantitative section, 51% were male and 49% were female as shown in Table 1.

#### **4.2.2 Age of participants**

The age ranges of the participants who took part in the quantitative section represented in Table 1 indicates that 19% of the participants were between the ages of 18 and 24, 33% percent were between the ages of 25-34, 25% were between the ages of 35-44, 13% were between the ages of 45-54, 6% were between the ages of 55-64 and 4% were 65 years and older.

#### **4.2.3 Educational Level of participants**

Participants who took part in the CAMI questionnaire were also asked to indicate the highest level of education they had completed. The options provided in the questionnaire were as follows: No schooling completed; some schooling, not completed; some high school, no diploma; high school graduate; some college credit,



no degree; trade/technical/vocational training; bachelor’s degree; master’s degree and doctorate degree. Table 1 illustrates the range of education for participants that were surveyed, 7% had not completed any schooling; 9% percent had some primary schooling background, but not completed; 36% had some high school background, but did not complete it; 17% had graduate high school; 9% had completed some college credit, but had no degree; 6% had completed training within a trade, technical or vocational course; 12% had completed a bachelor’s degree; and 4% had completed a master’s degree.

### 4.3 Biographical information of participants for the qualitative section

The sex and age ranges were also gathered from the participants who took part in the focus groups discussions for the qualitative part of this study. The results obtained (Figure 2) indicate that within the lower socioeconomic (LSE) group, three women and five men took part. The middle socioeconomic (MSE) focus group consisted of two men and six women. The higher socioeconomic (HSE) group consisted of three men and five women.

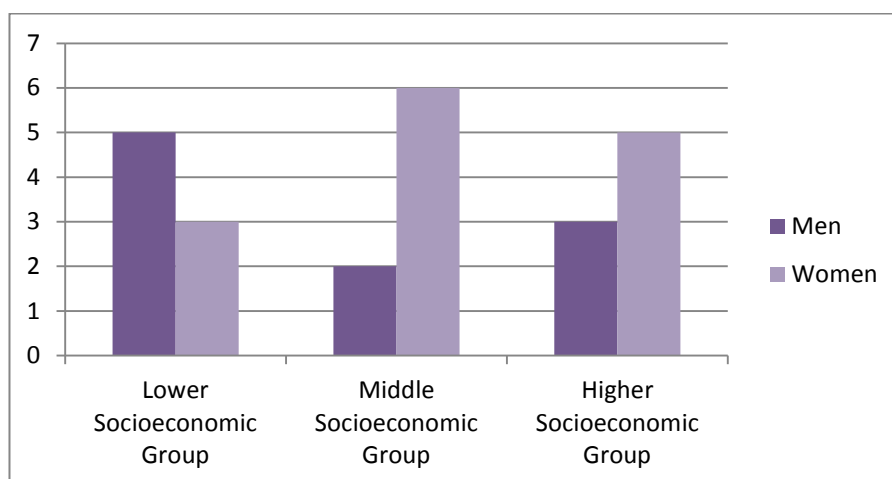


Figure 2: Number of men and women who took part in the three different socioeconomic focus group discussions.

Ages of group members were placed in the same age ranges used for CAMI questionnaire (Figure 3). The LSE group consisted of one member in the 18-24 range, two members within the 25-34 age range, three members in the 35-44 age range, one member in the 45-54 age range and one member in the 55-64 age range. The MSE age range consisted of four participants in the 25-34 age range, two participants in the 35-44 age range, one participant in the 55-64 age range and one participant in the 65 and over age range. The HSE group consisted of two participants in the 25-34 age range, three participants in the 35-44 age range, one participant in the 45-54 age range, one participant in the 55-64 age range and one participant in the 65 and over age range.

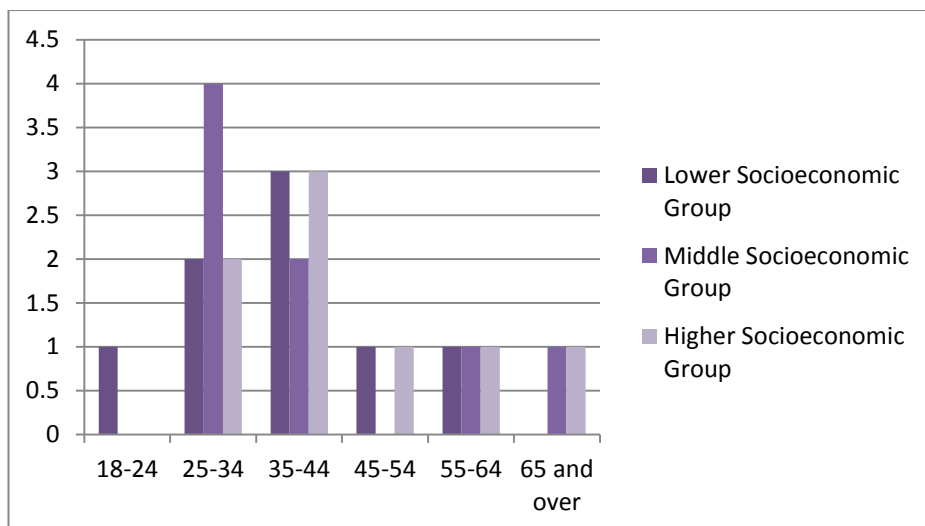


Figure 3: Age ranges of participants in the three different socioeconomic focus group discussions.

#### 4.4 Results from Community Attitudes towards Mental Illness Scale

##### 4.4.1 Overall level of public stigma

Results from the CAMI were calculated in the following way. The CAMI questionnaire made use of a Likert response scale. Each item's response was ranked

between 1-5, with one being the lowest and indicating the lowest stigma response and 5 being the highest and indicating the highest stigma response. Negative items on the scale were inverted and scored accordingly. The responses were recorded and converted into ordinal data. Responses from 150 participants were totalled and the average score resulted in 41%. This result indicated that the level of PS towards mental illness in the sample collected within the Windhoek region was 41%.

In this study three variables were considered for possible influence on stigma levels, namely, age, sex and educational levels. The Statistical Package for Social Sciences (SSPS) (25) was used to identify whether any correlations between these variables existed (IBM Corp, 2017). When correlations between age, sex and education were done, the results provided an indication of possible demographic variables that could contribute to higher levels of stigma. The data that was collected from the CAMI questionnaire was converted into ordinal data, as a result Spearman's rho was utilised to calculate the significance of the correlations between the variables (Coolican, 2013). The results will be discussed in the following sections.

#### **4.4.2 Correlation between age and public stigma**

The first correlation that was assessed was that between age and stigma. Spearman's correlation coefficient (rho) looks at the degree of strength between two variables, this degree of strength can range from -1 to +1, with 0 indicating that there is no correlation (Schober et al., 2018). Spearman's correlation analysis was conducted using SSPS (25) to assess whether any correlation existed between an individual's age and their level of PS. There was found to be a moderate positive correlation between the level of PS and an individual's age, which was found to be statistically significant,  $r_s = .443$ ,  $p = .001$ . The results of which are illustrated below.

Table 2: *Correlation between age and level of PS.*

		Public Stigma	Age
Spearman's rho	Public Stigma	Correlation Coefficient	1.000
		Sig. (2-tailed)	.443**
		N	150
	Age	Correlation Coefficient	.443**
		Sig. (2-tailed)	.000
		N	150

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Six categories of age groups were identified for this study, they consisted of 18-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years and 65 years and older. The results of the CAMI questionnaire for age and PS are illustrated in the graph below.

