DOI: 10.7860/JCDR/2017/27906.10832

Original Article

Psychiatry/Mental Health Section

Exploring Social Factors of Mental Illness Stigmatization in Adolescents with Mental Disorders

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ABSTRACT

Introduction: Labelling children and adolescents having mental disorders as "mentally ill" leads to their isolation from the society. Little information is available about the impact of this stigma on such individuals in Iran.

Aim: The purpose of the current study is to explore social factors of mental illness stigma in adolescents diagnosed with mental diseases.

Materials and Methods: This descriptive-analytic study was done using purposive convenience sampling. Data was collected using the questions of 'stigma dimension' of Experience of Care giving Inventory (ECI). A total of 113 adolescents having mental disorders with/without a history of psychiatric hospitalization answered the questions.

Results: The results showed that the stigma of mental illness has a significant relationship with schizophrenia, affective disorder, substance-induced psychosis and Obsessive–Compulsive Disorder (OCD) (p=0.001), but it does not have such a relationship with depression, anxiety and hyperactivity. It was revealed that if a teenager with mental disorder has a friend while undergoing treatment; it will be much easier to overcome the stress of stigma. Moreover, there was a significant relationship between the worry of adolescents concerning the attributing of stigmatization to their families and schizophrenia, affective disorder, substance-induced psychosis and depression (p=0.001). The relationship between the stigma of mental illness and the type of treatment (outpatient, inpatient at least once, history of more than one hospitalization) was significant in psychotic patients (p=0.001) but not so in the case of adolescents with depression, anxiety, OCD and hyperactivity.

Conclusion: Factors such as the low awareness level of Iranians with respect to the symptoms of mental diseases and the family's fear of this stigma result in further widening the gap between early signs of a mental disorder and its treatment, so that families are ashamed of having a mentally ill person at home. The labeling of mental illness can be threatening to teenagers by leading them to associate with small heterogeneous social groups which often include people with a history of misbehaviour; hence there is rise of crime rates in this group of patients.

Keywords: Psychiatric hospitalization, Psychosis, Stigma

INTRODUCTION

Young people with mental disorders who undergo treatment are subjected to stigmatization. They are worried about being undervalued [1]. Behaviours associated with mental conditions of the patient and disease diagnosis are related to stigmatizing patients [2]. A longitudinal study on depression in adolescents showed that depression symptoms can predict social helplessness, exemplified by lack of initiative and lack of power to resolve conflicts. Various teachers have observed that behaviours related to social helplessness in adolescents with mental disorders are caused when a person is neglected by other students [3]. The overwhelming power of the stigma of mental illness drives children and adolescents to isolation. Unfortunately, the cost of this rejection by friends is enormous, and in the long run it badly damages the body and mind of children and adolescents [4,5]. Adolescents better understand this exclusion than children [6,7]. Mental patients experience three types of stigmatization: 1) guilt stigma in which a person harbors feelings of failure and inadequacy; 2) stigmatization by the family who reject him/her; 3) Social stigmatization towards the patients which can influence their acculturation in the society [8].

Recent research on young people with mental illness shows that the stigma society attaches to these individuals has a lot to do with the particular disorder one struggles with [9]. Firstly, diagnosis determines to what extent society is affected by the possible harm that mentally ill people could have to the community and secondly, it shows in which conditions the patients may be ignored by others in the society [10]. These labels are very complex; thus for example, adolescents with psychotic disorders, including those associated with substance abuse, are often stereotypically labeled "dangerous" whereas people with anxiety or depression are commonly characterised with poor social relations [11], and still individuals with attention deficit hyperactivity disorder are identified by "destructive behaviours" causing anger and resentment and leading people to keep their distance from such patients [12]. Negative attitudes towards patients with psychosis are greater than for patients with neurotic disorders [13], and the stigma of mental illness is more commonly applied to hyperactive children than those with depression [14]. Studies have indicated that adolescents who receive the stigma of mental illness are evidently ostracised from both society and family, and when their disorder is disclosed, society and family tend to distrust them and to regard them as individuals who need support. Young people with anxiety and mood disorders are better supported by their peers, compared with psychotic patients [15]. It seems adolescents with mental disorders feel greater intimacy with these groups; thereby they are better able to mitigate the risk of being stigmatised with mental illness [16]. In a study conducted on young people diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), it was observed that adolescents with ADHD experience different conditions in criminal groups where their behaviours, instead of being called "bad" or "destructive," are

regarded as daring, exciting and interesting [17]. Having a friend next to them is the best condition for adolescents with mental disorders who are under psychiatric hospitalization; this way, they are less likely to be threatened with the stigma of mental illness [18]. In fact, friends are the best individuals who can support these patients [19,20]. A study showed that after adolescents and young adults are affected by mental disorders, the amount of acceptance and support on the part of peers will diminish further in boys than girls [21]. The reason for this difference could be that when people are in a minority, they care more for their people and, reject each other less frequently. There has been no research done on mental illness stigma among adolescents in Iran, especially, in individuals with psychotic symptoms who had history of hospitalization Therefore, the author decided to investigate social factors surrounding the stigma of mental illness in adolescents with mental disorder.

