AALBORG UNIVERSITY

# MENTAL ILLNESS STIGMA IN DENMARK AND CAMEROON:

## EXPLORING THE SOCIAL WORKERS' PERSPECTIVES AND APPROACHES TO STIGMA REDUCTION.

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# MENTAL ILLNESS STIGMA IN DENMARK AND CAMEROON: EXPLORING THE SOCIAL WORKERS' PERSPECTIVES AND APPROACHES TO STIGMA REDUCTION


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## DEDICATION

This work is dedicated to all those who feel excluded in their daily social interactions – those who are discriminated against because of their health status, race, disability, gender, and socioeconomic status.

For you, I have two quotes from Unknown and David Mitchell

> *"When someone judges you, it isn't actually about you. It's about them and their own insecurities, limitations, and needs."*
>
> *– Unknown*

> *"You say you're depressed – all I see is resilience. You are allowed to feel messed up and inside out. It doesn't mean you're defective – it just means you're human."*
>
> *– David Mitchell*

## ABSTRACT

Negative attitudes toward people with mental disorders are prevalent and have disastrous consequences on their wellbeing and recovery. In Denmark and Cameroon, persons living with mental illness are challenged at two levels; On the one hand, they struggle with the symptoms and disabilities that result from the disease. On the other hand, they struggle with stereotypes and prejudice resulting from misconceptions about mental illness. Social workers have a mandate to reduce Stigma to support social justice are missions. Addressing stigma should be a critical focus of social work interventions in clinical and community settings.

This study explores and interprets how Danish and Cameroonian social workers perceive the dimensions of mental illness Stigma and how they calibrate Social Justice in anti-stigma practice at the micro (individual), mezzo (society) and macro levels.

A purposive sample technique permitted the recruitment of 4 participants for the study. Hermeneutic individual semi-structured interviews were conducted. This approach allowed participants to discuss their perceptions of mental illness stigma, their interpretations of the ethical principle of Social Justice and how this principle is mainstreamed in the strategies employed to mitigate Stigma at intrapersonal, interpersonal and structural levels.

Link's Modelling Labelling Theory, Honneth's theory of Recognition, Transpersonal Theory, Andersen's Empowerment theory, and the Protest, Education and Contact Framework for Stigma Reduction proposed by Corrigan et al. (2001) were used as theories to interpret the empirical data.

It was found that the Social Workers from both Denmark and Cameroon consider stigma as a complex phenomenon rooted in cultural identities and stereotypes that mediate the process of stigmatisation by othering and labelling those affected by the illness. The social workers equally deployed a variety of stigma reduction strategies which are informed my empowerment perspectives.



## KEYWORDS

Mental illness, Stigmatisation, Denmark, Social workers, Social exclusion, Stigma, Cameroon, Social Justice, destigmatisation, Ethics, Anti- stigma intervention

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# CHAPTER ONE
## INTRODUCTION AND PROBLEM FORMULATION

This study aims to explore the implications of the perception of social workers on the stigma of mental illness. It explores the social worker's understanding of Social Justice as a professional and moral principle in stigma reduction strategies and their challenges/possibilities in two different contexts – Denmark and Cameroon. Finally, the study makes recommendations for action in both practice and research.

### 1.1 Setting the Scene: From Ignorance, through Curiosity, to Interest

Embarking on this research without acknowledging my preunderstandings of mental illness and persons living with mental illness would be blather. Growing up in Cameroon, where mental illness is still largely considered "*a thing of the West*", led me to think that way. Yes – before starting the Nordic Master in Social Work program in August 2019 and this research in March 2021, I considered persons living with mental illness crazy. Each time I saw a mentally ill person, I would look away and think of the kind of "awful" things this person might have done to find themselves in that condition.

In January 2019, a close relative became mentally ill. He often tried to explain to me the processes going through his mind, and all I said to him was, "get your shit together. You're just weak. Be a man." His situation worsened as he multiplied was not getting help. In August of the same year, I travelled to Denmark to start this program. While in Denmark, I met persons who seemed extremely functional but disclosed struggling with these unique forms of illnesses that I couldn't see. Then I understand what my relative was dealing with. I became curious about mental health disorders. A fundamental question kept running through my mind as I was getting educated about these issues: Why is mental health given so much attention in the West (or Nordic countries) and so little in Cameroon? What are the stumbling blocks? My supervisor recommended that I get in touch with Social Workers on the ground in Cameroon to discuss these issues. After consultations with them, my curiosity matured into an interest in finding out what stands in the way of prioritising or addressing mental illness – They were unanimous. Stigma "is the thing". It was surprising that although Mental illness was well addressed in this part of the world, stigma still exists.

### 1.2 Background to the Study

The World Health Organization (WHO) ha defined Mental Health as *"a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community"* (WHO, 2004:1). Mental Health, therefore, is a concept regarded as encompassing dimensions of hedonic (positive feelings, affect, emotions) and eudemonic (positive functioning, mindset, and relationships) well-being (Stewart-Brown, 2013). Over the past decade, interest in the concept of mental well-being has increased, along with recognising its impact on public health (Koushede et al., 2019; WHO, 2013). These developments have increased researchers, policymakers, and service providers' interest in improving mental well-being measurement, preservation, and recovery (Slade et al., 2014).

The Institute for Health Metrics and Evaluation reported in their flagship ***Global Burden of Disease study*** report a 2017 estimate that 792 million people lived with a mental health disorder globally. This is slightly more than one in ten people globally (10.7%). In their report titled ***Mental health: Strengthening our response***, the World Health Organisation concedes that globally 10 per cent of any country's adult population is affected by mental illness at any point in time. They equally report that an estimated 25 per cent of the worldwide population is affected by a mental or behavioural disorder at some time during their lives. Mental and substance use disorders are now the leading cause of disability worldwide (Wainberg et al., 2017). This documented global burden of disease associated with mental disorders widens the *"mental health treatment gap"*. Worldwide, more than 70% of persons who need mental health services lack access to care (Wainberg et al., 2017). Existing knowledge suggests that (1) individuals who need care often do not seek services, and (2) those that begin receiving care frequently do not complete the recommended treatment plan (Ahmedani, 2011 citing Corrigan, 2004).

Advancements in neuroscience and technology, and research sophistication have led to significantly increased understanding of mental illnesses and improved treatment and recovery from these disorders. However, there are also critical psychosocial aspects of mental illness that hinder recovery from these conditions. One set of these factors involves prejudice and discrimination, often referred to as *'stigma'*, when others find out that someone has been diagnosed with, and are treated for, a mental disorder.

### 1.3 Problem Formulation

Stigma (the negative stereotypes and perception of prejudiced beliefs and discriminatory behaviour) is a significant barrier to recovery. While a substantial body of research defines the extent and impact of Stigma, few studies reveal what works to diminish it. The WHO (2017) identify Stigma as a critical barrier to successful treatment engagement, including seeking and sustaining participation in recovery services. It interferes with community living and the attainment of resources and goals and damages self-esteem and self-efficacy. Stigma plays a prominent role in how certain groups function psychosocially, impacting their psychological well-being and their ability to work in social relationships. Persons living with mental illness, a highly stigmatised population, have reported emotional reactions such as anger, hurt, sadness, and discouragement because of stigmatising experiences (Corrigan & Kleinlein, 2005). Stigmatised individuals fear rejection, which severely strains their social relationships (Ahmedani, 2011). Those who experience stigmatisation report lower self-esteem, more significant depression, social withdrawal, and difficulty trusting others (Scheyett, 2005; Corrigan & Kleinlein, 2005). Research-based evidence equally indicates that negative public attitudes about a wide range of undesirable conditions have negative impacts on the lives of people, including those with (a) epilepsy, (b) stuttering (also called stammering), (c) HIV/AIDS, (d) mental illness, (e) obesity (Louis & Roberts, 2013).

Many persons living with mental illness are challenged at two levels. On the one hand, they struggle with the symptoms and disabilities that result from the disease. On the other hand, they struggle with stereotypes and prejudice resulting from misconceptions about mental illness (Watson et al, 2017). Stigma is arguably the most significant barrier to recovery and full community inclusion for people with mental illnesses. It deprives of opportunities in several areas, including; education, employment, safe housing, social networks, and even other basic life choices (Watson et al., 2017). Often, mental disorders trigger marginalisation, social

vulnerability, and a range of social problems, such as homelessness and drug and alcohol abuse (Lund et al., 2011; Becker & Kleinman, 2013).

Social work is crucial to modern mental health service provision to individuals with mental disorders. Social workers intervene in several aspects of people's lives, including stigmatisation, dysfunctional family relationships, homelessness, ill health, empowerment of oppressed and vulnerable people to promote social inclusion. Human rights and social justice comes very much to the front as a duty in anti-stigma actions for users. The International Federation of Social Workers (IFSW) **Global Social Work Statement of Ethical Principles,** from which the *Dansk socialrådgiverforening* (Danish Association of Social Workers') and *Association Nationale des Travailleurs Sociaux du Cameroun* (Cameroon Association of Social Workers') Code of Ethics are developed, mandates social workers in Denmark and Cameroon respectively to promote Social justice, and specifically challenge discrimination and institutional oppression (IFSW, 2018). These specific ethical professional values pointedly call social workers to work to mitigate their levels of Stigma and work with others to dispel forms of stigma at intrapersonal, interpersonal and structural levels.

Stigma is an issue of significant concern to social workers because empowerment and social justice are the underpinnings of the profession. They ought to challenge discrimination, advocate for the equitable distribution of resources, challenge unjust policies and practices, and work in solidarity with communities and individuals to create a socially just society. Watson & Eack (2011) have suggested that social workers must know the different ways the Stigma of mental illness can manifest itself; second, the severe impact stigma can have on recovery from mental illness and the enhancement of well being; and finally, the strategies to prevent and manage mental health stigma individual and structural levels. Considering that social workers play a prominent role in mental health service provision and that actions to reduce Stigma to support social justice are missions, addressing Stigma should be a critical focus of social work interventions in clinical and community settings.

However, social work seems not to connect its dedication to social justice, anti-stigma interventions, and mental health service provision. The profession has not turned its full attention to Stigma and discrimination against individuals with mental health disorders. Scheyett (2005) notes that social work has been noticeably absent from research and anti-stigma initiatives for people with mental disorders. Social work's lack of focus on issues of mental illness stigma is shocking when one considers the profession's ontology and core values at intrapersonal/micro levels, interpersonal/mezzo and structural/macro levels. Emphasising this passivity, Steyaert (2013) argues that social work seems to have become a *'partner in crime'* due to its silence advocating for social justice.

Moreso, despite various research projects on stigma reduction programs (Corbiere et al., 2012). It seems that stigma reduction strategies vary according to contextual factors, including politics, socio-economic status, culture, religion, and media (Taghva et al., 2017). Thus, more culturally sensitive and contextual studies are needed to explore suitable strategies in different countries and identify best practices for stigma reduction. This paper identifies Cameroon and Denmark for a cross-cultural study that engages social workers in a critical reflection about their mandate and professional practice. This approach will equally broaden social work's horizon: allowing social work practice to reflect upon a system through the lens of other procedures or practices.

This study attempts to explore the perceptions and actions of social workers regarding Stigma on mental health services in Denmark and Cameroon, with a specific focus on uncovering how the social workers work to reduce the impacts of these oppressive labels for persons who are already challenged by illness.

### 1.4 Denmark and Cameroon: On level grounds

his study explores the stigma phenomenon in a collectivistic society (which adheres to psycho-cultural-spiritual values and Judeo-Christian/Islamic values) with a modern individualistic secularised western society through an emic exploration of meanings the Social Worker's ascribe to Stigma in Cameroon and Denmark, respectively. The rationale for the country selection is described below.

Social work is a global profession. Although the methods might differ in almost all parts of the world, the profession's identity, purpose, and ethics are the same (International Federation of Social Workers, 2014). Gray and Fook (2004) have theorised this universality of social work, noting that the profession transcends national boundaries as it presents commonalities in theory and practice across widely divergent contexts. Social workers in all contexts work for the well-being of people within their ecological and social contexts, intervening to resolve tensions between individuals, groups, and communities. In this paper, the tension in question is the Stigma of Mental illness. Therefore, this research proceeds from the assumption that Social Workers are social experts. It is crucial to understand their perception of stigma and how they work to reduce stigma due to their societal implications.

That said, The researcher chose these two different contexts based on his positionality as both an insider and outsider to both contexts. Being of Cameroonian origin and residing in Denmark offers various perspectives (from within and without). Thus, the risk of making misleading comparisons or reproducing what is taken for granted in these different contexts is reduced. Wendt (2020) argues that when nationally specific understandings are systematically compared, constructions of national identities and naturalised *'truths'* within a particular national paradigm can become more visible. It would create a platform of knowledge exchange with professional practice learning from professional practice. In addition, with the practitioners re-engaging in an honest, productive self-evaluation on their mandate and the profession's ethics, particularly in their responsibility in addressing Stigma in society. This research will equally strengthen the social partnership between social workers and individuals with mental illness.

### 1.5 Different contexts (cultures), same problem

Stigma seems to be a universal problem, but the experiences, manifestations, perceptions, and strategies to overcome them are context-specific. Rössler (2016) argues that the Stigma attached to mental illness is ubiquitous. He further argues that: "*There is no country, society or culture where people with mental illness have the same societal value as people without a mental illness" (Rössler, 2016:1251)*. Studies across the globe present different pictures of stigma experiences in different countries and communities. Caplan et al. (2016) examined the attitudes of multidisciplinary health care providers toward mental illness in the Dominican Republic. They found that some health care providers engaged in overt and stigmatising beliefs toward patients living with mental illness, limiting patient empowerment. In Ethiopia, 75% of family members (of mentally ill persons) are stigmatised. Urban residents experience more Stigma, as well as the older age group (Murthy, 2002). In Canada, persons aged 60 years and older are more socially distancing (Murthy, 2002). Studies from Bangalore, India, found that

people with somatic depression are less stigmatised than those with psychological symptoms (Murthy, 2002). This paints the picture of a globalised phenomenon that cuts across cultural divides. Cameroon and Denmark will be the focus of this study.

Research within the last few years has demonstrated broadly negative and stigmatising attitudes and discriminatory behaviours towards individuals with mental illnesses in Western cultures - even in the advanced welfare states (Høgsbro, 2008). For example, in Denmark, employers are less likely to hire people labelled mentally ill (Jensen et al., 2017), less likely to lease their apartments (Jensen et al., 2017), and more likely to keep social distance from them than individuals not so labelled. This stigmatisation damages self-esteem and sense of self-efficacy and limits the full opportunity for recovery (Scheyett, 2005). This is quite disturbing considering that approximately one-third of the Danish population receive treatment for mental disorders (Jensen et al., 2017).

A Danish study of the public's attitudes towards people who have a mental illness showed that stigmatisation of persons with a mental illness is strikingly evident when comparing with somatic illness. While only 1% find it more acceptable to suffer from a mental illness, 81% find it more acceptable to suffer from a somatic disease (Jensen et al., 2017 p.165). Besides, almost half of the respondents would try to hide it if they had a mental illness. Strangely, two danish studies on mental health professionals' attitudes have shown that beliefs from mental health providers in most respects do not differ from those of the public (Jensen et al., 2017 & Hansson et al., 2013). The government's vision for psychiatry towards 2025 ("Regeringens visioner for psykiatrien frem mod 2025"), 2018-2025 identifies reducing prejudice (Stigma) as a significant focus area of psychiatry in Denmark, meaning changing attitudes and fighting stigma.

Studies of stigmatised medical conditions in Cameroon have overwhelmingly focused on HIV/AIDS. In Cameroon, there are diverse explanations of mental illness. Complex pathways may cause significant delays to treatment-seeking for mental illness, and family members or caregivers may have higher self-stigma. For example, Louis & Roberts (2013) revealed that in Cameroon, 75% of family members of people with mental illness reported some sort of perceived Stigma from others due to their mentally ill family member. Compounding to the situation of mental health patients is the fact that the country has no clear-cut mental health policy (Nguendo-Yongsi, 2020). Moreover, health policy frequently does not cover mental and behavioural disorders at the same level as somatic illnesses. These structural dysfunctionalities have further exacerbated the Stigma associated with mental health problems, with patients often identified as 'mad' or 'cursed' (Monteiro, 2015).

### 1.6 Purpose Statement and Research Questions

This study aims to explore and interpret how Danish and Cameroonian social workers perceive the dimensions of mental illness Stigma and how they calibrate Social Justice in anti-stigma practice.

The research questions that guide this study are:

**RQ 1:** How do social workers in Cameroonian and Danish social psychiatry perceive mental illness stigma?

**RQ 2:** How do Social workers, in their practice, work to reduce the stigma of mental illness for their service users at clinical/micro and community/macro levels?

Specifically, these subquestions will help to address the broader question stated above:

- How do social workers mainstream the ethical principle of Social Justice in minimising Stigma?
- What strategies are the social workers deploying to reduce Stigma in their practice?
- What challenges do social workers face in their duty to reduce Stigma at clinical and community levels?

### 1.7 Significance of the study

This qualitative study explores and interprets how Danish and Cameroonian social workers perceive the dimensions of mental illness Stigma and how they calibrate Social Justice in anti-stigma practice. The knowledge produced from this research may help identify successful policies and best practices to reduce Stigma and improve health care services (Montes, 2021).

