PODURI CHINNA REDDY VENKATA RAMAMMA AWARD

A CROSS-SECTIONAL STUDY OF STIGMA AND QUALITY OF LIFE IN PATIENTS WITH MENTAL ILLNESS

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ABSTRACT

Despite the scientific advances stigma still continues to be an important barrier in the management of mental illness (MI). In this study we assessed the stigma and quality of life in patients with MI.
Method: 30patients with mental illness were assessed on DISC- 12 and WHOQOL-BREF.
Results*:* Environment domain of QOL showed significant negative correlation with subscale-1, i.e. "unfair treatment of DISC (p value 0.046). Delay in psychiatric management, showed significant positive correlation with subscale-2, i.e. "stopped patients from doing things" of DISC (p value 0.000), (p value 0.03).
Conclusion: Stigma affects several aspects of patient's life and has far reaching implications. There is unnecessary delay in seeking psychiatric treatment and poor QOL. Various domains like marriage, family life, social and interpersonal relations, work and productivity, are badly affected.
Recommendations: Public education programs to increase awareness and knowledge of the nature of mental illness and treatment options were recommended. Reducing stigma will go a long way in the appropriate management of mental illness.

Keywords: Stigma; Quality of life, Mental Illness.

INTRODUCTION

Mental illness stigma existed long before psychiatry. Patients with mental illness have stigma and reduced quality of life. Stigma is defined as a sign of disgrace or discredit, which sets a person apart from others.

The stigma of mental illness remains a powerful negative attribute in all social relations. Stigma has become a marker for adverse experiences like shame, blame, secrecy, role isolation, social exclusion, stereotype discrimination, first among these is a sense of shame.[1] Stigma refers to undesirable characteristics linked to MI and the adverse cognitive and behavioral consequences.[2] Discriminatory practices lead to secrecy. Patients who pursue the secrecy strategy and withdraw have a more insular support network. Discrimination occurs across every aspect of social and economic existence.[2] Persons with mental illness frequently encounter public stigma and may suffer from self-stigma.[3] Stigma surrounding major mental illness creates many barriers. People who experience mental illness face discrimination and prejudice when renting homes, applying for jobs, and accessing mental health services. Counselor training is a peak time to identify and begin to mitigate stigma related to people with mental illness.[4]

The health services of any country are meaningful only if they bring a change in the well-being of individuals. Wellbeing can be assessed by measuring the improvement in the quality of life. Quality of life(QOL) is the general well-being of a person or society, defined in terms of health and happiness, rather than wealth.[5] Much of the negative effect of mental illness is explained by perceived stigma, lower self-esteem, and a higher level of depressive symptomatology.[6] A New Zealand study reported that experiencing stigma and discrimination in a variety of contexts is associated with dissatisfaction in number of areas.[7] Persons with MI are more likely to be unemployed have less income, experience diminished sense of self and have fewer social supports.[8]

INDIAN STUDIES:

Srivastava et al found that stigma leads to negative mental health outcomes, is responsible for delay in treatment seeking and reduces the likelihood that a mentally ill patient will receive adequate care.[9]In one study, Talsohe found duration of untreated illness, i.e. onset of psychiatric illness to neuroleptic treatment in schizophrenia patients in India was 796wks.[10] Thara et al also found that stigma related to schizophrenia in India is particularly high [11]. Being a developing country, in India stigma is still high. This in turn is affecting Quality of life of patients with mental illness.

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Hence it is pertinent to study the stigma due to mental illness in our country.

AIMS AND OBJECTIVES:

1. To study the stigma in patients with mental illness.
2. To study the correlation between quality of life and stigma in patients with mental illness.
3. To Study correlation between socio-demographic variable with stigma.

METHODOLOGY

Study Setting: Study sample was collected from Government hospital, Institute of Mental Health, Erragadda, Hyderabad.
Size of Sample: 30 Patients with mental illness.
Study Period: 25/04/2015 to 25/05/2015.
Study Design: Cross sectional study.
Inclusion criteria:
1. Mentally ill patients between 20-55yrs age.
2. Patients who gave consent and were cooperative.

Exclusion Criteria:
1. Patients who did not give consent.
2. Patients with history of Substance dependence.
3. Patients who are excited, non-cooperative and acutely ill.
4. Not having insight in to illness.

