**ORIGINAL ARTICLE:**

**STIGMA TOWARDS PATIENTS WITH MENTAL ILLNESS AMONG POSTGRADUATE TRAINEES OF A TERTIARY CARE HOSPITAL**

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**ABSTRACT:**

**Objective**

To assess stigmatizing attitude by using “Community Attitudes Towards Mental Illness” (CAMI) subscale scores toward patients with mental illness among postgraduate trainees of a tertiary care facility.

Study Design

Descriptive Cross sectional study.

**Place and duration of study**

This study was conducted at Jinnah Postgraduate Medical Centre, Karachi, from December to June 2019.

**Methods**

A total number of 110 of FCPS Postgraduate Trainees working in different departments of JPMC were selected. Study variables like age, gender, marital status, speciality, year of training, total duration of clinical experience, experience of working in psychiatry department, family and personal history of psychiatric illness were collected through semi-structured proforma and stigma was assessed by “Community Attitudes Towards Mental Illness” (CAMI) scale which had four sub scales: Authoritarianism, Benevolence, Social Restrictiveness and Community Mental Health Ideology (CMHI).

**Results**

110 doctors participated in the study. We found 30.9% stigma among postgraduate trainees. Female postgraduate trainees and trainees with personal histories of psychiatric illness displayed lower levels of stigma compared to those without such experiences.

**Conclusion**

This study underscores the presence of stigma towards patients with mental illness among postgraduate trainees. The findings emphasise the need for targeted interventions and training programs to promote empathy and understanding among future healthcare professionals. By addressing specific dimensions of stigma, a supportive environment can be fostered, facilitating the delivery of high-quality care to individuals with mental health conditions.

**Keywords**

Authoritarianism; Beneficence; Community Attitudes Towards Mental Illness (CAMI) scale; Empathy; Stereotyping; Stigma.

**INTRODUCTION**

Stigma can be defined in many ways as there is no commonly approved definition of it 1. However, it can be defined as a characteristic regarded as a highly unpleasant, degraded reaction. It discriminates the criticized individuals from other members of the community where they reside. It is a process by which the response of others destroys normal identity2.

Stigma towards mental illness is still prevalent in many parts of the world. These stigmatizing attitudes include discrimination, prejudice, stereotyping and maintaining a social distance from people with mental illness. Such attitudes extend from the convictions that all psychiatric patients are threatening and need to be avoided and disconnected from society 3. Stigmatization occurs globally and is prevalent not only among the public but even among healthcare professionals4. Individuals seeking help for their mental illness issues experience feeling "patronized, punished and humiliated" in their communication with health care providers5. Various studies showed that physical symptoms of psychiatric patients are misattributed to their mental illness by medical professionals, which results in rejection and refusal of treating these patients in a medical setting. This discrimination by the hands of health care professionals causes a delay in diagnosis and treatment, resulting in the poorer physical care of these patients. 6Literature suggested that 64.1% of doctors have high social distance and stigma against mentally unwell patients7. Previous study showed stigma among doctors by using sub scales of Community Attitude Towards Mental Illness (CAMI) scales. In the subscale, the Authoritarianism mean score was 2.47 with S.D ±0.55; in the Benevolence, the subscale mean score was 3.95 with S.D ±0.47; in the social restrictiveness mean score was 2.24 with S.D ±0.39, and in subscale community mental health ideology mean 3.78 with S.D ±0.43.8.

Among health professionals, postgraduate trainees are the influential group to target in studying attitudes towards patient with mental illness. They experience these patients during training and hold biased thoughts and attitudes towards psychiatric patients. However, in the initial years of training, attitudes and perspectives regarding psychiatric illness are flexible but become fixed as the individual progresses through medical education and residency training9-11. As future specialists, they will be compelling in forming the culture of medicine. Their responses, or need, to episodes of stigmatizing behaviour or attitude, will demonstrate to others what doctors consider being proper behaviour.

Therefore, the aim of the proposed study was to determine the stigmatizing attitude harboured by postgraduate trainees toward patients with mental illnesses in different fields of specialization and to find out whether the field of specialization, the experience of working in psychiatry and having a family member with psychiatric illness and a personal history of psychiatric illness affect these attitudes.

