

Original Research Article

Stigma among doctors towards people with mental illness

Bishnu Sharma, Harshavardhan Sampath*, Geeta Soohinda, Sanjiba Dutta

Department of Psychiatry, Sikkim Manipal Institute of Medical Sciences, Sikkim Manipal University, Sikkim, India

Received: 23 October 2018

Accepted: 30 November 2018

***Correspondence:**

Dr. Harshavardhan Sampath,

E-mail: drharsha79@yahoo.co.in

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Stigma towards adults with mental illness is a longstanding and widespread phenomenon. Stigmatizing attitudes are prevalent not only among the general population but also among doctors. Negative stereotyping of people with mental illness (PMI) leads to prejudice and discrimination, affecting all aspects of their medical care and well-being. The present study attempted to explore stigmatizing attitudes among doctors towards PMI.

Methods: The research was observational and cross-sectional in design carried out on doctors in a medical college. Socio-demographic data including field of specialization, experience, and academic post were recorded. The community attitudes towards mental illness (CAMI) and social distance scale were administered. Social desirability bias was corrected for by using the Marlowe-Crowne social desirability scale.

Results: Around 54 doctors from the specializations of medicine (n=24), surgery (n=19), and non-clinical fields (n=11) participated. We found no significant differences in attitudes towards mentally ill and social distance between medical specializations (p-values >0.05) even after adjusting for the effects of social desirability bias. Years of specialization experience (p=0.037) and having a family member or close friend with mental illness (p=0.012) were significantly associated with higher scores in the community mental health ideology sub-scale of CAMI. Higher social restrictiveness (p=0.014) and lower community mental health ideology (p=0.008) were associated with greater social distance from PMI.

Conclusions: Doctors are not immune to biases and stigmatizing attitudes towards PMI. These attitudes are present across all fields of medical specialization and must be addressed by mental health professionals to ensure optimal care of this vulnerable population.

Keywords: Attitudes, Mentally ill, Social distance, Stigma

INTRODUCTION

Stigma has been defined as the negative effect of a label and a product of disgrace that sets a person apart from others.¹ It leads to social devaluation of a person due to his/her personal attributes resulting in an experience of shame, disgrace and social isolation.² Stigma towards people with mental illness (PMI) is prevalent in all societies in Western and non-Western cultures.³ It continues to be detrimental to the lives of those

diagnosed with a mental illness.⁴ Such stigmatizing attitudes range from the beliefs that all psychiatric patients are dangerous and need to be avoided or isolated, that people afflicted with mental illness are weak in character, are incompetent and therefore need constant oversight without which they pose a constant danger to themselves and the society at large to beliefs that they are to be blamed for their illness. These stigmatizing attitudes result in a number of inter-related cognitive and behavioral biases when we encounter PMI. These include

discrimination, prejudice, stereotyping, and maintaining a social distance from PMI.⁵

Unfortunately, stigma about mental illness originates not only from the general population but also from the medical community.⁶ In fact, it has been suggested that stigma should be examined in a way that shifts the focus from the receiver of the stigma (PMI) to the people contributing to the stigma, including medical, paramedical professionals and organizations.⁷ When investigators have looked at medical professional's attitudes, it seems that they harbor some of the same stigmatizing attitudes as the general population.⁸ These attitudes are held towards patients with a wide range of diagnostic categories like drug/alcohol users, depression, deliberate self-harm, and schizophrenia.

It has been suggested that negative attitudes might be the result of inadequate knowledge and training about mental illness among doctors during their undergraduate course, especially in India.^{9,10} When medical professionals harbor even covert negative attitudes and stigma towards PMI, it adversely affects the care given to the PMI experiencing a medical or surgical (non-psychiatric) illness.¹¹ Hence, it is imperative that doctors of all specialties are aware of their attitudes towards PMI and make a concentrated effort to change them for the better.

