بسم الله الرحمن الرحيم

Napata College

Faculty of Medicine

Batch (3)

Impact of Stigma of Mental Illness on Seeking Mental Care in Medical Students of Napata College at Khartoum State 2022.

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سورة النمل: الآية (١٥)

Dedication

We dedicate this work to our loving fathers and mothers whose affection, love, encouragement, and prayers of day and night make us able to get such success and honor.

Acknowledgment

All thanks to Allah for giving us the strength to complete this research, and we would like to express our deep thank to our supervisor for guiding and helping to make this thesis as well-done achievement, deep thank for all the people who gives us support and advice throughout this research, finally, all thanks to the participants who agree to volunteer in the study.

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Abstract

Background: Stigma is defined as a sign of disgrace or discredit, which sets a person apart from others. The fear of being stigmatized by others often leads people to avoid professional help. This stigma can also be internalized, further reducing the likelihood of seeking help.

Objectives: This study was conducted to assess the impact of stigma of mental illness on seeking mental care.

Materials and Method: This is an observational cross-sectional community base study conducted in Napata College in Khartoum state. A total of 150 students were investigated and all information was gathered via a questionnaire that was coded and analyzed by SPSS.

Results: the result show a significant correlation between stigma and delay seeking help, 56% of the students expressed symptoms of mental illness, 48% feel that stigma affected their academic level, 84% of the students were never seen by a psychiatrist, 70.6% of the students think that they never seen a psychiatrist because of the lack of support from the surroundings, 53% of the students hasn't shared their symptoms with someone close to them, 63% of the students didn't share with their surroundings their desire to see a psychiatrist, 42% of the students think that stigma affects the request to consult a psychiatrist.

Conclusion: There was a high incidence of mental illness among students and there was a significant correlation between stigma and delay seeking help.

المستخلص

الخلفية: يتم تعريف وصمة العار على أنها علامة على الخزي أو التقليل من المصداقية ، مما يضع الشخص بصرف النظر عن الآخرين. غالبًا ما يؤدي الخوف من وصم الآخرين بالعار إلى تجنبه مساعدة مهنية. يمكن أيضًا استيعاب هذه الوصمة، مما يؤدي إلى تقليل احتمالية طلب المساعدة. الأهداف: أجريت هذه الدراسة لتقييم أثر وصمة العار للأمراض النفسية في طلب الرعاية النفسية. المواد والطريقة: هذه قاعدة مجتمعية مقطعية رصدية أجريت الدراسة في كلية نبتة بولاية الخرطوم. كان ما مجموعه 150 طالبًا تم التحقيق فيها وتم ترميز وتحليل جميع المعلومات التي تم جمعها عبر الاستبيان بواسطة SPSS. النتائج: أظهرت النتائج علاقة ارتباط معنوية بين وصمة العار وطلب التأخير مساعدة ، 56٪ من الطلاب عبروا عن أعراض مرض عقلي ، و 48٪ يشعرون بذلك أثرت وصمة العار على مستواهم الأكاديمي ، ولم يشاهد 84٪ من الطلاب أ طبيب نفساني ، 70.6٪ من الطلاب يرون أنهم لم يروا طبيباً نفسياً بسبب عدم وجود دعم من المناطق المحيطة ، لم يتم مشاركة 53٪ من الطلاب معهم الأعراض مع شخص مقرب منه ، لم يشارك 63٪ من الطلاب بها من حولهم يرغبون في رؤية طبيب نفسي ، يعتقد 423٪ من الطلاب ذلك تؤثر وصمة العار على طلب استشارة طبيب نفسي. الخلاصة: كانت هناك نسبة عالية من الأمراض النفسية بين الطلاب وهناك كان هناك ارتباط كبير بين وصمة العار والتأخير في طلب المساعدة.

CHAPTER INTRODUCTION

1.1 Background

Stigma is defined as a sign of disgrace or discredit, which sets a person apart from others. The fear of being stigmatized by others often leads people to avoid professional help. This stigma can also be internalized, further reducing the likelihood of seeking help. Understanding these different forms of stigma can help psychologists target interventions at different levels to help people overcome the barriers to seeking help.

One of the most common reasons for people to not seek treatment is concern about stigma. In the psychotherapy literature, stigma has generally referred to the public stigma of having a mental illness, with the clearest example being schizophrenia. Public stigma is society's rejection of a person due to certain behaviors or physical appearances that are deemed unacceptable, dangerous or frightening.