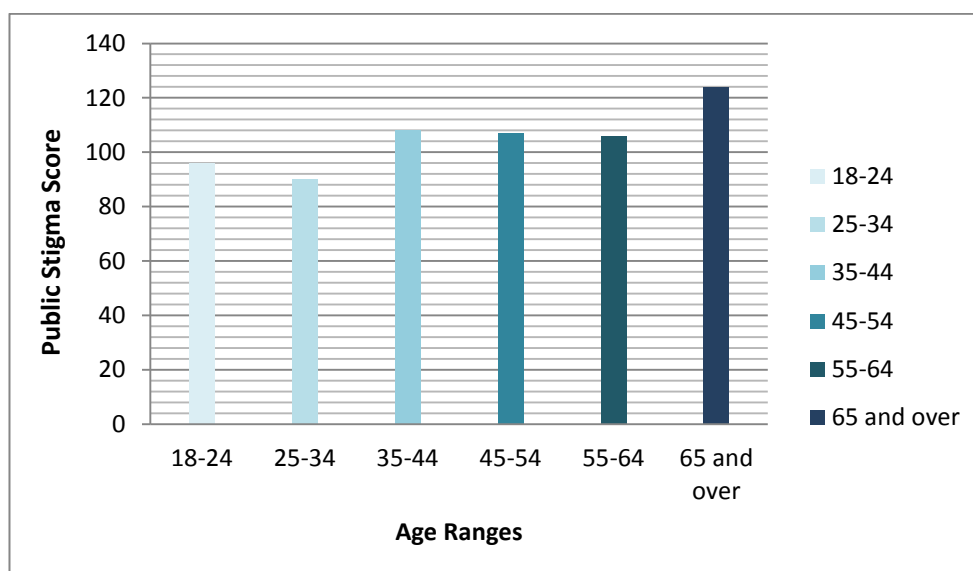


Figure 4: *Level of PS among the various age groups.*

Figure 4 illustrates that individuals aged 65 and older held the highest levels of stigma against people with mental illness, whereas people aged 25-34 held the lowest levels of stigma against people with mental illness.

#### 4.4.3 Correlation between sex and public stigma

Participants were asked to indicate their sex when taking the CAMI questionnaire.

The second correlation that was assessed was that of the sex of the participants and

the level of PS. Spearman’s correlation was again conducted to assess whether there was any correlation between the sex of participants and the level of PS. There was also found to be a moderate positive relationship between the sex of participants and their level of PS, which was shown to be statistically significant,  $r_s = .433$ ,  $p = .001$ . Results from the correlation are illustrated below.

Table 3: *Correlation between sex and level of PS.*

		Public Stigma	Sex
Spearman’s rho	Correlation Coefficient	1.000	.443**
	Sig. (2-tailed)	.	.000
	N	150	150
Sex	Correlation Coefficient	.433**	1.000
	Sig. (2-tailed)	.000	.
	N	150	150

\*\* . Correlation is significant at the 0.01 level (2-tailed).

The results indicated that men overall had higher levels of PS than women. Figure 5 below indicates the difference of PS between men and women who took part in the CAMI questionnaire.

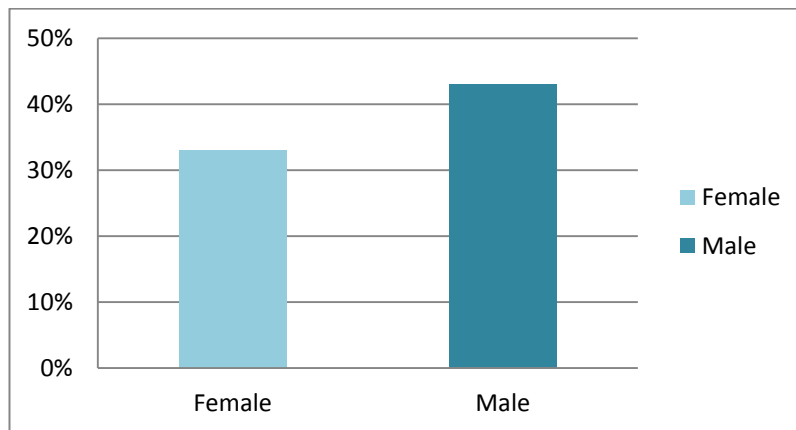


Figure 5: *Level of PS between male and female participants.*

#### 4.4.4 Correlation between level of education and public stigma

The third and final variable that was assessed for any correlation was that of level of education and its impact on the degree of PS. Participants were also asked to indicate

the highest level of education they had attained. The options provided ranged from no schooling completed; some schooling not completed; some high school, no diploma; high school graduate; some college credit; trade/technical/vocational training; bachelor's degree; master's degree and doctorate degree. Spearman's correlation was conducted to assess whether there was any correlation between the level of education obtained of the participants and the level of PS that existed. There was found to be a strong negative relationship between the level of education of participants and their level of PS, which was shown to be statistically significant,  $r_s = -.608$ ,  $p = .001$ . Results from the correlation are illustrated below in Table 4.

		Public Stigma	Education
Spearman's rho	Public Stigma	Correlation Coefficient Sig. (2-tailed) N	1.000 . 150
	Education	Correlation Coefficient Sig. (2-tailed) N	-.608** .000 150
			1.000 . 150

Table 4: *Correlation between level of education and level of PS.*

\*\* . Correlation is significant at the 0.01 level (2-tailed).

This result indicated that the higher the level of education obtained by a participant, the lower the level of PS that was possessed by a participant. Figure 6 below provides an illustration of the findings for the correlation between level of education and PS.

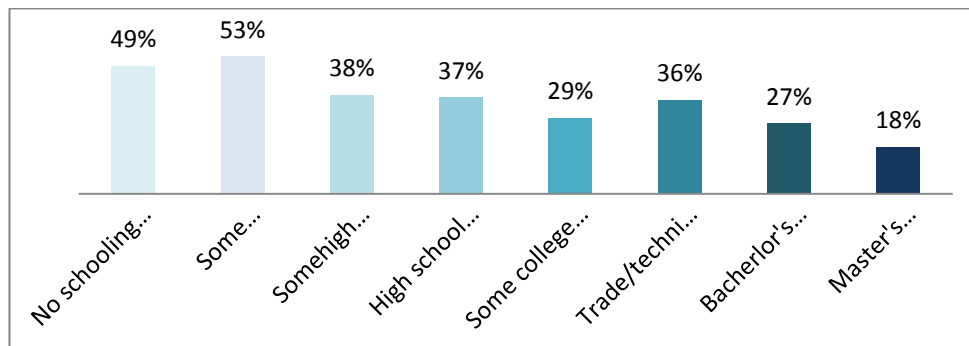


Figure 6: *Level of education and percentage of PS.*

#### 4.4.5 Predictors of public stigma

While there appeared to be moderate positive correlations between age and sex and a strong negative correlation between education level and the amount of public stigma, the researcher was also interested to establish which of the independent variables, between age, level of education and sex, had the greatest impact on an individual's level of public stigma. Multiple regression analysis was utilised to test whether these variables were able to significantly predict a participant's level of PS. Based on the standardised regression coefficients, level of education has the strongest predictor value ( $\beta = -.487$ ,  $p < .001$ ). There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.968. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by a Q-Q Plot.  $R^2$  for the overall model was 48.7% with an adjusted  $R^2$  of 47.7%, a large size effect according to Cohen (2003). Age, level of education and sex statistically significantly predicted PS,  $F(3, 146) = 46.278$ ,  $p < .001$  (Appendix E). All four variables added statistically significantly to the prediction,  $p < .05$ . Regression coefficients and standard errors can be found in Table 5 (below).

Table 5: *Summary of Multiple Regression Analysis*

Variable	B	SE <sub>B</sub>	$\beta$
Intercept (Constant)	97.524	5.149	
Age	3.422	.862	.243
Level of Education	-5.504	.715	-.487
Sex	9.498	2.379	.245

Note.  $*p < .05$ ;  $B$ =unstandardized regression coefficient;  $SE_B$ =Standard error of the coefficient;  $\beta$ =standardized coefficient

#### **4.5 Results from focus group interviews**

In addition to the CAMI questionnaire that was utilised for the quantitative section of this study, focus group interviews were also conducted with three groups, with each of the groups consisting of participants from different socioeconomic areas within the Windhoek area. The different areas were Ludwigsdorf to represent the HSE group, Pioneerspark to represent the MSE group and Otjomuise to represent the LSE group. Each group consisted of eight participants. The duration of the focus group discussion was between an hour and an hour and a half. Groups were asked the same four questions and each group member was asked to provide their opinions for each of the questions. Most participants identified more than one factor that they felt could be associated with the different questions. The results from each question will be discussed below.