Additionally, the processes and findings of this research may also provide a platform to engage Social Workers in the process of critical reflection on their practice and their responsibilities towards, on the one hand, the professional standards (core values) of Social Work. On the other, the marginalised mentally ill patients. Those standards require social work professionals to understand how public (and personal) beliefs, attitudes, and feelings impact their service users; therefore, acknowledging Stigma within social psychiatry is vital in addressing possible health disparities.

### 1.8 Organisation of thesis

This research includes five sections. In the first chapter, I present the foundation of the study. This section formulates the problem, main research questions, significance, and operational definition of the concepts. In the second chapter, I will present the contexts of this research, a literature review of this thesis. The third section will discuss the research design and describe data collection, including methodology, participant recruitment, instrumentation, data analysis, and ethical procedures deployed for the study. In the fourth chapter of the paper will present, discuss and analyse the finding. The final chapter of this paper will discuss the significance of this research to Social Work practice and a reflection on the experience of conducting this study.

### 1.9 Definition of Concepts

As a basis for this research, I provide an operational understanding of the concepts and discuss their relationship with the subject matter.

**Mental Health Disorder:** First, it is necessary to mention that each mental health and drug use disorder has a specific definition (See the Diagnostic and Statistical Manual of Mental Disorders [DSM-V]). However, the American Psychiatric Association (2013) offers a global description of mental disorders to explain the concept. They have defined mental disorders as a *" a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning"* (APA, 2013 p. 20).

Mental health disorders here broadly include; mood and anxiety disorders, psychotic disorders, substance abuse disorders, trauma-related disorders.

**Social Justice:** Craig (2002) has conceptualised the scope of social justice in four dimensions; (i) equal value of all the individuals, (ii) having equal rights in meeting their basic needs, (iii)

utilizing their chances and opportunities in life on the most significant possible scale while (iv) they are safeguarded from any idea or action that causes injustice (p.671).

**Stigma:** Although Erving Goffman (1963) has pioneered the theorisation of Stigma, his definition does not provide a specific understanding of mental health stigma. Weiss et al. (2006) define health-related Stigma as: *"a social process, experienced or anticipated, characterised by exclusion, rejection, blame, or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group"* (p. 280).

There are three levels where Stigma impacts our society, which includes micro-level (self-stigma), mezzo-level (family, community, institutions) and macro-level (structural, cultural).

**Interpersonal, Public or Social Stigma:** These are negative messages that emerge from public opinion and may lead to degrading labels (i.e., dangerous, weak-willed, unstable, and unworthy) (Goffman, 1963). They derive from harmful messages, stereotypes, and tags in society (Bos et al., 2013). In response to negative messages, individuals alter their responses, interactions, actions, and behaviours within their environment to avoid labels or hide them (Markowitz, 2017).

**Intrapersonal or Self-stigma:** Self-stigma from an individual's devaluation of themself due to the negative stereotypes, messages, and labels in their environment (Goffman, 1963).

**Structural Stigma:** This type of Stigma is defined as the culture, policies, procedures, legislation, and regulations impacting stigmatised groups (Livingstone & Boyd, 2010). Structural or Professional Stigma equally encompass negative attitudes and beliefs deriving from individuals associated with an agency in which stigmatised groups receive health care services.

**Service provider:** A mental health professional providing psychosocial services (i.e., talk therapy or psychotherapy) to service users. This paper primarily refers to Social Workers as Service providers.

**Recovery:** In this study, Mental health "recovery" refers to the process whereby people with mental illnesses progress to live autonomous, contributing and satisfying lives in the community, even with persisting symptoms (Mejlvig, 2015). Recovery involves development in life domains considered subjectively relevant to the person (Anthony, 1993), commonly related to progress in normative activities such as education, employment, housing and social relationships.

# CHAPTER TWO

## CONTEXTS, CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

### 2.0 Overview of the chapter

This chapter briefly presents the context of mental health and Social Work sectors in Cameroon and Denmark. It provides vital background information for understanding the context of social work and the possibilities available. This chapter equally presents a Literature Review, the gap identified in the literature, and this thesis's theoretical framework.

### 2.1 Cameroon: A Unitary Presidential Republic

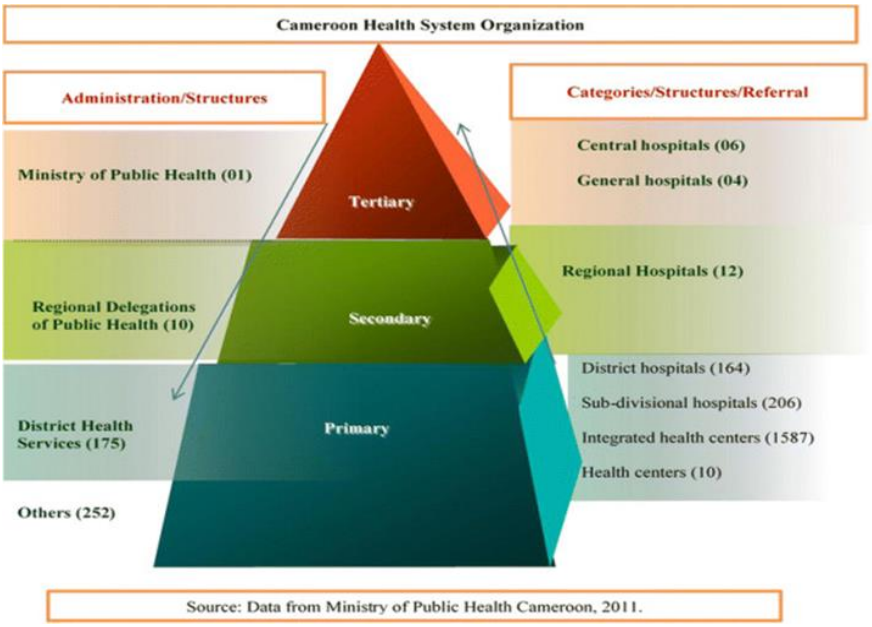
Cameroon is a unitary presidential republic, in which the governance occurs within three independent arms of government – the Legislative, Judiciary and Executive, all placed under a Head of State. Germany initially colonised Cameroon in 1884 and later ceded it to a French and British trusteeship after WWI in 1918 until it gained its independence in 1961. More than 230 languages are spoken in Cameroon. Indigenous beliefs are held by 40% of the population, 40% are Christian, and 20% are Muslim (Pirttilä-Backman, Kassea, & Ikonen, 2004)

#### 2.1.1 Profiling Cameroon's Health Care System

Cameroon is a lower-income African country with over 23 million people (WHO, 2017). Years of economic crises and Structural Adjustment Programs negatively affected all facets of national life (IMF, 2014). In addition, adopting austerity measures led to the deterioration of people's living conditions and mental health.

Six countries border Cameroon: Nigeria, Chad, the Central African Republic, Equatorial Guinea, Gabon, and the Congo (Ray et al., 2017). Socio-economic and political strife in surrounding nations in recent years has put a strain on Cameroon. As of December 2019, the Norwegian Refugee Council reported over 1.9 million people affected by displacement (NRC, 2020). Cameroon has a rich socio-cultural tradition but a poor economy. Cameroon's difficulties include high unemployment rates, political challenges, insufficient infrastructure, a resource-lacking educational system, and a flawed healthcare system struggling to meet its growing population's needs (Ray et al., 2017). Cameroon ranks 152 on the United Nations Human Development Index, indicating that the rate of desirable life outcomes of the people of Cameroon is below the world average (Ray et al., 2017).

In 2010, there were 1.1 physicians per 10,000 people (WHO, 2017). Although life expectancy is rising, it is currently only 55.7 years compared to the average global life expectancy of 71 years (WHO, 2017).




Cameroon comprises ten (10) administrative regions divided into 189 health districts, all placed under the executive management of the Ministry of Public Health at the national level, Regional Delegations of Public Health at the Regional level and District Health Services at the District

level. Primary health care (PHC) is provided in line with the health district framework proposed by the World Health Organization (WHO) Regional Office for Africa, entailing a “nurse-based, doctor-supported infrastructure of State-owned, denominational, and private integrated health centres.” It is supported by diverse and fragmented community health workers recruited by priority public health vertical programmes.

Commonly prevalent primary health conditions include high blood pressure, blindness, diabetes, cancers, dental diseases, depression, stress and poverty (WHO, 2017). The epidemiological profile of the country is marked by a predominance of infectious diseases, including HIV/ AIDS, malaria and tuberculosis, which represent 23.66% of the overall disease burden. Non-infectious conditions are broadly reported, including cardiovascular diseases, cancers, mental illnesses and trauma due to road accidents, accidents at work and occupational diseases (Fofuleng, 2015). Mental health remains a significant challenge for the healthcare system.

### 2.1.2 The Mental Health Sector

Mental illnesses are addressed by both the formal and the informal sectors of healthcare, the formal sector in which overall health care policy is operationalised and delivered by hospitals. A parallel (informal) health system equally exists - where patients consult with indigenous and sometimes formal medical professionals simultaneously.

**Formal Mental health sector**

Cameroon is a medically pluralistic society. The formal and informal sectors are often integrated with mental health problems in the therapeutic recourse strategy. However, Cameroon’s healthcare system and its mental health architecture suffer from a quantitative and qualitative shortage of human and medical resources, particularly psychiatry. Cameroon has ten regional hospitals, only two of these, Hôpital Jamot in Yaoundé and Hôpital Laquintinie in Douala (the two major cities in Cameroon), provide preventive and curative services for mental health disorders (WHO, 2014; Fofuleng, 2015). The decline in the quality of health is partly due to the massive exodus of medical personnel that followed the economic crisis in the 1990s and the significant cuts in salaries (Fofuleng, 2015).

Self-medication has become an integral part of Cameroon’s medical landscape as many people resort to other sources of medicines and traditional healers (Abena et al., 2003). Cameroon’s medical system is in crisis due to a severe physician shortage resulting from the massive exodus of medical personnel for greener pastures abroad. Presently Cameroon has an estimate of 1,555 registered medical doctors. There is also an eminent shortage of psychiatric health experts and social workers (Amani, 2010). Information on the number of doctors and social workers training in mental health disorders is very scanty (Fofuleng, 2015 citing cf. Pemunta, 2011a:143-144, and Pemunta, 2011b).

According to WHO (2014), investment in mental health is not a government priority. There is neither a state-sponsored mental health plan nor dedicated mental health legislation in the country. No university or medical school has any official mental health program. There is no state insurance coverage for mental health patients or any available medications (WHO, 2014). Patients pay for medical treatment from their pockets.

These immense infrastructural and systemic challenges result in that prevention and primary and secondary interventions for recovery-oriented practices are often missing (Becker & Kleinman, 2013). Often, many symptoms escalate and become worse due to lack of diagnosis,

under-or mistreatment or. Moreover, patients' structural difficulties accessing medical healthcare favours stigmatisation and leads to a boom in a parallel mental health care system – the informal sector.

**Informal Mental Health Sector**

The informal health sector is comprised of traditional (indigenous) healers and the clergy (churches). It is primarily based on both a *personalistic* and *naturalistic* disease theory system. In Cameroon, personalistic agents, including indigenous conceptual beliefs of illness like curses and witchcraft, are often advanced as aetiologies of mental health disorders (Patel, 1995).

### 2.1.3 Indigenous healers

Indigenous healers are believed to possess supernatural powers, undertake diagnoses and propose treatment. They can connect the past and present by mapping out the circumstances through which the *"evil spirits"* that caused sickness gained access to the mentally sick individuals (Fofuleng, 2015, citing Pemunta et al., 2014). According to WHO, there is one traditional healer per 200 people in Africa, and it is estimated that they cover 80–90% of mental health care (WHO, 2008). Several explanations for the popularity of traditional practitioners within existing knowledge. The most frequently cited reasons are consistency with local cultural values and beliefs, a better healer–patient relationship, proximity, and lower cost than "Western" health care facilities (Labhardt et al., 2010). The Cameroonian Ministry of Public Health of Cameroon, in 2002, estimated that the population allocates 7% of their household health budget to traditional medicine. Poor people rely twice as often on indigenous healers as rich people (Labhardt et al., 2010). Studies in Cameroon's North-West and South-West regions showed that in case of acute illness, seeking care from a traditional healer was more often the first choice than consulting a public health care facility (Labhardt et al., 2010 citing Ndeso-Atanga, 2003).

### 2.1.4 Faith, Churches and the Clergy

The clergy regularly provides mental health support to patients. However, no church has received any training that would enable them to diagnose or support mentally ill patients. Faith healers with *"curative powers"* are on the rise in Cameroon. Healing church ministries are increasing and promise healing to mentally ill persons and their families. They believe that healing comes from believing in the word of God, and through prayers and divine interventions, treatment is immediate. Pastors or Preachers explain that (mental) illnesses are the product of sin and that healing (recovery) is conditioned by repentance from sin and following the footsteps of God (Fofuleng, 2015).

### 2.1.5 Social Work in Cameroon

In Cameroon, social work is relatively young and faces similar plights that characterise the growth of any new profession. A Cameroonian National Association of Social Workers exists since 2012, made up of 68 practitioners, three academicians, and one association member (IFSW, n.d.). A national Code of Ethics is equally enforced, aligned with the International Federation of Social Workers' (IFSW) Global Social Work Statement of Ethical Principles. However, persistent environmental conditions (structural and infrastructural) challenge the development of the profession. These factors include; lack of adequate organisational infrastructure for the profession, the need to develop adapted curricula for social work

education/research, government under-regulation of the profession, the lack of resources to meet multiple demands from vulnerable service users.

### 2.2 Denmark: A Nordic Welfare State

The Nordic Welfare States broadly include Norway, Denmark, Finland, Iceland, and Sweden. These countries have a similar model to social welfare. The Nordic welfare model's emergence can be traced back to the Great Depression during the 1930s (Goul Andersen, 2019). The main characteristics of this model unique model can be summed up in these terms: a large public sector that provides welfare and benefits; redistribution of wealth through taxation; decommodification; free-market capitalism (mitigating poverty) and these have allowed citizens to benefit from the “social safety net” of high-standard services, including free education and free healthcare. All the Nordic countries occupy places in the top 10 of the World Happiness Report 2020, with Finland, Iceland and Denmark taking the top 3 spots.

#### 2.2.1 Profiling Denmark’s Health Care System

Denmark is a high-income country with a population of 5.5 million. The population under the age of 20 is 24%, and the population above 60 is 24%. Denmark has a unique situation regarding the registration of health issues, including mental health. Many register-based psychiatric epidemiology studies have been based on the existing well-organised registers (Sundhedsstyrelsen 2014; Bauer, Okkels, and Munk-Jørgensen, 2012). Early on, it is necessary to mention that Denmark is a welfare state. The Danish welfare model is based on the universalism of welfare based on citizenship (Goul Andersen, 2019). The public sector provides most of the health care and operates at three levels: National, Regional and Local levels.


***Figure 1Organisation of Danish Public Health Sector***

The Danish healthcare system is tax-funded and free at delivery for primary and secondary care; dental care and psychotherapy are only partly subsidised for adults. The most significant part of the Danish public healthcare system is universal, free and provides equal access to all citizens. Public expenditure on healthcare accounts for 30 per cent of total public expenditures (EUR 20.7 billion). In 2014, the Danish healthcare expenditure amounted to 10.6 per cent of GDP, which is more than the OECD average of 9.0 per cent (Ministry of Health and the Elderly, 2017). Life expectancy in Denmark has risen from 77.9 years in 2005 to 80.6 years in 2015. Danish women and men had a life expectancy of 82.5 years and 78.6 years respectively in 20015 (Ministry of Health and the Elderly, 2017).

### 2.2.2 Mental Health: Responsibilities and Legislation

In Denmark, the overall responsibility for services and support for people with mental health problems is shared between two ministries: The Danish Ministry of Health and the Elderly; and the Ministry of Social Affairs and the Interior. (this section is extracted mainly from Sommar's, (2016) report. See bibliography for full citation)

The Ministry of Health is responsible for **hospital psychiatry**, provided by the Regions and primarily governed by the **Danish Health Care Act** and the **Danish Psychiatry Act**. The role of hospital psychiatry is to give examinations, diagnoses, and treatment and administer the procedures for admission of inpatients (Sommar, 2016 p.11). In addition, district psychiatry is a part of hospital psychiatry, offering outpatient and interdisciplinary psychiatric treatment.

Ministry of Social Affairs and the Interior provides **Social psychiatry,** primarily governed by the **Danish Service Act**. Social psychiatry offers various social services and is organised and delivered by both regions and municipalities (Sommar, 2016).

In Denmark, mental health services have undergone a restructuring process in the past three decades (Sommer, 2016 p 11). The fundamental changes have been the dismantling of institutional psychiatry, the building up and strengthening of local mental health services, and the developing measures to serve the target group in the social sector. This reorganisation aligns with the objectives that persons with mental health problems will live in a local environment and have a sense of belonging equal to other citizens. Accordingly, the Danish Health and Medicines Authority's National Strategy for Psychiatry highlights five focus points for action:

*1) It must be easier to be mentally ill, meaning changing attitudes and fighting stigma.*
*2) It must be possible to get rapid help.*
*3) There must be a range of services adapted to the individual citizen's needs.*
*4) There must be a sufficient qualified labour force.*
*5) New knowledge will be made readily available.*

This action plan also adds Danish Government's action plan from 2014: *Equality - New focus on treatment initiatives concerning people suffering from mental illness* will have the same services and rights as people with somatic disorders, which has not traditionally been the case in Denmark (Sommer, 2016 p.11 citing Ministry of Health, 2014).