The study was aimed to explore the various stigmatizing attitudes harbored by doctors in all fields of specialization. We wanted to find whether the field of specialization (medical, surgical and non-clinical), years of specialty experience and having a family member with mental illness affected these attitudes. We also wanted to know if there was a significant relationship between stigmatizing attitudes and the desire to maintain a social distance from PMI. Finally, we wanted to control for the effects of social desirability on the responses given by doctors.

METHODS

A cross-sectional observational study design was chosen to address the objectives of the study. The sample population consisted of all doctors from the post of Resident to Professor in both clinical and non-clinical streams working in a tertiary care hospital and medical college. The study was approved by the institutional ethical committee. Written informed consent was obtained from the doctors prior to their participation. The following scales were administered:

Socio-demographic questionnaire: Demographic data such as age, gender, field of specialization, years of experience in that specialization, and position held were collected. The doctors also had to record what diagnosis that came to their mind that typically represented mental illness. They also had to mention if they had a family member with mental illness.

The community attitudes toward the mentally ill (CAMI) was used to measure the attitudes of doctors toward mental illness. The CAMI is a widely used tool both in Western and non-Western populations.¹² It has four sub-scales that assess the levels of authoritarianism, benevolence, social restrictiveness, and community mental health ideology. There are 10 statements for each of the four attitudes. Five of the 10 items for each domain are reverse scored. Likert type responses (5= strongly agree to 1= strongly disagree) are given to each question. Responses to each item of a domain are added together to obtain a score for each factor. A mean score is then calculated for each total sub-scale score. Thus, attitudes are measured by mean item responses for each sub-scale. Evidence for internal consistency of the CAMI is good with Cronbach alpha scores ranging from 0.76 to 0.88.¹³

The social distance scale measures a person's willingness to interact with PMI in various relationships. It was developed from the World Psychiatric Association program to reduce stigma and discrimination due to mental illness.¹⁴ Answers are given on a Likert-type scale ranging from definitely (1), probably (2), probably not (3), or definitely not (4). Each response score is added together to get a total social distance score, with high scores indicating less social distance and lower scores indicating more social distance. The Marlowe-Crowne social desirability scale measures an individual's need for approval.¹⁵ In order to ensure that participants were not answering the CAMI and social distance scale in a socially desirable way and validate the attitudes captured by these instruments, the Marlowe-Crowne Social Desirability Scale was included in our study. There are 33 items on the scale, 18 are keyed as true and 15 as false.¹⁶ Minitab 17 was used for statistical analyses.

RESULTS

Around 54 doctors participated in our study. The mean age of doctors was 35.96 (SD 10.02) with 11.81 (SD 9.93) years of post MBBS experience. In their chosen field of specialization, doctors had 8.27 (SD 8.72) years of experience with medical specialists having 9.11 (SD 9.24) years, surgical specialists having 6.28 (SD 7.89) years, and non-clinical doctors having 9.86 (SD 9.07) years. 35 doctors (64.82%) reported they had a family member/friend with mental illness. Depression (44.44%) was the most common illness prototype reported, followed by schizophrenia (31.48%), anxiety disorders (9.26%), drug abuse (7.41%), bipolar (5.56%), and OCD (1.85%).

Table 2 displays the scores on the 4 sub-scales of CAMI. The mean score on the social distance scale was 17.48 (SD 2.03). A one-way ANOVA was conducted to find out if the field of specialization (medical versus surgical versus non-clinical) had any effect on CAMI sub-scale scores (Table 3). Results showed that social distance and CAMI sub-scale scores did not significantly differ across specialties (all p-values >0.05).

Table 1: Baseline socio-demographic data of the sample of doctors (N=54).

Demographic variables		n	%
Gender	Male	40	74.07
	Female	14	25.93
Field of specialization	Medical	24	44.44
	Surgical	19	35.19
	Non-clinical	11	20.37
Post held	Junior Resident	17	31.48
	Senior Resident	8	14.81
	Assistant Professor	16	29.63
	Associate Professor	4	7.41
	Professor	9	16.67

Table 2: Community attitudes towards mental illness sub-scale scores.

