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Research article

Stigma and discrimination among persons with mental Illness in a tertiary care medical institution in Southern India

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ABSTRACT

The proportional contribution of mental disorders to the total disease burden in India has almost doubled since 1990. Stigma and discrimination are major barriers to seeking treatment for persons with mental illness (PMI). Stigma reduction strategies are thus crucial, and for this, there needs to be an understanding of the various factors associated with them. The current study intended to assess stigma and discrimination in PMI visiting the department of psychiatry in a teaching hospital in Southern India and their association with various clinical and sociodemographic factors in them. The index study was a descriptive cross-sectional study involving consenting adults who presented to the Department of Psychiatry with mental disorders from August 2013 to January 2014. Socio-demographic and clinical data were collected using a semi-structured proforma, and the Discrimination and Stigma Scale (DISC-12) was used to assess discrimination and stigma. Most PMI suffered from bipolar disorder, followed by depression, schizophrenia, and other disorders, such as obsessive-compulsive disorder, somatoform disorder, and substance use disorder. Discrimination was experienced by 56% of them and 46% had stigmatizing experiences. Both discrimination and stigma were found to be significantly associated with their age, gender, education, occupation, place of residence, and illness duration. While PMI suffering from depression experienced the highest discrimination, those with schizophrenia faced the stronger stigma. Binary logistic regression revealed depression, family history of psychiatric illness, age of less than 45 years, and rural locality of residence to be the significant determinants of discrimination and stigma. The study thus found that stigma and discrimination were associated with multiple social, demographic, and clinical factors in PMI. A rights-based approach to PMI is the need of the hour to tackle stigma and discrimination, which is already included in recent Indian acts and statutes. Implementation of these approaches is the need of the hour.

KEYWORDS: Mental illness, stigma, discrimination, persons with mental illness.

Introduction

Mental disorders are among the leading causes of non-fatal disease burden in India, affecting one in seven Indians.[1] The proportional contribution of mental disorders to the total disease burden in India has almost doubled since 1990.[2] Stigma remains a major barrier to seeking treatment for persons with mental illness (PMI). Stigma is a complex issue that exists in different forms, and many factors like the public, family members, media, patients themselves, and even sometimes the health providers are involved.[3–5] It is also significantly associated with self-stigma among PMI.[6,7] The latter seems

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to be the worst form of stigma against PMI that can directly affect the patient's overall well-being.[8] It negatively affects adherence to psychiatric services, self-esteem, hope, and quality of life, apart from preventing effective rehabilitation and social integration.[8,9]

Mental illness stigma can be explained using parameters like stereotypes, prejudice, and discrimination.[10] Stereotype is the collective notion of society imposed upon a group of people (here PMI) which may create negative emotional responses in prejudiced people against them. Discrimination is the behavioral response to prejudice. Stigma, however, can be both public and personal. Public stigma is the reaction that people have toward PMI. Personal stigma includes perceived stigma (an individual's thinking on society's perception of oneself), experienced stigma (an individual faces discrimination from society), and internalized stigma (internalization of public stigma).[11]

Most of our understanding of internalized stigma originated in developed nations and may not be applicable to other settings because of socio-cultural differences.[12,13] In India, studies have mostly focused on assessing the stigma associated with mental illness among family members, caretakers, or the general population. One of the major goals of mental health research and policy is to identify ways to reduce stigma. To accomplish this, it is necessary to understand the background factors of stigma, one of which is the use of psychiatric labels and societal misinformation about mental illness, which is often mediated by the media.[14] Efforts to reduce stigma by replacing mental health myths with more accurate, empirically based information on mental illness have, however, not lived up to expectations. Studies investigating this conclude that negative attitudes are easier to affect in education programs directed at smaller and chosen groups[15,16] and if the content in the program is focused on specific negative stereotypes, i.e., schizophrenia and depression.[16,17]

Societal misinformation and psychiatric diagnosis are not the only factors accounting for stigma. Studies indicate that PMI with severe symptoms and poorer social skills are more likely to experience stigma.[18] Severe symptoms such as disorganized behavior and flat affect may scare others and reinforce the fear of mental illness.[19] Results are divergent with regard to studies investigating factors associated with stigma in schizophrenia. While Dickerson et al (2002) reported no relationship between symptoms or social functioning and stigma,[20] Penn et al (2000) found a robust association between them and concluded that social skills, negative symptoms, and perceived strangeness, may contribute to stigma.[21] To identify ways to reduce stigma on an individual level, knowledge about sociodemographic and clinical factors associated with stigma is important. The current study intends to assess stigma and discrimination among PMI attending a psychiatric department and explore the association between socio-demographic factors and internalized stigma.