Following the Danish municipality reform in 2007, the municipalities took overall responsibility for providing services for people with mental health problems. The regions are now responsible for hospital care, including general practitioners, psychiatric specialists, and psychologists (Sommar, 2016). They must provide sufficient capacity and ensure a range of necessary and relevant treatment services for mental health problems. 'Health agreements' are an essential tool in ensuring holistic help and support from health and social services. These are agreements between municipalities and regions to secure obligatory coordination and collaboration across sectors (Sommar, 2016 p.12 citing *Regeringens udvalg om psykiatri*, *2013b*). There is a significant distinction between psychiatric health services and psychiatric social services in Denmark, where specific expertise and measures are gathered under their corresponding professional areas. However, most persons with mental health problems are likely to be users of both the health service and the social service.

### 2.2.3 Danish Hospital psychiatry

In Denmark, the hospital-based mental health work is called '*the regional psychiatry'* or *'hospital psychiatry'.* Hospital psychiatry is anchored in the regions and performs diagnostics, treatment and prevention of mental health problems (Sommar, 2016). Therapy at the hospital is constituted of medicinal treatment, psychotherapy and psychosocial methods, psychoeducation, environmental treatment, support, care and rehabilitation. A fundamental principle is to offer a suitable and sufficient treatment, which involves the least possible use of coercion (Sommar, 2016; Ministry of Health and the Elderly, 2017). Hospital psychiatry is organised into adult psychiatry and child and adolescent psychiatry. Adult psychiatry is often simply called 'psychiatry'. Persons with mental health problems often encounter a combination of services in regional psychiatry (Sommar, 2016).

In Denmark, 'outpatient treatment' is care that does not involve admission to a hospital (Sommar, 2016 citing Danske Regioner, 2008). Persons treated as outpatients remain in their everyday surroundings, and therapy can be likened to *'polyclinical treatment'* in Norway and *'specialised non-institutional care'* in Sweden. Polyclinical treatment takes place in varying degrees of intensity, is individually adapted according to needs, and takes place several times a week, weekly or at intervals of several weeks.

District psychiatric centres are situated in local environments and provide treatment for adults with mental health problems who live in the area. The local anchoring gives an excellent opportunity for collaboration with other players in the local environment. It focuses on creating a networked approach to mental health work via an interdisciplinary and cross-sectoral perspective. Outreach outpatient treatment and treatment offers in the person's own home will often be anchored here (Sommar, 2016).

### 2.2.4 Dansih Social Psychiatry

Social psychiatry is part of the municipal administration. It provides guidance and support to citizens with impaired physical or mental functional capabilities or social problems, focusing on recovery and inclusion. The municipalities have established cross-sectorial collaborations with their Regions (Ministry of Health and the Elderly, 2017). Social Psychiatry aims to provide personalised (adapted) support to help citizens manage their own lives, simplify everyday challenges, and improve their quality of life. The primary benefits to citizens with mental health problems are socio-educational and psychological support, Housing support (Bostøtte), community living, accommodation, and day activity services. The municipalities also offer home help and advice on housing, maintenance and education. Social workers are widely involved in providing those services through collaborations with the users (citizens).

Sommer, 2016 notes that Social Psychiatry services may be organised differently in the municipalities, and the competencies, experiences, and offers vary from one municipality to another (Sommer, 2016 citing Regeringen, 2013b). In some cities, the service for people with mental health problems is a separate unit.

### 2.2.5 The General Practitioners

The practice sector's services for people with mental health problems comprise general practice doctors (GPs), practising psychologists and practising specialist doctors in psychiatry and paediatric psychiatry. GPs are the citizens' primary entrance to health services. In Denmark, GPs provide primary treatment and prevention of disease and serve as family doctors and generalists. Apart from this, general practitioners have a task as gatekeepers to

specialist treatment in the health service. General practice can refer patients with mental health problems to practising specialist doctors in psychiatry or paediatric psychiatry, practising psychologists, district psychiatry and psychiatric hospital wards. Denmark uses an evidence-based model and a biological, psychological and social understanding of mental illness. The treatment, which is anchored in general practice, is based on close collaboration between psychiatry and general practice (Sommar, 2016 p.14)

### 2.2.6 Social Work with Mentally ill citizens in Denmark

The place of Social Work and Social Work education is well established in Denmark. The emergence of Social work education and practice can be traced back to 1937 in Copenhagen at the Municipal Hospital as a Social Aid course of 15 months (Henriksen, 2018). The year 1938 marked the creation of the Danish Association of Social Workers. The DASW counts approximately 18.000 members – all of whom hold a degree as a professional social worker or are students. Danish Social workers are comprehensively involved in a lot of different areas in the public sector with many kinds of social services, within the state, in the municipalities and its administration, and the private sector and NGO's.

Danish social workers, today, work in a wide range of areas including; adoption, alcohol addiction or substance abuse, counselling in housing associations, with employment and rehabilitation in both the public and the private sector, with homelessness, children and families in need in both the public and the private sector and NGOs, in [hospital and Social] psychiatry, with support services to children (in foster care) and adults, (in foster in residential care), in the labour union movement, with children and adults with disabilities, with integration in both the public and the private sectors. Social workers are equally involved in state administration and the hospitals as advisors in social affairs (Henriksen, 2018 p.3).

The Danish association of social workers (DS) has signed IFSW – International Federation of Social Workers – ethical principles. At present social work in Denmark is facing some challenges, especially when it comes to the public administration of social laws, which employs many Danish social workers (Henriksen, 2018). Henriksen, 2018 further discusses that the biggest challenge is the New Public Management or Management by objectives, which promotes bureaucratic checklist behaviour at the expense of professional judgment. However, there is a paradigm shift towards New Public Governance where the citizens are actors who make decisions on their behalf and have a degree of self-determination (Andersen, 2018)

## 2.3 THEORETICAL FRAMEWORK

This paper employs stigma theory as a theoretical framework to examine how Danish and Cameroonian social workers perceive stigma perceive the dimensions of mental illness Stigma and how Social Justice is mainstreamed in anti-stigma practice.

The term stigma comes from the Greek, referring to a mark made by a pointed instrument or brand to identify persons as tainted or immoral, who should be avoided (Goffman, 1963). Stigma is an attribute that causes widespread social estrangement-a discrediting social difference that produces what Goffman has called *"spoiled identity"*. Bos et al. (2013) note that the vast majority of definitions of Stigma comprise two essential elements: recognising difference and devaluation. They equally emphasise that Stigma occurs in social interactions. As such, Stigma, according to most researchers, is not considered to reside in the person but rather in the social context as a stigmatised identity in one social context may not be stigmatised (ing) in another situation. (Bos et al., 2013)

This theory holds that negative perceptions affect certain groups held in low esteem, helping to contribute toward inequalities (Link & Phelan, 2014). Within this theory, as discussed earlier, mental health stigma may occur on three different levels (i.e., interpersonal, intrapersonal, and structural levels). For instance, self-stigma includes an individual's harmful devaluations of themself due to critical public opinions or Stigma (Goffman, 1963). On the other hand, public Stigma involves messages in literature or media that negatively depict a group of individuals (Bos et al., 2013). Lastly, structural Stigma describes the process in which societal policies or standards perpetuate inequalities through negative perceptions of particular groups (Livingstone & Boyd, 2010).

Stigma theory helps understand the interaction that occurs between users and social workers. Researchers have used this theoretical model to analyse health disparities in society (Link & Phelan, 2001). Furthermore, stigma theory provides a multi-faceted view of challenges patients may experience when accessing health care services.

## 2.4 LITERATURE REVIEW

It is essential to discover what is already known about the subject and how researchers take on an issue related to what others have said (Campbell & Gregor, 2004). To understand how Service providers perceive Stigma, I used Oria (provided by the University of Stavanger) as the primary library to select scholarly articles for the literature review. Through Oria, several databases were accessed to acquire information about the research topic. Linking the words "stigma", "social justice", "social work", "social exclusion", "destigmatisation" "Denmark" and "Cameroon" "social justice," the following search engines have been searched for papers in English and Danish: Psychinfo APA, Academic Research Library, Proquest, Google Scholar and Academic Search Premier. Key terms narrowed down the search of peer-reviewed articles published years between 1960 to 2021.

I also obtained government reports to gather mental health care statistics in Denmark from Sundhedsstyrelsen (Danish Health Authority) and Socialstyrelsen (the National Board of Health and Welfare). For reports about Cameroon, I used the Ministry of Public Health's published reports. The scientific articles collected will allow me to explore the relationship between Stigma and mental illness, exploring the causes of stigma and the interactions between its various forms.

### 2.4.1 Mental Illness Stigma: Exploring the causes

It is necessary to discuss the research on the origin of mental illness and Stigma. A review of existing literature reveals that—regardless of cross-cultural context—the most recurrently indicated types of causes of mental illness are both biological (from abnormalities in brain structure or functioning) and psychosocial factors (Mannarini and Rossi, 2019).

Contemporary studies of stigma aetiology in Mental Illness and have identified three primary elements that underpin attitudes towards people with these conditions from the general public: ***authoritarianism*** (the belief that individuals with mental illnesses are worthless or irresponsible and unable to make life decisions); ***benevolence*** (the view that persons with mental illnesses are helpless and childlike); and ***fear and exclusion*** (the belief that individuals with mental illness are dangerous and unpredictable and in need of segregation from society) (Scheyett, 2005 citing Holmes et al., 1999). Explanations for two of these elements, ***authoritarianism*** and ***fear***, have been extensively explored within the existing literature.

Growing evidence suggests that the public's perception of individuals with Mental illness as extremely dangerous is a critical component of Stigma (Scheyett, 2005)

Whether persons living with mental diseases are dangerous has been a controversy for years. This controversy has led researchers to explore the associations between violence and mental illness (particularly those involving psychosis). In addition to fear of violence, mental conditions can evoke fear of the unknown, fear of a lack of reason and predictability, and to a lesser extent, fear that mental illness may happen to oneself or someone close (Scheyett, 2005). Swanson and colleagues (2006) have established a correlation. However, they warn that notwithstanding the association between mental illness and danger, the critical fact remains that far more individuals with a mental illness are not dangerous than those who are (Swanson et al., 2006).

In her review of existing Afrocentric literature, Nicole Monteiro (2015) posits that much has been written about African societies' social and cultural causal beliefs of mental illness. She notes that each community (society) has its own specific beliefs. Still, there is a pattern in that many beliefs relate to underlying supernatural causes or social causality of mental illness symptoms (Monteiro, 2015). These beliefs, she argues, shape societal perception negatively by increasing Stigma and retarding help-seeking for diagnosis and treatment of mental disorders.

### 2.4.2 Stigma: The Badges of Shame

The term *stigma* comes from the Greek, referring to a mark made by a pointed instrument or brand (Scheyett, 2005 citing The Oxford English Dictionary, 1933). Thus, Stigma was a sign (or a distinctive symbol), usually worn or cut or burned into the body, indicating the status of a discredited individual such as a slave, traitor, or criminal. Stigma against individuals with mental illnesses and other "shameful" attributes have been a widespread (Scheyett, 2005). Historically, individuals with a mental health condition have been widely represented in the visual arts, where they were often depicted as unruly beasts, shackled and naked, evoking fear (Alexander, 2018:24). These negative representations of mental illness are firmly entrenched in medieval history where individuals likely afflicted with a mental health condition were seen as possessed, demonic, held accountable for evil-doings and responsible for the cause of social unrest, famine and natural disasters (Alexander, 2018:24).

However, the theorisation of stigma did not begin until early in the 1900s (Scheyett, 2005). Traces of stigma theory are tied to some early social scientists such as W. E. B. Du Bois (1903) described a process in which persons evaluate themselves through the perception of others called "double consciousness" (p. 2). Du Bois theorised that this phenomenon helped shape African Americans' identity and actions, thus impacting their ability to advance in society. Later, Erving Goffman (1963) provided a more detailed definition of Stigma through the seminal writing, *Stigma: Notes on the Management of Spoiled Identity*. Goffman's first books on Stigma provided the platform for stigma theory in the United States and the West and has been widely used as a framework in Stigma research. This distinction allows us to separate mere stereotypes from prejudice and discrimination

### 2.4.3 Mad, Cursed, Dangerous or Useless?

Stigmatic practices on the mentally ill are as old as civilisation and have evolved over the years. In *The History of Madness* (1974), Foucault describes a movement across Europe in the seventeenth century that saw the establishment of institutions that locked up people deemed

unreasonable. At the time, people who did not meet societies' expectations were secluded. This included "mad" persons and the unemployed, single mothers, defrocked priests, failed suicides, heretics, prostitutes, debauchees – summarily, anyone deemed socially unproductive or disruptive. This is essential to my thesis because the perception towards the mentally ill suggests that, in a neoliberal context, they are unproductive and, therefore, useless.

In Madness and Civilisation (1988), Foucault distinguishes madness and sanity, the logic for separating "mad persons" from the "sane" and "lepers" from the "healthy" through the confinement of those unwanted in society. In the early nineteenth century, this was termed the medicalisation of madness (Fofuleng, 2015 p.18). Confinement was thus, an apparatus and a technique of power used in the organisation of the mad treatment. Madness is, however, relative. Various cultural, intellectual and economic structures determine how madness is defined and experienced within a given community: "madness is located within a particular cultural "space" within society".

### 2.4.4 Stigma and Mental Health

In a review of Stigma and health care in the literature, interpersonal stigma, intrapersonal Stigma, and structural Stigma were three specific forms of Stigma (Bos et al., 2013). The literature also noted these identified stigmas tend to operate interactively in a sophisticated manner with each other. Therefore, researchers acknowledged a consistent interplay among the specific forms of Stigma that may negatively influence a patient's response, reaction, and receipt of mental health services (Montes, 2021). Furthermore, the research identifies stigmas that may potentially impact health care workers' actions and attitudes of social workers working directly with stigmatised groups.

For instance, intrapersonal stigma, defined as an individual's devaluation of themself, arises mainly from negative stereotypes or labels from the society or environment in which a person lives (Goffman, 1963). Moreover, society's negative messages may occur through various outlets such as written material, social media, or everyday casual conversations between people (Montes, 2021).

Structural Stigma, defined as the creation of legislation, policies, and procedures that directly impact stigmatised groups, is another form of Stigma that interacts fluidly with self-stigma and public Stigma. It may also affect health care services (Corrigan et al., 2004). For example, researchers contended that certain groups' negative perceptions and low status greatly influenced policymakers and managed. One result is that "stigma makes a community and health decision-makers see people with mental illness with low regard, resulting in a reluctance to invest resources into mental health care" (Sartorius, 2007, p. 810)

Additionally, Ahmedani (2011) notes that Social workers may develop their own biases from their upbringing or even burnout in their functional roles, mainly when working with individuals who have severe and persistent mental illnesses (Ahmedani, 2011 citing Acker & Lawrence, 2009). Nonetheless, some indications suggest that health professional stigma may also develop uniquely. For instance, social workers and other health professionals, similar to persons in the general public, experience their mental health and drug use problems and often have friends or family members who share these same issues (Ahmedani, 2011).

### 2.4.5 Stigma and Health Care

Another way Stigma may affect health care services includes the interaction between users and social workers. For example, evidence has shown that Stigma may influence an

individual's thought process and actions in health care settings (Montes, 2021). For instance, multiple studies have suggested Stigma may contribute to nondisclosure from a user to a health care provider and impede treatment services (Montes, 2021).

Researchers have found that Stigma may impact a person's decision to seek help for a suspected mental health condition and their ability to access literature about a suspected mental health need (Corrigan et al., 2014). Stigma also negatively impacts those in close contact with someone living with a mental health condition. For instance, in Sri Lanka, Fernando et al. (2017) interviewed family members caring for a loved one with a mental health condition. They found 20% of caretakers made a conscientious decision to delay or avoid mental health services when Stigma was present. Corrigan (2014) described that label avoidance often impacts stigmatised groups and occurs when a person consciously attempts to avoid discrimination or negative labels by declining treatment to negative public perception.

### 2.5 The place of social work: Ethics, Social Justice and the Social Worker

In seeking to interpret social justice, it is necessary to understand what constitutes social work globally. Social work promotes social change, problem-solving in human relationships, and people's empowerment and liberation to enhance well-being. Social work intervenes at the points where people interact with their environments (Loue, 2013 p.1039).

Reamer (1999, p. 3 cited in Banks, 2012) argues that *'social work is among the most value [ethics] based of all professions'*, grounded in 'concepts such as justice and fairness' (p.5). Therefore, Social work practice rests on a normative, ethical, and moral base. In her review of current Social Work literature, Sarah Banks identifies three clusters of core intersectional ethical values of the profession of Social Work (Banks, 2012a, p. 60):

a) Respect for the dignity and worth of all human beings
b) Promotion of welfare or well-being
c) Promotion of social justice

But what is social justice? The International Federation of Social Workers proclaims that social workers have a responsibility to *'challenge discrimination, which includes but is not limited to age, capacity, civil status, class, culture, ethnicity, gender, gender identity, language, nationality (or lack thereof), opinions, other physical characteristics, physical or mental abilities, political beliefs, poverty, race, relationship status, religion, sex, sexual orientation, socio-economic status, spiritual beliefs, or family structure*' (IFSW, 2018: Principle 3.1). Social justice orients the discussion – along with equality, human rights and diversity – to the frame of social work (Clifford and Burke, 2009: 124–5). Social justice is a complex and contested term by seral researchers and practitioners who consider it an organizing value and foundation of social work (Morgaine, 2014). Then, advocacy on behalf of clients and communities is not only an accepted component of social work practice but is, in fact, an ethical obligation (Loue, 2013)

Gary Craig has made a robust attempt to unify the various trends in the debate and defines Social Justice as:

*"…a framework of political objectives, pursued through social, economic, environmental and political policies, based on an acceptance of difference and diversity, and informed by values concerned with: achieving fairness, and equality of outcomes and treatment; recognising the dignity and equal worth and encouraging the self-esteem of all; the meeting of basic needs; maximizing the reduction of inequalities in wealth, income and life chances; and the participation of all, including the most disadvantaged" (Craig, 2002, p. 671-672).*

## 2.6 Stigma Reduction

While a substantial body of research defines the extent and impact of Stigma, there is little study of what works in diminishing it. However, both experience and current research indicate that Stigma can be reduced.

