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Stigma among Mentally Ill Patients

By

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Abstract

This study aims at assessing the stigma among mentally ill patients. It has been carried out using a descriptive cross-sectional design. The subjects were constituted of 215 patients from in-patient Psychiatric Department of Mansoura University Hospital. In order to collect the necessary information for the study structure interview sheet was used to collect data. Data collection was conducted during the period from February 2011 to August 2011. The main findings of the study were that there is a positive moderate significant correlation between score of stigma subscale. So it is recommended to increase public awareness about the harmful consequences of mental illness stigma through mass media, taking into consideration the predisposing factors identified in the present study and how to attach patient with their treatment plan and raising his self esteem.

Keywords: Stigma – mental illness

Introduction:

The stigmatization of mental illness is currently considered to be one of the most important issues facing the mental health field [1]. Although individuals with mental illness suffer from a wide range of negative effects and impairments related to the disorder itself, these outcomes are exacerbated by societal stigmatization of their illness. In fact, harsh stigmatization of mental illness occurs across nations and cultures around the world, creating significant barriers to personal development and receipt of treatment [2]&[3]. People suffering from severe mental disorders, especially from schizophrenia, are frequently subject to stigmatization and discrimination because of their illness. This stigma also affects their families and close relationships which cause social isolation, a derogation of life chances, hampering potential rehabilitation and social integration efforts. Additionally, the stigma of mental illness concerns psychiatric treatment methods and institutions, thus negatively affecting help-seeking behavior [4].

Furthermore, stigma leads to poorer individual and family functioning: High percentages of individuals with mental disorders avoid seeking treatment, even though public awareness of problems related to mental illness has

increased. Stigma is real, with devastating consequences [5]&[6]. So it is important to assess the stigma among mentally ill patients and its effect.

Aim of the study:

To describe the pattern and variation of stigma among mentally ill patients

Subjects and Method:-

Study Design:-

A descriptive cross-sectional design.

Setting:-

The study was carried out in the in-patient section of Psychiatric Department of Mansoura University Hospital

Subjects:

Mentally ill patients in the in-patient section of Psychiatric Department of Mansoura University Hospital.

Sample size: Consists of 215 patients **Tools:** the questionnaire was used to collect data, includes:

Section I: Socio- Demographic and psychiatric history. It includes: name, age, gender, level of education and social status, occupation, address, number of admission to psychiatric hospital, duration of stay in psychiatric hospital, diagnosis, length of mental illness, medication taken to treat mental illness.

Section II: A Stigma scale: Stigma scale developed by 7 King et al (2007) consists of 28 items with three subscales the first is discrimination (Dc) that consists of 12 statements and the second is disclosure (D) that consists of 11 statements and the last is positive aspects (P) that consists of 5 sentences. The scale has been translated into Arabic (slang language) by two researchers independently; The Arabic version was back translated to English by other two researchers. Inconsistencies were solved by consensus of all of them.

Ethical consideration:

- The permission was obtained from the faculty of nursing ethics committee.

Statistical analysis:

Data entry and statistical analysis was done using SPSS (Statistical Package for Social Sciences) 16.0 statistical software package. Data were presented using Descriptive statistics in the form of frequencies and percentages for qualitative variables, and means and standard deviations for quantitative variables. The chi-square ($\chi 2$) was used to test the association between variables of qualitative data. The t-test used to compare means of two groups. For all above mentioned statistical tests done, P value of ($\leq$ 0.05) was considered statistically significant. During statistical analysis we use KS-test (kolmographe- smirnov test) to test normality of the non parametric (stigma sub domains). Also the

(mannwittney test) that used for two independent sample tests and (kruskal wallis h test) that used for several independent samples.

Results:

Table (1) shows that age of the study sample ranged from 18-60 year with a mean±SD of 34.80±12.22. More than half of the sample (51.7%) is between 30-50 years. More than half of the sample 52.6% is female. The majority of the study sample was from rural area (79.5%). According to the level education the majority were of general and technical secondary school (49.8%). Nearly 46.0% of the study sample was married. Regarding to occupation, (44.7%) was not working, (28.4%) were governmental employee, (12.6%) was house wife and 14.0% were manual worker and nearly two-thirds of the sample 64.2% reported unsatisfactory income.

