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A STUDY TO COMPARE THE LEVEL OF STIGMA IN PSYCHIATRIC AND TUBERCULOSIS PATIENTS

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ABSTRACT   **INTRODUCTION** The study was planned to compare self-stigma experienced by psychiatric patients with tuberculosis patients and its relation to patient's age, gender, marital status, employment status and education level.

MATERIAL AND METHODS A cross-sectional study was conducted in tertiary care hospital during March- October 2017 comprising patients from psychiatric and tuberculosis groups. We collected data on Socio-demographic Pro forma and the stigma scale & the statistical analysis by SPSS version 16.0.

RESULTS Patients attending psychiatry OPD consistently gave responses showing a greater degree of self -stigma than those attending general medicine OPD for tuberculosis. The impact of demographic factors and psychiatric diagnosis on the perception of stigma was not statistically significant.

CONCLUSION The findings of this study suggest high self-stigma among patients attending the Psychiatric Clinic in comparison with tuberculosis patients in the same setting. There was no significant correlation between stigma scores, patient's diagnosis, and demographic factors.

KEYWORDS : psychiatry patients, stigma, tuberculosis, study

INTRODUCTION

The term stigma is derived from Greek word "steizen" which means tattooing or branding. According to Goffman, stigma can be defined as the "negative evaluation of a person as tainted or discredited on the basis of attributes such as mental disorder, ethnicity, drug misuse or physical disability".[1] Self-stigma emerges when sufferers internalize others attitudes and experience numerous negative consequences.[2] Self-discrimination, especially in the form of self-isolation, has deleterious impact resulting in decreased utilization of healthcare service, poor health outcomes, and unfavourable quality of life. Low self-esteem and sense of worthlessness have been recognized factors hindering them from employment and independent living.[3,4]

Stigma can be a barrier to recovery from mental illness as it can lead to delays in treatment seeking and interferes with compliance.[5] Even after recovery, stigma can affect the quality of social relations of the patient. Research and strategies to reduce stigma among people suffering from mental illness have been recommended.[6] Besides, mental illnesses, certain other conditions such as HIV/AIDS, leprosy, tuberculosis, epilepsy, etc., are associated with stigma which aggravates the misery of the affected patients.[7-12] Stigma has been argued to be a major determinant of outcome of severe mental illness across cultures.[13]

Systemic review and meta-analysis on self-stigma showed that stigma is not related to the age or sex of the patient, duration of illness, diagnosis, marital status or having a family history of mental illness. However, it revealed an association between severity of the mental disorder non-adherence to treatment and high level of internalized stigma.[14] This self-stigmatization causes low self-esteem and discrimination which contributes in failure to pursue work in the society.

This study was planned to compare the characteristics and extent of stigma in two different patient groups having the illnesses that are thought to be possessed with stigma.

MATERIALS AND METHODS
Study design and period
This is a cross-sectional study conducted over 8 months from March to October 2017 comprising 103 & 102 patients of above 18 years from psychiatric and tuberculosis groups respectively.

Participants and settings
OPD patients from Psychiatry and medicine departments who gave consent and met the eligibility criteria were approached for data collection on OPD days, till the required sample size was met.

The participants were patients, aged 18 years and above from both sexes with major psychiatric illness of more than three months duration in Psychiatry OPD and Tuberculosis Patients attending Medicine OPD since three months or more at a tertiary hospital setting. We included patients of both sexes, who could read and understand Hindi. The Questionnaire was distributed to the participants by a clinic nurse who explained to the participants the aim of the study and took the consent. The questionnaire was administered to the respondents by one of the authors. Patients attending for follow-up were included. In Psychiatry OPD, Patients attending for the first time, those who were acutely disturbed, poor insight were excluded from the study. The diagnoses of the patients were made as per ICD 10.[15]

Ethical considerations
The ethical and research committee of the institute has approved the study protocol. Written informed consent was obtained from the participants by the clinic nurse after explaining the aims and objectives of the study to them.

Tools
The participants were administered the following tools for detailed assessment:
1. Socio-demographic Pro forma: A semi structured pro forma was used for recording sociodemographic details of the patient and diagnosis, total duration of illness, course of illness.
2. Stigma scale developed by King et al. was translated into Hindi.[16] The scale consists of 28 items, divided into 3 domains namely discrimination (13 items), disclosure (10 items) and positive aspects (5 items). Each item was rated as agree, neither agree nor disagree and disagree. Higher scores on total scale and 3 subscales indicated higher stigma. The Hindi version of stigma scale has been tested on a total of 102 psychiatric patients and 101 patients having tuberculosis. It was found to have good reliability (Cronbach's alpha = 0.812). The domains

named discrimination (Cronbach's alpha = 0.778) and disclosure (Cronbach's alpha = 0.805) were also found to be reliable independently.