Material and Method

Participants and procedures

This descriptive cross-sectional study recruited patients (after obtaining informed consent) between age groups of 18 years to 65 years, using a convenient sampling method, with an ICD-10 (World Health Organization, 1992)[22] psychiatric diagnosis of at least more than a year of being ill, attending the department of psychiatry of a tertiary care medical institution of Southern India. Data were collected between August 2013 and January 2014. It was approved by the institution's ethics committee. Acutely ill patients, those with intellectual disability, or sensory impairment, and those who didn't give us written consent for their inclusion are all excluded from the study.

Measures

Data were collected using a semi-structured proforma to assess their socio-demographic and relevant clinical data. The Discrimination and Stigma Scale (DISC 12) was used to assess discrimination faced by the study participants due to their mental illness in the last year.[23] DISC-12 contains 32 questions about aspects of everyday life including work, marriage, parenting, housing, leisure, and religious activities wherein discrimination experienced is being recorded. It has 4 subscales (Items 1–21: Unfair treatment; items 22–25: Stopping self; items 26 and 27: Overcoming stigma and items 28–32: Positive treatment which assesses coping strategies to overcome discrimination). The responses were rated on a 4-point Likert scale. The calculation of both a mean and total score is recommended for each subscale. This allows both the level of stigma in each applicable area of life and its spread over the different areas to be presented. Higher scores indicate higher levels of stigma (including positive stigma).[24] The mean DISC-12 score is calculated for individual subscales by adding up the scores obtained in each subscale and dividing them by the number of applicable and non-missing items in the subscale.[24] For the sake of this study, instead of subscale mean scores, a total mean score is calculated by adding all the items marked for all 4 subscales and dividing them by the total number of applicable and non-missing items in the 32-item DISC-12 scale. DISC-12 is a self-reported scale that was translated into the local language following the translation and back translation protocol for its application.

Stigma experienced was assessed with direct questioning that evoked a dichotomous response (yes/no) from the study participants. The responses were analyz-

ed with further open-ended questioning of the experiences (if any) before accepting the dichotomous (yes/no) responses.

Statistical analysis

The data were analyzed using SPSS for Windows. Data were normally distributed according to the Shapiro-Wilk test. Graphs and tables were used to present the data. DISC-12 scores were compared between various socio-demographic and clinical variables using the t-test and one-way ANOVA while the chi-square test was used to determine associations between stigma and socio-demographic/clinical variables. Multiple linear regression analysis was used to predict the impact of socio-demographic and clinical variables on DSIC scores. Logistic regression was done to identify predictors resulting in stigma. The level of significance was set at p ≤0.05.

Results

General characteristics of study subjects

Three hundred PMI attending the outpatient department (OPD) of a tertiary care hospital in western India with specialized psychiatry services participated in the study. The socio-demographic and clinical profiles of the study participants are described in table 1.

Table 1. Associations of socio-demographic and clinical profile with discrimination.

		N	Mean	SD	t(df)/F(df)	p
Age	<25 years	35	2.8	0.3	2.1 (4)	0.001
	25 – 34 years	70	3.1	0.29		
	35 – 44 years	110	3.3	0.32		
	45 – 54 years	57	3	0.36		
	>55 years	28	2.8	0.23		
Gender[a]	Male	146	2.9	0.3	-1.02 (298)	0.02
	Female	154	3.3	0.31		
Education	Less than high school	158	3.8	0.29	1.92 (3)	0.001
	SSLC	92	3.6	0.26		
	Pre-degree	28	3.3	0.36		
	Degree	22	2.9	0.29		
Occupation	Unskilled	112	2.6	0.3	2.03 (2)	0.001
	Semiskilled	148	3.4	0.32		
	Skilled	40	3.9	0.36		
Location	Rural	50	3.7	0.34	1.04 (2)	0.01
	Semi urban	208	3.3	0.28		
	Urban	42	2.6	0.23		
Marital Status	Unmarried	144	3.4	0.28	1.1 (2)	0.77
	Married	108	3.1	0.25		
	Separated	48	2.9	0.23		
Psychiatric diagnosis	Depression	72	3.7	0.39	2.8 (6)	0.001
	Bipolar disorder	98	3.1	0.28		
	Obsessive Compulsive Disorder	34	2.3	0.23		
	Somatoform disorder	34	2.1	0.21		
	Schizophrenia	41	3.5	0.37		
	Substance Use Disorder	8	2.7	0.28		
	Others	13	2.9	0.27		
Illness duration	<10 years	147	2.7	0.29	2.31 (2)	0.02
	10–15 years	75	3	0.31		
	>15 years	78	3.4	0.35		
Family history of mental Illness[a]	Yes	165	0.38	0.28	-1.2 (298)	0.01
	No	135	0.29	0.19		
On current Treatment[a]	Yes	188	0.21	0.09	-1.5 (298)	0.049
	No	112	0.25	0.075		