##### **4.5.1 Focus group opinions on what is understood by the term mental illness**

The first question asked in the focus group was what each participant understood by the term mental illness. This question aimed to look at group members' understanding of what constitutes a mental illness and whether there were any misconceptions that possibly existed around the term mental illness. It also sought to provide insight about possible misunderstandings relating to what constitutes mental illness or by what the general public may be influenced by regarding their conceptualisation of mental illness.



#### **4.5.1.1 Low socio-economic group**

Three participants within the LSE group believed that mental illness was strongly related to abnormal behaviour and believed that it was the way in which PWMI behaved that showed that they were mentally ill. Two participants believed that mental illness was either a spiritual affliction or supernaturally caused with one participant explaining that PWMI:

*“Have something sent from God.” [P3]*

and another suggesting that:

*“It is something caused through witchcraft.” [P2]*

A further two participants believed that mental illness was an illness like any other:

*“It’s someone who is sick and needs help, like any other disease, they need help.” [P6]*

One group participant believed that mental illness was either a disturbance in thinking, something that develops over time or an emotional disturbance:

*“It’s something in the way they think, they become crazy because of thinking, so it develops and becomes worse over time and they start to act crazy.” [P5]*

#### **4.5.1.2 Medium socio-economic group**

The majority of participants in the MSE group also believed that mental illness was mainly associated with abnormal behaviour with three participants believing it was a disturbance in thinking explaining that:

*“There is a disturbance in their brain that is affecting their thinking.” [P7]*

As well as:

*“They are people having problems with their mind and they cannot think properly.” [P8]*

One of the participants believed that mental illness was an illness like any other explaining:

*“They are normal people, like any other person, there is just something that isn’t working right and they need help with that, just like someone who is sick.” [P12]*

and another participant also believed it was associated with emotional instability stating:

*“They can’t control their minds and do dangerous things towards people.”[P.11]*

#### **4.5.1.3 High Socio-Economic Group**

Three of participants within the HSE group believed that mental illness was associated with emotional volatility. Two of the participants in this group believed that it was associated with abnormal behaviour:

*“You always think of worst case scenario, some psychopath or serial killer that’s dangerous.”[P13]*

One group member believed it was something that develops over time, suggesting it was due to life stressors or certain experiences:

*“It’s like someone with anxiety or depression, which brought on by certain stressors and gets worse over time if not treated.” [P15]*

Another participant believed mental illness was due to a chemical imbalance or due to genetic factors:

*“It’s a chemical imbalance, often with some genetic influence.”[P17]*

Disturbance in thinking was also suggested by another participant as defining what constitutes mental illness.

The differences in responses among the three socioeconomic groups for question 1 are illustrated in Table 6 below.

<b>Themes of responses to question 1</b>	<b>LSE</b>	<b>MSE</b>	<b>HSE</b>
<b>Spiritual affliction</b>	25%	0%	0
<b>Abnormal behaviour</b>	38%	50%	25%
<b>Something that develops</b>	13%	0	13%
<b>Supernatural cause</b>	25%	0	0
<b>Illness</b>	25%	13%	0
<b>Emotional disturbance</b>	13%	0	0%
<b>Emotional volatility</b>	0	13%	38%
<b>Chemical Imbalance</b>	0	0	13%
<b>Genetic</b>	0	0	13%
<b>Disturbance in thinking</b>	13%	38%	13%

Table 6: *Differences in responses to question 1 between different socioeconomic groups*

#### **4.5.2 Focus group opinions on what mental illness stigma and discrimination means**

The second question asked in the focus groups was how members comprehend the phenomena of mental illness stigma and discrimination. This question aimed to assess firstly, whether group members were aware of the existence of stigma and discrimination towards people with mental illness and secondly, how they described and understood this stigma and discrimination. The question aimed to gain an

understanding of whether there was awareness around the existence of mental illness stigma and discrimination and if so, how it was conceived.

#### **4.5.2.1 Low socio-economic group**

The responses within the LSE group ranged as follows. Three of the participants in this group admitted to not knowing what stigma and discrimination towards mental illness was or how to define it. Three participants described stigma and discrimination as being associated with various forms of negative treatment, such as being neglected, pushed away or made fun of. One of the group participants did not believe that stigma towards mental illness existed. Another participant suggested that it was associated with the belief that one would never be “normal”.

#### **4.5.2.2 Middle socio-economic group**

Three participants in the MSE group felt they did not know what stigma and discrimination meant when referring to mental illness. Three of the participants suggested that it was also related to the belief that one may never be “normal” again. A further two participants suggested that it was related to how individuals with mental illness were treated. One participant suggested that it was related to the idea that mental illness is not taken seriously by the general public or given the same legitimacy as other illnesses.

#### **4.5.2.3 High socio-economic group**

Within the HSE group, four of the participants believed that stigma and discrimination was related to the way in which PWMI are treated. Three participants believed that stigma and discrimination was associated with a lack of understanding

about what mental illness is and that in many cases there were various misconceptions around what constituted mental illness, as one participant explained:

*“You think of ‘One Flew over the Cuckoo’s Nest’ when you think of mental illness, you always go to worst case scenario.” [P13]*

and another explaining:

*“Mental illness was just a word, until my father was diagnosed with it.” [P18]*

One of the participants also suggested that in many instances mental illness is not taken seriously and symptoms are often easily dismissed. Table 7 illustrates the various responses from the groups for question 2.

<b>Themes of responses to question 2</b>	<b>LSE</b>	<b>MSE</b>	<b>HSE</b>
<b>Treatment due to their behaviour</b>	38%	38%	50%
<b>Does not exist</b>	13%	0	0
<b>Did not know</b>	38%	38%	0
<b>Misunderstandings about mental illness</b>	0	0	38%
<b>Belief that MI is not serious</b>	0	13%	13%
<b>Belief that they will never be normal</b>	13%	25%	0

Table 7: Differences in responses of different socioeconomic groups to what mental illness stigma and discrimination means.

#### **4.5.3 Focus group opinions on why PWMI do not seek treatment**

The third question discussed in the focus groups focused on the beliefs that people hold about why people with mental illness (PWMI) are likely not to seek treatment. This question aimed to understand the reasons why individuals with mental illness are not prone to seek treatment, especially when consideration is made to the number of individuals within Namibia struggling with mental illness and the associated

symptoms (Ministry of Health and Social Services, 2005; World Health Organization, 2001).

#### **4.5.3.1 Low socio-economic group**

When participants in the LSE group were asked to discuss their views regarding the reasons PWMI might not seek treatment, four of the participants agreed that it was due to:

- the fact that PWMI are just not aware that something was wrong with them
- a lack of resources to access treatment
- fear of stigma and discriminatory behaviours from the general public. These behaviours were described as being neglected, pushed away and judged by society.

