Stigma towards people with psychiatric disorders

WWS Mak *, FMC Cheung, SYS Wong, WK Tang, JTF Lau, J Woo, DTF Lee

KEY MESSAGES

1. Doctors had the greatest and social workers had the lowest social distance from five disorder groups. Social work students had significantly greater social distance from people with bipolar disorder and schizophrenia than nursing students. People with more severe psychiatric disorders (schizophrenia, bipolar disorder, comorbid psychiatric disorders) had greater self-stigma towards themselves, compared with people having depression or alcohol dependence.
2. Based on the common sense model, professionals' perception of psychiatric disorders contributed to the formation of negative attitude that affected their prognostic predictions and reduced their endorsement of recovery-oriented practice for specific psychiatric disorders.
3. People with psychiatric disorders (schizophrenia, bipolar disorder, depression, alcohol and drug dependence) were adversely affected by public and professional discrimination. Their experienced discrimination and negative perceptions of mental health services reduced their engagement with therapeutic services, intensified their self-stigma, and led to poorer recovery.

Hong Kong Med J 2015;21(Suppl 2):S9-12
SMH project number: SMH-14

[1] WWS Mak *, [1] FMC Cheung, [2] SYS Wong, [3] WK Tang, [2] JTF Lau, [4] J Woo, [4] DTF Lee

[1] *Department of Psychology, The Chinese University of Hong Kong*
[2] *School of Public Health and Primary Care, The Chinese University of Hong Kong*
[3] *Department of Psychiatry, The Chinese University of Hong Kong*
[4] *Faculty of Medicine, The Chinese University of Hong Kong*

* Principal applicant and corresponding author: wwsmak@psy.cuhk.edu.hk

Introduction

Psychiatric disorders (such as schizophrenia, bipolar disorder and depression, alcohol and drug dependence) increase years of life with disability. People with psychiatric disorder often are reluctant to seek help, as they experience stigma while visiting medical or human services. Stigma refers to the endorsement of prejudicial attitudes, negative emotional responses, discriminatory behaviour, and biased social structures towards a subgroup.[1] Stigma not only delays or reduces adherence to treatment and increases dropouts, it also contributes to increased self-stigma and poorer psychosocial outcome.[2]

Nursing and medical students, nurses, and doctors were found to have greater levels of stigma and less optimistic prognoses towards people with psychiatric disorders than the general public. Nurses in Beijing and nursing students in Hong Kong also reported greater social distance from people with psychiatric disorders. In Hong Kong, most studies were confined to schizophrenia and depression; no study examined underlying mechanisms of stigma from professionals.

The common sense model (CSM) was used to demonstrate how individual perception of psychiatric disorders impacts the way such illness is appraised.[3] Development of stigma is related to prognostic decisions of the professionals and students, and service engagement and recovery outcomes of people with psychiatric disorders.

This study aimed to (1) examine the illness perceptions and extent of stigma among students and professionals towards five types of psychiatric disorder; (2) apply the CSM to professionals and students by testing the effects of their illness perceptions on their attitudes, prognostic predictions, and management decisions towards people with psychiatric disorders, accounting for their recovery knowledge; (3) examine the extent of self-stigma[4] among people with psychiatric disorders and to test how their experienced discrimination by professionals and the public and their perceived service orientation of the professionals may impact their self-stigma, service engagement, and recovery, controlling for their symptom severity; and (4) apply the CSM to people with psychiatric disorders by testing the effects of their own illness perceptions on their self-stigma and recovery. This study enabled development of a conceptual model of stigma to explain stigma formation and the impact of stigma on treatment decisions and patient recovery.

Methods

This study was conducted from August 2010 to July 2012. Informed consent was obtained from each participant. A total of 1143 students (mean±standard deviation [SD] age, 22±4 years) of various social work, nursing, and medical programmes were recruited through mass e-mails (78%, 78%, and 53% were females respectively) and randomised to two of the five vignettes describing schizophrenia (n=440),

bipolar disorder (n=434), depression (n=470), alcohol dependence (n=478), or drug dependence (n=464). In addition, 3064 registered professionals (mean±SD age, 38±10 years) from the respective programmes (73%, 88%, 41% were females respectively) were recruited from three waves of invitation mails and randomised to one of the five vignettes in the numbers of 607, 641, 556, 634, and 626, respectively. A HK$50 coupon was given upon receipt of a completed questionnaire. The overall response rate for professionals was 16%, compatible with other surveys.[5] Upon reading the vignette, respondents were asked to rate their perceived causes, timeline, consequence, personal and treatment control, illness coherence, and emotional representations of the depicted character's disorder based on the CSM and to complete a set of questionnaires.