SD-Standard Deviation; df- degrees of freedom, Superscript ‘a’- t-test

Bipolar disorder (32.7%) was the predominant psychiatric diagnosis, followed by depression (24%), schizophrenia (13.7%), somatoform disorders (11.3%), obsessive-compulsive disorder (OCD) (11.3%), substance use disorder (SUD) (2.7%) and others (4.3%). 51.3% of the participants were on treatment. Nearly half (49%) of the study subjects had an illness duration of fewer than 10 years, 26% had an illness of more than 15 years, and 25% of study subjects had an illness for a period of between 10–15 years. A family history of psychiatric illness was present in 55% of the study subjects. 62.7% of the subjects were on treatment during study recruitment, while 37.3% were non-adherent/ treatment-naive to their prescribed regimens.

Discrimination and stigma

Discrimination was faced by 56% of the study subjects, while 46% have been subjected to stigmatizing experiences. The total mean DISC-12 score was 3.2±1.8 which was calculated by counting the scores of all 32 items of the scale and dividing them by the number of applicable and non-missing items. The four sub-scale scores are; unfair treatment (total score: 4.8, mean score: 0.23), stopping self (total score: 2.3, mean score: 0.09), overcoming stigma (total score: 1.2, mean score: 0.06) and positive treatment (total score: 2.6, mean score: 0.10).

The discrimination experienced (figure 1) was mostly from neighbors (32%), followed by discrimination from intimate partners in a relationship (21.3%). The other sources of discrimination experienced by the study participants were their physical health (18%), in areas of education (15.3%), places of worship and religious practices (12.7%), their interaction with the legal system and police (9%) and when they played their role as parents (9.7%).

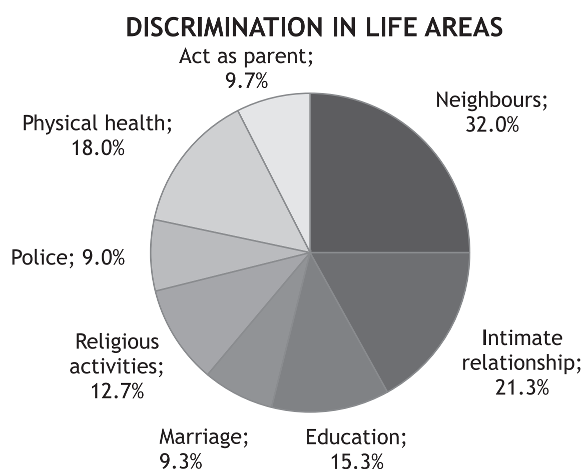

Figure 1. Discrimination in life areas.

Factors associated with discrimination and stigma

Table 1 describes the statistical associations between various socio-demographic and clinical parameters of the participants and DISC-12 mean scores.

The associations between the stigma faced by the participants and their socio-demographic and clinical parameters (variables) are mentioned in table 2. Stigma was found to be statistically high in 35–44 years of age, female sex, having pre-degree education, those who were unskilled workers, and those staying in an urban location. Patients suffering from schizophrenia (68.3%) experienced stigma the most in the study, followed by depression (58.3%), bipolar disorder (38.7%), and SUD (37.5%). Stigma experienced was higher in those who didn't have a family history of mental illness as opposed to those who have one, but this was not statistically significant. Those who stopped treatment or were non-adherent or treatment naïve experienced significantly higher stigma than those who were on treatment for their mental illness.