Corrigan and colleagues have identified three approaches that reduce stigma: *protest, education, and contact*. **Education strategies** aim at providing factual information about mental illnesses to counter the myths and stereotypes that individuals may harbour. Through **Contact strategies**, persons with lived experience of mental illness or substance use disorders interact with the public describing their challenges and stories of success. **Protest Strategies** require one to identify, highlight, and speak out against prejudices and discriminatory acts toward those with mental illness, can also potentially reduce Stigma (Corrigan et al., 2001). Although these approaches have promise, they are not without weaknesses. For example, a potential disadvantage of using protest is that it may increase rather than decrease Stigma. Research has shown that instructing individuals to ignore or suppress negative thoughts and attitudes towards a particular group can have paradoxical rebound effects; Stigma will be augmented rather than reduced (Penn & Couture, 2003).

A unique national and institutional anti-stigma initiative exists in Denmark called '**EN AF OS'** (ONE OF US). Launched in 2011 and supported (and partially funded) by the Danish Health Authority and the Danish National Board of Social Services, this project aims to reduce the stigma and discrimination experienced by persons with mental illness and promote their social inclusion by organising nationwide community-based programmes.

'ONE OF US' uses strategies such as mass media campaigns; contact methods by promoting active involvement of persons with experience of mental illness, thereby empowering people with lived experiences in reducing stigma. In ONE OF US works through ambassadors, who share their lived experiences and organise community action in all regions of Denmark by developing and implementing locally based education, training and grassroots activities aimed at attitude and behaviour change (Bratbo & Vedelsby, 2017).

In Cameroon, campaigns around Stigma have overwhelmingly been organised by international organisations and NGO's on World Mental Health Day (10 October).

## 2.7 Knowledge gap

Currently, extensive literature exists on Stigma; most of the scholarly research on the topic of Stigma has tended to focus on definitions or terminology associated with stigma theory (Link & Phelan, 2014). However, limited research demonstrates how Stigma can be reduced and approaches that produce substantial results in Stigma reduction. Even more absent in the literature is knowledge about how Social work practitioners are working to reduce the Stigma of Mental illness. This study attempts to fill that gap by explicitly focusing on the social work practitioner' perception of Stigma and anti-stigma.

## Summary of the chapter

This chapter reviewed the Cameroonian and Danish Welfare state's organisation of health care, mental health care and social work. The chapter equally discussed the causes of stigma and its forms. Relationships between Stigma and mental health were discussed. Social justice as an ethical principle in social work was equally unpacked, and the chapter concluded with the gaps available in the existing literature.

# CHAPTER THREE
## METHODOLOGICAL AND ANALYTICAL FRAMEWORK

### 3.0 Overview of the chapter

This chapter discusses the methodological approach of the research. This chapter is adapted from Margo Paterson and Joy Higgs' paper *Using Hermeneutics as a Qualitative Research Approach in Professional Practice (2005, p.339-357).* This model was selected because it seems to present guarantees of preserving a harmonic relationship between the research topic and approach. The first part of this section presents the research and phenomenon investigated. It moves on to discuss the scientific approach. It deploys the hermeneutic circle, which is broken down into five spirals: recruitment of participants, data collection, analytical strategy, and ethical considerations.

### 3.1 Painting the picture: The research phenomenon and the principal research questions

The phenomenon investigated in this research was Stigma. The Stigma of Mental illness was explored from a Social Worker's perspective using a responsibility/normative framework (the professional ethics of Social Justice).

The main research questions in this study were: "How do social workers in Cameroonian and Danish social psychiatry perceive mental illness stigma at micro, mezzo, and macro levels?" and "How do Social workers, in their practice, work to reduce the stigma of mental illness for their service users at personal/micro and community/macro levels?". The research involved bringing Social work practitioners' unique knowledge base, unravelling stigma and anti-stigma practices, aligned with moral and ethical values, beliefs, and assumptions to advance social work (education, practice and research) (based on Higgs & Patterson, 2005).

### 3.2 Scientific Approach

#### 3.2.1 Hermeneutic Phenomenology and Practice Research: Ontology, epistemology, and Axiology

To inductively study the perception of Social Workers on Mental Illness Stigma, this research used *Hermeneutics* and *Practice Research on Social Work* (Andersen, Henriksen, Mejlvig & Uggerhøj, 2017; ) as its qualitative research paradigms.

This research was conducted in the interpretive paradigm where the central goal was to seek to *"interpret the world, particularly the social world, (and where) knowledge... comprises constructions arising from the minds and bodies of knowing, conscious and feeling beings... generated through a search for meaning, beliefs, and values, and through looking for wholes and relationships with other wholes"* (Higgs & Patterson 2005 citing Higgs, 2001, p.49). Hermeneutics, therefore, was an appropriate research method since the research goal was to understand and interpret how the Social Workers (in different contexts) understand the construct of Stigma and practice their professional and ethical duty towards marginalised groups. Moreso, this approach is relevant in illustrating social workers' experiences, practice, and discursive conduct (Lipsky, 2010) and is suitable for extracting first-hand experiences (Newberry, 2012). Interpretive inquiry is highly consistent with social work due to its inclusion of concepts of (situated) agency, closeness to subjects (subjects understood as human actors), and a critical inter-subjectivity that seeks to disrupt oppressive social discourses

through a hermeneutic understanding that connects private troubles to public issues (Newberry, 2012).

Ontologically, the position of this research is *Interpretivism*. Suggesting that the social world and its constructs is *'out there'* and can only be grasped by circular interactions between its participants. Meaning that this approach seeks to uncover "truths" and not "the truth". Stressing this point, Higgs & Patterson (2005) argue that this dialogue-understanding-interpretation nexus is infinite, with "*movement of understanding from the whole, to the part, and back to the whole.*" (p.346)

Epistemologically, Hermeneutics involves understanding and description over prediction and control. Higgs & Patterson have called this approach a *"fusion of horizons"* whereby different interpretations of the phenomenon (in this case, the Stigma of mental illness) under investigation are brought together through social interaction (dialogue between the interviewer and interviewee) to produce shared understanding (Higgs & Patterson, 2005).

Considering that attaining complete researcher objectivity or neutrality is impossible, the Hermeneutic approach was particularly relevant to me as a novice researcher. It allowed me to explore social work practice without negating my subjectivity and preunderstandings of mental illness and Stigma. Consequently, through this intersubjectivity, a new self will emerge from my old self from the intersubjectivity between; social workers and user, between researcher and participants, and between researcher, participants, other researchers and their environments.

The researcher, however, acknowledges that the strength of the Hermeneutic approach to knowledge is equally its limitation. Positivists have criticised the method's reliance on subjective understandings coupled with the researcher's preconceptions as inaccurate and not representative of "general" reality (Cresswell, 2007).

### 3.2.2 Practice Research on Social Work

*Practice Research on Social work* was equally used as a method in this study. Within this method, as discussed by Andersen et al. (2017), the research process primarily is led, directed and executed by researchers. They further argue that the aim of Practice research is, through a collaboration (through mutual commitment) between the researcher and the practitioners of Social work, to create knowledge that is relevant to practice and solve problems of the thereof. Because this study had a specific interest in making an impact on Social work practice, this method seemed adapted.

Uggerhøj (2012, 2017) has argued that *Practice Research on Social Work* is connected to traditional forms of research as a democratic process rooted in dialogue, context-dependency, and interactions with stakeholders to a specific phenomenon. This Practice Research on Social is therefore consistent with the Hermeneutic approach chosen for this research.

### 3.2.3 Exploring Mental Illness Stigma in a Hermeneutic Circle

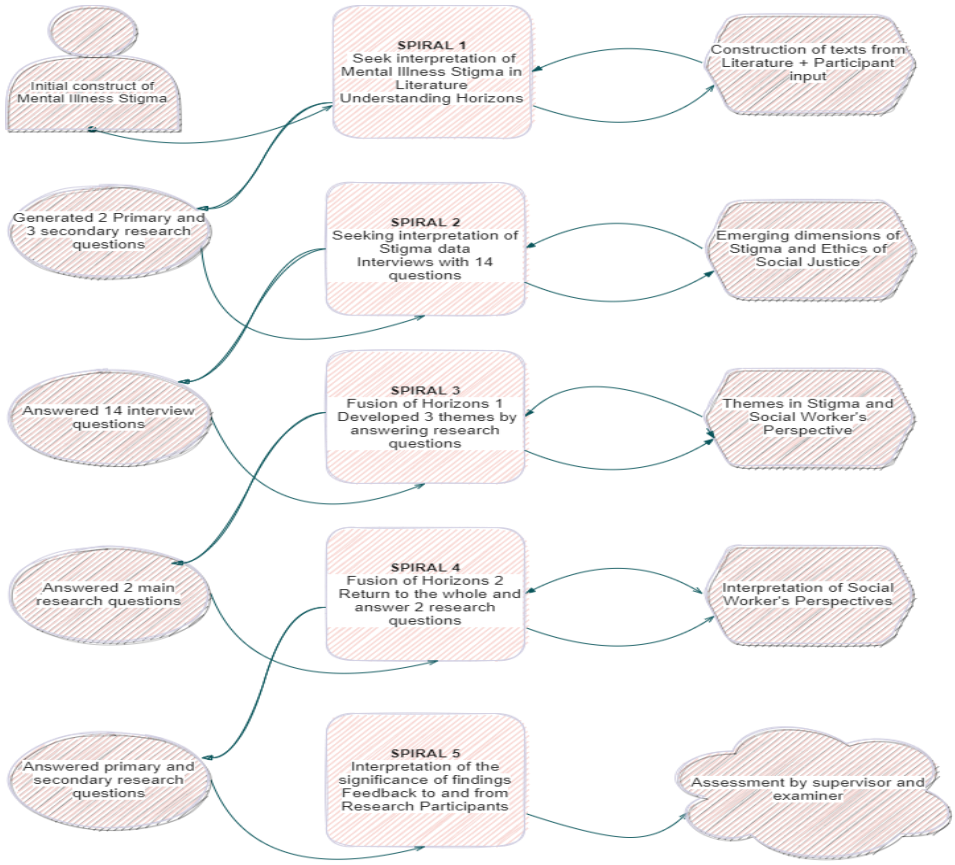



*Figure 2 Hermeneutic Circle describing the methodological and analytical processes of this thesis Source: Adapted from Higgs & Patterson (2005, p.344)*

This section of the paper will explain the blend of the method as technique and method as logic of justification by spiralling through the hermeneutic process.

**Spiral 1 – Creating the texts**

The researcher started this process by recognising biases and pre-understandings about the concepts of "Stigma" and "mental illness" and how they play out in Cameroon and Denmark. This subjectivity took the form of experience, research and learning:

a) Experience: A family member, who the researcher reports, has been treated in psychiatry for drug abuse two years before this study.

b) Research: Prior discussions with Social workers in identifying problem areas in Cameroonian psychiatry and equally through meetings with supervisor.

c) Learning: By pursuing an education in Nordic Social work and Welfare at the University of Aalborg, Denmark.

Two pathways opened up reflections about potential sources of interpretations from external sources:

(a) a literature review to produce a text containing existing conceptual understandings of mental illness stigma and (b) texts comprising transcriptions from individual interviews with

social work practitioners who discussed their perception of Stigma and their duties/roles in stigma reduction.

The rationale for using a hermeneutic circle was to understand the phenomenon of Stigma from the perspectives of researchers and practitioners to answer the research questions.

This research equally sought to explore the Social workers' interpretation of Social Justice's ethical principle, a critical foundation of the profession. The Practitioners know their responsibility towards promoting Social Justice. Still, it might be interesting to explore how they understand and do "social justice in practice", mainly to reduce the Stigma of mental illness for their service users.

Recruitment of participants and Interviews were necessary to transition into the exploration of professional practice.

### 3.2.4 Recruitment of Participants

A non-probability purposive technique was used to identify participants for this by selecting units with direct reference to our research questions (Bryman, 2008 p.375). A total of four (4) participants were strategically selected from Cameroonian hospital psychiatry and danish social psychiatry, providing mental health services to patients [and citizens] respectively, because of their experiences and knowledge in working with these stigmatised groups (Montes, 2021).

The two social workers in Cameroonian hospital psychiatry were recruited through Facebook on 17th March 2021. A post was made on the Facebook page of the Cameroonian National Association of Social Workers where I discussed the purpose of the research and called for empirical input. Five Social workers showed interest in participating in the study. Another screening was done to select Social workers with the most experience, the hospital they worked at, and the highest level of education in Social Work. Two interesting matches were found. One from *Hôpital Jamot in Yaoundé* and another *Hôpital Laquintinie in Douala*, both trained Social workers with more than ten years of experience working in psychiatry, agreed to a recorded telephone interview.

The recruitment of two educated social workers in Danish Social Psychiatry was facilitated by a Gatekeeper (Andoh-Arthur, 2019) whose invaluable knowledge and connections facilitated access into a Bostøtte (Housing support for citizens with physical and/or mental disabilities or special social problems) unit which is part of Social Psychiatry in a largescale Municipality in Denmark. The organisation was approached by email, and favourable replies were received. Two Social workers, including the leader of the Housing Support unit, agreed to a recorded verbal face-to-face interview.

After establishing that potential participants met the study's inclusion requirements, the next step was to obtain written consent to participate in the study. Each potential participant was served with an electronic copy of an information sheet containing a summary of the study purpose and an informed consent form for review and signature. Prospective participants were directed to send an electronic copy of their signed consent to me for participation in the study. All four social workers agreed to participate in an interview. Although four participants might not make for generalised results (Cresswell, 2007), the nature of the topic (i.e. complexity, accessibility) and research design generated a detailed description of ideas and experiences in both contexts. The table below shows the participants' demographic characteristics.

### 3.2.5 Social Psychiatry versus Hospital Psychiatry

Recruiting social workers in Danish Social psychiatry was motivated by the "sociological areas" where social psychiatry operates. These areas were in direct connection with the subject matter of this research. Lauber (2008) has argued that the *social* sphere of social psychiatry is made up of the society or social structures constituting '*the environment'* of the individual who has a mental illness. In Denmark, Social workers are principal service providers (in the public sector). Therefore research into the relationship of mental disorders, social integration and exclusion, (e.g. attitudes towards people with mental illness and the resulting stigmatization and discrimination can be directed in this institution.

Cameroon doesn't have a formal institutionalised Social psychiatry. Therefore, the next best alternative was interviewing the Social workers working in the social affairs office in Hospital Psychiatry.

| Participant | Gender | Educational Background | Years of work experience | Organisation |
|---|---|---|---|---|
| $SWD_1$ | Male | Social Work | 21 years | Social Psychiatry |
| $SWD_2$ | Female | Social Work | 17 years | Social Psychiatry |
| $SWC_1$ | Male | Social Work | 22 years | Hospital Psychiatry |
| $SWC_2$ | Female | Social Work | 9 years | Hospital Psychiatry |

***Table 1 Participants' Demographic Characteristics***

### 3.2.6 Semi-structured Interviews

Verbal one-to-one semi-structured interviews were conducted with each of the four Social Workers who had agreed to participate in the interviews. The interviews lasted from between 1 hour to 1 hour 15 minutes. To foster flexibility in exploring the subject matter, the interviews took a conversational format (semi-structured). Van Manen has argued that "the art of the researcher in the hermeneutic interview is to keep the question (of the meaning of the phenomenon) open, [and] to keep himself or herself and the interviewee orientated to the substance of the thing being questioned" (van Manen, 1997, p. 98 cited in Higgs & Patterson, 2005). Therefore open-ended questions were used to encourage reflection and rich description of ideas and experiences. Participants were invited to elaborate on their answers using story-telling, critical incidents (Schon, 1983) and experiences from practice (Higgs & Patterson, 2005). Empirical data was collected between 29th June and 3rd July 2021.

### 3.2.7 Telephone Interviews and Face-to-Face Interviews

As discussed above, four telephone interviews were conducted. The Danish participants were interviewed face-to-face because the researcher was geographically located in Denmark at the time of the research. Owing to the impossibility of travelling from Denmark to Cameroon (principally because of the restrictions in connection to the pandemic), telephone interviews represented a solid alternative to face-to-face interviews. Telephone interviews took the form

of a telephone call on a mobile cellular line. The telephone interviews provided neutral grounds for interactions without social pressure. Vogl (2013) has argued that telephone interviews offer a more balanced distribution of power between interviewer and interviewee while building a rapport. This balance of power was essential in obtaining rich experience on practice in Cameroon considering that Cameroon is a high power distance country (Pirttilä-Backman, Kassea, & Ikonen, 2004)

However, the telephone interviews had some setbacks considering that facial expressions and body language are integral to the communication process. In this study, the researcher could not rely on visual cues to assess the interviewee's level of interest and reduce the risk of misunderstandings. On the other hand, the face-to-face interviews were rich with visual cues and body language expressions, which helped collect key contextual data. Vogl (2013) has noted that visual cues are essential to inform the researcher when there is a need to motivate and stimulate participants' interest in an interview.