A total of 376 patients (mean±SD age, 43±13 years) with schizophrenia (n=73), bipolar disorder (n=60), depression (n=75), alcohol dependence (n=60), drug dependence (n=60), or comorbid diagnoses (n=48) for a mean±SD of 7±8 years were recruited from public specialist out-patient clinics and substance abuse assessment clinics and asked to complete a self-report questionnaire. Upon completion, a HK$100 coupon was given.

For professionals and students, the questionnaires included Brief Illness Perception Questionnaire, Perceived Devaluation and Discrimination Scale, Social Distance Scale, Psychosocial Outcome scale, a self-developed recovery-oriented case management scale, and the Recovery Knowledge Inventory. For people with psychiatric disorders, the questionnaires included Brief Illness Perception Questionnaire, Perceived Devaluation and Discrimination Scale, Social Distance Scale, Self-Stigma Scale, Service Engagement Scale, Behaviour and Symptom Identification Scale, Life Satisfaction Scale, and the Recovery Markers Questionnaire.

Results

Social distance of professionals from disorder groups

Multivariate analysis of variance was used to examine the social distance of professionals from the five disorder groups. Doctors consistently showed the greatest and social workers the least social distance from the five disorder groups. Social work students exhibited significantly greater social distance from people with bipolar disorder or schizophrenia than nursing students (Table 1).

Student and professional perceptions and devaluation model for people with psychiatric disorders

Structural equation modelling was used to evaluate the association of students' and professionals' perception of psychiatric disorders with their attitude, prognostic prediction, and service orientation. The model was a satisfactory fit for students ($\chi^2(896)=2116.90$, $P<0.001$, CFI=0.92, TLI=0.91, RMSEA=0.06, Fig 1) and an excellent fit for professionals ($\chi^2(528)=747.61$, $P<0.001$, CFI=0.96, TLI=0.95, RMSEA=0.05, Fig 1). Students' perception of psychiatric disorders negatively affected the prognostic prediction for people with psychiatric disorders through devaluation. Professionals' perception of schizophrenia influenced their attitude towards people diagnosed with schizophrenia and further affected their service direction and prognostic prediction for these individuals.

Self-stigma of people with psychiatric disorders and their social distance from health care professionals

For people with psychiatric disorders, self-stigma and perceived devaluation and social distance from professionals were evaluated using multivariate analysis of variance. Compared with patients with alcohol dependence, patients with depression or bipolar disorder perceived significantly less social distance from health care professionals. Regarding self-stigma, people with more severe psychiatric disorders (schizophrenia, bipolar disorder, or more than one psychiatric disorder) experienced a greater level of self-stigma towards themselves, compared with people with depression or alcohol dependence (Table 1).

Stigma model on service engagement and recovery

Structural equation modelling was used to examine the pathways through which discrimination by general public and professionals impedes patient service engagement and recovery ($\chi^2(243)=651.14$, $P<0.001$, CFI=0.92, TLI=0.91, RMSEA=0.07, Fig 2). The model demonstrated the adverse impact of discrimination by the public and professionals. In particular, negative perception of recovery orientation of mental health services and discrimination reduced service engagement, intensified self-stigma, and hampered recovery of patients.

Common sense model on self-stigma and recovery

Structural equation modelling was used to investigate how illness perception of people with psychiatric disorders can affect their self-stigma and recovery. The model was a satisfactory fit ($\chi^2(61)=173.15$, $P<0.001$, CFI=0.94, TLI=0.92, RMSEA=0.07, Fig 3). Specifically, people who viewed their psychiatric disorders as having long-term negative consequences and experienced negative emotional response to their psychiatric disorders were more likely to report self-stigma that hampered recovery.

