

Stigmatising attitudes towards persons with mental illness: a survey of medical students and interns from Southern Nigeria

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Abstract

Stigmatising attitudes towards persons with mental illness are commonly reported among health professionals. Familiarity with mental illness has been reported to improve these attitudes. Very few studies have compared future medical doctors' attitudes toward types of mental illness, substance use disorders and physical illness. A cross-sectional survey of 5th and 6th year medical students as well as recently graduated medical doctors was conducted in April 2011. The 12-item level of contact report and the Attitude towards Mental Illness Questionnaire were administered. Participants endorsed stigmatising attitudes towards mental illness; with attitudes more adverse for schizophrenia compared to depression. Stigmatising attitudes were similarly endorsed for substance use disorders. Paradoxically, attitudes towards HIV/AIDS were positive and similar to diabetes mellitus. Increasing familiarity with mental illness was weakly associated with better attitudes towards depression and schizophrenia. Stigmatising attitudes towards depression and schizophrenia are common among future doctors. Efforts to combat stigma are urgently needed and should be promoted among medical students and recent medical graduates.

Introduction

Stigma is a major impediment to accessing appropriate care by individuals with mental illness. It is a recognized barrier to the effective management of mental health disorders in several parts of the world.¹ It affects the health professionals' readiness to provide wholesome interventions for individuals with psychiatric disorders. Furthermore, stigma promotes discrimination, increases the burden experienced

by patients and their caregivers, and places restrictions on social integration.²

Sadly, stigmatising attitudes towards mental illness are prevalent among health professionals, and in some reports these attitudes have not differed from views expressed by lay persons.³⁻⁵ In addition, findings have been variable concerning the effects of educational programs, psychiatry clerkships or courses on changing negative dispositions in various groups of health professionals or trainees.⁶

It has been suggested that advocacy to change or reduce stigmatising attitudes towards the mentally ill should be promoted by healthcare providers. They are role models in society, and their views greatly influence societal dispositions towards the mentally ill. It is recommended that programs aimed at correcting negative stereotypes about mental illness should be pioneered among medical students.⁷ Advocacy programs must be evidenced based and suited to the peculiar needs of a particular society or population group.⁸ An earlier survey on doctors attitudes towards mental illness in Nigeria, identified that examining stigmatising attitudes towards mental illness as a broad concept was a major limitation. The authors believed that doctors surveyed might hold differing attitudinal dispositions towards various diagnostic labels.⁵ In Pakistan, stigmatising attitudes of medical students and doctors were varied according to a range of psychiatric disorders.⁹ Familiarity with mental illness has been identified in previous reports as having a mitigating effect towards negative attitudinal dispositions towards mentally ill persons. It is less likely that negative attitudes would be endorsed with closer familiarity.¹⁰ This survey sought to determine attitudes of medical students in their final years of study and recent medical graduates undertaking a mandatory one-year housemanship towards schizophrenia and depression and compare same with a chronic physical illness that is known to be stigmatised (HIV/AIDS) and substance use disorders. We also aimed to test the hypothesis that closer familiarity with mental illness is associated with a more positive attitude towards the mentally ill.

Materials and Methods

Study design

This was a descriptive cross-sectional study.

Participants

All medical students in their final years who had completed a clerkship in psychiatry were surveyed. In addition recent medical graduates undertaking a mandatory one-year housemanship were also included in the survey. At the

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universities/teaching hospital where the study was carried out, students undergo a 4 or 8 week clerkship in psychiatry. This comprises; lectures, seminars, tutorials, bed side teaching at ward rounds and case presentations. A total of 300 questionnaires were distributed across both study sites. 260 questionnaires were returned; of these 254 were analysable (84% participation rate) and included in the study. There were 205 medical students and 49 housemen. The mean age (SD) of the participants was 25.62 (6.02) years. There was a slight male preponderance (54.3%). Male participants were significantly older than their female colleagues were ($t=5.316$, $P<0.001$).

Instruments

Socio-demographic data: we obtained socio-demographic variables; age, gender and ethnic group and current class of study.

Level of Contact Report (LCR): this measure was developed by Holmes *et al.*,¹¹ with its psychometric properties validated by other reports. It has been used previously in this geographical area.³ This instrument assesses the familiarity of persons with mental illness. It comprises of 12 statements which were adapted from other scales used in stigma research. The 12 statements are listed in increasing order of familiarity, the first being:

I have never observed a person with mental illness and the last: I have a serious mental illness. The statement checked that ranks the highest on the order of familiarity scale determine the respondents' score.