Although in most industrialized societies today the mentally ill are no longer overtly persecuted, there are clear indications of the presence of public stigma towards individuals with a mental illness. These perceptions of the mentally ill are not lost on those needing treatment and can lead to the hiding of mental health concerns and avoidance of treatment in an attempt to reduce the negative consequences associated with stigma.

1.2. Problem Statement:

People who experience mental illness face discrimination and prejudice when renting homes, applying for jobs, and accessing mental health services. Many people suffering from serious mental illness do not seek appropriate medical help. The stigma of mental illness has often been considered a potential cause for reluctance in seeking help.

1.3 Rationale

Unfortunately, people distressed by mental illnesses often do not seek out services or choose to fully engage in them. One factor that impedes care seeking and undermines the service system is mental illness stigma. Stigma is a complex construct that includes public, self, and structural components. It directly affects people with mental illness, as well as their support system, provider network, and community resources. The effects of stigma are moderated by knowledge of mental illness and cultural relevance. Understanding stigma is central to reducing its negative impact on care seeking and treatment engagement.

1.3 Objectives:

1.3.1 General Objective:

To assess the impact of stigma of mental illness on seeking mental care.

1.3.2 Specific Objective

1. To verify the existence of a relationship between the stigma and poor prognosis
2. To explore relationship between stigma and delay seeking help.

CHAPTER TWO

Literature Review

2.1 Stigma

Stigma is a term that applies to labelling certain people as different and inferior. It is a mark of shame, a sign of worthlessness applied to the stigmatized. Its consequence is avoidance and even expulsion from society. It can be described as a form of social monitoring or omission of minorities from certain competitive areas, working as a form of intangible control over groups of people with mental disorders (Goffman, 1963). Its influence is in proportion to social, economic and political forces that make possible the creation of stereotypes, destruction of reputation, and other forms of discrimination.

2.2 Stereotypes

Stereotypes are knowledge acquired by the majority of a social group so that knowledge of other social groups can be categorized. A stereotype is a collective agreement, needed for quick orientation as far as expectations and impressions are concerned. They are dynamic constructs, dependent on social judgment. Having a stereotypical opinion of a patient with mental health disorder would be thinking of him as dangerous and severely behaviorally disturbed. These stereotypes do not fit the facts. A typical patient life in the community, his behavior socially managed. A typical person with mental disorder has far less trouble in social adaptation than the usual hospitalized patient. Patients who must be treated regularly throughout their lives are a minority in the mentally ill fringe group. They function according to the severity of the illness, associated disabilities, the level and quality of available support and treatment capabilities.

Patients who have recovered are usually invisible to professionals and public, as they generally hide their illness from others, because of stigma. They avoid institutions and social services so that they can pursue their careers, education or other personal goals. A diagnosis only describes the part of a person that the symptoms fit. A person with schizophrenic symptoms is not a schizophrenic, as these symptoms are only a part of his personality at the moment of diagnosis. A diagnosis is used to set treatment goals and methods and to estimate the illness' course. It is only to be referenced correctly in medical classification and professional assessment. Any other use of a psychiatrist's diagnostic terminology is considered to be stereotyping, aimed at discriminating against people with mental health disorders. Psychiatric diagnoses are often carelessly used to discredit political or other opponents, which is hurtful to people who have been diagnosed and have to live with illness and disability. People do not always agree with stereotypes. Belief in them forms prejudice.

2.3 Prejudice

Prejudice is a wrong conviction, an ideological construct based on stereotyping and oversimplification. It motivates an authoritative bearing, hate and exclusion. In Nastran Ule's (1999) opinion, prejudice is simply a set of evaluations passed by privileged groups. Their main trait is helping repression. She defines repression as dominion of the strong over the weak, with the strong never allowing the weak to question the fairness of this arrangement. People are always very interested in learning how to have more power than others. If prejudice is collective, as those surrounding people with mental disorders are, people adapt to it. The general opinion is that people with mental disorders are less capable and that they require constant monitoring and care, which is followed by disdain and patronizing.