MATERIALS AND METHODS

In this descriptive analytic study, a total number of 113 adolescents from 13 to 19 years of age, living in Guilan Province were included. They were affected with either psychotic (schizophrenia, mood disorder, substance-induced psychosis) or neurotic (depression, anxiety, OCD) disorders with/without a history of psychiatric hospitalization and/or hyperactivity. The sample size was based on Morgan Table. All the patients were informed about the study and signed a consent form.

Inclusion criteria: Psychiatric diagnosis based on DSM-4 and no chronic somatic diseases like diabetes, blood pressure.
Exclusion criteria were cognitive or intelligence disorders.

Instrument: The data is based on the six questions of stigma dimension of Experience of Caregiving Inventory (ECI). ECI is one of the questionnaires used to assess the experience of families having patients with psychiatric disorders. To develop ECI, Szmukler GI et al., [21] conducted various stages of interviews with patients' families, reviewed the questionnaires to adjust the list of items, set up the final list and validated it using Goldberg's General Health Questionnaire (GHQ). Studies suggest that ECI scores have a high predictive capability in various clinical conditions such as psychosis and anorexia [22]. To carry out this research, the author employed the Persian modified version of ECI, localised by Mottaghipour Y et al., [22].
ECI is a self-report questionnaire consisting of 66 items and 10 subscales. The subscales of the Persian ECI included: (1) difficult behaviour; (2) negative symptoms; (3) stigma; (4) problem with services; (5) effects on the family; (6) need to backup; (7) dependency; (8) loss; (9) positive personal experience; (10) good aspects of relationship.

STATISTICAL ANALYSIS

Using Cronbach's alpha, we measured internal consistency of the subscales of difficult behaviour, negative symptoms, stigma and problem with services, effects on the family, need to backup, dependency, loss, positive personal experience and good aspects of relationship to be respectively 0.86, 0.84, 0.65, 0.59, 0.70, 0.46, 0.52, 0.67, 0.69 and 0.68.

Similarly, internal consistency of 52 negative items and 14 positive items was respectively 0.90 and 0.76 (Cronbach's alpha). Reliability coefficient was obtained 0.8, using split-half method and Spearman correlation coefficient [23]. The collected data were analysed using SPSS 21.0.

Researches show that ECI is characterised by a greater predictive capability [24]. ECI consists of five questions on stigma, and the researcher asked these questions from the families of patients with mental disorder. Having been granted the permission by the parents, the researchers interviewed the patients afterwards. Sample selection was based on the following criteria:

1) The first group included adolescents who had referred to specialised outpatient clinics and private psychiatric offices and received one of the diagnoses listed above.
2) The second group consisted of patients whose six months had passed from their diagnosis and who had undergone substance treatment in addition to at least one hospitalization.
3) The third group was composed of patients affected by the disease for at least one year and who had a history of hospitalization.

RESULTS

Total number of 113 patients, 66 (58.4%) male and 47 (41.6%) female participated in the study. The mean age and standard deviation was 15.56±1.64. Among the patient, 12 (10.6%), 17 (15%), 28 (24.8%), 17 (15%), 25 (22.1%), 8 (7.1%) and 6 (5.3%) of adolescent patients had respectively 13, 14, 15, 16, 17, 18 and 19-year-old. Based on the diagnosis of the disease by the treating psychiatrist, 14 patients (12.4%) had schizophrenia, 21 (18.6 %) had mood disorder, 6 (5.3%) had substance-induced psychosis, 28 (13.3%) had depression, 15 (13.3%) had anxiety, 6 (5.3%) had OCD and 23 (20.4 %) had hyperactivity. Regarding education, 28 (24.8%), 46 (40.7%), 20 (17.7%) and 15 (13.3%) individuals had respectively elementary school, secondary school, high school and diploma degrees, and 4 (3.5%) individuals were university students. As for the history of hospitalization, 79 (69.9%) had no history, 28 (24.7%) were hospitalised once and 6 (3.5%) patients had more than one history of psychiatric hospitalization. Besides, of sample group 28% mothers and 17% fathers had academic degrees.