Regression analysis

Regression analysis revealed that none of the predictor variables had any significant impact on the DISC-12 score (table 3). It was found that participants less than 45 years of age were more likely to face stigma [OR:1.4 (1.08–1.9); P=0.05] than older participants. In addition, participants residing in rural localities were 1.2 times more likely to face stigma [OR:1.2 (1.15–1.7); P=0.05] than those residing in urban areas (table 4).

Discussion

Bipolar disorder (32.7%) was the predominant psychiatric diagnosis, followed by depression (24%), schizophrenia (13.7%), somatoform disorder (11.3%), OCD (11.3%), and SUD (2.7%) in the sample of 300 patients who were included in the study. These are both common and severe mental disorders in India. The values, however, don't match with those in the recently published National Mental Health Survey 2016 (NMHS 2016).[1] These can be attributed to the fact that our study dealt with a hospital population, while NMHS 2016 is an epidemiological study, not restricted to any population group. More than half of our sample (62.7%) were on treatment during their index presentation, while the remaining (37.3%) were either treatment naïve or non-compliant. This went in line with the study by Jain et al (2017) that found 38.2% of patients, in an outpatient mental health service set-up in north India, discontinued their treatment after their first visit, and among the remaining patients, 61.8% discontin-

Table 2. Associations of socio-demographic and clinical profile with stigma.

		Stigma Experienced		Chi Square	p
		Yes	No		
		N (%)	N (%)		
Age	<25 years	4 (11.4)	31 (88.6)	5.02	0.001
	25–34 years	28 (40.0)	42 (60)		
	35–44 years	64 (58.1)	46 (31.9)		
	45–54 years	24 (42.1)	33 (57.9)		
	>55 years	18 (64.2)	10 (35.8)		
Gender	Male	53 (36.3)	93 (63.7)	4.1	0.032
	Female	85 (55.1)	69 (44.9)		
Education	Less than high school	79 (50)	79 (50)	3.8	0.043
	SSLC	36 (39.1)	56 (60.9)		
	Pre-degree	16 (57.1)	12 (42.9)		
	Degree	07 (31.8)	15 (68.2)		
Occupation	Unskilled	98 (87.5)	14 (12.5)	2.1	0.001
	Semiskilled	34 (22.9)	114 (70.1)		
	Skilled	06 (15)	34 (85)		
Location	Rural	12 (24)	38 (76)	5.01	0.001
	Semi urban	86 (41.3)	122 (59.7)		
	Urban	40 (95.2)	02 (4.8)		
Marital Status	Unmarried	64 (44.4)	80 (55.6)	0.502	0.57
	Married	48 (44.4)	60 (55.6)		
	Separated	24 (50.0)	24 (50.0)		
Psychiatric diagnosis	Depression	42 (58.3)	30 (41.7)	4.6	0.07
	Bipolar disorder	38 (38.7)	60 (61.3)		
	Obsessive Compulsive Disorder	12 (35.2)	22 (64.8)		
	Somatoform disorder	10 (29.4)	24 (70.6)		
	Schizophrenia	28 (68.3)	13 (31.7)		
	Substance Use Disorder	03 (37.5)	05 (62.5)		
	Others	05 (38.4)	08 (61.6)		
Illness duration	<10 years	64 (43.6)	83 (56.4)	2.4	0.29
	10–15 years	35 (46.6)	40 (53.4)		
	>15 years	46 (58.9)	32 (41.1)		
Family history of	Yes	71 (43.0)	94 (57.0)	0.78	0.23
mental illness	No	65 (48.1)	70 (51.9)		
On current	Yes	77 (41.0)	111 (59.0)	7.5	0.001
Treatment	No	59 (52.7)	53 (47.3)		

ued their treatment within 6 months.[26] A recent meta-analysis on psychotropic non-adherence also supports this (49% overall non-adherence).[27]

Discrimination was faced by 56% of the study subjects and 46% reported having experienced stigma. This is lower in comparison to the study by Bipeta et al (2020) in the Indian state of Telangana, wherein 76.32% reported having experienced a moderate-to-high level of stigma while 85.53% endorsed secrecy.[28] This difference can be explained by the geographical and cultural differences between the two places where the studies were conducted. Still, these figures point to the abysmally high level of stigma and discrimination that a PMI faces. Discrimination was reported more from the neighbors (32%) followed by that intimate relationships (21.3%), areas of

Table 3. Multiple linear regression with socio-demographic and clinical variables as predictors for discrimination.