CAMI sub-scale scores	Mean	SD
Authoritarianism	2.47	0.55
Benevolence	3.95	0.47
Social restrictiveness	2.24	0.39
Community mental health ideology	3.78	0.43

Table 3: One-way ANOVA comparing scores on CAMI sub-scales and the social distance scale between fields of specialization.

Scale scores	Medical	Surgical	Non-clinical	F-value	P-value
Authoritarianism	2.44 (0.62)	2.47 (0.48)	2.56 (0.56)	0.19	0.827
Benevolence	3.93 (0.42)	3.99 (0.58)	3.94 (0.42)	0.08	0.922
Social Restrictiveness	2.19 (0.36)	2.21 (0.41)	2.41 (0.36)	1.43	0.248
Mental Health Ideology	3.93 (0.44)	3.66 (0.40)	3.67 (0.39)	2.47	0.095
Social Distance Scale	17.88 (2.03)	17.47 (1.84)	16.64 (2.25)	1.43	0.248

P-values <0.05 were taking as statistically significant

Table 4: Correlation between years of specialization experience with CAMI and social distance.

Scale	Spearman's rho*	P-value
Authoritarianism	-0.016	0.910
Benevolence	-0.085	0.542
Social restrictiveness	0.0666	0.637
Community mental health ideology	0.284	0.037
Social Distance	-0.102	0.463

P-values <0.05 were taking as statistically significant

Table 5: Comparison of CAMI sub-scale and social distance scale scores among doctors with and without a family member with mental illness.

Scale scores	PMI in family	No PMI in family	T-value	P-value
Authoritarianism	2.43 (0.52)	2.55 (0.62)	-0.72	0.475
Benevolence	3.99 (0.51)	3.88 (0.39)	0.93	0.358
Social Restrictiveness	2.20 (0.35)	2.31 (0.43)	-0.89	0.381
Mental Health Ideology	3.89 (0.41)	3.58 (0.40)	2.63	0.012
Social Distance Scale	17.46 (1.90)	17.53 (2.29)	-0.11	0.911

P-values <0.05 were taking as statistically significant

Correlation analysis was conducted to find whether years of experience in specialization significantly affected attitudes towards PMI (CAMI) and social distance. Spearman's rank correlation was used as the variables did not follow a normal distribution (Table 4).

Results indicated that CAMI sub-scale measuring mental health ideology significantly correlated positively with years of experience in specialty. Students t-test was used to find whether having a family member with mental illness affected doctor's attitudes and social distance towards PMI (Table 5).

Results indicated that having a PMI in the family was significantly associated with higher scores in mental health ideology sub-scale of CAMI. Spearman's rank correlation was performed to find if attitude towards PMI (CAMI) was associated with the need to maintain a social distance from them (Table 6).

Results indicated that social restrictiveness (negatively) and mental health ideology (positively) significantly correlated with social distance scale scores.

Table 6: Correlation between CAMI and social distance scale scores.

Scale	Spearman's rho	P-value
Authoritarianism	-0.204	0.139
Benevolence	0.245	0.075
Social restrictiveness	-0.334	0.014
Community mental health ideology	0.359	0.008

P-values <0.05 were taken as statistically significant

Finally, we wanted to find if social desirability bias influenced the response of doctors in the CAMI and the social distance scale. We performed an ANCOVA using the general linear model using the Marlowe-Crowne social desirability scale scores as covariates. The results revealed that despite controlling for the effects of social desirability bias, none of the responses in CAMI and the social distance scale significantly differed between the specialties (all p-values >0.05 i.e., not statistically significant).