Attitude to Mental Illness Questionnaire (AMIQ): this five-item questionnaire is a brief, self-completion questionnaire.¹² Respondents read a short vignette describing an imaginary patient and answer five questions. Individual questions are scored on a five-point Likert scale ranging from strongly agree to strongly disagree (maximum +2, minimum -2) with *neutral* and *don't know* scored zero. The total score for each vignette ranges between -10 and +10. A higher (more positive) score indicates a favourable or less stigmatising attitude. For the purpose of this study, we adapted the vignettes from the original questionnaire in order to achieve the study's aims. In place of *heroin* in the first vignette we substituted it with *cannabis* which is a very common illicit drug of abuse in this environment. The vignette on a convicted criminal was replaced with that for an individual with HIV/AIDS. HIV/AIDS is an illness associated with stigma in Sub-Saharan Africa. We deleted the sentence *he has been detained in hospital under the Mental Health Act 1983* in the past as this does not apply to the local context. The vignette on a *practising Christian* was changed to a *nice person attending meetings of his religious organisation* to remove bias from the response of non-Christians. All names were changed to common names borne by persons indigenous to the setting of the study. A pilot of the adapted AMIQ conducted among 30 nursing and medical students showed it was well understood. The statement for each of the vignettes is shown in Table 1. A copy of the modified questionnaire is also available from the authors on request.

Procedure

The total number of medical students in the 5th and 6th years who had completed a clerkship in psychiatry across the two study sites (Igbinedion University, Okada, Edo State and Ambrose Alli University, Ekpoma, Edo State) was determined. Also the number of recent medical graduates who were undergoing their one-year mandatory housemanship at the Irrua Specialist Teaching Hospital, Edo State was determined. All students and housemen (n=315) were approached to participate. A total of 10 students declined to participate and 5 housemen could not be reached at the time of carrying out the study. For the medical students, questionnaires were distributed through their class representatives after attending a lecture in either internal medicine or surgery. They returned the questionnaires immediately following the lecture or the following day, to a sealed box at a conspicuous

location in the lecture hall. For the housemen, they were given the questionnaires via the chief residents in their respective postings (obstetrics/gynaecology, internal medicine, paediatrics and surgery). They were urged to return the questionnaires to boxes outside the offices of the chief residents.

Data analysis

Data were analysed using the Statistical Package for Social Sciences software (SPSS) version 17. Data were summarised using descriptive statistics and presented as means and standard deviations. The student's t-test was used to test the relationship between gender and attitudes to depression and schizophrenia. The relationship between familiarity with mental illness and stigmatising attitudes to schizophrenia and depression was tested using the Spearman rank correlations. Level of significance was set a $P < 0.05$

Results

There were differences in attitudinal responses of participants to the various vignette statements. For the vignettes on mental illness; participants' attitudes (when comparing group mean scores) towards schizophrenia (-2.97) were more negative compared to depression (-0.52). For substance use disorders, stigmatising attitudes were more negative for the vignette on cannabis (-4.20) use compared to that on alcohol (-1.63). There were positive endorsements for the vignettes on the physical illnesses of diabetes mellitus (5.55) and HIV/AIDS (3.54). The control vignette about a *nice person who was charitable and religious* also elicited positive attitudes (6.44). See Table 1. We found no significant associations between gender and attitudes to depression ($t = -0.530$, $P = 0.60$) or schizophre-

nia ($t = -0.254$, $P = 0.80$). We also note that there was no significant correlation between familiarity with mental illness and depression ($r = 0.043$, $P < 0.50$) or schizophrenia ($r = 0.094$, $P < 0.14$).

Discussion

To the knowledge of the authors, this is the first study in this geographical setting to examine attitudes of future or young medical professionals towards schizophrenia and depression specifically and not towards mental illness in general. Our findings confirm reports from studies with a similar methodology in other parts of the world.^{7,9,13} As in the study by Luty and his colleagues¹² participants in this study were more likely to stigmatise schizophrenia compared to depression. Though attitudes to depression by the lay public in the UK were positive, the reverse was the case in this study. A possible reason for this might be the effect of frequent awareness programmes about depression carried out in different parts of the UK which might have resulted in myths about the illness being dispelled.^{14,15} We had expected that knowledge about depression might have a moderating effect on the attitudes of future doctors in this survey, however as observed in other similar studies cases seen during their psychiatry clerkship are usually of the severe type and mild to moderate cases of depression rarely present to psychiatric facilities but to primary care practitioners if they present at all. It has been suggested that the way schizophrenia is taught to medical students creates an impression of chronicity and unpredictability.¹⁶ Furthermore, recent events in the media involving mass homicides perpetrated by individuals presumed to have schizophrenia might have biased their responses.