The negative effects of stigmatization of the mentally ill in Iran have been examined in the case of adults, and thus this study focused on adolescents by asking them:

1. Have you ever decided to conceal your disease from others?
2. Have you ever thought that you avoid from talking about your illness with someone?
3. Have you ever felt that you cannot entertain your guests because of your illness?
4. Have you ever thought that, because of your disorder, the stigma of mentally ill is applied to your family?
5. Have you ever thought of how to explain your symptoms to others?

The result [Table/Fig-1] shows that there is a significant relationship between hiding one's disorder and schizophrenia, affective disorder, substance-induced psychosis and OCD (P=0.001); however, such a relationship does not exist in the case of depression, anxiety and hyperactivity.

The results [Table/Fig-2] indicate that while avoiding from talking about one's disorder has a significant relationship with schizophrenia, affective disorder, substance-induced psychosis and hyperactivity, it does not have such a relationship with depression, anxiety and OCD.

The results [Table/Fig-3] demonstrate that there is a significant relationship between being unable to entertain one's guests and schizophrenia and affective disorder (p=0.005) as well as substance-induced psychosis and OCD (p=0.001); nevertheless, this inability does not have such a relationship with hyperactivity, depression and anxiety.

The results [Table/Fig-4] reveal that concern about stigmatization of one's family with mental disorder has a significant relationship with schizophrenia, affective disorder, substance-induced psychosis and depression, but not with hyperactivity, anxiety and OCD.

The results [Table/Fig-5] clarify that inability to explain the symptoms of one's mental disorder has a significant relationship with schizophrenia, affective disorder and depression (p=0.001) as well as substance-induced psychosis (p=0.005) but not with hyperactivity, anxiety and OCD.

Disorder	Response		Total (%)	χ^2	p
	No	Yes			
Schizophrenia	1	13	14 (12.4)	10.286	0.001
Affective disorder	1	20	21 (18.6)	16.18	0.001
Substance-induced psychosis	1	5	6 (5.3)	3.414	0.001
Hyperactivity	16	7	23 (20.4)	0.736	Ns
Depression	17	11	28 (24.8)	7.35	Ns
Anxiety	9	6	15 (13.3)	7.133	Ns
OCD	0	6	6 (5.3)	2.67	0.001

[Table/Fig-1]: The results of chi-square analysis with respect to hiding the disease from others.
Significant p-value=p<0.05

Disorder	Response		Total (%)	χ^2	p
	No	Yes			
Schizophrenia	2	12	14 (12.4)	11.190	0.001
Affective disorder	2	19	21 (18.6)	17.429	0.001
Substance-induced psychosis	1	5	6 (5.3)	3.414	0.001
Hyperactivity	5	18	23 (20.4)	17.625	0.001
Depression	10	18	28 (24.8)	8.071	Ns
Anxiety	6	9	15 (13.3)	3.933	Ns
OCD	3	3	6 (5.3)	0.667	Ns

[Table/Fig-2]: The results of chi-square analysis with respect to refraining from talking with others about the disease.
Significant p-value=p<0.05

Disorder	Response		Total (%)	χ^2	p
	No	Yes			
Schizophrenia	2	12	14 (12.4)	7.143	0.005
Affective disorder	3	18	21 (18.6)	12.33	0.005
Substance-induced psychosis	2	4	6 (5.3)	3.287	0.001
Hyperactivity	9	14	23 (20.4)	8. 078	Ns
Depression	12	16	28 (24.8)	10.571	Ns
Anxiety	7	8	15 (13.3)	0.323	Ns
OCD	4	2	6 (5.3)	0.233	0.001

[Table/Fig-3]: The results of chi-square analysis with respect to inability to entertain one's guests.

Disorder	Response		Total (%)	χ^2	p
	No	Yes			
Schizophrenia	2	12	14 (12.4)	21.429	0.001
Affective disorder	4	17	21 (18.6)	13.714	0.001
Substance-induced psychosis	1	5	6 (5.3)	3.009	0.001
Hyperactivity	13	10	23 (20.4)	0.088	0.237
Depression	13	15	28 (24.8)	17	0. 079
Anxiety	6	9	15 (13.3)	1.20	0.529
OCD	4	2	6 (5.3)	0.003	0.276

[Table/Fig-4]: The results of chi-square analysis with respect to stigmatization of mental patient's family.
Significant p-value=p<0.05