Parameter		B	t	p	Lower Bound	Upper Bound
Intercept		5.335	6.141	0.001	3.625	7.046
Age	<25 years	–0.167	–0.385	0.7	–1.018	0.684
25 – 34 years		–0.025	–0.063	0.95	–0.816	0.765
35 – 44 years		–0.274	–0.716	0.47	–1.026	0.479
45 – 54 years		–0.087	–0.219	0.83	–0.874	0.699
>55 years		0	.	.		
Gender	Male	–0.065	–0.392	0.70	–0.392	0.262
Female		0	.	.		
Education	< high school	0.319	0.783	0.43	–0.483	1.121
High school		0.702	1.698	0.09	–0.112	1.515
Pre–degree		0.54	1.258	0.21	–0.305	1.384
Degree		0	.	.		
Occupation	Unskilled	–0.141	–0.498	0.62	–0.699	0.417
Semiskilled		–0.204	–0.735	0.46	–0.75	0.343
Skilled		0	.	.		
Location	Rural	–0.196	–0.866	0.39	–0.44	0.506
Semi urban		–0.094	–0.455	0.65	–0.313	0.65
Urban		0	.	.		
Diagnosis	Depression	–0.458	–0.828	0.41	–1.54	0.631
Bipolar disorder		–0.236	–0.427	0.67	–1.32	0.85
Obsessive Compulsive Disorder		–0.312	–0.561	0.58	–1.4	0.78
Somatoform disorder		–0.811	–1.351	0.18	–1.77	0.57
Schizophrenia		–0.602	–1.011	0.31	–2.1	1.15
Substance Use Disorder		–0.489	–0.587	0.56		
Others		0	.	.		
illness duration	<10 years	0.243	0.811	0.42	–0.34	0.84
10 – 15 years		0.049	0.129	0.90	–0.703	0.802
>15 years		0	.	.		
Family History	Yes	0.18	1.092	0.28	–0.144	0.504
No		0	.	.		
Current illness	Yes	–0.103	–0.593	0.55	–0.44	0.23
No		0	.	.		

R^2 – 0.06; 0–reference category

education (15.3%), religious activities (12.7%), physical health (18%), with the police and law (9%) and when they played their role as a parent (9.7%). This is in line, albeit with subtle differences, with a study by Hansson et al (2014), where the most experienced discrimination was observed in the family (53.9%), in a marital relationship (16.8%) whereas, areas with the least perceived discrimination included religious practice (5.1%), starting a family (9.1%) and using public transport (11.5%).[8]

The total mean discrimination score was high among study subjects with depression followed by schizophrenia, which was closely followed by bipolar disorder, SUD, OCD, and somatoform disorder, and this was statistically significant. Concerning stigma, PMI suffering from schizophrenia suffered more than the other diagnostic entities. Together, this points to the fact that both affective disorders and non-affective psychosis top the list of discrimination and stigma faced by sufferers. This finds support from earlier studies

Table 4. Multiple logistic regression with demographic and clinical variables as predictors for stigma.

	B	SE	Wald	OR (95% CI)	p
Less than 45 years of age	0.115	0.275	0.175	1.4 (1.08–1.9)	0.05
Rural Locality	0.026	0.272	0.09	1.2 (1.15–1.7)	0.05

done abroad, where a higher level of stigma was experienced by those with a diagnosis of schizophrenia than those with bipolar disorder and depression.[29,30] Schizophrenia and bipolar disorder patients reported higher internalized stigma and discrimination than anxiety disorders in other studies that compared this factor across psychiatric diagnoses.[31,32] Farrely et al (2014) however, observed no significant differences in experienced discrimination among their sample of patients suffering from mental illness (schizophrenia, depression, and bipolar disorder).[33] These differences can be attributed to differences in assessments, but the overall point to a higher prevalence of discrimination across the diagnostic groups. Subtle differences thus exist, but as a whole, all these points to higher discrimination and stigma among mental disorders, more so with psychotic and affective spectrum disorders than neurotic disorders. A family history of psychiatric illness has also been found to be significantly associated with higher discrimination among those with mental illness and also a significant determinant for discrimination in the regression analysis.

Females experienced significantly higher discrimination and stigma than males in our study. Ertugul et al (2004) in their study involving schizophrenia patients, found no such gender differences in stigma experiences.[19] This difference can be explained by the difference in the study population in the two studies. The finding by Grover et al (2017) however, matched our; female gender had significantly higher stigma scores while males had a higher stigma resistance in their multisite study across Indian states involving severe mental illness.[34] These gender differences in experiencing stigma and discrimination can be partly attributed to the patriarchal society and its deeply entrenched societal patterns that this country still has to offer.