TABLE 1. (a) Professionals' and students' social distance from patients with psychiatric disorders, and (b) perceived stigma and self-stigma among people with psychiatric disorders

(a)

Diagnosis in vignette	Professionals			Students		
	No.	Mean±SD Social Distance Scale score	Significant difference between groups (P<0.001)	No.	Mean±SD Social Distance Scale score	Significant difference between groups (P<0.001)
Bipolar disorder			Medical, nursing > social work			-
Nursing	228	2.56±0.05		176	1.98±0.06	
Social work	144	2.10±0.06		191	2.20±0.05	
Medical	208	2.70±0.05		67	2.22±0.09	
Depression			Medical, nursing > social work			-
Nursing	209	2.33±0.05		203	1.83±0.05	
Social work	150	1.89±0.05		207	1.98±0.05	
Medical	149	2.41±0.06		60	1.90±0.09	
Alcohol dependence			Medical > nursing > social work			-
Nursing	253	2.71±0.05		204	2.48±0.05	
Social work	148	2.36±0.06		208	2.58±0.05	
Medical	168	3.01±0.05		65	2.62±0.10	
Drug dependence			Medical, nursing > social work			-
Nursing	231	2.97±0.05		184	2.79±0.06	
Social work	160	2.38±0.05		217	2.95±0.05	
Medical	186	3.11±0.05		62	2.95±0.10	
Schizophrenia			Medical > nursing > social work			Social work > nursing
Nursing	186	2.65±0.05		203	2.31±0.05	
Social work	154	2.23±0.05		185	2.57±0.06	
Medical	201	2.82±0.05		52	2.39±0.11	

(b)

Perceived stigma and self-stigma	People with psychiatric disorders		
	No.	Mean±SD score	Significant difference between groups (P<0.001)
Perceived discrimination and devaluation		Strongly disagree=1 to strongly agree=6	
Schizophrenia and other psychotic disorders	73	3.32±0.11	-
Depression	75	3.02±0.12	-
Bipolar disorder	60	3.00±0.13	-
Drug dependence/abuse	60	3.15±0.13	-
Alcohol dependence/abuse	60	3.05±0.13	-
Co-morbidity	48	3.31±0.14	-
Social distance with health professionals		Strongly disagree=1 to strongly agree=4	
Schizophrenia and other psychotic disorders	73	2.62±0.09	-
Depression	75	2.45±0.09	Alcohol dependence/abuse > depression
Bipolar disorder	60	2.41±0.10	Alcohol dependence/abuse > bipolar disorder
Drug dependence/abuse	60	2.62±0.10	-
Alcohol dependence/abuse	60	2.73±0.10	Alcohol dependence/abuse > Depression, bipolar disorder
Co-morbidity	48	2.54±0.11	-
Self-stigma		Strongly disagree=1 to strongly agree=4	
Schizophrenia and other psychotic disorders	73	2.68±0.08	Schizophrenia > depression, alcohol dependence/abuse
Depression	75	2.43±0.08	-
Bipolar disorder	60	2.56±0.09	Bipolar disorder > alcohol dependence/abuse
Drug dependence/abuse	60	2.49±0.09	-
Alcohol dependence/abuse	60	2.30±0.09	-
Co-morbidity	48	2.55±0.10	Co-morbidity > alcohol dependence/abuse

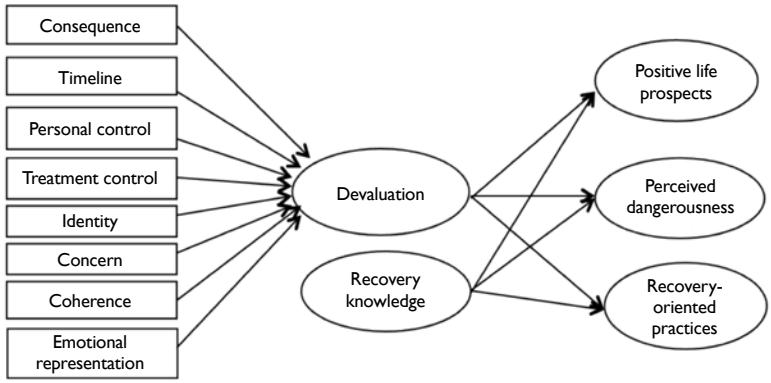

FIG 1. Professionals' and students' perception and devaluation model for people with psychiatric disorders