The statistical analysis was carried out using Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, version 16.0 for Windows). All quantitative variables were estimated using measures of central location (mean, median) and measures of dispersion (standard deviation and standard error).

RESULTS

Sociodemographic characteristics are described below in Table 1. By and large the patients attending psychiatric and non-psychiatric OPD were well-matched in demographic and socioeconomic profile.

Table 1: Sociodemographic profile of psychiatric and tuberculosis patients

	Psychiatric (103)		Tuberculosis (102)	
Age				
18-30	44	42.8%	29	28.4%
30-45	38	36.8%	42	41.2%
Above 45	21	20.4%	31	30.4%
Gender				
Male	53	51.4%	54	53%
Female	50	48.6%	48	47%
marital status				
Unmarried	21	20.4%	23	22.6%
Married	76	73.8%	72	70.6%
Separated/Divorced	2	1.9%	3	2.9%
Widowed	4	3.9%	4	3.9%
income group				
Rs.2000 and below	5	4.8%	3	2.9%
Rs.2000-5000	34	33%	22	21.6%
Rs.5000-10000	47	45.6%	56	54.9%
Above Rs.10000	17	16.5%	21	20.6%
Education				
Illiterate	11	10.6%	7	6.8%
Up to primary	20	19.4%	18	17.7%
6-8 std.	36	34.9%	35	34.3%
9-12 std.	28	27.2%	39	38.3%
Graduate	8	7.7%	3	2.9%
Occupation				
Unemployed	38	36.9%	27	26.5%
Self employed	12	11.6%	13	12.7%
Unskilled	34	33%	37	36.3%
Skilled	3	2.9%	6	5.9%
Student	16	15.6%	19	18.6%
Family type				
Nuclear	37	35.9%	35	34.3%
Extended	11	10.6%	9	8.8%
Joint	53	51.4%	58	56.9%
Living alone	2	1.9%	0	0%

Table 2: Stigma scale and subscale scores in study groups

	Psychiatric group			Tuberculosis group		
	Mean	Median	Std. deviation	Mean	Median	Std. deviation
Stigma scale total	70.95	71	6.09	55.33	57	16.4
Discrimination	33.47	34	3.49	21.3	22	8.5
Disclosure 25.1 26 8.7	25.2	26	8.7	13.24	13	3.26
Positive Aspects	24.24	25	3.73	8.8	9	3.5

Table 2 shows the mean scores and stigma categorization of the subjects on the sub-scales of the patients' stigma scale. The mean

score of total stigma scale of the tuberculosis group was 55.33 (SD=16.4, median=57), while the mean score of stigma scale for Psychiatric group was 70.95 (SD=6.09 median=71). The mean score of stigma subscales were as follows: discrimination in tuberculosis group 21.3 (SD=8.5, median=22) versus Psychiatric group 33.47 (SD=3.49, median=34), disclosure in tuberculosis group 13.24 (SD=3.26, median=13) versus Psychiatric group 25.2 (SD=8.7, median=26) and positive aspects in tuberculosis group 8.8 (SD=3.5, median=9) versus Psychiatric group 24.24 (SD=3.73, median=25). These results, therefore, indicate that disclosure and discrimination of mental illness were highest factor of self- or perceived stigma compared to the positive aspects. The cutoff points used were as following: stigma scale 62.6, discrimination sub-scale 29.1, disclosure sub-scale 24.7 and positive aspects sub-scale 8.8.

ANOVA and Student T test were utilized during the analysis to study the association between clinical and demographic factors and self-stigma subscales. However, there was no statistically significant correlation found between the clinical socio-demographic factors and self-stigma subscales.

DISCUSSION

This study aimed to assess the experience of self-stigma, its socio-demographic and clinical correlates among patients attending outpatient psychiatry and general medicine clinic in a tertiary care hospital of central India.

In addition to poorer social functioning, those with the stigma of mental illness also encounter a significant barrier to obtaining general medical care[17] and to recovery from mental illness.[18-20]

According to Jacoby, Stigma can still be experienced in the absence of any direct discrimination and may critically affect disclosure.[21] Patients may not be able to conceal their mental illness, but the most important point is whom to tell. Some patients may experience shame or embarrassment that makes them reluctant to disclose their mental illness.[16]

In this study, the mean score for stigma for tuberculosis was 55.33 (S.D ± 16.4), which was low compared to the psychiatric group where the mean scores for stigma scale were 70.95 (S.D ± 6.09). The mean score for the discrimination sub-scale was 21.3 (S.D ± 8.7) for tuberculosis group which was also lower than the 33.47 (S.D ± 3.49) reported in psychiatric group. In the same way, scores on disclosure and positive aspects subscale were lower in tuberculosis group as compared to psychiatric group (Table 2). This indicates that psychiatric sample is less likely to disclose or to perceive the positive aspects of their mental illnesses.