Disorder	Response		Total (%)	χ^2	p
	No	Yes			
Schizophrenia	2	12	14(12.4)	17.429	0.001
Affective disorder	1	20	21(18.6)	12.33	0.001
Substance-induced psychosis	1	5	6(5.3)	3.001	0.005
Hyperactivity	7	16	23(20.4)	0.763	0.351
Depression	6	22	28(24.8)	16.412	0.001
Anxiety	4	11	15(13.3)	3.399	0.771
OCD	3	3	6(5.3)	0.881	0.322

[Table/Fig-5]: The results of chi-square analysis with respect to inability to explain the symptoms to others.
Significant p-value= p<0.05

The last question was whether stigmatization of mental illness differed between the sexes so far as duration of outpatients' and inpatients' illness and the type of disease were concerned. Analysis of variance was employed to answer this question. The ANOVA test represents the difference between gender, disorders and treatment duration variables. The score of stigma of mental illness in adolescents has a significant difference so far as it is related to the type of disease diagnosed and the type of treatment (outpatient and hospitalization) (p=0.001); however, there was no significant difference between boys and girls in terms of being subject to mental illness stigma.

DISCUSSION

Stigmatization is an important issue affecting psychiatric patients and their families. Teenagers get the most damage in relation to their peers. Developing relationships with friends and peers is not only a factor for the socialization of a person but also affects one's learning, academic progress and verbal skills [25]. Researchers believe that increasing relationship with mentally ill patients will be helpful in reducing their fear of stigmatization [18]. The rate of relationship stigma in Iran has been estimated to range between 73 and 83 percent [8]. In this study, the patients were asked whether they had tried to hide their condition from others. Adolescents who were diagnosed with psychotic gave a positive response, which is consistent with the results of Sadeghi M et al., [26], Shahveisi B et al., [8] and Marcel AB and Halpern-Felsher BL, [15]. What was remarkable is that adolescents with OCD also had attempted to hide their symptoms. Since conflicts are what preoccupy OCD patients, one may associate it with patients' inability to solve them, as Angermeyer MC and Matschinger H, [27] and Elkington KS et al., [2] implied in relation to their outpatient subjects.

In response to the second question, whether subjects had felt to be unable to talk to others about their disorder, the results showed that hiding the disease is significantly correlated with schizophrenia, mood disorder, substance-induced psychosis and hyperactivity. Furlanetto LM and Stefanello B, [28] and Lindsey MA et al., [19] points out that if a teenager suffering from psychosis has a friend during treatment, he/she will have the lowest amount of pressure due to the usual stigmatization. Many adolescents of the sample group undergoing treatment had the minimum relationship with the people around them (i.e., relatives and friends).

In response to the third question the inability to entertain guests at home, a significant relationship was observed between this failure and the type of disorder in patients with schizophrenia, mood disorders and OCD. This is incompatible with the results of other researchers [19,28]. Studies have shown that identity and social relationships of adolescents could be determined by their experiences and impressions in relation to stigma of mental diseases, rather than by social institutions and networks such as those of friends and family.

As for the fourth question, concern about the extension of stigma to the whole family, the results exhibited that this worry has a significant relationship with schizophrenia, affective disorder, substance-induced psychosis and depression (p=0.001). Agoston AM and Rudolph KD demonstrated that depression is one of the predictors of passive behaviours in adolescent patients [3]. In the study by Rusch N [29], it was revealed that many of these dispositions in adolescents are cognitive [30], and teenager's judge situations based on their thoughts; that is, their concerns regarding the misapplication of mental illness to their family originate in their thinking. The relationship between mental illness stigma and the kind of illness diagnosed consists of the duration (outpatient, at least one hospitalization, a history of less/more than a year of diagnosis, and more than one hospitalization) and gender. No significant correlation was seen between duration of hospitalization and depression, anxiety, OCD and hyperactivity.

Similarly, no significant difference was observed between the two genders in terms of stigmatization of mental illness. These results are not consistent with those of Sadeghi M et al., [26] that proposed a significant difference in the major depressive disorder group.

CONCLUSION

This study indicated that there is a significant relationship between the duration of disease and the experience of stigma. While some studies have reported that adolescents with mental disorder experience disrespect, few patients had been totally rejected by their friends. Psycho education through public media, educational system and health centers can play a major role in raising the awareness of families in this regard and help them overcome the stigmatization.

ACKNOWLEDGEMENTS

The author appreciates parents and adolescents who participated in this research.

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FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Feb 26, 2017**
Date of Peer Review: **May 04, 2017**
Date of Acceptance: **Sep 13, 2017**
Date of Publishing: **Nov 01, 2017**