2.4 Fear

Most people are afraid of people suffering from mental illness. They fear »infection« despite it being general knowledge that mental illness can't be transmitted. For example, a common effect of fear are complaints from mental health staff about how hard it is to work with psychiatric patients, not because of the workload, but rather because they fear projective identification that could influence a staff member's mental health. This fear originates in prejudice of danger and unpredictability. People with mental health disorders may be dangerous, but only very rarely and always under foreseeable circumstances. Studies show that the percentage of patients with an affinity for violence is less than 10% in men and significantly less among women. Even this small percentage is not dangerous constantly, but only when they're under influence of psychoactive substances like alcohol and alternatively, when their psychotic symptoms are left untreated or poorly treated. Less severe mental disorders like depression and anxiety are not connected to violent behavior [(9).]

2.5 Discrimination

The behavioural manifestation of “applied prejudice” is discrimination. Affected people are discriminated against by being marginalized, avoided and being victims of violence. Even though discrimination can be an upfront protest against the mentally ill, it more often takes the form of avoidance. Openly ridiculing patients is no longer acceptable due to rising awareness. Hostility ambivalence is nowadays expressed more subtly. But many patients report feeling lonely, losing friends, not being in contact with their families, losing their jobs and being delegated to lower positions in their workplace. Discrimination is not authoritarian and directly aggressive anymore. most likely due to anti-stigmatization movements, which managed to influence the way discrimination is exhibited, but not what it's about.

2.6 Causes of stigma

Stigmatization is grounded in a narcissistic emotional satisfaction that crosses the boundaries of rational self-criticism. One who stigmatizes others finds validation in discrediting another. This discreditation enables him to join the majority; he finds himself stronger and agreed with. Regardless of whether this is the real majority or simply a privileged group, the stigmatised represent a “problem” which needs to be solved. For Jews, this was the »final solution of the Jewish question«, for African Americans it was open disdain and disrespect of their basic human rights. The mentally ill face the same sort of persecution, in the form of avoidance and isolation. In the 1950's, Adorno's study showed that any kind of hate directed towards the different is rooted in early childhood repression and loss, which is directed towards others in later life. These others are selected by criteria of social acceptability, meaning that those whom society shuns will be selected most often. Understanding the problem of discrimination, does not, however, help in moderating it. Social categorization plays a great part in the formation of prejudice, social categorization here meaning simply dividing people into two classes - us and them. Revulsion and violence directed toward stigmatized groups is only possible when personal prejudice finds either political or ideological backing [(11).] Being affiliated with a certain group incites favoritism for that group, as is evident in families and work environments. A positive group identity is the motive for stereotyping others, which leads to a better self-image. Stereotypes are thus born from negative self-image, or rather a person's inability to create one. Identity is built on being accepted as separate from »the others«. For the stigmatizing, this is a natural and effective means of countering a potential threat. For the stigmatized it is simply suffering.

2.7 Signs of stigma

A significant change can be observed in how prejudice shows itself. It is not shown aggressively and openly, but rather as exclusion in the form of avoidance, passive refusal and ignoring. Fringe groups are not the focus of clear negative beliefs, be it to their advantage or not. Simply put, stigmatization is moving into the subconscious [13]. Mental illness stigma is strongly linked with prejudice against patients with mental disorders: of danger, incompetence and irresponsibility. The World Health Organization (WHO), aware of this problem, issued a statement in 2001 that described the most common myths concerning mental illness and, of course, demystified them with scientific evidence, summarized below. Mental disorders are not imaginary, they are real diseases that cause suffering and reduce capabilities. It is not true that people with mental disorders or brain damage can not be helped. They can be treated and mental health can be restored, which is true of all mental disorders. Patients' suffering can be eased, their symptoms can be managed, and many make a complete recovery. Mental illness has nothing to do with a person's character, as it is always a consequence of biological, psychological and social causes. Furthermore, the correlation between genetics, lifestyle, environment and illness is as well established as with physical illness. Managing mental illness requires not only a serious effort on the patient's side, but also professional help.

2.8 Stigma of mental illness

Far more than any other type of illness, mental disorders are subject to negative judgements and stigmatization. Many patients not only have to cope with the often-devastating effects of their illness, but also suffer from social exclusion and prejudices. Stigmatization of the mentally ill has a long tradition, and the word “stigmatization” itself indicates the negative connotations: in ancient Greece, a “stigma” was a brand to mark slaves or criminals.

For millennia, society did not treat persons suffering from depression, autism, schizophrenia and other mental illnesses much better than slaves or criminals: they were imprisoned, tortured or killed. During the Middle Ages, mental illness was regarded as a punishment from God: sufferers were thought to be possessed by the devil and were burned at the stake, or thrown in penitentiaries and madhouses where they were chained to the walls or their beds. During the Enlightenment, the mentally ill were finally freed from their chains and institutions were established to help sufferers of mental illness.