Table (1): Socio - demographic characteristics of studied patients (n=215)

	N	(%)
Age(years)		
<30	80	(37.2)
30-	111	(51.7)
50+	24	(11.1)
Mean±SD	34.80±12.22	
Gender		
Male	102	(47.4)
Female	113	(52.6)
Residence		
Urban	44	(20.5)
Rural	171	(79.5)
Education		
Illiterate	42	(19.5)
Read write /primary/ preparatory	34	(15.8)
General / technical secondary school	107	(49.8)
Higher education	32	(14.9)
Marital status		
Single	82	(38.1)
Married	100	(46.6)
Divorced /Widow /Separated	33	(15.3)
Occupation		
Not working	96	(44.7)
Governmental Employee	62	(28.4)
Housewife	27	(12.6)
Manual Worker	30	(14.0)
Family income		
Satisfactory	77	(35.8)
Unsatisfactory	138	(64.2)
Total	215	(100%)

Table 2: shows that the most frequent diagnosis is schizophrenia (19.5%) followed by mania with psychosis (19.1%), schizo-affective (17.2%) then bipolar mania (14.4%). The most frequent treatment is antipsychotic (79.1%), then anticholinergic (63.3%), then anticonvulsant (53.0%), then antianxiety (31.6%), then antidepressant(29.8%) and finally antimanic (29.3%).Most of the study sample were smoker (66.5%) and most of the study sample

haven't any co-morbidity (73.0%), Diabetes mellitus, hypertension, bronchial asthma, hepatitis and peptic ulcer were reported by 8.8%, 14.9%, 1.4%, 1.4%, 0.5%; respectively

Table (2): Clinical data of studied patients**:-**

	N	(%)
Diagnosis		
Schizophrenia	42	(19.5)
Schizoaffective	37	(17.2)
Depression	26	(12.1)
Bipolar -mania	31	(14.4)
Bipolar-depression	8	(3.7)
Manic with psychosis	41	(19.1)
Depression with psychosis	12	(5.6)
Delusional disorder	6	(2.8)
Mood with abuse	4	(1.9)
Mixed mood with psychosis	7	(3.3)
Dementia	1	(0.5)
Treatment**		
Antipsychotic	170	(79.1)
Anti cholinergic	136	(63.3)
Anti manic	63	(29.3)
Antidepressant	64	(29.8)
Anti anxiety	68	(31.6)
Anti convulsant	114	(53.0)
Smoking habits		
Smoke	143	(66.5)
Not smoke	72	(33.5)
Co-morbidity		
No	157	(73.0)
Diabetes	19	(8.8)
Hypertension	32	(14.9)
Bronchial asthma	3	(1.4)
Hepatitis	3	(1.4)
Peptic ulcer	1	(0.5)
Total	215	(100%)

Table 3: shows that the highest mean of discrimination of stigma scale was shown in the following statement. A12-Having had mental health problems makes me feel that life is unfair (Dc). (2.79±1.20). The over all mean score of discrimination sub scale of stigma scale was (23.9±9.02) and the median of discrimination subscale items ranged from (0-3) with the total score of the discrimination subscale 25(0-40).

→While the highest mean of disclosure sub scale of stigma scale was shown in the following statement

B4-I would have had better chances in life if I had not had mental health problems (D). (3.02±1.29). The over all mean score of disclosure subscale of stigma scale was (29.2±8.4) and the median of disclosure subscale items ranged from (1-4) with the total score of the disclosure subscale 32(1-42).

→But the highest mean of positive aspect sub scale of stigma scale was shown in the following statement

C2-Some people with mental health problems are dangerous (P). (2.62±1.53). The over all mean score of positive aspect sub scale of stigma scale was (10.9±3.7) and the median of positive aspect subscale items ranged from (2-3) with the total score of the positive aspect subscale 11(0-20). Finally the over all mean score of stigma scale was (64±18.1) with median 69(10-95).