Two of the group participants believed that PWMI do not seek treatment due to a lack of support from family, friends, or the communities they form part of. One of the participants suggested that it might be possible that PWMI do not seek treatment solely because they were unable to, for example:

*“They are not able to get help. They need help from someone or there is a lack of resources, like no medications and no money.” [P2]*

One participant also suggested that in some instances the only appropriate treatment was through witchcraft:

*“It came from witchcraft, so hospitals can’t treat it.” [P1]*

#### **4.5.3.2 Medium socio-economic group**

Three of the participants within the MSE group believed that PWMI did not seek treatment mainly due to not having enough resources to travel to treatment centres and to pay for medical services and out of fear of stigma and discrimination. Two group participants believed that PWMI do not seek appropriate treatment because of a lack of support:

*“They’re afraid to be judged and rejected and that their families won’t show them love and they’ll be abandoned” [P9]*

One participant suggested that PWMI were not aware that they needed treatment and another believed that in some cases they do not believe they can get rid of their symptoms:

*“They have a belief that they will never be ok again.” [P8]*

#### **4.5.3.3 High socio-economic group**

Within the HSE group three of participants believed that PWMI not seeking treatment was mainly due to fear of stigma and discrimination. Three participants suggested it was due to people not knowing that there was something wrong with them and that they needed treatment:

*“There are misunderstandings around what constitutes appropriate treatment for a mental illness, it’s not as clear as when you have a physical illness, so when do you know that it’s time to get help.” [P13]*

Another participant suggested that in some cases individuals may not be aware of what the most appropriate treatment may be for mental illness:

*“Mental illnesses are not given the same legitimacy as physical illnesses, so you’re just supposed to ‘just get over it’ when you’re dealing with a mental illness.”[P14]*

One suggestion was related to self-stigma, with one participant explaining that:

*“Seeking treatment means that there is an admission that something is broken or wrong, and most people don’t know about it (mental illness) so there is this fear of being ostracised”. [P17]*

Theme of responses to question 3	LSE	MSE	HSE
<b>They do not believe there is anything wrong with them</b>	38%	0	38%
<b>They are not able to seek treatment</b>	13%	0	0
<b>Lack of resources</b>	38%	38%	0
<b>Lack of support</b>	25%	25%	0
<b>Stigma and discrimination</b>	38%	38%	50%
<b>Misunderstandings around appropriate treatment</b>	0	0	13%
<b>They believe they cannot get better</b>	0	13%	0
<b>Self-stigma</b>	0	0	13%

Table 8: *Differences in responses of different socioeconomic groups to why PWMI do not seek treatment*

#### **4.5.4 Focus group opinions on how mental illnesses differ from physical illnesses**

The final question discussed in the focus groups was aimed at understanding how group members compared mental illness to physical illness. This question, much like question one, sought to understand whether group members were aware of the various components that contributed to mental illness, as well as whether there was awareness around similarities and differences between mental illnesses and physical illnesses. This question also aimed to identify whether biases may exist within the groups around the legitimacy of mental illness when compared to physical illness.



#### **4.5.4.1 Low socio-economic group**

Two participants in the LSE group believed that no differences exist between mental illness and physical illness:

*“It’s the same thing, there is no difference.” [P1]*

A further two participants believed that abnormal behaviour was generally a good indicator for mental illness, unlike with physical illness:

*“It’s the way they behave and live, like they don’t bath, they don’t live a normal life, they behave in strange.” [P4]*

Two other participants suggested that mental illness was more of an internal disorder unlike physical illness where physical symptoms could be seen:

*“Mental illness is internal, physical illness can be seen externally, with mental illness it can only be seen through tests, there are no physical symptom.” [P2]*

Participant responses then ranged, from one participant suggesting mental illness was:

*“Sent from God and therefore can only be healed by God.” [P5]*

with another suggesting that mental illness was due to:

*“A spirit entering a person.” [P3]*

#### **4.5.4.2 Medium socio-economic group**

Three participants in the MSE group believed that no difference exists between physical and mental illness:

*“There is no difference; they both have to do with some type of illness.”*

*[P12]*

Two participants believed that mental illness was more internally based unlike physical illness:

*“It’s something you’re born with, something inside of you.” [P8]*

One participant believed that mental illness can be strongly related to behavioural symptoms:

*“With mental illness, the reactions will tell you. The way they act, you can see something is wrong.” [P9]*

Another felt that mental illness was a lifelong illness, unlike physical illness which could be cured:

*“A mental illness is a lifelong thing, but physical illnesses can be cured.”*  
*[P11]*

Another participant further suggested that mental illness mainly had a neurological basis explaining that:

*“Mental illness has to do with the brain.”[P7]*

#### **4.5.4.3 High socio-economic group**

Within the HSE group three of the participants believed there was no difference between mental illness and physical illness, except for how they are treated by society:

*“Both mental and physical illnesses can be caused by genetic or by lifestyle issues, we just accept physical illnesses more easily.”[P13]*

Two participants believed that the main difference between mental illness and physical illness was in the way mental and physical illnesses were treated by medical staff. Other group members’ responses ranged from believing mental illness is internal and physical is illness externally visible, thus mental illness symptoms are generally displayed through behaviour symptoms and that mental illness is a lifelong illness, in comparison to physical illness which often can be cured.

<b>Themes of responses to question 4</b>	<b>LSE</b>	<b>MSE</b>	<b>HSE</b>
<b>MI is sent from God and must be treated by God</b>	13%	0	0
<b>MI is internal, PI can be seen externally</b>	25%	25%	13%
<b>MI is a spirit that enters a person</b>	13%	0	0
<b>No difference</b>	25%	38%	38%
<b>MI behaviour will tell you</b>	25%	13%	13%
<b>MI and PI are treated differently</b>	0	0	25%
<b>MI can be lifelong, PI can be cured</b>	0	13%	13%
<b>MI has to do with the brain</b>	0	13%	0

Table 9: *Differences in responses of different socioeconomic groups to how mental illnesses differs from physical illnesses*

#### **4.6 Use of Data in Addressing Public Stigma**

The World Health Organisation (WHO) advised that initiatives combating stigma are implemented due to the significant impact stigma has on people with mental illness (Girma et al., 2013). Awareness of the existence of stigma allows for the development of initiatives and programmes that challenge the stigma processes (Teh, et al., 2014).

Three approaches that have been identified as ways of diminishing stigma are noted to be education, interpersonal contact and protest (Corrigan, 2004; Michaels et al., 2012). Approaches involving education aim to address the stereotypes and inaccurate information around mental illness and often involve various aids such as flyers and public service announcements and have the benefit of being low cost and far reaching (Corrigan & Shapiro, 2010; Michaels et al., 2012). Education seeks to provide more accurate information around mental illness, thus allowing the public to be better informed and respond to mental illness in more appropriate ways (Corrigan, 2004). Interpersonal contact is the second strategy proposed to combat stigma and involves the interaction of the public with those having a mental illness as this interaction is believed to lessen the degree of prejudice that may have existed before (Corrigan & Shapiro, 2010; Michaels et al., 2012). Stigma is additionally challenged and decreased when members of the public come into contact with mentally ill individuals who do not fit with the general stereotypes, forcing the public to re-evaluate their perceptions around those who are mentally ill (Corrigan, 2004).

The third approach in addressing stigma is social activism in which protest is used to confront various forms of prejudice and stereotyping (Corrigan & Shapiro, 2010; Michaels et al., 2012). Through protest inaccurate perceptions around mental illness are challenged and whilst protest also attempts to decrease negative stereotypes associated with mental illness.

#### **4.7 Conclusion**

This chapter reported on the data that was collected from both the quantitative and qualitative aspects of the study. Data in the quantitative section of the study was analysed using Spearman's correlation coefficient to calculate whether any

relationship existed between age, sex and level of education and if so, what the strength of this correlation was. Moderate positive correlations were found to exist between age and PS as well as sex and PS. A strong negative correlation was found to exist between level of education and level of PS. Multiple regression analysis was conducted to establish whether age, sex and level of education were able to predict the level of PS and which of these three variables were the strongest predictor of level of PS. Between these three variables, level of education was found to have the strongest predictor value. Data from the qualitative section of the study was coded and themes for each of the questions were identified. The responses from the three different socio-economic groups revealed higher levels of misinformation and misunderstandings around what mental illness is in the lower socio-economic groups than in the middle and higher socio-economic groups. However, misinformation was still evident in each of the groups.

## **CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Introduction**

The aim of this chapter is to provide the summary, conclusions and recommendations based on the results collected in this study. In addition it will also discuss certain considerations related to this study.

### **5.2 Discussion**

The aim of this study was to measure the level of public stigma of mental illness (PSMI) within the Windhoek area in order to provide an idea of the level of PS that exists within a Namibian context and to quantify the degree of stigma that was measured. The study also aimed to better understand attitudes held by the general population in the Windhoek region towards PWMI. In addition, it also sought to identify whether any demographic variables had an impact on the level of PS.