**METHODS**

**Participants**

A Cross-sectional observational study design was used to address the objective of the study. Non probability convenience sample was used. Using WHO calculator the sample size for this study was estimated to be 110 by keeping mean score of subscale benevolence 3.95 with S.D±0.478, confidence interval at 95% and absolute precision at 0.10% and non-respondent rate at 10%. Data was collected from different departments of Jinnah Postgraduate Medical Centre. The sample population consisted of FCPS postgraduate Trainees working in different departments of JPMC irrespective of the year of training after giving consent. Resident medical officers who are not enrolled in FCPS postgraduate training programs were excluded from the sample.

**Instruments**

Demographic variables like age, gender, department, year of training, total duration of clinical experience, experience of working in psychiatry department, family and personal history of psychiatric illness were collected through semi-structured proforma and stigma was assessed by Community Attitude Towards Mental Illness Scale (CAMI) by the investigator. The CAMI scale has four subscales, which are as follows.

 1. Authoritarianism: reflects the notion that individuals with mental illness are seen as an inferior group requiring forceful handling. It involves assessing attitudes towards the necessity of hospitalizing those with mental illness, the differentiation between individuals with mental illness and those without, and the perceived significance of custodial care.

 2. Benevolence: reflects humanistic and religious principles, displaying a compassionate outlook towards individuals suffering from mental illness. It emphasizes society's obligation to support those experiencing mental illness, the importance of empathetic and kind attitudes, and a willingness to personally engage and provide assistance.

3. Social Restrictiveness: This view considers individuals with mental illness as a potential threat to society. It encompasses beliefs regarding the perceived danger associated with mental illness, the need to maintain social distance, and the belief that those with mental illness bear limited responsibility for their actions.

4. Community Mental Health Ideology (CMHI): reflects a view that recognizes the therapeutic value of the community and acceptance of de-institutionalized care (Taylor and Dear 1981).13

The higher the mean score on Authoritarianism and Social restrictiveness subscale shows more stigmatizing attitude and reverse holds for Benevolence and CMHI subscale. This scale consisted of 40 statements with a Likert scale type of response (1 = strongly disagree to 5 = strongly agree). Each subscale comprises 10 items with 5 positively scored and 5 negatively scored items. Scores were reversed on negatively scored items. Score of each subscale was calculated by adding the ten relevant items and then dividing by ten to obtain a mean score for each of the four factors. The maximum score for each subscale was 50. Participant said to have stigmatizing attitude if he scores more on the Authoritarianism and Social restrictiveness subscale and less on Benevolence and Community Mental Health Ideology (CMHI) subscale.

**Procedure**

Ethical approval was sought from the Institutional review board. Written Informed consent was obtained from the trainees after informing them about the purpose of study. They were assured of confidentiality, especially regarding their identities; they were allowed to withdraw at any point in study without mentioning the reason, and any other ethical issue regarding participant’s confidentiality, or else, was handled according to the international guidelines.

The data collected were analysed using computer package SPSS (Statistical Packages of Social Sciences) version 22.0. Mean and standard deviation (SD) were computed for quantitative variables (Age, total duration of clinical experience and score of CAMI subscale). Frequency and percentage were calculated for stigma and qualitative variables like (Gender, marital status, name of specialty, year of training, working experience in psychiatry department, personal and family history of psychiatric illness). Stratification of stigmatising attitude by using CAMI sub scale scores with respect to age, gender, marital status, year of training, specialty, total duration of clinical experience, working experience in the psychiatry department, personal and family history of psychiatric illness was done. Post Stratification T-test / ANOVA was applied to find out the difference. P-value ≤0.05 was taken as significant.

**RESULTS**

Around 110 doctors participated in the study. There were 66 (60%) males and 44 (40%) female participants. The mean age of doctors was 31.08±2.91 years with 4.16±1.46 years of clinical experience. On frequency of marital status, there were 60 (54.5%) who were not yet married, 47 (42.7%) were married and 03 (2.7%) were divorced. On their chosen field of specialisation, 54 (49.1%) participants had a specialty in medicine, 35 (31.8%) in surgery, 16 (14.5%) had a speciality in psychiatry and 5 (4.5%) in radiology. Data on year of training showed 21 (19.1%) were in their first year of training, 13 (11.8%) were in the second year, 27 (24.5%) were in the third year, 41 (44.5%) were in the fourth year of training. There were 79 (71.8%) out of 110 participants who had working experience in the psychiatry department. There were 13 (11.82%) participants who had a family history of psychiatric illness and 97 (88.18%) had no family history of psychiatric illness. There were 09 (8.2%) participants who had a personal history of psychiatric illness and 101 (91.82%) had no family history of psychiatric illness.