DISCUSSION

Attitudes are positive or negative evaluations of objects of thought.¹⁷ According to social psychologists attitudes are made up of three components: a cognitive component (beliefs), an affective component (emotional feelings), and a behavioral component (predisposition to act in a certain way).¹⁷ Attitudes are one of the most important predictors of human behavior. Prejudice is harboring negative attitudes towards a particular group or community just because they can be identified to that group. Prejudice leads to discrimination, which involves behaving differently and unfairly, toward the members of a group. PMI have been victims of negative attitudes, prejudice, and discrimination. When these arise from members of the medical community, the care of these vulnerable individuals is compromised. The present study wanted to assess attitudes towards PMI among the medical community, particularly doctors, to explore this important and sensitive issue.

Among the 54 doctors who participated in our study, 24 were medical specialists, 19 belonged to the surgical specialty, and 11 were from the non-clinical teaching departments in the medical college. More than two-thirds had a family member or close friend who suffered from mental illness. Depression and schizophrenia were the most common prototypical mental illness that was reported by the doctors.

Out of the four sub-scales of the CAMI, two domains encompassed positive attitudes (benevolence, mental health ideology) while the remaining represented negative attitudes (authoritarianism and social restrictiveness). The authoritarianism sub-scale of CAMI measures the belief that PMI are substandard individuals who need to be kept in check by others. Higher scores on

the authoritarianism scale denote more coercive attitudes toward PMI. Benevolence sub-scale measures a paternalistic and sympathetic viewpoint toward PMI based on humanistic and religious principles. Higher scores reflect a more positive view of PMI. Social restrictiveness contends that PMI are dangerous and a threat to society. Scores higher on this sub-scale reflect fear of PMI and the need to contain them. Community mental health ideology suggests PMI can benefit from community-based care and support rather than isolation and seclusion based models of care. Higher scores suggest a more accepting belief toward PMI. It is encouraging to note that doctors scored higher in domains that were positive and lower in domains that represented negative attitudes to PMI.

We found no significant differences in attitudes towards PMI and social distance among doctors of different specialties. This is interesting, as we expected differences between the specialists. Even after adjusting for the effects of social desirability bias there were no significant differences. This is important as social desirability operates at an unconscious level. It predisposes an individual to convey an image in keeping with social norms and to avoid criticism in a 'testing' situation.¹⁸ Since the society expects doctors to be unbiased and above prejudice medical professionals frequently internalize these expectations. This ideal interferes in revealing their true attitudes in sensitive situations. To account for the confounding effects of this social bias, we used the Marlowe-Crowne social desirability scale and performed an ANCOVA to control for the effects of this bias.

Years of experience in the specialization did not significantly affect the attitudes towards PMI or the social distance except for the mental health ideology. Doctors with more years of experience scored significantly higher in the community mental health ideology sub-scale of CAMI. As discussed previously, having a community mental health ideology towards PMI would mean that they favor community-based care instead of isolation and seclusion based models of treatment. This is surprising as the older generation of doctors are more in tune with the mental hospital based care with seclusion as a mode of treatment while the younger generation of doctors are more used to the concept of rights of PWI and least restrictive care options.

Having a family member or close friend with mental illness was associated with significantly higher scores in the community mental health ideology sub-scale of CAMI. This is understandable, as the experiences shared by PMI with regards to their prolonged hospitalization are generally not positive.^{19,20} These unfavorable experiences, when recounted to doctors, might have influenced them in the favor of a community based mental health care model of care.

Finally, we found a statistically significant negative correlation between social restrictiveness and social distance. This means that as social restrictive attitudes increase the social distance that one is comfortable in keeping PMI also increase (remember that low scores in social distance scale mean more social distance). This is self-evident as social restrictiveness is essentially a view held by people who believe that PMI are dangerous and a threat to society. Thus, keeping a distance from them socially would be an appropriate behavior that stems from such an attitude. Also, we found a statistically significant positive correlation between having a community mental health ideology and less social distance, wherein people who believe in a community based care as opposed to hospitalization are comfortable in interaction socially with PMI.