So, our study found that those attending OPD for tuberculosis treatment had much lower stigma scores compared to those attending psychiatric OPD. This greater degree of felt stigma among psychiatric patients compared to tuberculosis patients were significant also.

Historically in the 19th century, not much was known about the etiology and cure of tuberculosis. This ignorance led to fear and stigmatization. Though tuberculosis is much better understood today fear and stigma associated with tuberculosis persists and interfere with effective management.[22] But, the stigma for psychiatric illnesses still higher than tuberculosis and continued to be a major obstacle in path of their understanding and managing them.

A nationwide survey of 1301 mental health consumers, the majority of respondents tended to try to conceal their disorders and worried a great deal that others would find out about their psychiatric status and treat them unfavorably.[23] Another study observed that 53% of 1824 persons with serious mental illness reported some experience of discrimination.[24] A study from Taiwan reported that 25% out of 247 outpatients had high levels of self-stigma.[25] Among 193 Chinese

patients attending a psychiatric outpatient clinic in Hong Kong, 11% indicated that they were neglected by health care professionals and 8% had been avoided by family members.[26]

We then analyzed the scores obtained on the Stigma scale with respect to the age of the patient, the sex, marital status and duration of illness and education. No difference was found in any of the groups except that, women reported facing more discrimination than their male counterparts. Studies have reported that women and children with psychotic disorders in developing countries may be vulnerable and have considerable social disadvantages such as having difficulty in getting married, being thrown out of the house by the in-laws due to mental illness and the fear of being a burden to their parents.[27,28]

Psychiatric patients experience stigma is well established. Lai *et al.*, elicited views of patients attending psychiatric OPD, mental health care workers, and cardiac OPD patients regarding stigma. They found that a significant percentage of patients with severe mental disorders perceived that stigma had a negative effect on their self-esteem, relationships, and job opportunities in comparison with cardiac patients among whom feeling of stigma was much less.[29]

A comparative study found that a fair proportion of patients with schizophrenia or depression perceived stigma in contrast, the cardiac patients reported very little stigmatization. The study revealed that the diagnostic label of mental illness may render the person vulnerable to stigmatization.[30]

The issue of stigma faced by patients suffering from psychiatric disorders attending hospital OPD has also been addressed by Kumari *et al.* In their study, they compared stigma and self-esteem among patients attending OPD in the hospital with those who were served by a community outreach program. They found lower stigma scores among patients attending community outreach program. Based on their findings, they recommend further studies and if their findings are replicated a policy decision can be taken to start more community outreach activities by hospitals. Besides reducing stigma, an added advantage would be that services will be available nearer the patients' homes.[31]

Stigma and the level of symptoms perpetuate each other. It has been reported in literature that stigma is inversely related to treatment use and thus it is a barrier to remission of symptoms.[32]

This further enhances the severity of psychopathology, thus leading to more stigma. So, stigma, prejudice and discrimination are common negative consequences experienced by psychiatric patients.

Limitation
The present study had a number of limitations. The sample in the present study comprised patients attending the OPD. This may not exactly represent the general population. In view of this, the actual stigma among patients with psychiatric disorders and tuberculosis is likely to be more than estimated in the present study. We also did not differentiate between different psychiatric conditions which may be associated with varying degrees of stigma. We also concede that the number of patients were limited in our sample. In last but not the least, the concept of social desirability often described in a study using a self-rated scale when the participants write down what they consider the idea description rather that their real feelings and experiences.

CONCLUSION
The findings of this study suggest high self-stigma among patients attending the Psychiatric Clinic in comparison with tuberculosis patients in the same setting. There was no significant correlation between stigma scores, patient's diagnosis, and demographic factors.

These findings highlight the need to incorporate stigma prevention into the treatment plan of psychiatric patients. A Further multicenter research with a larger sample size would help in confirming the findings of this study. Future studies should be conducted in various settings in India across different sociodemographic variables to understand the various facets of internalized stigma. Studies can further expand the scope of their interest by including persons with different psychiatric diagnosis and correlate self-stigma and self-esteem in each group of patients.

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