2.9 Related studies

study examined anticipated enacted stigma from military and nonmilitary sources, self-stigma, PTS, perceived likelihood of deploying again, marital status, and history of mental health care engagement as correlates of help-seeking intentions from a mental health professional or medical doctor/advance practice registered nurse (MD/APRN) in a sample of 165 combat veterans. Using structural equation modeling, results demonstrated that self-stigma was negatively associated with help- seeking intentions from a mental health professional and MD/APRN with small-to- medium effect sizes. Being married was positively associated with help-seeking intentions from a mental health professional and MD/APRN with small effect sizes. History of previous mental health care engagement was positively associated with help-seeking intentions from a mental health professional.

Random digit dialing was utilized to identify a representative sample of 248 African American and white older adults (older than 60 years) with depression, to identify the impact of public stigma (negative attitudes held by the public) and internalized stigma (negative attitudes held by stigmatized individuals about themselves) on racial differences in treatment-seeking attitudes and behaviors among older adults with depression, the results show that depressed older adult

participants endorsed a high level of public stigma and were not likely to be currently engaged in or did they intend to seek mental health treatment. Results also suggested that African American older adults were more likely to internalize stigma and endorsed less positive attitudes toward seeking mental health treatment than their white counterparts.

In study surveyed students at six medical schools in 2012, to measured burnout, symptoms of depression, and quality of life using validated instruments and explored help-seeking behaviors, perceived stigma, personal experiences, and attitudes toward seeking mental health treatment., Of 2,449 invited students, 873 (35.6%) responded. A third of respondents with burnout (154/454; 33.9%) sought help for an emotional/mental health problem in the last 12 months, only a third of medical students with burnout seek help. Perceived stigma, negative personal experiences, and the hidden curriculum may contribute.

Three samples were surveyed to investigate the predictors: a national sample of 1,001 Australian adults; a local community sample of 5,572 residents of the Australian Capital Territory and Queanbeyan aged 18 to 50 years; and a psychologically distressed subset (n = 487) of the latter sample. Personal and Perceived Stigma were measured using the two subscales of the Depression Stigma Scale. Personal stigma was consistently higher among men, those with less education and those born overseas. It was also associated with greater current psychological distress, lower prior contact with depression, not having heard of a national awareness raising initiative, and lower depression literacy. there was no evidence that perceived stigma was associated with service use.

This study used cross-sectional survey data from a representative sample of undergraduate and graduate students (N=2,782) at one university, Perceived stigma was higher among males, older students, Asian and Pacific Islanders, international students, students with lower socioeconomic status backgrounds, and students with current mental health problems. Perceived stigma was also higher among those without any family members or friends who had used mental health services and among those who believed that therapy or medication is not very helpful.

In a cross-sectional study, we examined 207 untreated persons with depressive syndromes, all fulfilling criteria for a current mental illness as confirmed with a structured diagnostic interview, (45.4%) participants had never received mental health treatment previously. Exploratory factor analysis of a list of 25 different causal explanations resulted in five factors: biomedical causes, person-related causes, childhood trauma, current stress and unhealthy behavior. Attributing the present problem to biomedical causes, person-related causes, childhood trauma and stress were all associated with stronger self-identification as having a mental illness. In persons who had never received mental health treatment previously, attribution to biomedical causes was related to greater perceived need and stronger help-seeking intentions. In those with treatment experience, lower attribution to person-related causes and stress were related to greater perceived need for professional help.

Public and individual stigma components and their association with suicidal ideation were examined among 227 unemployed persons with mental illness, about half reported no suicidal ideation during the past 30 days. In bivariate analyses all stigma components were significantly associated with suicidal ideation. In the path model and controlling for symptoms, the association between experienced discrimination and suicidal ideation was fully mediated by anticipated discrimination and self- stigma.

CHAPTER THREE

Methodology

3.1 Study design:

An observational cross-sectional community base study.

3.2 Study area:

was conducted at Napata college in Khartoum state.

3.3 Study population:

Students of Napata college.

3.4 Inclusion criteria:

Students from both genders in Napata college.

3.5 Exclusion criteria:

Students of other Universities / and All Students Below 18 Years.

3.6 Sample size:

1.96^2 *(p)(1-p)/e^2

e=(0.05) P=(prevents)

1.96^2*(0.5)(1-0.5)/0.05^2=150

3.7 Sample Technique:

By using Simple Random Technique.