The DISC-12 score was higher in the 35–44 age group while stigma experienced was higher in PMI above 55 years of age. Regression analysis, Grover et al (2017) discovered that younger age is associated with a significantly higher stigma score in patients with severe mental illness.[34] A younger age and thus an earlier age of onset of mental illness, leads to widespread negative consequences in overall functioning, seeking employment, and securing a fruitful relationship. These may be the reasons why PMI in younger groups experience more stigma and discrimination than their older counterparts. This also necessitates targeting young PMI for any form of stigma-alleviating programs.

The discrimination experienced was also higher among those who did not complete high school. Those who didn't complete their degree education (pre-degree) experienced a significantly highest stigma than the other educational attainments. The discrimination score and the proportion of PMI experiencing stigma were also significantly higher in those who were skilled workers in employment than those who were semi-skilled and unskilled. The findings match with those of Grover et al (2017) where sufferers of SMI who were educated until the 10th grade and those who were unemployed experienced significantly higher stigma.[34] However, education was not associated with stigmatizing experiences as reported by Ilic et al (2013).[32] This difference can be explained by the study population and the cultural differences in the study setting.

The place of residence in our study showed a conflicting picture in their association with discrimination score and stigma experienced. While the total mean DISC-12 score was significantly higher for rural dwellers than urbanites, the latter was reported to have experienced higher stigma than the former. The rural location has been found to be one of the significant determinants of stigma and discrimination in regression analysis. Loganathan et al (2008) also reported a similar finding in their study involving patients with schizophrenia, wherein rural dwellers experienced more ridicule, shame, and discrimination while urban respondents reportedly felt the need to hide their illness during job interviews.[12] Phillips et al (2002) report that patients' behavior is observed more in the crowded urban community compared to the rural community, which could perhaps explain the need to conceal their illness.35 Whatever the findings could be, this points to the need for a comprehensive stigma-reducing strategy to be planned for sufferers of mental illness, which would ultimately reciprocate in early treatment seeking, treatment compliance, and thus an overall holistic improvement in functioning and quality of life.

In the present study, the total mean DISC-12 score was found to be high among study subjects who had a family history of psychiatric illness. An important finding was the strong advantage (positive discrimination) conferred on the majority of respondents by family members. In contrast, a similar multi-site international study on stigma and discrimination against individuals with schizophrenia from Europe reported a positive advantage from family members in only a quarter (24%) of the respondents.[23] This finding demonstrates the importance of traditional (extended), closely knit family structure and its supportive influence as experienced by individuals with depression. Furthermore, depression may be a more socially acceptable condition than a more behaviorally disturbed diagnosis, such as a psychotic illness, even in this environment; and this may have accounted for the stronger family support reported in this study. Whatever the actual reason for the strong family support reported here, it is a noteworthy strength to be utilized, especially in the light of the world mental health survey report by Alonso et al (2008), which indicated that perceived stigma was nearly twice as prevalent at 21.1% in developing countries as compared with the developed ones (11.7%).[36]

This study is not without limitations. A small sample size in a hospital setting limits the generalizability of the findings. A more multicentric approach could have been taken to understand the topic under study across this country. The study could also have incorporated an intervention component for PMI, thus looking for their impact on reducing stigma and discrimination.

Conclusion

Stigma and discrimination are thus multifactorial and encompass a wide range of social and demographic parameters of a person suffering from any form of mental illness across a gamut of diagnostic entities, more commonly a primary psychotic disorder and a mood disorder. The current study found a younger age (<45 years), female gender, rural location, a family history of mental illness, and a diagnosis of a mood disorder (here depression) to be significantly associated with stigma and discrimination. Knowledge of these factors will help mental health professionals (MHPs) deal effectively with their clients (PMI) and alleviate the stigma and discrimination they face. The endeavor to lessen these experiences faced by PMI should be holistic. This should start with country-based legislations and acts percolating through the deeper layers of the country to the community setups. MHPs should be strong advocates for these activities. The recent legislation and government statutes on mental illness in this country, viz the Mental Health Care Act 2017 and the Rights of Persons with Disability Act 2016 have added important components that provide a rights-based approach to PMI with necessary clauses on promotion for a stigma- and discrimination-free environment for them.[37,38] They also include appropriate clauses for meting out punishments to those who discriminate against and stigmatize a PMI in any form. We need to look for further studies nationally and globally that look into stigma-reducing interventions for psychiatric disorders and their impact on the overall mental health of a country.