This study utilised a mixed methods approach in order to gather both quantitative and qualitative data. A non-probability sampling method was utilised for the quantitative part of the study, while a self-selecting sampling method was utilised for the qualitative part of the study. The study used two research instruments to collect data. The quantitative part of the study utilised the Community Attitudes towards Mental Illness (CAMI) questionnaire which was distributed to 150 participants within the Windhoek area. The qualitative part of the study utilised an interview guide for the focus group discussions. Three focus group discussions were conducted with each group being drawn from a different socioeconomic area within Windhoek.

The results from this study provide an indication of the level of PS that exists within a small sample of people living in Windhoek. Overall the level of PS that was

measured from the responses to the CAMI questionnaire was 41%. Based on Spearman's correlation, there was also found to be moderate correlation between age, sex and gender and levels of PS. Older adults, men and people with a lower level of education were found to have higher levels of PS.

Focus group discussions revealed that socioeconomic status also appeared to impact PS and that individuals within lower socioeconomics statuses have more misconceptions and misunderstandings around what mental illness is and what the appropriate treatment is. Responses from the three different groups indicated that within the low socio-economic (LSE) group more participants had misconceptions around mental illness when compared to the middle socio-economic (MSE) and high socio-economic (HSE) groups. While misinformation about mental illness was still apparent within both the MSE and HSE group, more participants appeared to have a better understanding of mental illness.

### **5.2.1 Age and public stigma**

According to the findings the older an individual was, the higher their level of PS was found to be. This indicates that older individuals possess higher levels of PS towards PWMI. This is consistent with findings that have also compared stigma and the impact of age (Angermeyer & Dietrich, 2006; Yuan et al., 2016). One possible explanation for this could be due to younger adults having more access to information related to mental illness, especially with the advancements in technology that have made this access easier to attain, specifically for younger adults who are more familiar with the use of this technology (Yuan et al., 2016).

### **5.2.2 Sex and public stigma**

The results indicated that men overall had higher levels of PS than women. This was found to be consistent among each age group. These results are consistent with what Taylor and Dear (1981) as well as other studies have found when comparing gender differences within stigma levels (Angermeyer & Dietrich, 2006; Lauber, Nordt, Sartorius, Falcató, & Rossler, 2000; Reavley & Jorm, 2011; Yuan et al., 2016). These studies suggested that these differences in gender could be as a result of cultural influences (Reavley & Jorm, 2011; Yuan et al., 2016). Culture is noted to influence behavioural expectations for different genders, within each culture there exists different expectations, thus in some cultures women have been found to be more understanding of PWMI and have lower levels of PSMI whereas in others, the opposite exists (Green et al., 2005; Rao et al., 2007; Subramaniam et al., 2017).

### **5.2.3 Level of education and public stigma**

This result indicated that the higher the level of education obtained by a participant, the lower the level of PS that was possessed by a participant. This finding suggests that the more education an individual has received, the more they understand about mental illness and therefore possess a lower level of stigma towards it. This is consistent with other findings that also examined the link between stigma levels and level of education (Angermeyer & Dietrich, 2006; Subramaniam et al., 2017; Yuan et al., 2016).

### **5.2.4 Attitudes people hold towards mentally ill people in Windhoek**

The focus group discussions were centred on four questions aimed to gain more insights into possible misunderstandings regarding mental illness and PWMI. The first question's aim was to assist in gaining a clearer idea of what group participants



understood by the term mental illness. Within the lower socio-economic group, opinions revealed some misconceptions and uncertainty around what mental illness was, with some participants believing it was caused through supernatural means. The middle and higher socio-economic groups appeared to have a clearer understanding of mental illness. This is consistent with what other studies have found regarding misconceptions towards mental illness within lower socio-economic groups (Girma et al., 2013; Subramaniam et al., 2017).

The second question sought to identify if participants were aware of any stigma that existed towards PWMI and how they believed it was displayed in terms of discrimination. These findings show that there is a lack of awareness around the existence of PS within lower socio-economic groups. In addition, each of the groups identified negative treatment towards PWMI as discrimination. This could be related to limitations in accessing treatment, as this anticipated negative treatment could act as a barrier (Michaels et al., 2012; Teh et al., 2014; McCann et al., 2017).

The third question explored in the study was to identify what reasons there could be for PWMI not seeking treatment. Within each of the groups, participants identified a lack of awareness as well as fear of being rejected from ones community as being major limiting factors in seeking treatment, this fear of community reactions is also consistent with previous findings (Overton & Medina, 2008; Rao et al., 2007; Sartorius, 2007; Vogel et al., 2013). Additionally, both the lower and middle socio-economic groups identified a lack of resources as another contributing factor in why PWMI do not seek treatment, which is consistent with a previous study regarding limitations faced in addressing stigma in lower income countries such as Namibia (Mascayano et al., 2015).

The final question sought to understand how group participants thought mental illness differed from physical illness, if at all. It also aimed to identify whether any biases may exist within these definitions. This question, similar to question one, revealed misunderstandings around what mental illness is within the lower socio-economic group. Although definitions of abnormal behaviour were identified within this group, beliefs that it was based on supernatural causes were once again present. The middle and higher socio-economic groups showed a clearer understanding of the difference as well as similarities between mental and physical illness, identifying that the major difference was how they were treated by society. The difference in knowledge between the groups could be related to levels of education within the which has been found to impact knowledge around mental illness (Angermeyer & Dietrich, 2006; Subramaniam et al., 2017).

### **5.3 Conclusions**

This study sought to gain an understanding of the level of PS as it related to a Namibian context by looking at a sample within the Windhoek population. Findings firstly revealed that PS was higher in older individuals in comparison to younger individuals, which is consistent with previous studies that have also considered the relationship between age and stigma (Angermeyer & Dietrich, 2006; Yuan et al., 2016)

Secondly, PS was also found to be higher in men than in women. This is also consistent with findings from previous studies comparing the differences in stigma levels between men and women (Angermeyer & Dietrich, 2006; Lauber et al., 2000; Reavley & Jorm, 2011; Yuan et al., 2016).

Finally, people who had lower levels of education were found to have higher levels of PS in comparison with people with higher levels of education. This is also consistent with other studies comparing level of stigma and education which have also indicated that individuals with lower levels of education often have higher levels of stigma (Angermeyer & Dietrich, 2006; Subramaniam et al., 2017; Yuan et al., 2016).

The overall level of stigma was measured to be 41% which is below average. When one considers the scoring of the CAMI any scores above 0% indicate high levels of PS towards PWMI. It is necessary to note that the majority of participants that were surveyed had some degree of education, as they were required to be literate in order to participate in the CAMI survey. Therefore consideration would need to be given towards the correlation between level of education and level of PS, which according to this and other studies has been found to have a negative correlation (Angermeyer & Dietrich, 2006; Subramaniam et al., 2017; Yuan et al., 2016). Also, as the CAMI questionnaire required participants to be literate in order to participate, respondents who were illiterate were not able to take part in the survey, which again would result in responses not reflecting the overall level of stigma. This could mean that the result of the level of PS is higher than reflected in the results of the CAMI based on the number of the population in Namibia that do not have high levels of education (Ministry of Health and Social Services, 2013).

Results from the focus groups discussions show that there is a lack of knowledge and understanding around what mental illness is, especially within the lower socio-economic groups. This lack of understanding as well as the anticipated negative reactions towards PWMI was found to be a significant limiting factor in accessing

treatment. Similar to what other studies have found, education could be a major resource in addressing PSMI in this context (Michaels et al., 2012).

#### **5.4 Recommendations**

Findings from this study allow the following recommendations to be made.

Strategies of addressing PS would appear to be applicable based on the findings of this study as most misconceptions expressed by the focus groups were due to a lack of education and no contact. The strategies that were identified to effectively address PS were contact, education and protest (Corrigan, 2004; Michaels, López et al., 2012). In other words, people's understanding of what mental illness is and how to respond to PWMI is based on misunderstandings or misinformation based on stereotypes which ultimately inform prejudices and discrimination (Link & Phelan, 2001).