Table (3) Descriptive statistics of stigma scale

Items	Median (min-max)	Mean ±S.D
A- Discrimination (Dc):-	25(0-40)	23.9±9.02
A1- I have been discriminated against in education because of my mental health problems (Dc)	0(0-4)	1.16±1.60
A2-Sometimes I feel that I am being talked down to because of my mental health problems (Dc)	2(0-4)	1.55±1.49
A3-I have been discriminated against by police because of my mental health problems (Dc)	0(0-4)	0.99±1.28
A4-I have been discriminated against by employers because of my mental health problems (Dc)	1(0-4)	1.41±1.44
A5-Very often I feel alone because of my mental health problems (Dc)	3(0-4)	2.58±1.25
A6-People's reactions to my mental health problems make me keep myself to myself (Dc)	3(0-4)	2.61±1.90
A7-I am angry with the way people have reacted to my mental health problems (Dc)	3(0-4)	2.68±1.20
A8-I have not had any trouble from people because of my mental health problems (Dc)	3(0-4)	2.77±131
A9-I have been discriminated against by health professionals because of my mental health problems (Dc)	3(0-4)	1.51±1.39
A10-People have avoided me because of my mental health problems (Dc)	2(0-4)	1.73±1.23
A11-People have insulted me because of my mental health problems (Dc)	2(0-4)	2.13±1.14
A12-Having had mental health problems makes me feel that life is unfair (Dc)	3(0-4)	2.79±1.20
B- Disclosure (D):-	32(1-42)	29.2±8.4
B1-I do not feel bad about having had mental health problems (D)	1(0-4)	1.63±1.18
B2-Iworry about telling people I receive psychological treatment (D)	3(0-4)	2.34±1.42
B3-I am scared of how other people will react if they find out about my mental health problems (D)	3(0-4)	2.79±1.29
B4-I would have had better chances in life if I had not had mental health problems (D)	4(0-4)	3.02±1.29
B5-I do not mind people in my neighborhood knowing I have had mental health problems (D)	3(0-4)	2.84±1.39
B6-Iwould say I have had mental health problems if I was applying for a job (D)	3(0-9)	2.97±1.28
B7-Iworry about telling people that I take medicines/tablets for mental health problems (D)	3(0-4)	2.80±1.16
B8-I do not feel embarrassed because of my mental health problems (D)	2(0-4)	2.41±1.18
B9-I avoid telling people about my mental health problems (D)	3(0-4)	2.74±1.06
B10-I feel the need to hide my mental health problems from my friends (D)	3(0-4)	2.75±1.26
B11-I find it hard telling people I have mental health problems (D)	3(0-4)	2.92±1.10
C- Positive aspects (P):-	11(0-20)	10.9±3.7
C1-Having had mental health problems has made me a more understanding person (P)	2(0-4)	1.90±1.24
C2-Some people with mental health problems are dangerous (P)	3(0-4)	2.62±1.53
C3-People have been understanding of my mental health problems (P)	3(0-4)	2.51±1.36
C4-My mental health problems have made me more accepting of other people (P)	2(0-4)	1.69±1.25
C5-Having had mental health problems has made me a stronger person (P)	2(0-4)	2.13±1.07
D- Total stigma score	69(10-95)	64±18.1

Table 4: Table (4) shows that the median of **Discrimination subscale** in the younger age group 30year and below was found to be 25 compared to 24 in the older age group 50year and above and this is not statistically significant (kwχ2=0.6, p=0.7).

- The median in the patient with low education (Read write /primary/ preparatory) was found to be 28.5 compared to 24 in the patient with high education and this is statistically significant (kWχ2=9.1, p=0.03).

- The median of Disclosure subscale in the older age group 50 year and above was found to be 33 compared to 31 in the younger age group 30year and below and this is not statistically significant (kwχ2=3, p=0.2).

- The median in the female group was found to be 32 compared to 31 in the male group and this is statistically significant (Z= 2.1, p= 0.04).

- The median in the patient resides in rural area was found to be 32 compared to 28 in the patient resides in urban area and this is statistically significant (Z=2.1, p= 0.04).

- The median of Positive aspect subscale in the older age group 50 year and above was found to be 13 compared to 11 in the middle age group (30- 50 year) and this is statistically significant (kwχ2=6.5, p= 0.03).

- The median of the total stigma scale in the older age group 50year and above was found to be 72 compared to 68 in the middle age group (30- 50 year) and this is statistically significant (kwχ2=1.4, p= 0.05).