Notwithstanding, Sweet (2002) had found that telephone interviews are compatible with the hermeneutic approach and can produce rich and thick data in quality and quantity mainly because of its flexibility.

### 3.2.8 Researcher's Journal and Notes

A researcher's journal and pictures were used to record notes from supervision, personal ideas and participants' reflections during the research process. For example, during the interviews, notes from supervision reminded me of tips to make cross-cultural interviews smoother. The journal notes equally served in recording insights that facilitated the interpretation of empirical data.

### Spiral 2 – Exploring horizons and dialogue with questions and answers

It was essential to stay consistent with the leading research questions (stated above). Higgs & Patterson (2005, p.350) argued that when using a hermeneutic approach, it is imperative consistently to go back to the research question to "touch base" with the research phenomenon and purpose. So far, this research has gathered; perspectives from existing literature connected to the purpose of the study and the phenomenon under investigation; a researcher's journal was kept throughout the research to keep track of the emerging ideas and reflections.

The next step was to integrate the perspectives (horizons) of the participants obtained through interviews.

## 3.3 Analytical Framework

The data collected for this study were analysed using a Thematic Analysis technique. This analysis strategy was adopted because of its theoretical flexibility, and compatibility with the Hermeneutic phenomenology research design (Braun and Clarke, 2006). The thematic analysis involves the process of *"identifying, analysing, and then reporting the patterns (theme) that emerged from observation and interview"* (Braun and Clarke, 2006, p. 26). Precisely, this research scrupulously followed the six-phase steps outlined by Braun and Clarke (2006) for optimal analysis of empirical data. These steps include:

1. Familiarisation with the data (including transcribing verbal data)
2. Generation of initial codes

3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Audio recordings of individual interviews were transcribed word verbatim without altering their meaning. The transcripts and recordings were then uploaded to NVivo 12 (a computer-assisted qualitative data-management system), where transcriptions were reread, relistened and corrected. Transcripts from Cameroonian Social workers were translated from French to English. After organising the data, member checking was employed to ensure the credibility of the data received from each participant (Montes, 2021). I reached out to the Danish participants by email, asking them to spellcheck my transcription, particularly for the few words in Danish used in the interview. This was done to reduce misrepresentation and strengthen the accuracy and validity of transcripts (Montes, 2021, citing Varpio et al., 2017).

Next, the main codes were identified after deep immersion in the text. The codes were used to identify patterns or themes from the participants' responses to the interview protocol and later associated with the specific research questions. Throughout the analysis process, discrepancies, similarities, and patterns in the discourse were noted and gathered. At this point, four themes and five subthemes were generated and grouped into clusters. Each cluster consisted of metatext extracted from interviews that could answer parts of the two central research questions.

**Spiral 3 – Fusion of horizons**

Responses to the interview protocol allowed for the construction of themes and sub-themes. These themes were aggregated along with supporting quotations from the texts to answer the two main research questions. This analysis stage involved what Higgs & Patterson have called "the first fusion of the participants' and researchers' viewpoints" (2005, p.350). Individual participants' names were removed as analysis of the metatexts began to generate a pattern representative of answers given by the social workers $SWD_{1\text{-}2}$ and $SWC_{1\text{-}2}$. The first interview question on the subject matter, for instance, was "What do you understand by the term 'stigma'?" helped unravel the perceptions on Social Workers. Participants used descriptions, narratives of critical incidents and even diagnoses to identify dimensions and elements of Stigma and how Social Justice is calibrated for anti-stigma practice. This process resulted in clarifying and "testing the bigger picture", using hermeneutic analysis with constant comparison between the parts (text items) and the whole (the emerging interpretation of the phenomenon) by repeatedly reviewing the NVivo analysis codes and then returning to the original transcripts and the researcher's journal. The table below shows how the interview questions were connected to the research questions.

| INTERVIEW QUESTIONS | MAIN & SUB RESEARCH QUESTIONS |
|---|---|
| **Social Work Ethics and Social Justice**<br>1. What does the concept of Social Justice mean to you? What does it mean in practice?<br>2. What are the challenges and opportunities of promoting Social Justice?<br>3. To what extent do you integrate Social Justice into your Work in Social Psychiatry? | **RQ2 a** |
| **Social Worker's Perception of Stigma**<br>4. What do you understand by the term "stigma"?<br>5. Do you think the Stigma has consequences on patients' conditions? How big? And in what ways?<br>6. In what ways does the Stigma of mental illness manifest itself?<br>7. Has a citizen ever discussed with you an instance where they felt outrightly discriminated upon? | **RQ1** |
| **Social Worker's Actions in Stigma reduction**<br>8. What kind of actions do you undertake to reduce the Stigma of mental illness in your practice organisation?<br>9. What challenges exist in implementing actions to reduce the Stigma of mental illness in practice?<br>10. What, in your opinion, needs to be done to reduce the Stigma of mental illness in social work practice?<br>11. What intervention approaches (besides these you are involved in) will help reduce the stereotypes on the mentally ill?<br>12. Based on your experience with the patients, how do they perceive your actions to reduce Stigma?<br>13. How much training did you obtain in your organisation in connection to actions to reduce Stigma?<br>14. Outside of your organisation, what actions can researchers, health professionals (including other social workers) can be undertaken to reduce Stigma in society? | **RQ2 b & c** |

***Table 2 Establishing the connection between research questions and interview***

### Spiral 4 – Fusion of horizons – Spiraling back to the whole

This study achieved this through repeated use of a hermeneutical process shown in Figure 2. This spiral includes the second consolidation of perspectives from all textual sources and connecting them to answer the main research questions (Higgs & Patterson, 2005). By doing this, an interpretation of the themes provided specific answers to the problem formulation. These themes are 'essentially recurring motifs' (Bryman 2008:554) that have emerged from empirical data and been arranged into logical clusters to break down the whole into bids of knowledge that clarify the problem formulation. These spirals were adapted to explore and interpret the social workers' perceptions on the dimensions and elements of Stigma and how they calibrate Social Justice in anti-stigma practice. The themes selected adequately answered the research questions.

### Spiral 5 – Hermeneutic Circle – Answers to Research Questions and Interpretations

The "ultimate" spiral of this hermeneutic loop involved two-phased. The first phase involved interpreting the significance of the empirical knowledge gathered, identifying discrepancies, correlations, patterns, and relationships between the data sets. Participants' perspectives were contextualised within existing research and theory. The section equally allowed the researcher to integrate personal reflections from the journal and discuss the implications of this endeavour for social work (in education, practice and research). The primary considerations that animated the thoughts in this section were:

- What new knowledge can be learned from this research?

- How beneficial or detrimental will the findings be to persons living with mental disorders?
- What can Social work learn from a study in two different contexts?

The second phase was presenting the findings of this research to the participants for their appraisal. In case of significant disagreement with the results, at worst, the researcher would have pursued further member checking and additional hermeneutic analysis.

### 3.4 Ensuring Qualitative Rigour

As part of this interpretive research, credibility, rigour, and ethical behaviour were used to assess and ensure quality. Here are descriptions of these criteria and a description of the strategies used to conduct the research.

#### 3.4.1 Rigour

The rigour of the study was assured by incorporating member checking (Guba and Lincoln, 1989). To avoid misrepresentation, I asked participants to check their words with their intended meanings. Clarifying my understanding helped me find any blind spots or missed information from the previous discussion (Montes, 2021). During the member checking process, the participants did not alter their transcriptions from the interviews. Participants reported the transcriptions were accurate and reflected the essence and messaging of their perceptions on Stigma and anti-stigma.

#### 3.4.2 Credibility

Data triangulation was the strategy used to ensure the credibility of the findings of this research. Creswell (2014) argues that Triangulation involves using several sources of data and theories in interpreting findings. By way of Triangulation, the present study compared results with existing literature from Danish, Cameroonian and other contexts.

#### 3.4.3 Authenticity

This study employed open-ended questions during semi-structured interviews to delve into participants' responses to the two main research questions, drawing on ideas gleaned from the literature. Therefore the results obtained from this study are an authentic representation of the practitioners' perspectives

#### 3.4.4 Ethical Considerations

All participants consented voluntarily without coercion to contribute to the research, fully informed of the expectations and purpose. An informed consent form was distributed to guarantee the confidentiality and anonymity of social workers participating in the study. The informed consent form provided the purpose of the study, eligibility criteria for participation, an explanation of participant rights, and possible risks associated with the study. Sufficient time was allocated for each participant to review the informed consent form and ask questions regarding the study. In all aspects of the research process, I strove to maintain anonymity, confidentiality, and transparency. Other measures to protect confidentiality included using identifiers to keep the participant's data anonymous. All transcriptions and other electronic materials were password protected and encrypted to ensure confidentiality (Montes, 2021).

# CHAPTER FOUR

# PRESENTATION OF FINDINGS, ANALYSIS AND DISCUSSIONS

## 4.0 Overview of the chapter

This chapter juxtaposes the "Horizons" by simultaneously combining the responses provided by the practitioners during the interviews; with contextual interpretations using meta-data and theories. The theories used are Link's Modelling Labelling Theory, Honneth's theory of Recognition, Transpersonal Theory, Andersen's Empowerment theory, and the Protest, Education and Contact Framework for Stigma Reduction proposed by Corrigan et al., (2001).

## 4.1 Introduction

The purpose of this study was to explore and interpret how Danish and Cameroonian social workers perceive the dimensions of mental illness stigma and how they calibrate the ethical principle of Social Justice in anti-stigma interventions. A purposive sample technique permitted the recruitment of 4 participants for the study. Hermeneutic individual semi-structured interviews were conducted. This approach allowed participants to discuss their perceptions of mental illness stigma, their interpretations of the ethical principle of Social Justice and how this principle is mainstreamed in the strategies employed to mitigate Stigma at intrapersonal, interpersonal and structural levels.

Thematic analysis resulted in the elaboration of three significant themes: ***The Boxes of Stigma (which discusses the Stigma as oppressive labels)***, ***Social Justice: "Recognising" the Plurality of meanings*** and ***Boxing with Stigma (Social Workers' Stigma Reduction Strategies).***

## 4.2 Theme 1: The Boxes of Stigma (Stigma as oppressive labels)

To the interview question: "What do you understand by the term stigma?". This question aimed to uncover the perception of Social workers on Stigma within their contexts and thereby answer RQ1.

The participants had diverse perspectives, but summarily, one element seems to cut across. They seem not to, in their discourse, distinguish between the forms of Stigma (interpersonal, intrapersonal and structural). Moreso, they consider Stigma a complex phenomenon that operates through culturally constructed labels, intersecting with adversities arising from a diversity of social inequalities and oppressive identities.

In presenting her understanding of the concept, this participant from Denmark uses a diagnostic and widely uses the image of "a box" to support her perception. She said:

> *"When I hear Stigma, I hear that, oh, you're schizophrenic. And when I hear you're schizophrenic, I put you in a box, you're like, this, this and this, and you're really crazy. OK, so for me, Stigma is when people already have an opinion about you by your diagnosis. Yeah. So that is Stigma for me." $SWD_2$*

This other Danish participant discusses Stigma with the same diagnosis. It seems, to him, that stereotypes are formed or informed by the diagnosis. He equally positions Stigma within two perspectives; from that of the public (the stigmatisers). Stigma is a subconscious human

defence mechanism that leads them to label or "box" unfamiliar behaviour. Secondly, from the perspective of the stigmatised individuals who are generalised based on their symptoms and diagnoses. He said:

> *"Well, Stigma is when people set you in a specific light with small boundaries when you have been diagnosed with mental illness. Say, when you have schizophrenia, then you are like this… "I think it's a human trait. It's that we fear the unknown. And it's difficult to understand mental illness. Because that's what it is. It's behaviours, which are not understandable. So then we have to box it and say, okay, they are like this and let's keep our distance." SWD$_1$*

Labelling theory seems to be exceptionally well-equipped to illuminate the psychosocial mechanisms that the Social worker describes as "Boxes" and have been called "labels" within sociology. A central aspect of labelling theory is the focus on the Stigma associated with mental illness. Labelling theory is an essential framework for understanding the effect of Stigma associated with the devalued status of a "person with mental illness". The theory has its origins in the book *"Being Mentally Ill"* by Thomas Scheff (1966). Scheff introduced the idea that being labelled mentally ill is the sole cause of mental illness. Better still, society's negative perception of "crazy" is actually what disposes people to act that way.

Two main paradigms exist within Labelling Theory. Scheff's Labelling Theory briefly introduces the above and the more subtle *Modified Labeling Theory* presented and defended by Bruce Link (1982). The significant difference between these two theories lies in the fact that to the Modified theory, widely held stereotypical attitudes about persons with mental illness (being dangerous and incompetent) become personally relevant to the individuals diagnosed with mental illness. SWD1 and 2's understanding of Stigma seem to be associated more with the latter than the former; hence the Modified Labelling Theory will be the theoretical perspective of this analysis.

According to the classic definition provided by Erving Goffman, Stigma is "...an attribute that is deeply discrediting..." that reduces the bearer "...from a whole and usual person to a tainted discounted one" (1963 p.3). Mental illness is perhaps one of the most discrediting attributes. It is linked to an array of negative stereotypes traits (dangerousness, weakness and incompetence). Recently, studies have shown that when individuals are diagnosed with a mental illness, they are placed in a cultural category (e.g., "a mentally ill person") that damages their material, social, and psychological well-being (e.g., Link et al. 1989; Markowitz, 2017). According to the Modified labelling theory of mental illness, the negative consequences of psychiatric labelling arise through socially constructed psychological processes meaning that Labeling is a relational process that is rooted in Mead's Symbolic Interactionism (Mead, 1934).

The basic premise of symbolic interactionism is that the meaning of social objects (persons and actions) are socially constructed. Responses in social interaction are based on meanings drawn from shared cultural knowledge and the internalised attitudes of the "generalised other". Individuals learn cultural stereotypes through books, movies, real crime shows, jokes, cartoons and the media. SWD2 confirmed this when she said: *"Actually, all those movies and also Schizophrenia, and she killed that person... Come on, just call it something else. In the media, the boy diagnosed with schizophrenia killed that..."* and she goes on to say that it is precisely those sensational titles in media outlets *that "really creates stigma in our world." (SW$_2$)*

The public internalises these stereotypes. These generalised cultural ideas associated with the mentally ill (e.g., incompetent, dangerous) are quickly brandished when a person diagnosed with a mental disorder (like schizophrenia) and become personally relevant and foster negative self-feelings.

This probably explains why the danish participant said, *"… when I hear you're schizophrenic, I put you in a box, you're like, this, this and this, and you're really crazy".* The "box" here denotes an internalised (generalised) social construct of traits based on a diagnosis and are forced on a mentally ill person. The Social worker seemed to say that: In the mind of the stigmatizer, an unconscious syllogism is formed:

*Persons diagnosed with schizophrenia are dangerous - X has been diagnosed with schizophrenia - Therefore, X is dangerous (Personal reflection)*

When asked if Stigma had consequences on the mentally ill persons, all the participants interjected. The question had hardly been asked that they replied in the affirmative and all went further to discuss that exclusion on a societal level plays out for users. This danish social worker's response sums it up:

> *"Absolutely. Absolutely. At the level of the society, it makes the citizen excluded from the community. It makes them feel different, marginalised, not part of the things that the other citizens are part of." ($SWD_1$)*

When the labels discussed above have been placed, a person living with mental illness will adopt various coping strategies, such as *secrecy*, *disclosure* or *social withdrawal*, enhancing the effects of expected rejection by constricting social networks, leading to unemployment and lower-income (Markowitz, 2017). The "marginalisation" which the social worker describes here begins in the self and considerably blocks the users from social processes. Drawing on the *stress process model* (Turner et al., 1995) predicts a domino effect. Lower self-esteem leads to constricted interpersonal networks, leading to unemployment, low income, and stress. Stress, in turn, places persons at risk for increased symptoms and therefore reduced chances of recovery.

Stigma may adversely impact the dimensions of self and personal attributes (e.g. clever, pretty, cute), having significant consequences for recovery. Persons who, for example, consider themselves as less competent, capable or successful may act in ways that reduce their quality of life by not making friends, furthering their education or seeking jobs and even triggering symptoms of psychiatric disorders (Markowitz, 2017).

The Mental illness stigma creates withdrawal (or exclusion) in Denmark as well as in Cameroon. This participant from Cameroon discusses Stigma as exclusion. Exclusion based on difference. Mental illness to him is the product of othering. The "normal" wielding power and oppressing the "anormal". He says:

> *"Stigma, to me, is the sidelining of a person because their differences are considered contrary to the norms of society. In this case because their illness makes them dysfunctional." $SWC_1$*

Unlike in Denmark, where systems are organised to support every citizen, the exclusion is not a process but the finality within the Cameroonian context. Owing principally to the weakness of institutionalised support systems, stigmatised persons primarily rely on families who often

lack knowledge and resources to support their mentally ill relatives. In my experience with my relative, psychiatry was the last resort, and his help was inappropriate.