PROCEDURE
Patients were randomly selected; those who met inclusion criteria were explained about the study. Informed consent was obtained. Diagnosis of MI was made clinically as per ICD-10.[12]

Rating scales used:

Modified Kuppuswamy scale**[13]:**
It is a composite scale of education, occupation of head of the family, along with monthly income of family which yields a score of 3-29. This scale classifies the study population into high, middle and low socioeconomic status.

Discrimination and Stigma Scale (DISC), Version 12[14]:

DISC Scale gives information on how mental illness influences an individual's personal and social life. This scale was developed for use in face-to-face interviews. It collects quantitative and qualitative experiences of discrimination in key areas of everyday life and social participation, including work, marriage, parenting, housing, leisure and religious activities. The DISC Scale was designed for use by sites collaborating in the International Study of Discrimination and Stigma Outcomes (INDIGO) on schizophrenia (Thornicroft et al, 2009). The Principal Investigator and Study Coordinator was Professor Graham Thornicroft. DISC-12 comprises 34 questions and 4 subscales:
Subscale 1 - Unfair treatment
Subscale 2 - Stopping self from doing things
Subscale 3 - Overcoming stigma
Subscale 4 - Positive treatment

Each item is scored as 0 = no difference, 1= a little, 2= moderately and 3= a lot. A 'not applicable' option is available for occasions where the participant was not involved in a situation where they could have experienced discrimination. A total score is calculated for each subscale by counting the number of items for which the participant scores 1 (a little), 2 (moderately) or 3 (a lot) in each subscale. The Scale being in English language was administered by the interviewer (author) and with the help of translation for patients who were illiterate.

WHOQOL-BREF SCALE[15]:
Developed by The WHOQOL Group, Programme on Mental Health, WHO. (CH-1211 Geneva 27 and Switzerland). This document gives a conceptual background to the WHOQOL definition of quality of life and describes the development of the WHOQOL-BREF, an abbreviated version of the WHOQOL-100.

Quality of life is defined as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. The WHOQOL-BREF is therefore based on a four domain structure. Any national items should be scored separately from the core 26 item of the BREF. Each item scored as Not at all(1), A little(2), Moderately(3), Mostly(4), Completely(5).

It has 4 Domains:
1. Physical health domain
2. Psychological domain
3. Social relationships domain
4. Environment Domain gives raw score.

The WHOQOL-BREF (Field Trial Version) produces a quality of life profile. It is possible to derive four domain scores. There are also two items that are examined separately: question 1 asks about an individual's overall perception of quality of life and question 2 asks about an individual's overall perception of their health. The four domain scores denote an individual's perception of quality of life in each particular domain. Domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life). The mean score of items within each domain is used to calculate the domain score. Mean scores are then multiplied by 4 in order to make domain scores comparable with the scores used in theWHOQOL-100. The Scale was administered by self-

rating procedure for patients who were literate and was administered with the help of translation for patients who were illiterate.

STATISTICAL ANALYSIS

Data has been analyzed using SPSS version 22 of windows. Pearson's and spearman's correlation test was used to test correlation between variables. Statistical significance was set at 0.05.

RESULTS

In the sample of 30 patients, 22 were males (73.33%), and 8 females (26.67%). Majority of the patients (12) belong to the 26-35age group. Most of them were graduates and married. 63.32% were Hindus. 39.99% of the sample belongs to low socioeconomic status. 66.66% of the sample belongs to rural area.(Table 1)

In the clinical profile (Table 2) 60% of the sample was diagnosed with paranoid schizophrenia (PS), 16.33% BPAD Mania, 16.66% Depression and 3.33% each for OCD and GAD. The duration of MI was in the 1-5 years range for majority of the sample. 76.66% had no family history of psychiatric illness. 72.99% of the sample was first taken to a faith healer (FH) for treatment. Only 26.66% of the sample visited either a physician (PHY) or a psychiatrist (PSY) for the first time. 36.66% of the sample visited a psychiatrist only after 1-2years of suffering.