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Ερευνητική εργασία

Στίγμα και διακρίσεις σε άτομα με ψυχική ασθένειες σε ένα τριτοβάθμιο ιατρικό ίδρυμα στη Νότια Ινδία

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ΠΕΡΙΛΗΨΗ

Η συμβολή των ψυχικών διαταραχών στο συνολικό βάρος της νόσου στην Ινδία έχει σχεδόν διπλασιαστεί από το 1990. Το στίγμα και οι διακρίσεις αποτελούν μείζονα εμπόδια στην αναζήτηση θεραπείας για άτομα με ψυχικές ασθένειες (persons with mental illness, PMI). Επομένως, οι στρατηγικές μείωσης του στίγματος είναι ζωτικής σημασίας και γι' αυτό πρέπει να υπάρχει κατανόηση των διαφόρων παραγόντων που σχετίζονται με αυτές. Η παρούσα μελέτη είχε σκοπό να αξιολογήσει το στίγμα και τις διακρίσεις σε PMI που επισκέπτονται το τμήμα ψυχιατρικής σε ένα νοσοκομείο διδασκαλίας στη Νότια Ινδία και τη συσχέτισή τους με διάφορους κλινικούς και κοινωνικο-δημογραφικούς παράγοντες σε αυτά. Η μελέτη δεικτών ήταν μια περιγραφική συγχρονική μελέτη στην οποία συμμετείχαν κατόπιν συναίνεσης ενήλικες που παρουσιάστηκαν στο τμήμα ψυχιατρικής με ψυχικές διαταραχές από τον Αύγουστο του 2013 έως τον Ιανουάριο του 2014. Τα κοινωνικο-δημογραφικά και κλινικά δεδομένα συλλέχθηκαν χρησιμοποιώντας ημι-δομημένο ερωτηματολόγιο και η κλίμακα Discrimination and Stigma Scale (DISC-12) χρησιμοποιήθηκε για την αξιολόγηση των διακρίσεων και του στίγματος. Το μεγαλύτερο μέρος των PMI υπέφερε από διπολική διαταραχή, ακολουθούμενο από κατάθλιψη, σχιζοφρένεια και άλλες διαταραχές, όπως η ιδεοψυχαναγκαστική διαταραχή, η σωματομορφική διαταραχή και η διαταραχή χρήσης ουσιών. Το 56% από αυτούς υπέστη διακρίσεις και το 46% είχε εμπειρίες στιγματισμού. Τόσο οι διακρίσεις όσο και το στίγμα βρέθηκαν να συνδέονται σημαντικά με την ηλικία, το φύλο, την εκπαίδευση, το επάγγελμα, τον τόπο διαμονής και τη διάρκεια της ασθένειας. Ενώ οι PMI που έπασχαν από κατάθλιψη βίωσαν τις πλέον έντονες διακρίσεις, εκείνοι με σχιζοφρένεια αντιμετώπισαν το ισχυρότερο στίγμα. Η δυαδική λογιστική παλινδρόμηση έδειξε ότι η κατάθλιψη, το οικογενειακό ιστορικό ψυχιατρικής νόσου, η ηλικία κάτω των 45 ετών και η αγροτική τοποθεσία κατοικίας είναι οι σημαντικοί καθοριστικοί παράγοντες των διακρίσεων και του στίγματος. Συνεπώς η μελέτη διαπίστωσε ότι το στίγμα και οι διακρίσεις συσχετίστηκαν με πολλούς κοινωνικούς, δημογραφικούς και κλινικούς παράγοντες στους PMI. Μια προσέγγιση βασισμένη στα δικαιώματα των PMI είναι η επίκαιρη ανάγκη για την αντιμετώπιση του στίγματος και των διακρίσεων, η οποία περιλαμβάνεται ήδη σε πρόσφατες ινδικές πράξεις και καταστατικά. Η εφαρμογή αυτών των προσεγγίσεων είναι η επιτακτική ανάγκη.

ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ: Ψυχική νόσος, στίγμα, διακρίσεις, άτομα με ψυχικές ασθένειες.

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