This theme answered RQ1: **How do social workers in Cameroonian and Danish social psychiatry perceive mental illness stigma at micro, mezzo, and macro levels?** It was found that the Social Workers from both Denmark and Cameroon consider Mental health stigma as a continuum - a complex phenomenon rooted in cultural identities and stereotypes that mediate the process of stigmatisation by othering and labelling those affected by the illness. Cameroonian social workers discussed stereotypes as being constructed in culturally constructed stigmatic beliefs that sideline persons considered "anormal".

### 4.3 Theme 2: Social Justice: "Recognising" the Plurality of meanings

This theme sought to answer RQ2a: **How do social workers mainstream the ethical principle of Social Justice in minimising Stigma?** What stood out as a primary focal point in the interviews with Danish and Cameroonian Social Workers was the response to the initial question about how they defined social justice, which typically highlighted the concept's universalistic and relativistic nature. The purpose of this question was to allow the Social workers to discuss the meanings they ascribed to the ethics of Social Justice in their practice.

Although all four agreed that the principle of Social Justice was a critical value within the foundations of social work, the meaning they ascribed to the concept varied (rather considerably) from one respondent to another.

This Danish social worker illustrates these variations in the meanings of social justice through contextual reflections, what it means in theory and practice. She stated:

> *"To me, Social Justice is fairness. As I said before, you and me can get ill tomorrow, you and me could develop a diagnosis and we'll need to get the help. And everybody needs justice. I'm not better than you. And you're not better than me. And I'm not better than the girl I visited today who had so many diagnoses. So, social justice is for me to help them getting that justice to speak their case. To be their voices when they cannot speak. So for me, that is social justice." ($SWD_2$)*

The same social worker, elaborating further, deplores Social Justice's politicisation at institutional levels, as a significant challenge in Social work's strive for Social Justice.

> *"Social Justice isn't always fair justice. It's a really difficult balance […] It's political also, I cannot change that. But I can say my opinions out loud and I do that. But it's not always fair. Some persons are just lucky and some not." $SWD_2$*

The politicisation discussed by the SWD2 can be interpreted within what Henriksen (2018) has called a shift in the Danish Welfare state from *Welfare* to *Workfare*. A shift from "welfarism" to liberalism. Henriksen has argued that Danish Social policy, which was originally characterised by relatively generous universal public benefits for its citizens, has evolved to an international trend in the Anglo-Saxon countries, where many workfare-reforms have been introduced. The trend seems to be a gradual change favouring low benefits and more substantial activation of the unemployed for the labour market. The process is known as *recommodification*. The Social

worker seems to discuss that this recommodification is taking its toll on some citizens who are not getting as much support as they might need.

| | WELFARE | WORKFARE |
|---|---|---|
| **Foundation** | Rights | Rights in combination with duty |
| **Function** | Socialisation of risks | Individualisation of risks |
| **Goal** | Ensure standard of living and thus the opportunity | Ensure labour market integration and the reproduction of labour, thus reduced public social expenditures |

***Table 3 The paradigm shift from Welfare to Workfare in the Danish welfare state.***

Source: Torfing, 2004:25 cited by Henriksen (2018)

This Cameroonian social worker discusses the concept with a similar collectivist value system as the first but employing another concept - Solidarity:

*"Social justice, as I understand it, is some sort of collective solidarity between people." ($SWC_1$)*

The other Danish social worker gave another answer which highlights yet another concept – equality. The participant insists that the idea of social justice denotes equality and must be paired with respect for the worth of each user. The participant tells that:

> *"Right. So, to me social justice is that everyone is treated the same. And, that's a concept that has been all the time I've been working in this field has been the foundation of it." ($SWD_1$)*

The same participant goes on to add that:

> *It also means to have respect for the citizens. I'm a citizen, and the people we're helping are also citizens. So there is equality from the beginning." ($SWD_1$)*

This social worker from Cameroon took the legalist route. The participant considered that the concept has a duty-based focus on individuals and society. An interesting paradigm which no other social worker had discussed. The participant describes Social Justice as:

> *"a mechanism or a set of moral rules and regulations specific to a society or a community, and which is set up as a rule of law or norm". $SWC_2$*

The most intriguing aspect of the conversations was that all of the participants indicated that they believed that they did engage in social justice work in their practice despite the polysemic nature of their understandings of the concept and that the term could be politically loaded. But how can we understand the multiplicity of meanings to the same concept?

Social Justice is a complex and contested term; however, several researchers and practitioners have identified the concept as an organising value and foundation of social work practice (Morgaine, 2014; Banks, 2012).

Social Justice has been part of social work since its early beginnings during its formal inauguration in the late 19th century (Morgaine, 2014 citing Reisch, 2002). Reamer has noted that "*Since its beginning, social workers have wrestled with the complex relationship between "case" and "cause" and between amelioration of individual suffering and social change that addresses the structural flaws and injustices in the broader society that foster the problems people experience"* (2006). There has been a surge in interest in the meanings and roles of social justice in social work with stigmatised individuals.

The participants to the interview summarily discussed Social Justice with these words: **Fairness**, **Equality**, **Respect**, **Solidarity**, **Binding Norm**. It is necessary to examine how each relates to the broader concept of Social Justice in Social Work literature. Social Justice is a complex and contested term. Researchers and practitioners seem to understand the concept based on their subjective lenses. In broad terms, however, Lister (2008) has identified three components of the concept of Social Justice which intersect in contemporary debates. They are: *redistribution*, *recognition* and *respect*. A vital distinction is made in the book "*Redistribution or Recognition: A Political-Philosophical Exchange*" (2003), where Fraser and Honneth examine redistribution (of economic resources, access to economic commodities) and recognition (value and respect for cultural identities and difference) as principles of social justice. Because the respondents answered the interview questions within the context of a study on Mental Health Stigma, Honneth's theory of Recognition seems well adapted to interpret their responses.

Axel Honneth's Critical theory of Social Justice (Recognition) brings to the forefront the need for *"everyone is treated the same" ($SWD_1$),* not considering their abilities or disabilities but by their humanity. Because Stigma arises when certain groups consider themselves *"better"* than others ($SWD_2$). Honneth thinks Stigma is a misrecognition of the worth of another human's identity. Social Justice to these two Danish Social workers is that everyone should be treated equally and have access to justice by their humanity.

Since Aristotle, the concept of "justice" has always been intricately combined with "*equal distribution*". In the book V of the Nicomachean Ethics, Aristotle defined justice as the political virtue of giving anyone their equal share (Carrá, 2015). Injustice, by contrast, means refusing someone their equal share or treating equals as non-equals (and vice versa). In this sense, justice distributes material and non-material goods among people sharing the same status.

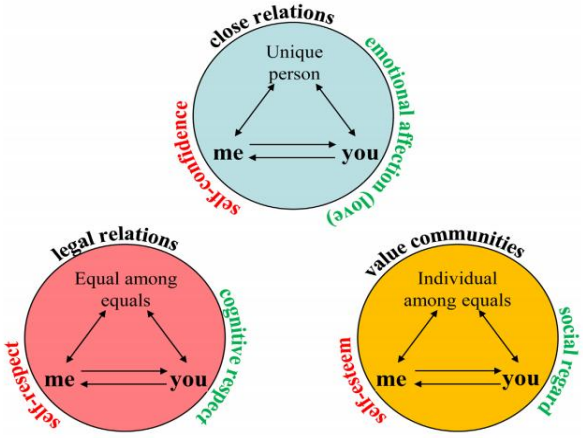
Rawls advanced the Aristotelian definition of social justice regarding the equal distribution of goods (Carrá, 2015 citing Rawls, 1999, p. 9-10). According to Rawls, social justice constitutes "the basic structure of society", that is ", how the major social institutions distribute fundamental rights and duties and determine the division of advantages from social cooperation" (Rawls, 1999, p. 6 cited in Carrá, 2015). Honneth discussed the limitations of the distributive paradigm, which, to him, deeply intertwined in what he described as based on *"proceduralism"*, *"atomism*", and *"state-centrism"* (Fraser & Honneth, 2003). According to Honneth, social justice is not achieved through the equal distribution of material and non-material goods but rather with the possibility for each member of society to participate in three spheres – affective, legal, and the social – of a unitary concept he calls "Recognition".

Recognition theory posits that the psychosocial mechanisms of social conflicts and inequalities are a product of experiences of *"misrecognition"* that violate the identity of subjects. For example, persons discriminated against and stigmatised perceive this Stigma as a denial of social recognition. The persons affected are supposed to be particularly motivated to resist,

that is, to engage in a *"struggle for recognition"* (Honneth, 1992). Honneth's theory of Recognition upholds that Social Justice needs to be decentralised and subsequently pluralised to encompass the claims of justice that arise from different parts of society.

The role of justice in this Recognition framework is not so much to provide an equal distribution of social goods, but to guarantee to the members of society access to those "*institutions of recognition*" (a term used by Honneth to denote the *intersubjective* dimension of personal autonomy) in which they have the opportunity to experience one form or another of "social freedom" based on mutual recognition. For Honneth, social justice means *"for the individual subject, the possibility of realising individual autonomy depends on being able to develop an intact self-relation through the experience of social recognition"* (Fraser & Honneth, 2003, pp. 180-181). When $SWD_1$ says "*It also means to have respect for the citizens. I'm a citizen, and the people we're helping are also citizens. So there is equality from the beginning"* clearly aligns with Honneth's understanding. The experience of recognition begins when each person is respected as a whole person.

Honneth has identified three equal spheres (or institutions of recognition) of an *"ethical"* theory of justice which conceptualise the meaning of Social Justice: *Love in intimate relations*, *Law in legal relations*, and *Achievement in social hierarchies (*Fraser & Honneth, 2003, pp. 138-150*).*




*Spheres and forms of recognition according to Honneth*

*Source: Altemeyer, (2018 p.420)*

Within *love in intimate relations (partnership, friendship)*, People experience their aspirations not as constraints or barriers between each other but as the fulfilment of mutual self-actualisation. None of the participants in this research discussed social justice in this light.

*Law in legal relations* refers to the legal recognition of the individual based on status (citizenship). Honneth insists that the law provides guidelines to ensure forms of recognition. This sphere seems to capture $SWC_1$'s statement who discussed social justice as *"a mechanism or a set of moral rules"* and $SWD_2$ who discussed Social justice as equality when he says *"So, to me social justice is that everyone is treated the same…".*

*Achievement in social hierarchies* where the principle of merit or achievement operates in work relationships like clubs to religious communities or the daily working life, recognition appears as social regard or solidarity. This sphere corroborates $SWC_1$'s conceptualisation of social justice as "solidarity"

Now, the participants in this research seemed to understand the concept of Social Justice within Honneth's three spheres of Recognition: Fairness, Equality, Respect, Solidarity, Binding Norm. Interestingly, although those understandings might seem different from each other, they fall within Honneth's spheres of conceptualisations of the unitary concept of recognition

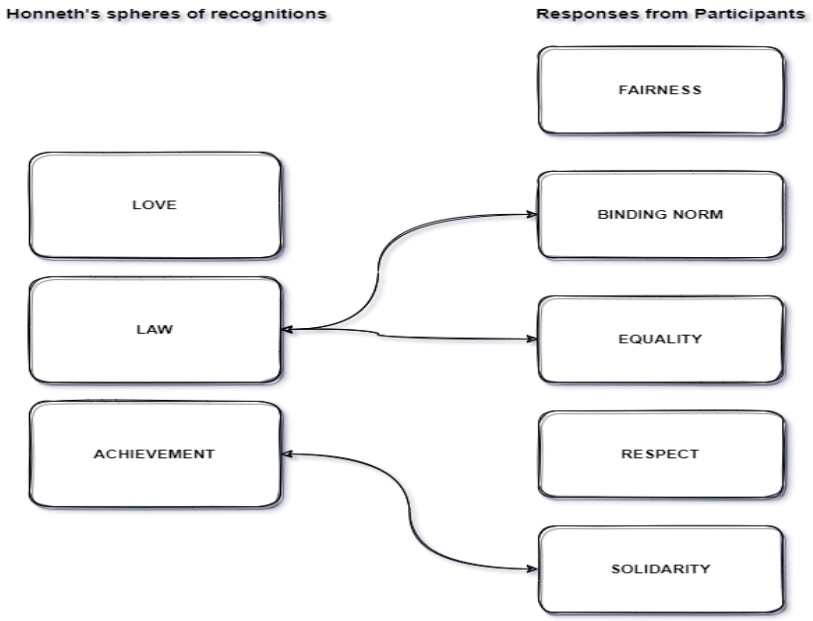



*Figure 3 Diagrammatic representation of Responses by participants within Honneth's spheres of recognition.*

The diagram above connects the participants' conceptual understanding to the interview with Honneth's theory of Recognition. Based on the preceding discussions, an interpretation is obvious. The Social Workers interviewed shunned the redistributive paradigm of Social Justice and aligned their understandings in the recognition paradigm.

This means the practitioners perceive the practice of social justice work as a normative framework of recognition enhanced by complementarity and mutuality in social practices. The heterogenous bonding of; the self with self, self with others in a regulated environment provided by the state where every person (mentally ill or not) fulfills his or her aspirations. In theme 4, the Social workers will undoubtedly discuss the practice of Social Justice in anti-stigma interventions.

Nonetheless, it has long been observed that social workers have polysemic views of social justice. This plurality of meanings creates a lack of cohesiveness that consistently inhibits the progress to a just society (Morgaine, 2014). Having differing ideas about the nature of social justice (and the role of the State in its achievement) seem to dilute the profession's attention to this core value. Reisch (2002) has noted that social work education, policy and practice is impeded by the "absence of conceptual or historical clarity or agreement" on the definition of social justice (p. 349).

This theme addressed RQ2a (How do social workers mainstream the ethical principle of social justice in minimising Stigma?). It was found out that all participants in this research have a common base despite having relatively different understandings of Social Justice. That social inequalities are a product of misrecognition. Achieving Social Justice involves the possibility of

participation in affective, legal, and social spheres of life. Honneth's Critical theory of justice was used as a theoretical lense to centralise the perspectives on social justice into a common understanding of Recognition. Theme 4 builds from this analysis to explore how the participants use these ethical principles in Stigma reduction.

### 4.4 Theme 3: Boxing with Stigma (Social Workers Anti-Stigma interventions)

This theme answered RQ2b & c: What strategies are the social workers deploying to reduce Stigma in their practice? What challenges do social workers face in their duty to mitigate Stigma at clinical and community levels? The aim was to fill the knowledge gap by exploring the social workers' actions to reduce stigma and the barriers in anti-stigma intervention.

When asked about the specific actions, participants reported an assortment of stigma reduction strategies. Interestingly, most of the methods mentioned occurred on an individual level as opposed to an organisation level. Similarly, their actions seem to be at an intrapersonal level to change public attitudes.

All the participants emphasised that stigma reduction is not a specific task within their institutions. However, they believed that Stigma reduction was integrated into the services they delivered on a day to day basis. This Danish participant sums it up when he said;

> "*Yeah, actually, I think it's mostly in the way we meet the citizens. Ourselves, the way we talk about citizens to others I think is the main part. Actually, we don't have a major theme about it [stigma reduction]. It's just integrated in the support system." SWD*$_1$

In Denmark, Stigma reduction is a government priority in psychiatry (discussed earlier in page 19). The Danish Government's action plan from 2014 titled ***Equality - new focus on treatment initiatives concerning people suffering from mental illness,*** outlines explicitly that interventions in all parts of psychiatry should be oriented towards better quality service and equality of care for somatic and mental disorders (Ministry of Health, 2014 cited in Sommar, 2016). Therefore, the Danish government identifies reducing prejudice (Stigma) as a focus area. The Social worker recognises that stigma reduction is enshrined in their service provision in Social psychiatry. Cameroon, however, lacks a Mental Health Policy, consequently leaving social workers without any framework.

During the interviews, participants were active in describing various strategies used with users who faced Stigma. The strategies discussed were grouped into five categories: **Religion, Empathy, Identification, reflexive consciousness, networking, and user empowerment.**

#### 4.4.1 Religion

A participant from Cameroon reported using the user's faith as a tool to address Stigma in clinical settings. She based her

Participants reported the following:

> *"A lot of times I even try to follow them down the religious lane. I ask about the churches they go for worship. I was supporting this boy called [tells the name]. He had psychosis very late at night and everyone called him a wizard. It took me 4 years to explain to him that he was [mentally] ill and not possessed (by an evil spirit)… I recommended to his family to get him baptised and in the catholic doctrine lessons, he was told that if he was*

*possessed, the baptismal water would melt him down. He didn't melt at baptism, so he believed me." SWC$_2$*

At first sight, Religion or Faith seems to be an unconventional approach in the practice of Social Work. Although social work recognises and values the entire spectrum of human experience, it often falls short in attending to the spiritual nature and growth of users, which may also be referred to as "*involving the transpersonal*", a domain encompassing *consciousness* as it exists outside the boundaries of the ego (or personal identity) (Sauter, 2019:2). The Transpersonal Theory seems to be an interesting lens to interpret this Social worker's use of psychospiritual therapy to simultaneously show empathy and recognise the user's (and societal) belief systems to transcend societal labels.

Transpersonal frameworks have gained relatively broad recognition since their initial conceptualisations by Carl Jung and Abraham Maslow. While the majority of the literature on transpersonal theory yields material regarding the spiritual transformation of the individual (the micro level), the approach also attends to relational, group (mezzo level) and environmental or cosmic (macro) levels of being (Sauter, 2019 citing Boucouvalas, 2016)

Transpersonal theory recognises and explains the "sacred" relationships between individuals and between the individual and their higher power(s), building on their strength experiences and the roles they play in both psychopathology and healing constituting a contextual (personal) psychotherapeutic practice (Sauter, 2019).