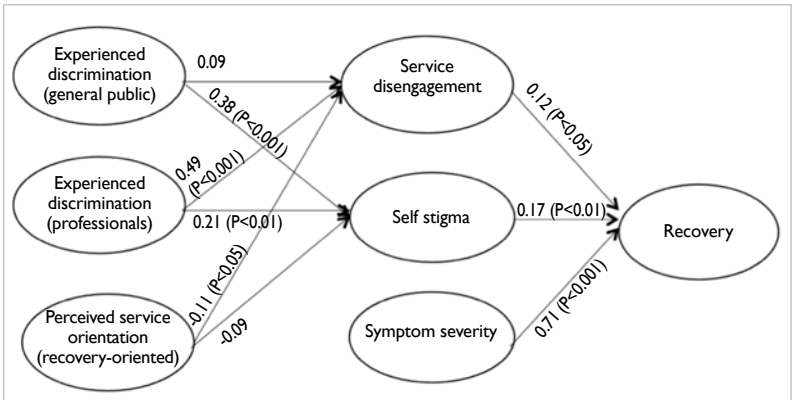

FIG 2. Model of experienced discrimination on self-stigma, service engagement, and recovery among people with psychiatric disorders

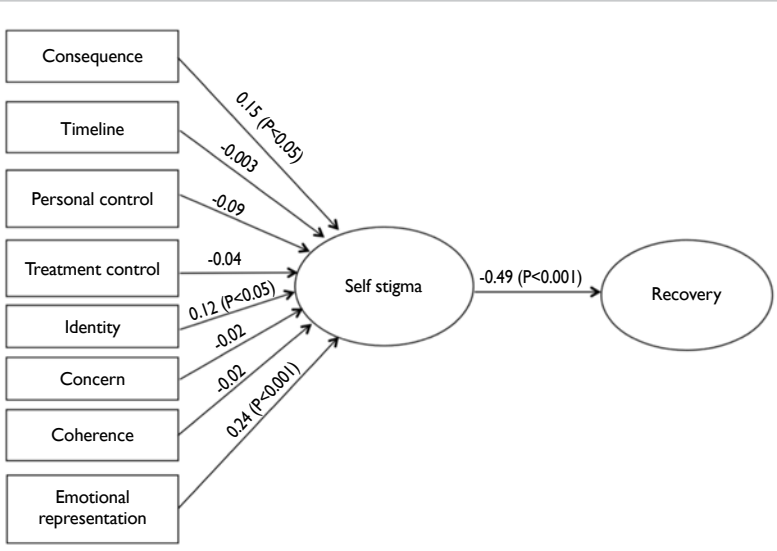

FIG 3. Common sense model of self-stigma and recovery for people with psychiatric disorders

Discussion

The CSM was an effective framework to understand the possible formation of negative attitudes among professionals, students, and people with psychiatric disorders. This study provided evidence of the need for anti-stigma campaigns in Hong Kong. Self-stigma reduction programmes are recommended to mitigate the effects that public stigma and experienced discrimination have on patient service engagement and recovery.

Having contact with people with psychiatric disorders has been the most successful means of stigma reduction. Nonetheless, for professionals and students, repeated exposure to people with chronic and recurrent psychiatric disorders may foster a negative attitude. The Department of Health and Human Services of the United States promotes the concept of consumer-defined recovery; people with psychiatric disorders demonstrate their achievement, strengths, and humanity through the pursuit of personally meaningful lives despite the limitations imposed by the illness. Unlike the traditional disease-oriented recovery framework that focuses on symptom reduction and functional capacity restoration, consumer-defined recovery emphasises the recovery process in which people with psychiatric disorders redefine themselves and strive to positively adapt to their illness. Continuing education and teaching of a more holistic and positive view of people with psychiatric disorders can better prepare professionals and students to serve people with varying psychiatric needs.

Acknowledgements

This study was supported by the Hospital Authority, Hong Kong SAR, China (SMH-14). We express our sincere gratitude to the hospitals / professional associations for facilitating the recruitment of eligible participants from their service users/members.

References

1. Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. Clin Psychol Sci Practice 2000;9:35-53.
2. Royal College of Psychiatrists. Mental illness: stigmatization and discrimination within the medical profession. London: British Medical Association; 2001.
3. Leventhal H, Diefenbach M, Leventhal EA. Illness cognition: using common sense to understand treatment adherence and affect cognition interactions. Cog Ther Res 1992;16:143-63.
4. Corrigan PW. The impact of stigma on severe mental illness. Cogn Behav Pract 1998;5:201-22.
5. Leung GM, Ho LM, Chan MF, Johnston JM, Wong FK. The effects of cash and lottery incentives on mailed surveys to physicians: a randomized trial. J Clin Epidemiol 2002;55:801-7.