- The median in the patient who is (Divorced /Widow /Separated) was found to be 70 compared to 63 in the patient who is single and this is statistically significant (kwχ2=7.2, p=0. 02).

Table (4) Factors associated with stigma sub-domain and total scale

	Discrimination (D)Median (min-max)	Disclosure (DC) Median (min-max)	Positive aspect(P) Median (min-max)	Total stigma Median (min-max)
Age(years)				
<30	25(4-37)	31(1-40)	11.5(2-18)	68.5(18-90)
30-	25(0-40)	32(8-41)	11(0-20)	68(10-95)
50+	24(0-34)	33(16-42)	13(6-20)	72(34-87)
Significant test	kwχ2= 0.6 p=0.7	kwχ2= 3 p=0.2	kwχ2= 6.5p=0.03	kwχ2= 1.4p=0.05
Gender				
Male	27(0-40)	31(1-40)	11(0-20)	71.5(10-93)
Female	25(0-39)	32(13-42)	11(2-20)	67(32-95)
Significant test	Z= 1.1 p= 0.3	Z= 2.1 p= 0.04	Z= 0.4 p= 0.7	Z= 0.09 p=0.9
Residence				
Urban	27(0-40)	28(15-40)	11(0-20)	72(32-93)
Rural	25(0-39)	32(1-42)	11(0-20)	68(10-95)
Significant test	Z= 1.1 p= 0.3	Z= 2.1 p= 0.04	Z= 0.4 p= 0.7	Z= 0.02 p= 0.97
Education				
Illiterate	24.5(0-40)	24.5(0-40)	24.5(0-40)	71(10-92)
R& W /primary/prep	28.5(10-37)	28.5(10-37)	28.5(10-37)	72.5(37-90)
General/technical school	24(0-39)	24(0-39)	24(0-39)	67(18-95)
Higher education	24 (5-38)	24 (5-38)	24 (5-38)	70.5(33-93)
Significant test	kwχ2= 9.1p=0.03	kwχ2= 0.4 p=0.9	kwχ2= 6.6 p=0.09	kwχ2= 2.3 p=0.5
Marital status				
Single	23.5(1-38)	28(1-40)	11(0-18)	63 (18-90)
Married	25(0-39)	33(8-42)	12(0-20)	70(18-95)
Divorced/Widow/Separated	26(0-40)	31(8-40)	12(2-20)	70(10-93)
Significant test	kwχ2= 2.4 p=0.3	kwχ2= 0.6 p=0.7	kwχ2= 3.4 p=0.2	kwχ2= 7.2 p=0.02
Occupation				
Not working	25(0-40)	31.5(1-41)	31.5(1-41)	70(10-95)
Governmental Employee	26.5(0-40)	32(8-42)	32(8-42)	71.5(18-93)
Housewife	25(4-37)	32(10-40)	32(10-40)	71(27-90)
Manual Worker	21(0-37)	32(13-41)	32(13-41)	63(32-88)
Significant test	kwχ2= 3.9 p=0.1	kwχ2= 0.1 p=0.9	kwχ2= 1.4 p=0.5	kwχ2= 1.5 p=0.5
Smoking habits				
No	25(0-39)	32(1-42)	12(2-20)	68(18-95)
Yes	26(0-40)	30(8-40)	11(0-20)	70(10-93)
Significant test	Z= 1.1 p= 0.3	Z= 0.1 p= 0.9	Z= 0.5 p= 0.7	Z= 0.64 p= 0.5

(Continued)