**TABLE 1**

**Socio-demographic data of Postgraduate Trainees (N=110)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Demographic variables** |  | **N** | **%** |
| Gender | Male | 44 | 40 |
| Female | 66 | 60 |
| Marital status | Married | 60 | 54.5 |
| Unmarried | 47 | 42.7 |
| Divorced | 3 | 2.7 |
| Field of Specialization | Medicine  | 54 | 49.1 |
| Surgery | 35 | 31.8 |
| Psychiatry | 16 | 14.5 |
| Radiology | 5 | 4.5 |
| Working experience in psychiatry department | Yes | 79 | 71.8 |
| No | 31 | 28.2 |
| Personal History of psychiatric illness | Yes | 9 | 8.2 |
| No | 101 | 91.8 |
| Family History of psychiatric illness | Yes | 13 | 11.8 |
| No | 97 | 88.1 |
| Year of training | First Year | 21 | 19.1 |
| Second year  | 13 | 11.8 |
| Third Year | 27 | 24.5 |
| Fourth Year | 41 | 44.5 |

Table 2 displays the score of CAMI subscales. Stigma was present in 34 (30.9%) participants. Stratification was also performed on the basis of age, gender, marital status, speciality, working experience in the psychiatry department, personal and family history of psychiatric illness, year of training and total duration of clinical experience. There was a statistically significant difference between the benevolence subscale of CAMI and duration of clinical experience. Those with clinical experience of 1-4 years had higher benevolence score than those who had clinical experience of 4-8 years.

**TABLE 2**

**Community attitude towards mental illness sub scale scores**

|  |  |  |
| --- | --- | --- |
| **Authoritarianism** | Mean | 3.03 |
| S.D. | +/-1.15 |
| **Benevolence** | Mean | 5.06 |
| S.D. | +/-2.48 |
| **Social Restrictiveness** | Mean | 4.51 |
| S.D. | +/-1.61 |
| **Community Mental Health Ideology (CMHI)** | Mean | 4.84 |
| S.D. | +/-2.21 |

**TABLE 3**

**Stratification of total duration of clinical experience to determine the association of total duration of clinical experience with CAMI sub scale scores.**

|  |  |  |
| --- | --- | --- |
| **CAMI Sub Scale Score** | **Total Duration of Clinical Experience** | **P-value** |
| **1-4 Years** | **4-8 Years** |
| **Authoritarianism** | Mean | 3.15 | 2.87 | 0.200 |
| S.D. | +/-1.29 | +/-0.92 |
| **Benevolence** | Mean | 5.49 | 4.48 | 0.035 |
| S.D. | +/-2.58 | +/-2.23 |
| **Social Restrictiveness** | Mean | 4.7 | 4.19 | 0.066 |
| S.D. | +/-1.67 | +/-1.48 |
| **Community Mental Health Ideology (CMHI)** | Mean | 4.96 | 4.68 | 0.504 |
| S.D. | +/-2.1 | +/-2.37 |

There were statistically significant difference in benevolence and community mental health ideology subscale between genders. Female gender has higher scores on Benevolence and Community Mental Health Ideology subscale than males, which showed female has more positive attitude towards mental illness. (Table 4)

**Table 4**

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**Stratification of gender to determine the association of gender with CAMI sub scale scores.**

|  |  |  |
| --- | --- | --- |
| **CAMI Sub Scale Score** | **Gender** | **P-value** |
| **Male** | **Female** |
| **Authoritarianism** | Mean | 3.06 | 3.00 | 0.789 |
| S.D. | +/-1.10 | +/-1.23 |
| **Benevolence** | Mean | 4.57 | 5.79 | 0.011 |
| S.D. | +/-2.48 | +/-2.29 |
| **Social Restrictiveness** | Mean | 4.31 | 4.81 | 0.112 |
| S.D | +/-1.68 | +/-1.46 |
| **Community Mental Health Ideology (CMHI)** | Mean | 4.42 | 5.47 | 0.011 |
| S.D. | +/-2.32 | +/-1.91 |

Results indicated that CAMI subscale measuring social restrictiveness significantly associated with personal history of psychiatric illness. Those who had no personal history of psychiatric illness had higher social restrictiveness score than those who had personal history of psychiatric illness. (Table 5)