Spearman's correlation test was done for various variables and subscales of DISC scale (Table 3). Positive correlation was found to be statistically significant for marital status with subscale 3 i.e. 'Overcoming stigma' (r= 0.431, p value 0.017) and delay in psychiatric management with subscale 2 of the DISC scale (r=0.387, p value 0.03).

Spearman's correlation test for other variables like occupation, first treatment taken from, socioeconomic status, and subscales of DISC scale were not statistically significant.

Pearson correlation was done between the QOL BREF and DISC scale (Table 4). The result was significant for the domain 4 of QOL with the subscale 1 of DISC scale(r=0.367, p value=0.046).

Table 1: Socio-Demographic Data of patients with mental illness

Variable		Gender		CHI-SQUARE	P Value
		Female(n=8) N(%)	Male(n=22) N(%)		
Age	20-25yrs	1(3.33)	5(16.66)	3.336	0.343
	26-35yrs	4(13.33)	8(26.66)		
	36-45yrs	0	5(16.66)		
	46-55yrs	3(10)	4(13.33)		
Education	NILL	1(3.33)	3(10)	2.434	0.656
	Professional	1(3.33)	2(6.66)		
	Undergraduate	2(6.66)	10(33.33)		
	Graduate	4(13.33)	7(23.33)		
Marital Status	Unmarried	3(10)	10(33.33)	0.627	0.733
	Married	5(16.66)	11(36.66)		
	Divorced	0	1(3.33)		
Occupation	NILL	3(10%)	8(26.66)	15.008	0.005 SIG
	House wife	4(13.33)	0		
	Semi-skilled	0	7(23.33)		
	Unskilled	0	4(13.33)		
	Skilled	1(3.33)	3(10)		
Religion	Hindu	5(16.66)	14(46.66)	3.277	0.194
	Christian	1(3.33)	7(23.33)		
	Muslim	2(6.66)	1(3.33)		
Socio Economic Status	Lower	2(6.66)	10(33.33)	3.068	0.546
	Lower Middle	3(10)	3(10)		
	Upper Lower	3(10)	7(23.33)		
	Upper Middle	0	1(3.33)		
	Upper	0	1(3.33)		
Region	Rural	4(13.33)	16(53.33)	1.364	0.243
	Urban	4(13.33)	6(20)		

Table 2: Clinical Profile of the patients with mental illness

Variable	Gender		CHI-SQUARE	P Value
	Female(n=8) N(%)	Male(n=22) N(%)		
DX			5.455	0.244
Paranoid Schizophrenia	6(20)	12(40)		
Bipolar Affective Disorder	0	5(16.66)		
Depression	1(3.33)	4(13.33)		
Generalized Anxiety Disorder	1(3.33)	0		
Obsessive Compulsive Disorder	0	1(3.33)		
FIRST Rx BY				
Faith Healer	5(16.66)	17(56.66)	1.294	0.524
Physician	1(3.33)	3(10)		
Psychiatrist	2(6.66)	2(6.66)		
REGION				
Urban	4(13.33)	6(20)	1.364	0.243
Rural	4(13.33)	16(53.33)		
DURATION OF MI				
1-5YRS	5(16.66)	9(30)	1.226	0.542
6-10YRS	2(6.66)	7(23.33)		
11-20YRS	1(3.33)	6(20)		
FAM H/O				
NILL	6(20)	17(56.66)	0.17	0.896
YES	2(6.66)	5(16.66)		

Table 3: **Correlation coefficient between DISC scale and other variables**

Variable		DISCD1 N=30	DISCD2 N=30	DISCD 3 N=30	DISCD 4 N=30
Marital status	Correlation Coefficient	.058	.089	**.431***	-.102
	Sig. (2-tailed)	.762	.639	**.017**	.591
Occupation	Correlation Coefficient	-.328	-.202	.300	-.030
	Sig. (2-tailed)	.077	.283	.107	.874
Socioeconomic status	Correlation Coefficient	-.179	-.008	-.024	.189
	Sig. (2-tailed)	.344	.969	.899	.316
First Treatment	Correlation Coefficient	.120	-.205	-.064	-.039
	Sig. (2-tailed)	.529	.276	.736	.838
Delay in psychiatry treatment	Correlation Coefficient	.256	.387*	.242	-.069
	Sig. (2-tailed)	.172	.034	.199	.719

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 4: Correlation between QOL BREF and DISC scale