Table 1. Mean scores on the attitude towards mental illness questionnaire for future medical doctors.

Vignette	Mean score (Standard deviation)
Bunmi has been smoking cannabis daily for 1 year	-4.20 (3.10)
Osa is depressed and took a paracetamol overdose last month to kill herself	-.52 (3.54)
Blessing has been drinking heavily for 5 years and is now undergoing treatment with regular counselling	-1.63 (.24)
Ehi has HIV/AIDS. She is on regular medications and is able to keep up with work and family duties	3.54 (3.13)
Temitope has diabetes and needs to inject insulin every day and has a special diet	5.55 (3.18)
Uche has schizophrenia. He needs an injection of medication every two weeks. He was detained in hospital for several weeks 2 years ago because he was hearing voices from the devil and thought he had power to cause earthquakes.	-2.97 (3.85)
Busayo is a nice person. He attends meetings of his religious organisation regularly and carries out a lot of charitable work in the community.	6.44 (3.06)

Future doctors surveyed stigmatised individuals who use cannabis. Cannabis is a common illicit substance of abuse in this environment. The variant of cannabis grown in this part of the world is associated with psychopathology and cannabis use accounts for a significant proportion of patients presenting to psychiatric services.¹⁷ Respondents' negative attitudes may also mirror this association, as well as the relationship between cannabis use and offending. Negative attitudes to alcohol may hamper the readiness of future doctors to manage or willingness to offer care for individuals with alcohol use disorders. A surprising finding from this study was the tendency not to stigmatise persons with HIV/AIDS. This condition is heavily stigmatised in sub-Saharan Africa.¹⁸ Our findings are consistent with a recent review in which lay persons are more likely to stigmatise individuals who misuse psychoactive substances, compared to schizophrenia and depression.¹⁹ In recent years, concerted efforts to combat stigma which acts as a barrier to treatment have involved advertising in the print and electronic media. Advocacy efforts have had an effect on changing stereotypes. In addition, funding from the government and donor agencies has made screening and the management of the disease easily accessible and affordable. As a result, persons infected with the virus seek treatment early and live healthy lives. Doctors and medical students get to manage and interact with individuals in the early stage of the disease unlike the case of persons with mental illness in our setting. Perhaps, similar strategies can be employed here, where individuals speak about their mental illness and encourage others who might be suffering similar symptoms to seek prompt care.²⁰ Furthermore, subsidising mental health care might result in service users engaging with services regularly and reduce default rates and development of severe forms of mental illness. Undergraduate training in psychiatry should focus less on teaching in psychiatric hospitals or departments in teaching hospitals where severe cases are managed to community or primary care settings where mild or moderate cases present to reduce stigma. We did not test for the effect of their clerkships on attitudes towards persons with mental illness, though other reports have produced inconsistent effects.²¹ While change or improvement in knowledge have been observed, attitude change has been minimal. Another strategy to improve attitudes towards persons with mental illness has been suggested. The undergraduate curriculum should incorporate anti-stigma lectures or seminars. These seminars might involve close interactions and discussions between students and persons with mental illness who are recovered and their caregivers on how they perceive stigma including its deleterious effects on their lives.^{21,22} We did not observe a significant relationship between increasing familiarity and

better attitudes towards the mentally ill in this study. Though, earlier reports have noted the positive effect of familiarity on mental illness and certain constructs of stigma such as reduced social distance.²³ Perhaps the effect of familiarity are readily observed in lay persons unlike in a group such as doctors because of their previous knowledge and a counteractive effect of seeing very severe cases during their clerkships. This study is not without limitations. The sample size was moderate and findings are not generalisable to all medical students from this part of the world. The AMIQ was adapted and the psychometric properties were not determined, however distribution of scores was similar to the study conducted in the UK.¹²

Conclusions

Stigmatising attitudes towards psychiatric diagnostic labels vary among future medical doctors. Individuals with substance use problems were similarly stigmatised, however attitudes towards individuals with HIV/AIDS were positive. Strategies are needed to combat the stigma of mental illness among medical professionals in this setting.

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