In keeping with Corrigan and Shapiro's (2010) recommendations in addressing PS, the three strategies identified can be utilised. It became evident within both the focus group discussions as well as through the responses given to the CAMI questionnaire that certain individuals who were exposed to different versions to their preconceived assumptions and stereotypes around PWMI began to question their own held views around mental illness. While these individuals weren't overtly challenged regarding their misconceptions, simply the provision of an alternate possibility as well as a questioning around their own views provided an opportunity for shifts in their attitudes. In this way protest was provided through challenging these negatively held views towards PWMI (Corrigan & Shapiro, 2010).

The second strategy, that of contact, became evident within the group discussions in that participants who had been exposed to or somehow knew someone who had

struggled with mental illness had a better understanding and fewer misconceptions around what mental illness was. Individuals who have had limited or no interaction with PWMI have more misconceptions and negative stereotypes towards mental illness (Corrigan and Shapiro, 2010) .

The final strategy discussed is that of education, which was also noted in this study as impacting the level of PS (Corrigan & Shapiro, 2010). As previously discussed, the correlation found between the levels of education and PS, indicated that individuals with higher levels of education had lower levels of PS. Thus it is possible that if the public become better informed and educated around mental illness, their levels of PS towards mental illness could be decreased.

Future research would be advised in order to provide greater and more in depth understanding around PS and its impact within the Namibian context. This would provide more insight towards anti-stigma initiatives that could be used in addressing PS and the impact it has on PWMI.

Additionally, future treatment services for mental illness can be developed. Opinions from both the focus group discussions and CAMI questionnaire indicated that the majority of individuals felt that there were not enough treatment facilities for treating PWMI. Thus further research to specifically identify more appropriate and specialised treatment for PWMI would be recommended.

## **5.5 Considerations**

Several considerations for this study were also noted.

Firstly, consideration would need to be given around the sample size used for this study. The sample size for the quantitative section of this study consisted of 150

participants, thus consideration must be given towards the ability to draw an accurate representative result from such sample size given the total population of Windhoek or Namibia.

In addition, prospective participants who were not literate were unable to take part in the questionnaire. When consideration is given to the potential socioeconomic levels these prospective participants could have represented it needs to be considered the data that was potentially lost at their inability to partake in this study.

The scales used for future research in measuring PS could be considered. In order to combat possible self-presentation bias, the use of different assessment tools to measure PS could also be used. Additionally, when considering the restrictions in some participants being unable to take part in the study due to limitations in language and literacy, consideration could also be given to utilising scales that have either been translated into more Namibian languages as well as scales that would not require participants to be literate.

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## APPENDIX A: Ethical clearance certificate



### ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS /346/2017      Date: 20 October, 2017

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy And Guidelines. Ethical Approval Is Given In Respect Of Undertakings Contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Exploring possible public stigma towards mental illness in Windhoek

Researcher: Marleen Laubscher

Student Number: 201601340

Supervisor(s): Dr M Janik

Faculty: Faculty of Humanities and Social Sciences

Take note of the following:

- (a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
- (b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
- (c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
- (d) The UREC retains the right to:
  - (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected.
  - (ii) Request for an ethical compliance report at any point during the course of the research;

UREC wishes you the best in your research.

Prof. P. Odonkoe: UREC Chairperson

A handwritten signature in black ink, appearing to be "P. Odonkoe", written over a horizontal line.

Ms. B. Claassen: UREC Secretary

A handwritten signature in black ink, appearing to be "B. Claassen", written over a horizontal line.

## **APPENDIX B: Consent Form**

**TITLE OF THE RESEARCH PROJECT: Exploring possible public stigma towards mental illness in Windhoek**

**REFERENCE NUMBER:**

**PRINCIPAL INVESTIGATOR: Marleen Laubscher**

**ADDRESS: 23 Luderitz Street , Swakopmund Namibia**

**CONTACT NUMBER: 081 802 9011**

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

### **1. What is this research study all about?**

- a) *The study aims to understand the public's attitudes towards mental illness. The study is composed of two sections, with one section consisting of a questionnaire that will be randomly distributed and the other section consisting of focus group discussions that will be conducted in three different socio-economic areas. This study will be conducted within the Windhoek area.*
- b) *According to previous studies, community attitudes or public stigma towards mental illness can have a significant impact on people who are struggling with mental illness. Thus, this study seeks to better understand the levels of public stigma towards mental illness that exists in Windhoek as a way of improving future approaches to mental illness.*
- c) *The questionnaire section of the study will aim to collect information from 150 anonymous participants within the Windhoek area. The questionnaire consists of 40 questions and takes 15 min to complete. The questionnaires will be handed out in the city. The focus group section of the study will aim to conduct three focus groups consisting of 8 participants each, within three different socio-economic areas in Windhoek. Participation in the focus groups will be completely anonymous and no identifying information about the participants would be collected or used.*
- d) *No medication will be used in this study.*

## **2. Why have you been invited to participate?**

- a) *As a Namibian citizen currently living in Namibia, you have valuable insights on the way in which mental illness is seen and how mentally ill people are treated. These insights would be a valuable contribution to this study.*
- b) *If you are above the age of 18 years, a Namibian citizen currently living in Windhoek and have not been diagnosed with a mental illness, you are eligible to take part in the study.*

## **3. What will your responsibilities be?**

- a) *Participation in this study would be in either the questionnaire section or the focus group discussion section. If you are taking part in the questionnaire section of the study, you will be asked to answer the 40 questions in the questionnaire as honestly as possible. If you are taking part in the focus group discussion section, you will be asked to provide your honest opinions on the questions posed by the researcher during the focus group.*
- b) *Participants who are taking part in the questionnaire part of the study can expect to spend approximately 15 min answering the questionnaire. Participants taking part in the focus group discussion part of the study can expect to spend approximately 2 hours in the focus group.*

## **4. Will you benefit from taking part in this research?**

- a) *While the study is not expected to directly benefit those who partake in it, there is a wider social impact that could be expected as a result of the study being conducted in that there will be a better understanding of the degree of public stigma that exists within a Namibian context.*

## **5. Are there any risks involved in your taking part in this research?**

- a) *There are no identifiable risks involved in taking part in this study.*

## **6. If you do not agree to take part, what alternatives do you have?**

- a) *Those who choose not to take part in the study, but would like to know more about the impact of community attitudes or public stigma on the mentally ill can request more information on the subject.*

## **7. Who will have access to the information you provide?**

- a) *The information collected from participants will be protected and treated confidentially. All information will be stored within a password protected file. Any information used within a publication or thesis will maintain the anonymity of the participants. Only the researcher and the researcher's supervisor will have access to that information.*

## **8. The use of voice recordings in the study.**

a) Participants taking part in the focus group section of the study will also be asked to give permission for their responses to be electronically recorded using a voice recorder.

b) The recordings will only be heard by the researcher and will be stored on a password protected file on the researcher's computer as a way of ensuring anonymity for the participants.

c) The electronic recordings will be deleted after five years after the completion of the study.

d) If a participant wants to take part in the study but does not want to be recorded they will be able to take part in the questionnaire section of the study.

### **9. Will you be paid to take part in this study and are there any costs involved?**

a) Participation in the study is completely voluntary and no participant will be paid to take part. There are no costs involved for participants taking part in this study.

### **10. Is there anything else that you should know or do?**

a) You can contact Marleen Laubscher at 081 802 9011 if you have any further queries or encounter any problems.

b) You can contact the Health Research Ethics Committee at **+264 061 2063061** if you have any concerns or complaints that have not been adequately addressed by your study doctor.

c) You will receive a copy of this information and consent form for your own records.

### **11. Declaration by participant**

By signing below, I ..... agree to take part in a research study entitled (*Exploring possible public stigma towards mental illness in Windhoek*).

#### **I declare that:**

a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

b) I have had a chance to ask questions and all my questions have been adequately answered.

c) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

d) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

e) I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (place) ..... on (date) ..... 2005.

.....

Signature of participant

.....

Signature of witness

**12. Declaration by investigator**

I (*Marleen Laubscher*) declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did not use an interpreter.