		DISCD1	DISCD2	DISCD3	DISCD4
QOLD1	Pearson Correlation	-.349	-.057	.310	.167
	Sig. (2-tailed)	.058	.765	.096	.379
	N	30	30	30	30
QOLD2	Pearson Correlation	-.310	-.143	.260	.284
	Sig. (2-tailed)	.095	.451	.165	.128
	N	30	30	30	30
QOLD3	Pearson Correlation	-.290	-.045	.239	.192
	Sig. (2-tailed)	.120	.813	.204	.309
	N	30	30	30	30
QOLD4	Pearson Correlation	-.367*	-.039	.248	.215
	Sig. (2-tailed)	.046	.838	.187	.253
	N	30	30	30	30

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

DISCUSSION

The socio-demographic factors of the present study showed that the majority of the patients were males between 25-36 years of age, graduates and married, from rural back ground and Hindu.

60% of the sample had Paranoid Schizophrenia (PS). 36.66% of the sample made a delay of 1-2yrs to meet psychiatrist. These findings were similar to studies by, Johnson et al[9], Srivastava[17], Tripati[10]and Tara[11].

In our study 72.99% of the samples were first taken to a faith healer. In African population Makanjola et al[18] found that majority of their patients consulted faith healers first.

Marital status showed positive correlation with subscale 3 i.e. "overcoming stigma and discrimination" on DISC ($p = 0.017$). Deborah et al[19] study showed marital status is negatively correlated with psychological isolation and rejection sensitivity. Occupation and socioeconomic status had negative correlation with stigma and discrimination similar to studies by Fred[8], Shunncounture,[16] Lai YM et al[20] Patric W Corrigon et al.[21]

Delay in psychiatric management had significant positive correlation with subscale 2 of DISC scale i.e. "stopping patients from doing things"($p = 0.03$). These findings were along with a study by Shrivastava et al.[9] Stigma isolates people and delays treatment of mental illness which in turn causes great economic and social burden. Other study by Tripati et al[10] found delay of 796 weeks for schizophrenia management.

Pearson correlation test was done between QOL BREF and DISC. The environment domain of QOL {financial resources freedom, physical safety and security, health and social care: accessibility and quality Home environment Opportunities for acquiring new information and skills Participation in and opportunities for recreation/ leisure activities, physical environment (pollution/ noise/ traffic/ climate) and transport} showed significant negative correlation with subscale 1 i.e. "unfair treatment of DISC"($p=0.046$). This results were in concordance with a New Zealand study by Badri et al[7] where majority of patients reported experiencing stigma and discrimination. They also experienced dissatisfaction with number of events.

The stigma associated with mental illness harms the self-esteem of many people who have serious mental illnesses. An important consequence of reducing stigma would be to improve the self-esteem of people who have mental illnesses (Bruce G et al.[22]) Consequences of internalized stigma are reduction in self-esteem and hope. (Mashiach-Eizenberg et al.[23]) Batanic et al[24] concluded that higher levels of stigma had significantly poorer quality of life and lower self-esteem.

CONCLUSION

1. Married patients could overcome stigma by their coping skills and making relationships.
2. Delay in psychiatric treatment made the patients'Stopping self from doing things' such as doing work, applying for education and training, maintaining close interpersonal relationships and revealing their mental health problems
3. Positive Environmental factors have a de-stigmatizing effect especially on the 'unfair treatment' by family members, society or working environment.

4. It was seen that major number of sample first visited a faith healer and this led to delay in getting psychiatric treatment.

LIMITATIONS

1. Size of sample is small.
2. No control group.
3. Diagnostic instrument is not used to rule out acute illness and to assess low levels of symptoms.

RECOMMENDATIONS FOR FUTURE RESEARCH:

Similar study can be conducted with a larger sample size.
Patients with other medical illness can be compared with mental illness.
Multidimensional efforts are needed to overcome stigma, like changes in legislation, better depictions of mental illness by media, inclusion of family in the treatment programs and public education.

ACKNOWLEDGEMENTS:

Authors would like to thank Superintendent Dr. V. Pramod Kumar for permitting to carry out the study, and all patients for their cooperation and participation in the study.