	Discrimination(D) Median (min-max)	Disclosure (DC) Median (min-max)	Positive aspect(P) Median (min-max)	Total stigma Median (min-max)
Co morbidity				
No	25(0-39)	31(1-41)	11(0-18)	68(10-93)
Yes	25(0-40)	32(8-42)	12(0-20)	70.5(18-95)
Significant test	Z= 1.4 p= 0.2	Z= 0.9 p= 0.4	Z= 0.7 p= 0.5	Z= 1.4 p= 0.2
Family income				
Unsatisfactory	25(0-40)	31(1-41)	11(0-20)	69(10-92)
Satisfactory	24(4-39)	33(13-42)	11(5-20)	68(27-95)
Significant test	Z= 0.3 p= 0.8	Z= 1.3 p= 0.2	Z= 0.9 p= 0.4	Z= 0.6 p= 0.5
Diagnosis				
Schizophrenia	24(0-40)	31(8-42)	11(0-20)	70(10-93)
Mood disorder	26(5-40)	32(1-41)	11(0-18)	69.5(18-93)
Organic disorder	24(0-39)	32(13-40)	11(6-20)	61.5(34-95)
Significant test	kwχ2= 0.5 p=0.8	kwχ2= 0.7 p=0.7	Kwχ2= 1.1 p=0.6	kwχ2= 0.19 p=0.9
Treatment**				
1- Antipsychotic				
No	24(5-39)	32(1-40)	11(6-18)	64(18-93)
Yes	25(0-40)	31(8-42)	11(0-20)	70(10-95)
Significant test	Z= 1.8 p= 0.1	Z= 0.4 p= 0.7	Z= 0.2 p= 0.8	Z= 0.9 p= 0.4
2- Anti cholinergic				
No	24(0-40)	32(1-40)	11(2-20)	66(13-95)
Yes	25(0-40)	31(8-42)	11(0-20)	70(10-93)
Significant test	Z= 0.6 p= 0.5	Z= 0.2 p= 0.8	Z= 0.5 p= 0.6	Z= 0.23 p= 0.8
3- Anti manic				
No	25(0-40)	32(8-42)	12(0-20)	69.5(10-95)
Yes	25(0-40)	32(1-41)	11(0-17)	67(13-93)
Significant test	Z= 0.9 p= 0.9	Z= 0.04 p= 0.9	Z= 1.2 p= 0.2	Z= 0.1 p= 0.9
4- Antidepressant				
No	25(0-40)	31(8-42)	11(0-20)	67(10-93)
Yes	26.5(0-39)	32.5(1-40)	12(6-20)	70.5(18-95)
Significant test	Z= 0.3 p= 0.7	Z= 1.9 p= 0.1	Z= 1.3 p= 0.2	Z=1.1 p= 0.3
5- Anti anxiety				
No	25(0-40)	32(8-42)	11(0-20)	70(10-95)
Yes	25(0-40)	31.5(1-41)	11(2-18)	68(18-93)
Significant test	Z= 0.4 p= 0.7	Z= 0.1 p= 0.9	Z= 0.01 p= 0.9	Z= 0.3 p= 0.8
6- Anti convulsant				
No	25(0-38)	31(1-41)	12(0-18)	67(18-93)
Yes	25(0-40)	32(8-42)	11(0-20)	69.5 (10-95)
Significant test	Z= 0.9 p= 0.3	Z= 0.9 p= 0.3	Z= 1.4 p= 0.2	Z= 0.8 p= 0.4

Discussion:

The stigma associated with having a mental health problem can have a more profound impact than the mental health problem itself. The surgeon General of the United States stated that stigma is the most important problem facing the entire mental health field [8]. People with mental health problems are known to experience more stigma than those with other health problems [9]. The median of the total stigma scale in the older age group 50year and above was found to be higher compared to the middle age group (30- 50 year) and this is statistically significant. This from my point of view is due to duplication of mental illness with physical illness that need much care and much money to overcome it. This view is consistent to the hypotheses of

(Corcoran E) that says as age increased perceived dangerousness would increase. Also this result was consistent with Both World Health Organization (WHO) and World Psychiatric Association (WPA) who recognized that the stigma and discrimination attached to mental disorders are strongly associated with suffering and disability which jeopardize their role in society. Older people with mental disorders therefore carry a double burden which merits special attention. [10]&[11]

Mental disorders in old age are common; they are a source of massive burden and represent important costs for societies. This will increase dramatically with the ageing of populations. In this context, stigma remains a major obstacle to ensuring access to good care for older people with mental disorders [11]. and the result varies with the following point of view young people have more negative attitudes to mental health, it seems that young people with mental health problems are more likely to experience higher levels of stigma than adults[12].