**Table 5**

**Stratification of personal history of psychiatric illness to determine the association of personal history of psychiatric illness with CAMI sub scale scores.**

|  |  |  |
| --- | --- | --- |
|  **CAMI Sub Scale Score** | **Personal History of Psychiatric Illness** | **P-value** |
| **Yes** | **No** |
| **Authoritarianism** | Mean | 3.22 | 3.01 | 0.617 |
| S.D. | +/-1.71 | +/-1.10 |
| **Benevolence** | Mean | 4.44 | 5.11 | 0.437 |
| S.D. | +/-3.28 | +/-2.40 |
| **Social Restrictiveness** | Mean | 3.77 | 4.58 | 0.009 |
| S.D. | +/-0.66 | +/-1.65 |
| **Community Mental Health Ideology** | Mean | 4.11 | 4.91 | 0.302 |
| S.D. | +/-2.47 | +/-2.19 | 0.302 |

Results showed that CAMI subscale scores did not significantly differ across age, specialization, year of training, age, working experience in psychiatry department and family history of psychiatric illness( all p-values >0.05).

**DISCUSSION**

In our study, we found 30.9% stigma among postgraduate trainees towards patient with psychiatric illness using CAMI questionnaire which was similar with the study done by Chandramouleeswaran et al. which revealed 30% stigma 12 . Finding of our study showed a statistically significant difference in benevolence and community mental health ideology subscale between genders. Female gender has higher scores on Benevolence and Community Mental Health Ideology subscale than males, which showed female has more positive attitude towards mental illness. Previous research also found men having more stigmatizing attitude than women as they showed less compassion towards people with mental illness 13.

Our results showed doctors with higher clinical experience had a less score on the benevolence sub-scale. Benevolence sub scale reflects a sympathetic view of those suffering from a mental illness based on humanistic and religious principles. This is in line with Mukherjee et al. which revealed that clinical students showed less stigmatizing attitudes to that of junior doctors and senior doctors14. We found no significant difference between positive family history and stigmatizing attitude. However, Personal history of psychiatric illness is associated with less score on social restrictiveness which reflects a view of mentally ill as a threat to society. This is contrast to the previous studies which shows having a positive family history reduced the stigma and suffering personally from it heightened the stigma 15-18.

The study exhibits several strengths, employing the widely recognized and validated "Community Attitudes Towards Mental Illness" (CAMI) scale, the study ensures the use of a standardized measurement tool. Furthermore, the study explores the impact of variables like clinical experience, gender, and personal/family history of psychiatric illness on stigmatizing attitudes, thereby identifying influential factors for targeted interventions and training programs. However, limitations of the study include its cross-sectional design, which hinders establishing causal relationships, and the single-centre setting, potentially limiting generalizability. Reliance on self-reported data may introduce response biases, and convenience sampling might lead to selection bias. The study also overlooks other relevant factors, such as cultural background. Future research could address these limitations to provide a more comprehensive understanding of stigma in healthcare settings.

**CONCLUSION**

The findings of this study revealed the presence of stigmatizing attitudes among a significant proportion of postgraduate trainees. Specifically, the results indicated a tendency towards authoritarianism and social restrictiveness, suggesting a need for interventions to address these negative attitudes. However, benevolence scores were relatively higher, indicating a positive inclination towards supporting and helping individuals with mental illness.

While these findings highlight the existence of stigma, it is important to note that postgraduate trainees are at a critical stage of their medical education and training. Therefore, targeted interventions and training programs can play a pivotal role in shaping their attitudes and promoting patient-centred care. It is recommended that future research explores the factors contributing to stigmatizing attitudes among postgraduate trainees and evaluates the effectiveness of interventions aimed at reducing stigma.

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19. **UNDERTAKING STATEMENT**

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| --- | --- | --- | --- | --- |
| Sr. # | Author Name | Affliation of Author | Contribution | Signature |
| 01 | Aliya Khan | JPMC | Conception and design | https://o.remove.bg/downloads/60624c47-ddeb-4e82-a207-b3e80c9c34de/image-removebg-preview.png |
| 02 | Darshana Kumari | JPMC | Analysis and interpretation of data | C:\Users\Surface\Downloads\WhatsApp Image 2023-03-10 at 1.57.10 PM.jpeg |
| 03 |  Muhammad Ayub | JPMC | Drafting of the article | C:\Users\Surface\Downloads\WhatsApp Image 2023-03-10 at 2.57.50 PM.jpeg |
| 04 | Muhammad Ali Imtiaz | Medecins Sans Frontieres | Critical Revision of the article  |  |
| 05 | Muhammad Shaheryar Ali | JPMC | Statistical expertise |  |
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