CONFLICT OF INTEREST: NIL

SOURCE OF SUPPORT: NIL

REFERENCES

1. Peter Byrne, Stigma of mental illness and ways of diminishing it, Advances in Psychiatric Treatment Jan 2000;6(1)65-72.
2. Byrne P. Stigma of mental illness and ways of diminishing it. Advances in Psychiatric treatment. 2000 Jan 1;6(1):65-72.
3. Rüsch N, Angermeyer MC, Corrigan PW. Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. European psychiatry. 2005 Dec 31;20(8):529-39.
4. Overton SL, Medina SL. The stigma of mental illness. Journal of Counseling & Development. 2008 Apr 1;86(2):143-51.
5. Collins English Dictionary: Complete & Unabridged. Collins, 2006.
6. Mechanic D, McAlpine D, Rosenfield S, Davis D. Effects of illness attribution and depression on the quality of life among persons with serious mental illness. Social science & medicine. 1994 Jul 31;39(2):155-64.
7. El-Badri S, Mellsop G. Stigma and quality of life as experienced by people with mental illness. Australasian Psychiatry. 2007 Jan 1;15(3):195-200.
8. Markowitz FE. The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. Journal of Health and Social Behavior. 1998 Dec 1:335-47.
9. Shrivastava A, Johnston M, Bureau Y. Stigma of mental illness-1: Clinical reflections. Mens sana monographs. 2012 Jan;10(1):70.
10. Srinivasan Tirupati N, Rangaswamy T, Raman P. Duration of untreated psychosis and treatment outcome in schizophrenia patients untreated for many years. Australian and New Zealand journal of psychiatry. 2004 Jan 1;38(5):339-43.
11. Thara R, Srinivasan TN. How stigmatising is schizophrenia in India? International Journal of Social Psychiatry. 2000 Jun 1;46(2):135-41.
12. World Health Organization. The ICD-10 classification of mental and behavioral disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization; 1992.
13. Park, editor. Medicine and Social sciences. Textbook of preventive and social medicine. 21st edition. Jabalpur: In Banarasi das, Bhanot publishers, 2011:638-40.
14. Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M, INDIGO Study Group. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. The Lancet. 2009 Feb 6;373(9661):408-15.
15. Bergner M, Bobbitt RA, Carter WB, Gilson BS. The Sickness Impact Profile: development and final revision of a health status measure. Medical care. 1981 Aug 1:787-805.
16. Couture S, Penn D. Interpersonal contact and the stigma of mental illness: A review of the literature. Journal of mental health. 2003;12(3):291-305.
17. Shrivastava A, Johnston ME, Thakar M, Shrivastava S, Sarkhel G, Sunita I, Parkar S. Impact and origin of stigma and discrimination in schizophrenia: Patient perceptions. Stigma Research and Action. 2011 Feb 25;1(1):67-72.
18. Adelekan ML, Makanjuola AB, Ndom RJ. Traditional mental health practitioners in Kwara State, Nigeria. East African Medical Journal. 2001;78(4):190-6.
19. Perlick DA, Rosenheck RA, Clarkin JF, Sirey JA, Salahi J, Struening EL, Link BG. Stigma as a barrier to recovery: adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. Psychiatric Services. 2001 Dec;52(12):1627-32.
20. Lai YM, Hong CP, Chee CY. Stigma of mental illness. Singapore Medical Journal. 2001 Mar;42(3):111-4.
21. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. World Psychiatry. 2002 Feb;1(1):16.
22. Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. Psychiatric services. 2014 Oct 14.
23. Mashiach-Eizenberg M, Hasson-Ohayon I, Yanos PT, Lysaker PH, Roe D. Internalized stigma and quality of life among persons with severe mental illness: the mediating roles of self-esteem and hope. Psychiatry research. 2013 Jun 30;208(1):15-20.
24. Batinic B, Lemonis E, Opacic G. 1004–Effects of internalized stigma of mental disorder on quality of life and self-esteem in schizophrenic patients. European Psychiatry. 2013 Dec 31;28:1.

How to cite the article: Shanthi C, Siva Kumar Ch, Nikhil Ravindranath T, Manok Kumar P. A cross-sectional study of stigma and quality of life in patients with mental illness. TJP 2015; 1(1): 15-20.