Signed at (*place*) ..... on (*date*) ..... 2005.

.....

Signature of investigator

.....

Signature of witness

## APPENDIX C: Community Attitudes towards Mental Illness Survey

### COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL

Thank you for taking the time to complete this survey. Please know that no identifying information will be requested from you and that the survey is completely anonymous. This survey should take between 5-10 minutes to complete.

1. What age group do you belong to?

A. 18-24	B. 25-34	C. 35-44	D. 45-54	E. 55-64	F. 65 and over
----------	----------	----------	----------	----------	----------------

2. Sex

A. Male	B. Female
---------	-----------

3. Ethnicity

A. Ovambo	B. Kavango	C. Herero	D. Tswana	E. Himba	F. Damara
G. Baster	H. Coloured	I. Nama	J. Caprivian	K. San	

4. What is the highest degree or level of school you have completed?

A. No schooling completed	B. Some schooling, not completed	C. Some high school, no diploma
D. High school graduate	E. Some college credit, no degree	F. Trade/technical/vocational training
G. Bachelor's degree	H. Master's degree	I. Doctorate degree

The following 40 statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please choose the response which most accurately describes your reaction to each statement (**SA= Strongly Agree; A= Agree; N= Neither Agree Nor Disagree; D= Disagree; SD= Strongly Disagree**). It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

1. As soon as a person shows signs of mental disturbance, he should be hospitalized.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

2. More tax money should be spent on the care and treatment of the mentally ill.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

3. The mentally ill should be isolated from the rest of the community.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

4. The best therapy for many mental patients is to be part of a normal community.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

5. Mental illness is an illness like any other.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

6. The mentally ill are a burden on society.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

7. The mentally ill are far less of a danger than most people suppose.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

8. Locating mental health facilities in a residential area downgrades the neighbourhood.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

9. There is something about the mentally ill that makes it easy to tell them from normal people.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

10. The mentally ill have for too long been the subject of ridicule.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree

E. Strongly Disagree

11. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

12. As far as possible mental health services should be provided through community-based facilities.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

13. Less emphasis should be placed on protecting the public from the mentally ill.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

14. Increased spending on mental health services is a waste of tax dollars.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

15. No one has the right to exclude the mentally ill from their neighbourhood.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

16. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

17. Mental patients need the same kind of control and discipline as a young child.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

18. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

19. I would not want to live next door to someone who has been mentally ill.

- |                               |             |
|-------------------------------|-------------|
| A. Strongly Agree             | B. Agree    |
| C. Neither agree nor disagree | D. Disagree |
| E. Strongly Disagree          |             |

20. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.



A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

21. The mentally ill should not be treated as outcasts of society.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

22. There are sufficient existing services for the mentally ill.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

23. Mental patients should be encouraged to assume the responsibilities of normal life.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

24. Local residents have good reason to resist the location of mental health services in their neighbourhood.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

25. The best way to handle the mentally ill is to keep them behind locked doors.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

26. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

27. Anyone with a history of mental problems should be excluded from taking public office.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

28. Locating mental health services in residential neighbourhoods does not endanger local residents.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

29. Mental hospitals are an outdated means of treating the mentally ill.

A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

30. The mentally ill do not deserve our sympathy.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

31. The mentally ill should not be denied their individual rights. 4.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

32. Mental health facilities should be kept out of residential neighbourhoods..	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

33. One of the main causes of mental illness is a lack of self-discipline and will power.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

34. We have the responsibility to provide the best possible care for the mentally ill.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

35. The mentally ill should not be given any responsibility.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

36. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

37. Virtually anyone can become mentally ill.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

38. It is best to avoid anyone who has mental problems.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

39. Most women who were once patients in a mental hospital can be trusted as baby sitters.	
A. Strongly Agree	B. Agree
C. Neither agree nor disagree	D. Disagree
E. Strongly Disagree	

40. It is frightening to think of people with mental problems living in residential neighbourhoods.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

E. Strongly Disagree

## **APPENDIX D: Interview Guide for Focus Group Discussions**

1. What do you understand by the term mental illness?
2. What does mental health stigma and discrimination mean to you?
3. Why do you think people with mental illness don't seek treatment in Namibia
4. How do you think mental illness differs from physical illness?

## APPENDIX E: Multiple Regression Results

Table 10: *Independence of residuals*

	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.698 <sup>a</sup>	.487	.477	14.04363	1.968

a. Predictors: (Constant), Age, Sex, LevelOfEducation

b. Dependent Variable: PublicStigma

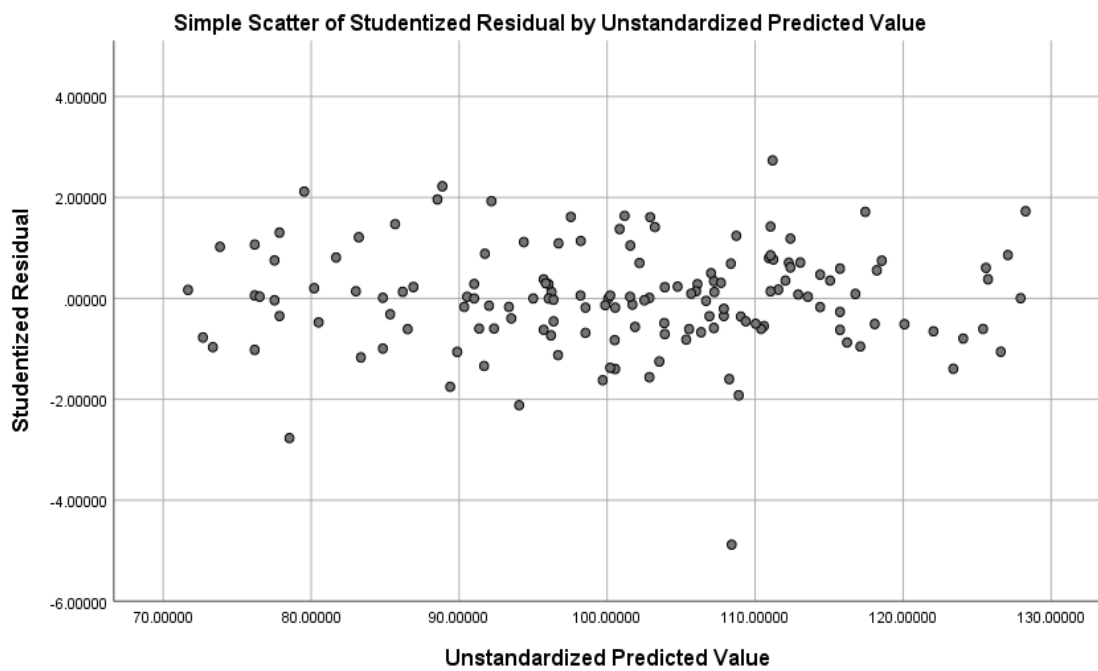


Figure 7: *Studentized residuals indicating linear relationship between variable (age, sex, education level and public stigma)*