Personal relationships involving transpersonal social engagement, which connect psychological, social and spiritual dimensions, are sources of spiritual education, by trial or on purpose (Rothberg and Coder, 2013). Better still, the relationship between the individual and the Divine (which is often discovered through interpersonal means as many communicate their most meaningful experiences to one another) provides the individual with guidance and purpose (Sauter, 2019). This perhaps explains why the social worker "follows the user down the religious lane" (SWC$_2$) rather than "leading them to the religious lane."

The transpersonal theory still goes further to value the relationship between individuals and nature, specifically, becoming the profession's value as indicated by recent social work research (Ryan, 2013). According to Sauter (2019), Transpersonal theory has intricate connections with social justice, as the theory posits a path to self-awareness, which ultimately includes the knowledge of privilege and oppression within the individual. Therefore, through the employment of transpersonal therapy, social workers might be able to facilitate clients' arrival at a state of "recognition" by fostering the development of compassion, essentially increasing society's ability to mobilise around social issues. Several therapeutic practices are acknowledged within Transpersonal theory. These practices support individuals in returning home to the core of their spiritual being, including Jungian-based expressive arts therapy, meditation, existential therapy, logotherapy, hypnotherapy. Wong (2015) argued that these approaches could potentially enhance awareness, self-understanding, and personal purpose when carefully employed.

The importance of social, cultural and spiritual understandings of illness in many African societies has been recognised and discussed as being related to the collectivist orientation of many African cultures. (Monteiro, 2015). By fostering a religious belief system constructed by the person and ecosystem, the Cameroonian Social Worker was able to transform the user from a victim (of Stigma) to a person who struggles with psychosis - deconstructing social

Stigma. This finding is consistent with Wong (2015 cited in Sauter 2019), who employed a heuristic inquiry approach to explore the relationship between the transpersonal experiences of clients and the therapist. He found out that all participants, along with the therapist, were, in fact, able to transcend ego boundaries and reach a transformed state of consciousness in the transpersonal domain during the therapeutic process.

However, despite the increasing popularity of transpersonal therapies, the approach and theory face fierce criticism as unscientific and thus irrational and illegitimate (Sauter, 2019). Lukoff (1985) suggests that transpersonal psychotherapy may be particularly appropriate for severe mental disorders (involving psychosis).

### 4.4.2 Empathy

All participants reported using empathy as their first strategy for stigma reduction. This Danish participant opens up about her "disrespect" for Stigma to enhance the user's self-esteem and countering (or ignoring) Stigma. **[Reader discretion advised]**

> *"Yeah. Actually, if you asked me... Some of the best help I can give those people is to show them that I don't believe in Stigma. It is to show them that you have a place here as well as anybody else. And fuck Stigma by the way! To teach those people how to avoid stigmatic voices and live their lives. To embrace themselves. It's the best help I can give them if you ask me." $SWD_2$*

She goes further to say:

> *Actually, sometimes when I am supporting a citizen for work, I would stand right next to them and say, "It's okay. You'll handle it." I help them so other people can see they are fighting a battle and it's okay. So I stand next to them. To show people don't be afraid. It's okay. $SWD_2$*

There seems to be a general agreement within Social work that empathy is the ability to imagine what another person is feeling and thinking. In this context, empathy has been presented as a dispositional trait, cognitive skill, physiological reaction, or combination of these components (Gerdes and Segal, 2009). $SWD_2$'s use of empathy seems to fall within the intersubjectivity discussed in Honneth's spheres of Recognition in theme 3. Honneth (2008, pp.40ff. cited in Fuchs, 2019) has argued that *"recognition is primary to cognition":* babies are attached to their caregivers from the first months of life; they experience their welcoming and caring attitude and identify with them. According to Honneth, this creates primary form of recognition that heralds cognitive access to other minds, which is primal (unconscious) empathy (Fuchs, 2019)

Hence, Honneth gives a two-level account of recognition: an "elementary", pre-reflective recognition at the level of primary intersubjectivity, and second-order, normative recognition at a higher level, implies the recognition of the other as a person (Fuchs, 2019). For example, as a person struggling doubly: with the illness and with stereotypical social constructs about the disease. Fuchs (2019) notes that in its fully developed sense, empathy within recognition would summarily mean 'decentering': *I experience the other as someone with his own point of view, his own wishes and purposes; as someone whose claim I have to answer, who restricts my unlimited freedom and suspends my egocentric perspective (p. 242)*. This process seems to be followed by $SWD_2$ as she insists on the existence of a value for the users as she wants "*To teach those people how to avoid stigmatic voices and live their lives. To embrace themselves*" in the face of Stigma.

### 4.4.3 Reflexive Consciousness

This Danish social worker discusses an approach of empowerment based on a discursive collaboration in the identification of needs of the user and methods to achieve change in the user's life. The following statement summarised their efforts in reducing Stigma by providing information provided to patients:

> *So when we see that Stigma], as social workers, we talk to the citizen about it. If we find that they feel excluded, then will say okay, what behaviour can you do something about? okay... Maybe make sure not to shout or something… Maybe you should shower before going into the groceries. So in that direction, you can say that by talking about for example, the shower you try to connect the things that's going on in the person's life to something they can do something about themselves. And then motivate them to shower. And then say, "okay, what's the difference now?" SWD$_1$*

This participant from Cameroon reports utilising the user's immediate family to provide care and support to their own. An approach that could secure welfare which a dysfunctional health care system cannot offer. He said:

> *"What I often do is reach out to the families of the patients and educate them about the diagnosis and how it affects the brain. They often think it can be treated with some medication but I make them understand that it's a long journey and the patient needs them more than ever before. I tell them, you have to pay for medicines, feed them and love them. That's the only way they will get well" SWC$_1$*

### 4.4.4 Identification

A Danish participant noted identification as another means used to reduce Stigma with the patients experiencing Stigma by communicating with the user to identify the sources of Stigma to discuss the incident from another perspective. She mentioned that:

> *"Communication. Talking with the mentally ill person. "What happened here?" "What do you think happened?". To enlighten them and so they can see it from the other perspective. Because some people are using Stigma because they're not in line with themselves. So I think some of the things I do is to say "why do you think they said that to you". It's because… okay, but it can also be another perspective. So I help people to see it from different perspectives. Because then you realise that it's not said out of malice. It's said out of ignorance. It's more easy to accept and get over it." SWD$_2$*

### 4.4.5 Networking and user-empowerment

Another strategy in addressing stigma that the participants reported was involving their users in a nationwide campaign regrouping persons living with or have recovered from a mental disorder. This Danish Social Worker discusses involving the users in a larger

> *"But in our municipality, we have different kinds of offers. It's when you have Bostøtte, you can also go to places where you can be in the daytime and have different kinds of activities. And they often participate or are involved in organising a lot of activities, for example, a day called ONE OF US campaign, which is again to show other people that yes, "this person has depression,*

*this person has been diagnosed with schizophrenia, but they're just one of us". So, as a larger organisation, we are involved in this." ($SWD_1$)*

Central to the Social Worker's use of what has been termed in this research as *Reflexive Consciousness*, *Identification*, *Networking, and user empowerment* is a shift operated by social workers to entering into a seemingly democratic partnership with mentally ill persons to participate in their welfare by co-sharing ownership (control) of realities and cooperating to solve problems (in this case to manage Stigma). The Empowerment Theory comes very much to the front.

Brazilian educator Paulo Freire (1973, 1998) has been widely credited for articulating the concept of empowerment as he recognises the humanity of oppressed people and believes it was necessary to enter into their world and empathise and identify with them to understand their needs (Turner and Maschi, 2014).

The International Federation of Social Workers (IFSW) has stated that social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people (IFSW, 2018). The concept of empowerment in this new definition continues its longstanding and wide endorsement in social work practice.

Andersen (2015) referred to empowerment as the process by which power is developed, facilitated or verified with the purpose of enhancing underprivileged individuals and groups in three aspects:

a. Increase their resources

b. Strengthen their self image

c. Act for themselves on the political, economic and social realms

Empowerment theory also situates human problems in a person-in-environment perspective, recognising the interdependence and mutual influence of individuals and communities and proposing that successful interventions to human issues occur at the intrapersonal, interpersonal, and community levels simultaneously. According to Andersen (2018), within social work, an emphasis on empowerment-oriented interventions may primarily help individuals develop psychological self-efficacy or coping skills to adjust to the existing social environment to gain control over their destiny. She further identifies three dominant variants of Empowerment as articulated in Social policy, practice and research;

**A neoliberal understanding** - a somewhat symbolic form of empowerment, where social workers only offer options to the users.

**A social liberal understanding** - a form of empowerment which focuses on the involvement of the individual user.

**A critical understanding** - in this paradigm, empowerment takes the form of a collective critical awareness that will lead to improved opportunities for marginalised individuals, groups, and organisations by strengthening the development of power that can influence structures and oppressive conditions. (Andersen, 2018 p.285-286).

Now, this begs the question in what paradigm the Social Workers who participated in this interview placed their practice of anti-stigma interventions. ***Identification, Reflexive***

***Consciousness and Networking and user empowerment*** seem to be operating in the critical understanding paradigm. The Danish Social workers' use of a larger national campaign provides the opportunity for persons living with mental illness to build on their strength, affirm their difference and influence the social construct of Stigma in society when she says:

"*It is to show them that you have a place here as well as anybody else" $SWD_2$*

The Danish Social Workers' use of Empowerment is inextricably linked to the new paradigm of demands for social workers and citizens – New Public Governance. Andersen (2018) discuss empowerment strategies need to be organised in cooperation with citizens as they are the experts of their realities and needs. In this process, the worker acts as a coach and a motivator in attaining the citizen's objectives. This can be seen in the following excerpt where SWD1 motivates the user to take smaill steps through a democratic dialogue :

> *So when we see that Stigma], as social workers, we talk to the citizen about it. If we find that they feel excluded, then will say okay, what behaviour can you do something about? okay... Maybe make sure not to shout or something… Maybe you should shower before going into the groceries. So in that direction, you can say that by talking about for example, the shower you try to connect the things that's going on in the person's life to something they can do something about themselves (SWC1)*

From the Cameroonian perspective, although it might seem symbolic to involve the family, it remains that family networks are vast with plenty of possibilities, including tribal, ethnic and regional affiliations. Raising critical awareness in families has the potential of deconstructing Stigma from the bottom to the top. The collectivistic nature of Cameroon allows the social workers to empower families for the benefit of the users.

### 4.6 Anti Stigma intervention: Stigma Protest, Education and Contact

Three approaches to reducing Stigma have been widely used in literature: *protest, education, and contact*.

Protest involves opposition to stigmatising public depictions of mental illness and taking action against discrimination. These can involve informing people about stigmatising messages in the media and organising a joint protest or response.

Education strategies often entail disseminating information and brief education on mental illness and seeking to contradict false beliefs and unjustified fear of individuals with mental illness. Often, education is used directly to counter myths with facts. Couture and Penn (2003) found that education helps change attitudes but has little effect on subsequent behaviours.

Contact strategies are based on research showing that contact with a person from a marginalised group can lead to reduced stigmatisation of that group. Contact involves interactions with people who have recovered or are living a mental illness, which may challenge prejudices.

During the interviews, the Social Workers reported doing Stigma reduction interventions. Their actions were categorised into subthemes: **Religion, Empathy, Identification, Reflexive Consciousness and Networking and user empowerment.** Based on these five strategies to fight Stigma, Figure highlights their conceptual association with Corrigan et al's (2001) framework for Stigma Reduction.

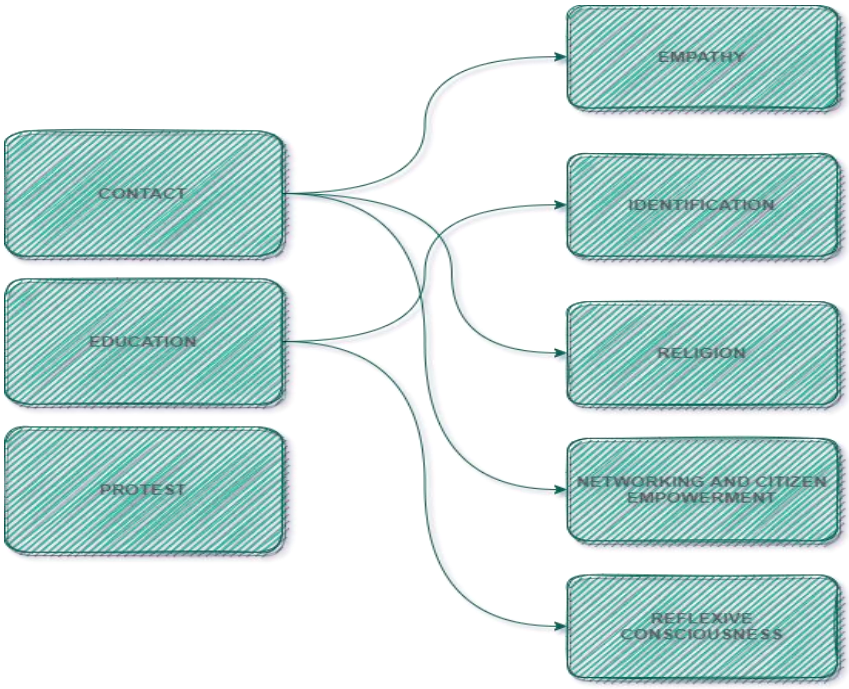



***Figure 4 Trends from participant responses***

This figure shows that the participants tend to be involved in Contact and Education stigma reduction strategies. However, none of the Social Workers interviewed in this research reported participating in Protest activities either in person or on Social Media platforms. This reliance on *Contact and Education Strategies* can be explained by Contact's emergence as an essential strategy for people with a mental disorder diagnosis. The literature widely emphasises the efficiency of Contact strategies to combat Stigma. Alexander and Link (2003) found that a combination of personal contact and education significantly reduces mental health stigma. Similarly, Thornicroft et al. (2016) argue that mass media campaigns in Norway and England have produced improvements in knowledge and decreased negative public attitudes, and increased supportive behaviours toward individuals with mental health problems.

Corbiere et al. (2012), in their multi-stakeholder approach, found that Contact is the most efficient strategy according to persons with clinical, organisational, and experiential knowledge. Similarly, A systematic review of reviews conducted by the Swedish Public Health Agency equally confirms this notion stating, “Contact strategies appeared to be more effective among adults, while educational strategies were more effective among youths”.

Particularly interesting was that the Danish Social Workers reported involving their users in a national anti-stigma campaign when he said:

> *“And they often participate or are involved in organising a lot of activities, for example, a day called ONE OF US campaign, which is again to show other people that yes, “this person has depression, this person has been diagnosed with schizophrenia, but they’re just one of us”. SWD$_1$*

ONE OF US which is a programme to increase social inclusion and reduce stigma and discrimination through and for people with experience of mental illness. This programme has produced considerable improvements in knowledge and attitude outcomes. Unlike education,

which changes attitudes and not behaviours, contact can change both. The more personal contact a person has with a stigmatised group, the lower their stigmatising opinions will be. (Livingstone & Boyd, 2010). As total contact increases, the perception of danger and attempts to keep a social distance decrease. Alexander & Link (2003) found that minimal contact with someone with a mental illness, either professionally or personally, can change stigmatising beliefs. Livingstone & Boyd (2010) note that "As little contact as a 15-minute video can dispel myths about mental illness." People begin to see someone diagnosed with mental illness as an individual who is not unlike them.

Protest interventions reduce Stigma through the denunciation of public statements, media reports, and advertisements. This strategy was absent in the practitioner's discourse. Perhaps the reason why Social Workers do not engage in Protest strategies can be found in the current paradigm in which Danish and Cameroonian Social Work operates in - Managerialism. One of the fundamental ways managerialism is translated into practice is through New Public Governance (Greve, 2012). Timor-Shlevin & Benjamin (2020 p.954) argue that under managerialist pressures, the professional standpoint of social work is under mutation. They say that "*This transformation is due in particular to the prioritisation of clinical work, the refusal to engage with exclusions created by the structural context, and objections to the critical practice of standing by service users in an ongoing, intensive manner."* This non-engagement with users beyond conventional frameworks is perhaps symptomatic of Social Work's transition from *occupational professionalism* (strictly based on professional considerations), to *organisational professionalism* (strictly based on economic considerations) which involves cost-benefit calculations in service provision (Timor-Shlevin & Benjamin, 2020). This seems to be particularly relevant to Cameroon because of the lack of professional infrastructure to support mentally ill patients compounded by multiple demands and limited resources available to meet those demands.

Social workers have to follow strict, standardised procedures in administering the Social service Laws which often come with pressure caused by an overload of cases. Hence, as Henriksen argues, there could be reason to believe that social workers cannot work within a holistic approach. Coping strategies can also accordingly occur in forms of routines of practice, which has important implications for the quality of the intervention and service in the public sector and hence for the citizens and their life (Henriksen, 2018)

Another reason why Social workers did not report being engaged in protest strategies can be found in evidence-based research. Couture and Penn (2003) indicated that the attempt to suppress stereotypes through protest could often result in "paradoxical rebound effects" and generally does not affect Stigma. According to these researchers, the very attempt to suppress negative stereotypes about mental illness. Similarly, the systematic review of reviews conducted by the Swedish Public Health Agency equally confirms that no evidence has been found that protest can lead to change in mental health-related Stigma.