Some studies revealed that young people have mental health problems because they are born with them. Unfortunately, what is also clear from research studies is that many people think that mental health problems are the fault of the person who has these difficulties. [13]. these attitudes are formed in early childhood, and even very young children hold negative attitudes toward mental health [8&9]. In the present study the median of total stigma revealed that the male gender is more than the female gender this is may be due to exposure of male gender to many stressful event than female and have special role in the community and this is consistent with the following point of view the gender of an individual provides information about the societal expectations of that individual, that is, the social roles they are expected to maintain and fulfill. Men and women both have different gender role expectations, which dictate how men and women are expected to act. Deviations from these gender role expectations, which are highly stereotyped, result in negative reactions and consequences [14]. Socially contrived gender roles significantly influence the public's impressions and beliefs about mental illness and labeling of abnormal behavior. Deviance from socially accepted, gender associated behavior is often viewed as abnormal and believed to be caused by a mental illness [14&15].

Additionally, research supports the greater tolerance towards mentally ill women, with findings that show women are less stigmatized, on

average, than men will the same mental illness [16]. This isn't consistent to the view of (Corcoran E; R.) [10] That says the relationship between gender and perceived dangerousness indicated that females would demonstrate more perceived dangerousness than the males would.

The current study reveal that the median of total stigma is higher in the urban area than in rural area this may be due to isolation of each family and decrease rapport and feeling between them so the patient is seen as a shame for all of the family and this isn't agree with the following point of view Mental health and mental disorders are serious problems in rural areas. These problems are reflected in the frequent failure to identify such conditions early on, lack of access to mental health professionals to treat such conditions, and the tremendous consequences of mental illness for treatment of physical illnesses and for day-to-day life. Mental health needs occur among men, women, and children of all ages, ethnic groups, and social backgrounds. Some of these groups appear particularly disadvantaged in rural areas in gaining necessary treatment. Among these groups experiencing rural disparities are children, the poor, the elderly, and African Americans and other minority groups. [17]

The median in the patient with low education (Read write /primary/ preparatory) was found to be high compared to the patient with high education this mean that patient with low education is highly stigmatized this may be due to patient with low education is highly exposed to be looked down on them and feeling of inferiority may enhance this experience and decrease knowledge also affect persons feeling of their dignity, humanity and intellectuality and this view consistent to the view of (Corcoran E; R) [10] that say As knowledge and education increase social distance and perceived dangerousness decrease. Significant positive correlations were found between social distance and perceived dangerousness, and between familiarity and knowledge. This suggests that as knowledge of mental illness increases familiarity increases and as social distance increases so does perceived dangerousness.

The median in the patient who is (Divorced /Widow /Separated) was found to be high compared to the patient who is single and this is statistically significant this is may be due to the social problem they suffer from is burdensome and they may feel distress that increase feeling of stigma This view isn't harmonious with the results of the study by (Mahmoud N) [18] as married subjects in her study felt

less self stigma this may be because married patients felt supported by their partners. Another finding by (Bean et. al) [19] who reported that the partners of schizophrenic patients may negatively evaluate the patients as it may reflect that the behavior of the ill person is burdensome and they may feel distress from their partners' symptoms, lowered social performance, and work problems,; therefore they feel more inner stigma. The median in the patient who suffer from schizophrenia was found to be high compared to the patient with organic mental disorder this means that patient with schizophrenia suffer high stigma than others this may be due to the disruptive behavior the schizophrenia causes that give the appearance of abnormality and bizarreness and this is consistent to the view of (Connolly, T) [20] that say that Perceptions of dangerousness have been found to be allied with a particular increase in fear of people with schizophrenia, and also more anger and less pity [21,22,23,24.2526,27,28&29]

People who reported fear were consistently more likely to desire social distance from people with mental health problems [30,23,25,26,28,31] The evolutionary function of fear has also been highlighted in encouraging greater distance from people who may act unpredictably[32]

Recommendation:

Based on the study results, it is evident that the stigma of mental illness needs strong interventions for mitigation of its effects. The following is recommended:

1- Increasing public awareness about the harmful consequences of mental illness stigma is needed through mass media, taking into consideration the predisposing factors identified in the present study and how to attach patient with their treatment plan and raising his self esteem.

2-Planning and implementation of public health awareness programs to raise the orientation toward the nature of psychiatric disorders, these programs should reach all social classes and cultures in: schools, universities, social clubs, religious institutions, and mass media.

3-Mass media should exert role in destigmatization of psychiatric patients and psychiatric illness as well.

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