Understanding Stigma

A study on mental health related stigma by Portuguese health care professionals

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Background: Mental illness-related stigma creates serious barriers to access employment, education, housing, health and social care. Growing evidence shows that health care professionals also stigmatise and discriminate against people with mental illness. This form of interpersonal stigma leads to unequal attention to emotional and physical complaints, paternalistic behaviours, coercive treatment and exclusion of patients from decisions. Furthermore, it is deeply related to self-stigma and to the recovery process.

Objectives: To explore mental health-related stigma in a Portuguese health care setting.

Methods:

We designed our own questionnaire especially for this study, based on questions used in earlier investigations with comparable objectives and on validated scales about stigma. The scales that we consulted were: Social Distance Scale, Attribution Questionnaire (AQ 27), Mental Illness Clinicians' Attitudes Scale, version 4 (MICA) and Opinions About Mental Illness Scale. Our questionnaire had 38 questions (multiple choice questions) and was divided in two parts: 1) sociodemographic questions – age, gender, family and/or personal history on psychiatric disorders; 2) queries about beliefs and attitudes about psychiatric illnesses, in a Likert scale (from totally disagree to totally agree). We evaluate the following stigma dimensions: responsibility, pity, perceived, dangerousness and social restriction. It had a total of 38 questions.

We applied the paper-based questionnaire to general practitioners, working on primary health care units in the *Agrupamento de Centros de Saúde* of *Porto Ocidental – ACeS*, Porto district (Portugal).

Our project was submiteed and approved by the Ethical Committee of Hospital Magalhães Lemos, Porto, Portugal.

Results:

from a total of 15, 13 Health Local Units agreed to participate in our study. We estimated a response rate of 58% - a total of 66 participants.

The demographic variables are presented in table 1.

Variables	% (n)	
Age	41.2 years (25-66)	
Gender	Female 66.7% (n=44)	Male 33.3% (n=22)
Category	Specialist 65.2% (n=24)	Trainee 34.8% (n= 23)
Internship in Psychiatry	No 6.1% (n=4)	Yes 93.4% (n=62)
Previous Psychiatric history	No 81.9% (n=54)	Yes 18.2% (=12)
Familial psychiatric history	No 59.1% (n=39)	Yes 40.9% (=27)
Friend with Psychiatric History	No 30.3% (n=20)	Yes 69.7% (n=46)

Table 1

We find that psychiatry internship reduces the likelihood of pitying the patient. Furthermore, while having personal history reduces pity, family history increases it (table 2).

Pity	Coef.	z	P> z	[95% Conf. Interval]	
Internship in Psychiatry	-1.975566	-1.99	0.046	-3.918659	-.0324718
Previous Psychiatric history	-1.563532	-2.12	0.034	-3.010304	-.1167596
Familial psychiatric history	1.261631	2.26	0.024	.1681032	2.355158

Table 2

We find that having a friend with psychiatry history reduces social restriction (table 3).

Social Restriction	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
Friend with Psychiatric History	.972 2997	.4810959	2.02	0.043	.0293691	1.91523

Table 3

Our results suggest that gender may influence the believe that people are responsible for their mental illness- male professionals tend to hold patients accountable for the disease (table 4).

Responsibility	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]	
Gender – Male	1.308846	.5135616	2.55	0.011	.3022834	2.315408

Table 4

Conclusions: Our work allows a better understanding of the complex and multidimensional concept of stigma related to mental health. Adding new insights on stigma research, we hope to promote more successful and lasting anti-stigma strategies.

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