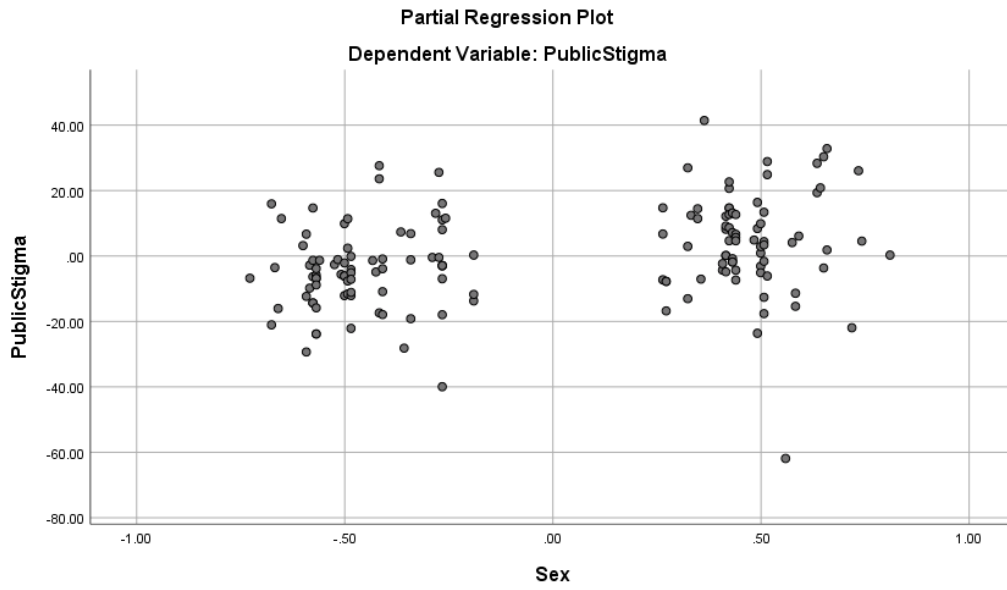


Figure 8: *Partial regression plot between sex and PS*

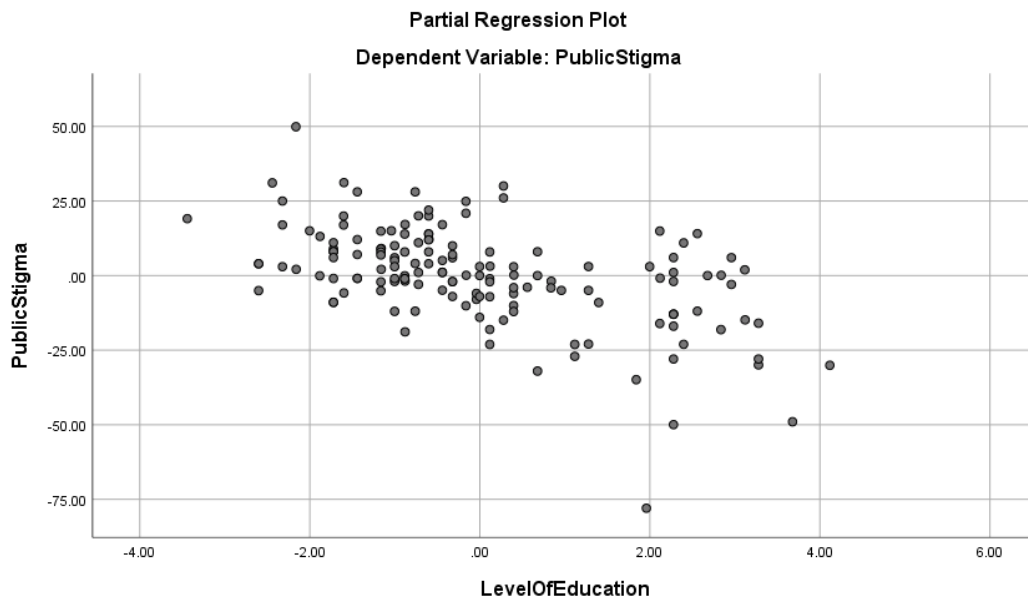


Figure 9: *Partial regression plot between level of education and PS*



Figure 10: *Partial regression plot between age and PS*

Table 11: *Collinearity Statistics*

	<i>Tolerance</i>	<i>VIF</i>
(Constant)		
Sex	.930	1.076
Level of Education	.884	1.137
Age	.939	1.065

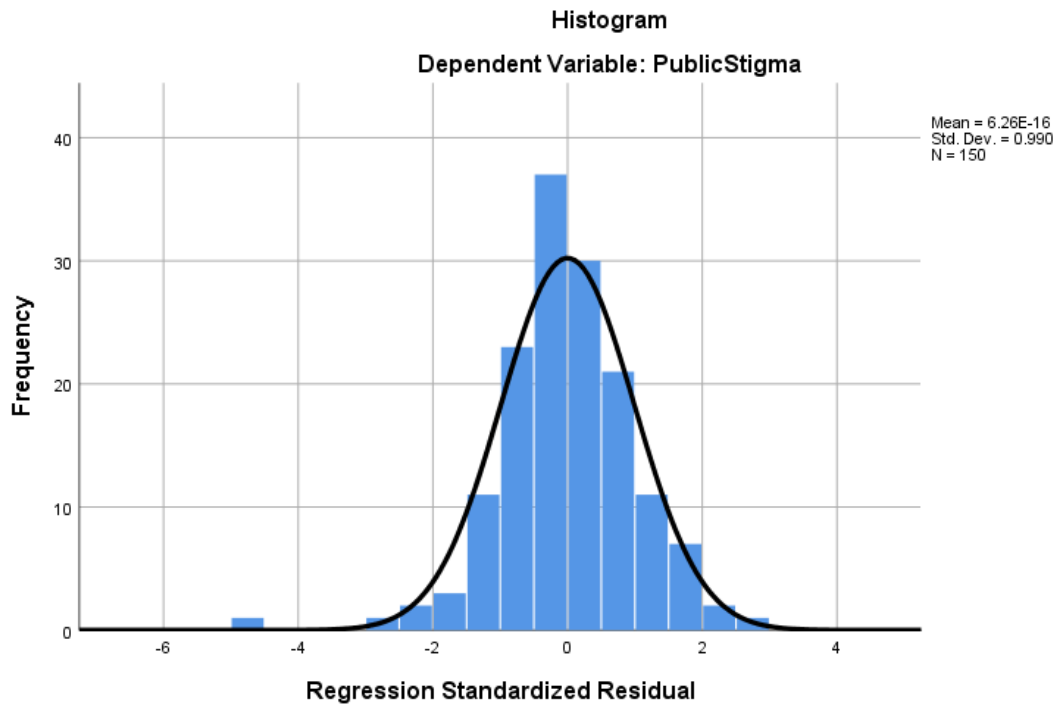


Figure 11: *Tests of normality (Histogram)*

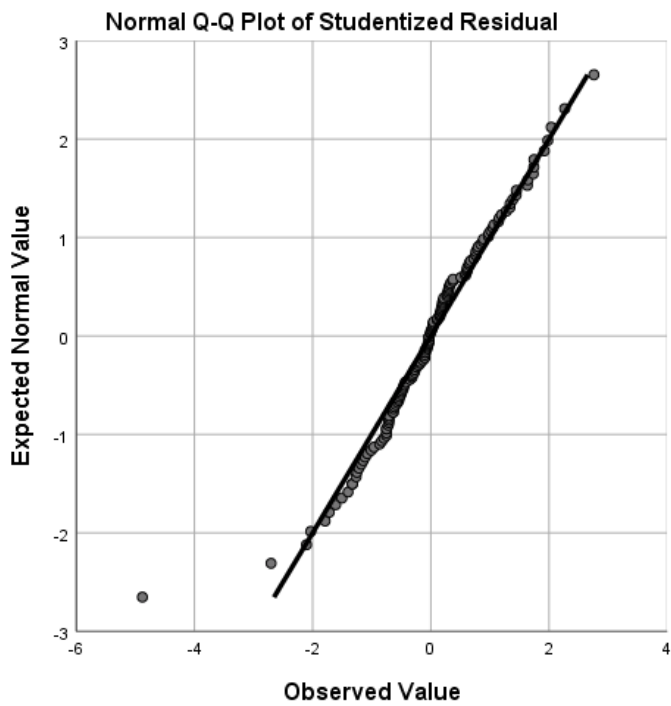
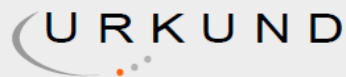


Figure 12: *Tests of normality (Q-Plot)*



## APPENDIX F: Urkund Analysis Result

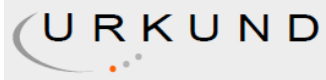


### Urkund Analysis Result

Analysed Document: Laubscher20.docx (D64307971)  
Submitted: 2/24/2020 10:47:00 AM  
Submitted By: mjanik@unam.na  
Significance: 8 %

#### Sources included in the report:

EDITED THESIS FOR PRINT VIP.docx (D26999721)  
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