This theme answered RQ2b and c. In summary, it was discussed that Social Workers use a variety of stigma reduction strategies which are informed my empowerment perspectives. Five distinct perspectives were highlighted; Religion, Empathy, Identification, reflexive consciousness, networking, and user empowerment. These strategies were interpreted within existing theoretical constructions: Transpersonal Theory, Honneth's theory of recognition, Andersen's Empowerment, and Corrigan and colleague's framework of Protest, Education and Contact to reduce Stigma at all levels.

**Summary of the chapter**

Globally, although the forms of state (sociopolitical traditions), the complexity of social problems, the dynamics of organisational structure, social work education, and socio-cultural beliefs and values are different in Denmark and Cameroon, only a few discrepancies in the social workers' perceptions were registered. The significant differences were located in the Cameroonian Social Worker's use of religion, informal family and community networks in Stigma Reduction interventions. In contrast, the Danish Social workers reported a more individualised support network focusing on citizen empowerment and recovery. The similarities in the social workers' perception can be explained by at least two factors: the internationalisation and superiority of professional social work values (Gray & Fook, 2004). Secondly, by the universality of mental illness, Stigma exists in every single society, according to Rossler (2016).

# CHAPTER FIVE

# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

## 5.0 Overview of the chapter

This chapter concludes the study by placing the findings within each of the two contexts discussed. It presents the summary of the main findings and briefly states out some recommendations for social work practice.

## 5.1 Conclusions, Summary of findings and Answers to the research questions

The aim of this study was to explore and interpret how Danish and Cameroonian social workers perceive the dimensions of mental illness stigma and how they calibrate the ethical principle of Social Justice in anti-stigma interventions. A purposive sample technique permitted the recruitment of 4 participants for the study. Hermeneutic individual semi-structured interviews were conducted. This approach allowed participants to discuss their perceptions of mental illness stigma, their interpretations of the ethical principle of Social Justice and how this principle is mainstreamed in the strategies employed to mitigate Stigma at intrapersonal, interpersonal and structural levels. Thematic analysis resulted in the elaboration of three significant themes: The Boxes of Stigma (which discusses the Stigma as oppressive labels), Social Justice: "Recognising" the Plurality of meanings and Boxing with Stigma (Social Workers' Stigma Reduction Strategies). These allowed in answering the research questions:

This research set out with two main research questions and three sub-questions: These were;

1) How do social workers in Cameroonian and Danish social psychiatry perceive mental illness stigma?

It was found that the Social Workers from both Denmark and Cameroon consider Mental health stigma as a continuum - a complex phenomenon rooted cultural identities and stereotypes that mediate the process of stigmatisation by othering and labelling those affected by the illness. Cameroonian social workers discussed stereotypes as being constructed in culturally constructed stigmatic beliefs that sideline persons considered "anormal".

2) How do Social workers, in their practice, work to reduce the stigma of mental illness for their service users at clinical/micro and community/macro levels?

Specifically, these subquestions will help to address the broader question stated above:

a) How do social workers mainstream the ethical principle of Social Justice in minimising Stigma?

It was found that all participants in this research have a common base despite having relatively different understandings of Social Justice. That social inequalities are a product of misrecognition. Achieving Social Justice involves the possibility of affective, legal, and social spheres of life through **Fairness**, **Equality**, **Respect**, **Solidarity**, **Norm.**

b) What strategies are the social workers deploying to reduce Stigma in their practice?

It was discussed that Social Workers use a variety of stigma reduction strategies that informed my empowerment perspectives. Five distinct approaches were highlighted; Religion, Empathy, Identification, Reflexive Consciousness, Networking and user empowerment. These

approaches were aligned to the well-established trilogy in the existing literature: Contact, Protest and Education.

What challenges do social workers face in their duty to reduce Stigma at clinical and community levels?

Barriers were identified; in Cameroon, the lack of an established Mental Health policy forces social workers to use alternative methods whose efficiency cannot be ascertained. In Denmark, mental illness stigma is a government priority in psychiatry, but the media was still identified as channels of labels on persons with mental illness in society.

### 5.2 Contextualising the study findings within the Nordic Context

Although the Nordic Welfare State presents an enviable outlook with its universalistic welfare scheme (Henriksen, 2018), some segments of the population still fall between the cracks of the safety net. Persons living with mental health conditions seem to require a lot more than they are offered. Despite the Government's visions for reducing prejudice (Stigma) as a focus area of psychiatry in Denmark; Stigma continues to exist precisely because of the influences of the media. Social Workers battle with these oppressive cultural constructs of mental illness in society but are held back by the existing paradigm of New Public Management, which seems to dissociate the "social" from the "work".

### 5.3 Contextualising the findings within the African context

The findings of this research have several implications for Cameroon in particular and Subsaharan countries in general. First, this research demonstrated that Mental illness interacts pervasively with Social inequalities mainly. Stigma is nebulous and requires holistic strategies involving social work for micro-level intervention and equally the States to recognise Mental illness as an issue of Public Health. This comprehensive and holistic mental health framework ought to be made in democratic concertation with users who are experts in their illnesses. Within this framework, the social workers, medical doctors, nurses and even families will have more possibilities to be involved in recovery-oriented support. In the same way HIV/AIDS was a priority in 1990's and more recently COVID-19, it is possible to turn attention to the plight of the persons living with mental health problems.

Still, there might be challenges related to insufficient financial resources. Therefore, there will need to be locally-driven and culturally responsive solutions. Integrating internationally recognised best practices with community-based interventions can lead to policy, research and treatment improvements.

### 5.3 Implications of the study for Social work: Education, policy, practice and research

#### 5.3.1 The Profession

Given the value base of social work, it is essential that all actions model anti-stigmatising practice; therefore, all actions must be done in full and equal partnership with individuals with mental disorders in a context of collaborative and participatory effort. In addressing the Stigma of mental illness, social work must be honest, self-evaluation and reflection on the profession's fundamental values and ethics. The core values of social work in the Global Definition of Social Work call for social workers to promote social change, social development, social cohesion, and the empowerment of persons living in oppression. Addressing the Stigma stigma of mental illness from the forgoing is a critical mission of social work at all levels (IFSW, 2018; Scheyett, 2005)

In addition, as Andersen (2018) discusses, Social workers need to create a democratic dialogue for involvement in social partnership between social workers and users (citizens) living with mental disorders by developing less tokenistic forms of participation. Through this partnership, several promising actions should be explored in the arenas of research, policy, and practice. In parallel, the profession needs to take a more proactive role in rejecting the stigmatising attitudes and socio-culturally constructed stereotypes. Social media can be a starting point for organising social anti-stigma protests to counter the dominant view of mental illness created in the mainstream media.

### 5.3.2 Policy

Social work can partner with (in Cameroon) or strengthen (in the case of Denmark) partnerships with consumer rights and recovery movements at the policy level to enhance individuals' social capital and political power with mental illnesses. Considering that Stigma can only occur in the context of the socially constructed label, by regulating movies and of individuals with mental illnesses, the possibility of Stigma is lessened. Social work has learned much about empowerment practice, advocacy strategies, and policy practice (Andersen, 2018; Schyett, 2005); this knowledge can have tremendous application in combating the Stigma and oppression of individuals with mental illnesses

### 5.3.3 Practice

At the practice level, social workers could engage in individual and community interventions to decrease Stigma and its negative impacts. Scheyett (2005) has identified activities such as structured dialogues, community service projects, joint information sessions between people with mental illnesses, law enforcement, civic leaders can advance stigma reduction at community levels. This study showed that mezzo and macro stigma intervention needs to be strengthened in Denmark and Cameroon

### 5.3.4 Social Work Education

For social work education, the main recommendation is to reduce the gap between policy and practice by including stigma reduction training for Social Workers in education settings (Scheyett, 2005). This research identified an array of stigma reduction strategies social workers use in their practice. Social work education would focus on analysis and situational practice of social justice, what Henriksen (2018) has called "real social work". This will allow students to gain competence in the missions of social work in action. Stigmatised groups will benefit more efficiently from well trained social workers.

## 5.4 What have I learnt: Reflections on (after) the Nordic Master in Social Work Journey

The Nordic Master in Social and Welfare program has been a significant focus of my life for the last couple of years. Within the last two years, what stood out beyond the experience of learning [to acquire knowledge] is learning to solve problems. This was a fundamental part of the program – being Problem-based and searching for methods that provide guarantees of facilitating answers to questions or solutions to problems. Negotiations, collaboration, and teamwork were the pillars on which rested the Problem-based approach at the University of Stavanger even more prominently in Aalborg University. In addition, Cross-cultural sensitivity

and communication spawned automatically because the focus was on finding solutions rather than explaining differences.

However, on closing this research, new questions run through my mind: What contribution can I make to reduce Stigma (s) and social injustice(s)? What can I do to challenge the solid socio-cultural beliefs about mental illness in Cameroon? If I cannot change established beliefs, what can I do to advance Social Work education, practice and research in Cameroon? These and several other interrogations are running through my relatively young mind. But at the moment, the questions seem not to have concrete answers.

Conducting this research, digging into the literature, particularly the concepts and values of the profession of Social, has altered my perspective on mental illness, disabilities, poverty, and minority groups. This research has sharpened my empathy for persons living with mental illnesses with stigmatised identities. I have learned to see the worth and essence of every person. I have learnt tolerance, accepting persons as they are, with their strengths, weaknesses and challenges.

### 5.5 Limitations of the study

This study has several significant limitations. The first lies in the scientific method chosen for exploration of the practitioners perspective. Perhaps an ethnographic approach would have provided better insights into the social workers' perspectives on Stigma and would have equally facilitated an interpretation of the macro ecosystemic (institutional) understanding. As a result, conclusions drawn from these are general and may not reflect the nature of the interactions between social workers, Stigma, ethics and the users entirely.

This study utilised an extremely small sample (four) of social workers from Denmark and Cameroon for a vast scope of the study. This ultimately led to sampling bias and non-generalisable conclusions. These elements considerably restrict the cross-cultural generalizability of these findings.

The third limitation is that this study was not specific about the mental disorder. Neither did it discriminate between mental disorders and personality disorders. This is particularly important when we consider that mental illnesses and personality disorders do not operate in the same ways and are neither stigmatised at the same magnitudes.

Furthermore, this study identifies strategies to fight Stigma used by various groups of people connected to mental disorders, but it does not assess nor measure the effectiveness of these strategies. Perhaps some quantitative studies need to be conducted to measure the progress of the Social workers' anti-stigma strategies on the public but equally on the mentally ill persons.

### 5.6 Recommendation for Further research

Considering the nebulous nature of mental health stigma, further research should include a larger number of social work stakeholders to increase transferability. Persons living with mental disorders should be involved in more extensive research to discuss their experiences of Stigma and how it can be reduced.

In Denmark, longitudinal studies should be done to measure the effectiveness of stigma reduction strategies and contextualise best practices from the other Nordic Welfare States. In

addition, studies need to be conducted to measure the evolution of the forms of Stigma in the 98 municipalities and five regions in Denmark to measure what methods are effective in Stigma reduction

In Cameroon, research should be organised around the socio-cultural constructs of mental illnesses providing thick descriptions of their origins and evolution over time in the different ethnic groups. Another area which needs to be considered for further research is a thorough assessment of the country's economic cost of mental illnesses. Evaluating the financial burden of mental diseases costs the country and how much it will cost to scale up mental health services. These would probably attract more attention to the Stigma of mental illness in Cameroon.

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# APPENDIX A

## INFORMATION SHEET & CONSENT FORM

**TITLE: MENTAL ILLNESS STIGMA IN DENMARK AND CAMEROON: Exploring the Social Workers' Perspectives and Approaches to Stigma Reduction.**

Please note that this Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signature if you agree to participate)

**Section 1: Information Sheet**

**Introduction**

Thank you for agreeing to participate. I am pursuing a Nordic Master's in Social Work and Welfare at Aalborg University. I am a student researching the Social Workers' Perception of Mental Illness Stigma in Denmark and Cameroon, which is partly your work field, and I would like to invite you to be a part of this research. Below, I will be discussing the thematic areas and focus points of this research. I invite you to ask me any questions in case you have any queries regarding the study. More, you can talk about this to anyone that you feel comfortable talking to. I would like you to reflect on whether to participate and answer questions asked during the interview. If you need clarification on words or concepts, I will explain as we go along. If you have any more questions or worries, you can contact me by text or email.

**Purpose of the research/ interview**

This research is carried out as partial fulfilment of the requirement to obtain a master's degree in Nordic Social Work and Welfare. The two primary research questions I am studying is

**How do social workers in Cameroonian and Danish social psychiatry perceive mental illness stigma?**

And secondly**:**

**How do Social workers, in their practice, work to reduce the Stigma of mental illness for their service users at clinical/micro and community/macro levels?**

Specifically, these subquestions will help to address the broader question stated above:

- **How do social workers mainstream the ethical principle of social justice in minimising Stigma?**
- **What strategies are the social workers deploying to reduce Stigma in their practice?**
- **What challenges do social workers face in their duty to reduce Stigma at clinical and community levels?**

Stigma seems to be a universal problem, but the experiences, manifestations and perceptions are context-specific—studies across the globe present different pictures of stigma experiences in different countries and communities. Existing literature widely concedes that Stigma poses a significant challenge to recovery from mental illness. Considering that social workers play a prominent role in mental health service provision and that actions to support social justice are missions of social workers (as per the DASW Code of Ethics), addressing Stigma should be a critical focus of social work interventions in clinical and community settings.

This research is interested in getting the stakeholders' viewpoint involved in supporting stigmatised mentally ill patients in connection with the Social Worker's code of ethics. The study will be focusing on exploring your perception (as a Social Worker) as this research is based on learning about the situation, your actions, and results in stigma reduction. I am particularly interested in your subjective experiences and opinions regarding this issue, so there are neither right nor wrong answers.

**Your Participation**

This research will involve Corona-safe participation in an interview which will last about 45 minutes. The interview follows the format of a semi-structured interview where I will guide the interview. The discussion will be recorded and will be used for this research only. All information you share is confidential, and no one except the researcher you met will access the information documented during the interview. Your identity will not be mentioned in any document (written or recorded).

The choice of where and what time to meet is entirely yours.

**Confidentiality Clause**

All the information you share with me will be treated confidentially, and the knowledge gained from the interview will be shared anonymously with my supervisor at the Department of Sociology and Social Work, Aalborg University. Disguised extracts from the interview may be quoted in the research paper. After the completion of the result, you will receive a summary of the result.

If you have any questions, you can contact me at:

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Nordic Master's in Social Work and Welfare (NOSWEL)

Aalborg University

**Section 2: Consent to take part in research**

I, _____, have been invited to participate in research about Social Worker's Perception of Mental Illness Stigma in Denmark and Cameroon and I voluntarily agree to participate in this research. I have read the information about the research in section 1: Information sheet provided to me with this informed consent. Even if I agree to participate now, I can withdraw anytime or refuse to answer any of the questions. I have had an opportunity to ask a question about the study. I agree with my interview being audio recorded, and I am entitled to access the information I have provided at any time while it is in storage. I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Name of Participant:

Signature of Participant:

Date (dd/mm/yyyy):

**Statement by the researcher/person taking consent**

I have accurately read out the information sheet to the potential participant, and to the best of my ability, made sure that the participant understands the information stated above.

I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability.

I confirm that the individual has not been coerced into giving consent, and the permission has been given freely and voluntarily.

A copy of this informed consent has been provided to the participant.

Name of Researcher:

Signature of Researcher:

Date (dd/mm/yyyy):

# APPENDIX B

# INTERVIEW PROTOCOL

**A) Personal Background**

i. Age:

ii. Gender:

iii. Highest Level of Education/Training Completed:

iv. Major:

v. The number of years in the profession:

vi. Have you or anyone in your family ever been diagnosed with a mental illness?

vii. Can you give me a brief description of your work as a social worker in psychiatry?

viii. Which group of citizens do they mainly work with?

ix. How long have they been working with the group?

x. How many citizens are you directly in contact with?

xi. Can you briefly tell me what is your role (in Social Psychiatry)? What kind of tasks do you and your colleagues undertake?

xii. What was the main idea behind it?

xiii. How do you think the citizens receive the support they get from you?

**B) Introduction and Social Work Ethics and Social Justice**

1. What does the concept of *Social Justice* mean to you? What does it mean in practice?
2. What are the challenges and opportunities of promoting Social Justice?
3. To what extent do you integrate Social Justice into your Social Work in Social Psychiatry?

**C) Social Worker's Perception of Stigma**

4. What do you understand by the term *"stigma"*?
5. Do you think the Stigma has consequences on patients' conditions? How big? And in what ways?
6. In what ways does the Stigma of mental illness manifest itself?
7. Has a citizen ever discussed with you an instance where they felt outrightly discriminated upon?

**D) Social Worker's Actions in Stigma reduction**

8. What kind of actions do you undertake to reduce the Stigma of mental illness in your practice organisation?
9. What challenges exist in implementing actions to reduce the Stigma of mental illness in practice?
10. What, in your opinion, needs to be done to reduce the Stigma of mental illness in social work practice?
11. What intervention approaches (besides these you are involved in) will help reduce the stereotypes on the mentally ill?
12. Based on your experience with the patients, how do they perceive your actions to reduce Stigma?
13. How much training did you obtain in your organisation in connection to actions to reduce Stigma?
14. Outside of your organisation, what actions can researchers, health professionals (including other social workers) take to reduce Stigma in society?


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