CONCLUSION

The importance of the present study lies in assessing the attitudes of doctors towards PMI. Though globally there is a trend towards fighting the stigma of mental illness in the general public, we as mental health clinicians have recognized the need to first address stigmatizing attitudes towards PMI among our colleagues. This study has revealed some encouraging signs in finding less negative and more positive attitudes towards PMI among doctors irrespective of their field of expertise. More importantly, we found that having a close friend or family member with mental illness is associated with a more accommodating attitude towards PMI. Finally, our findings agree with the aphorism that attitudes dictate behavior as we observed that doctors with positive attitudes towards PMI were more comfortable socially with them and vice versa.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

- Hayward P, Bright JA. Stigma and mental illness: A review and critique. *J Ment Heal.* 1997;6(4):345-54.
- Byrne P. Stigma of mental illness and ways of diminishing it. *Adv Psychiat Treat* 2000;6(1):65-72.
- Thara R, Srinivasan TN. How stigmatising is schizophrenia in India? *Int J Soc Psychiatry.* 2000;46(2):135-41.
- Corrigan PW, Druss BG, Perlick DA. The impact of mental illness stigma on seeking and participating in mental health care. *Psychol Sci Pub Int.* 2014;15(2):37-70.
- Byrne P. Psychiatric stigma. *Brit J Psychiat.* 2001;178(3):281-4.
- Smith AL, Cashwell CS. Stigma and mental illness: Investigating attitudes of mental health and non-mental health professionals and trainees. *J Humanist Educ Dev.* 2010;49(2):189-202.
- Sayce L. Stigma, discrimination and social exclusion: What's in a word? *J Ment Health.* 1998;7(4):331-43.
- Mukherjee R, Fialho A, Wijetunge A, Checinski K, Surgenor T. The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. *Psychol Bull.* 2002;26(5):178-81.
- Kallivayalil RA. The importance of psychiatry in undergraduate medical education in India. *Indian J Psychiat.* 2012;54(3):208.
- Chawla JM, Balhara YP, Rajesh Sagar S. Undergraduate medical students' attitude toward psychiatry: A cross-sectional study. *Ind J Psychiat.* 2012;54(1):37.
- Naeem F, Ayub M, Javed Z, Irfan M, Haral F, Kingdon D. Stigma and psychiatric illness. A survey of attitude of medical students and doctors in Lahore, Pakistan. *J Ayub Med Coll Abbottabad.* 2006;18(3):46-9.
- Vibha P, Saddichha S, Kumar R. Attitudes of ward attendants towards mental illness: Comparisons and predictors. *Int J Soc Psychiatr.* 2008;54(5):469-78.
- Taylor SM, Dear MJ, Hall GB. Attitudes toward the mentally ill and reactions to mental health facilities. *Social Science and Medicine. Part D: Medical Geography.* 1979;13(4):281-90.
- World Psychiatric Association. The WPA global programme to reduce the stigma and discrimination because of schizophrenia-an interim report 2001. Geneva: World Psychiatric Association. Available at: http://www.wpanet.org/detail.php?section_id=8&content_id=397.
- Crowne DP, Marlowe D. A new scale of social desirability independent of psychopathology. *J Consult Psychol.* 1960;24(4):349.
- Leite WL, Beretvas SN. Validation of scores on the Marlowe-Crowne social desirability scale and the balanced inventory of desirable responding. *Educ Psychol Meas.* 2005;65(1):140-54.
- Weiten W. *Psychology: Themes and variations: Themes and variations.* Cengage Learning; 2007.
- Edwards A. *The Social Desirability Variable in Personality. Assessment and Research.* New York: Dryden; 1957.
- Gilbert H, Rose D, Slade M. The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Serv Res.* 2008;8(1):92.
- Lilja L, Hellzén O. Former patients' experience of psychiatric care: a qualitative investigation. *Int J Ment Health Nu.* 2008;17(4):279-86.

Cite this article as: Sharma B, Sampath H, Soohinda G, Dutta S. Stigma among doctors towards people with mental illness. *Int J Res Med Sci* 2019;7:15-9.