3.8 Data Collection Method

Participants were counselled on the details of the study. The questionnaire was structured and contains items relating to study objectives.

3.9 Study Variables

1/Gender

2/Age

3/Father education level

4/ mother education level

3.10 Data analysis:

Data was entered and organized into Microsoft Office Excel 2010 data sheet, then for the analysis, Statistical Package for Social Sciences software, version 23.0 (SPSS Inc.) was used.

3.11 Ethical consideration:

This research was approved by the Ethics Committee of the College. a verbal agreement was taken from each participant.

CHAPTER FOUR

RESULTS

This is an observational cross-sectional community base study conducted in Napata college to assess the impact of stigma of mental illness on seeking mental care, a total of 150 students was investigated, and the sociodemographic result was as follow:

Table (4.1) show the frequency of gender

Gender		Frequency	Percent
	Male	38	25.3%
	Female	112	74.7%
	Total	150	100.0%

Table (4.2) show the frequency of Age

Age		Frequency	Percent
	18-25 year	74	49.3%
	26-30 year	71	47.3%
	More than 30 years	5	3.3%
	Total	150	100.0%

Table (4.3) show the frequency of Mother educational level

Mother educational level	Frequency	Percent
Primary school	10	6.7%
Middle school	34	22.7%
High school	52	34.7%
University	40	26.7%
Post University	14	9.2%
Total	150	100.0%

Table (4.4) show the frequency of Father educational level

Father educational level	Frequency	Percent
Primary school	12	8.0%
Middle school	26	17.3%
High school	22	14.7%
University	73	48.7%
Post University	17	11.3%
Total	150	100.0%

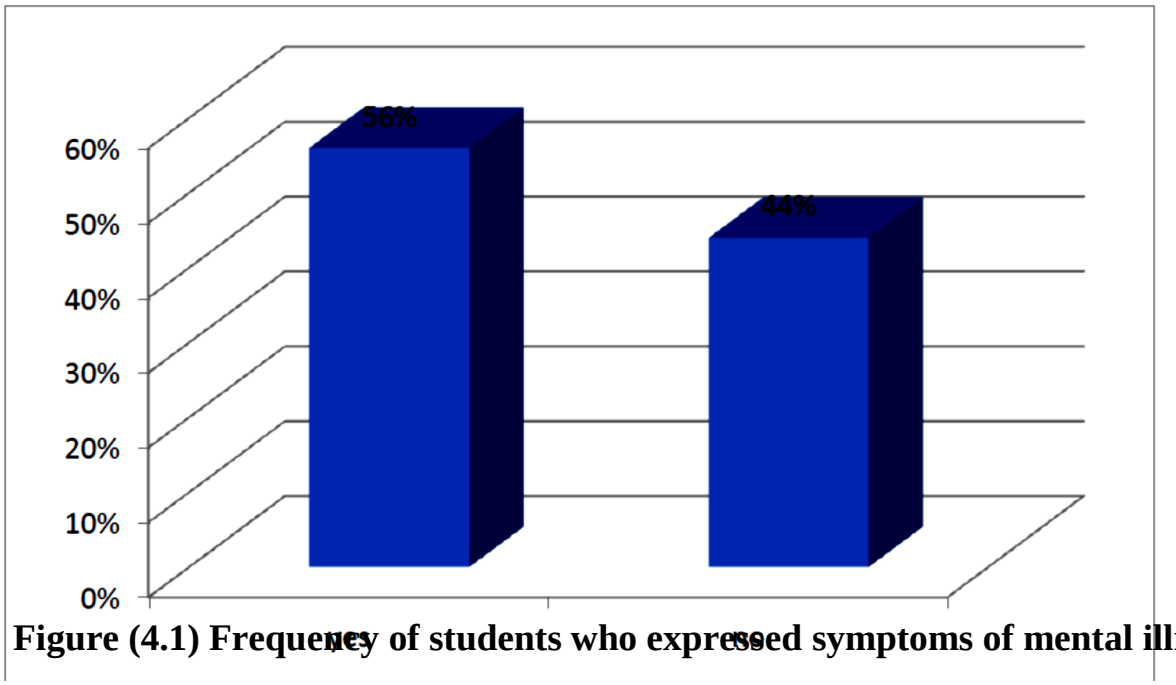

Figure (4.1) Frequency of students who expressed symptoms of mental illness

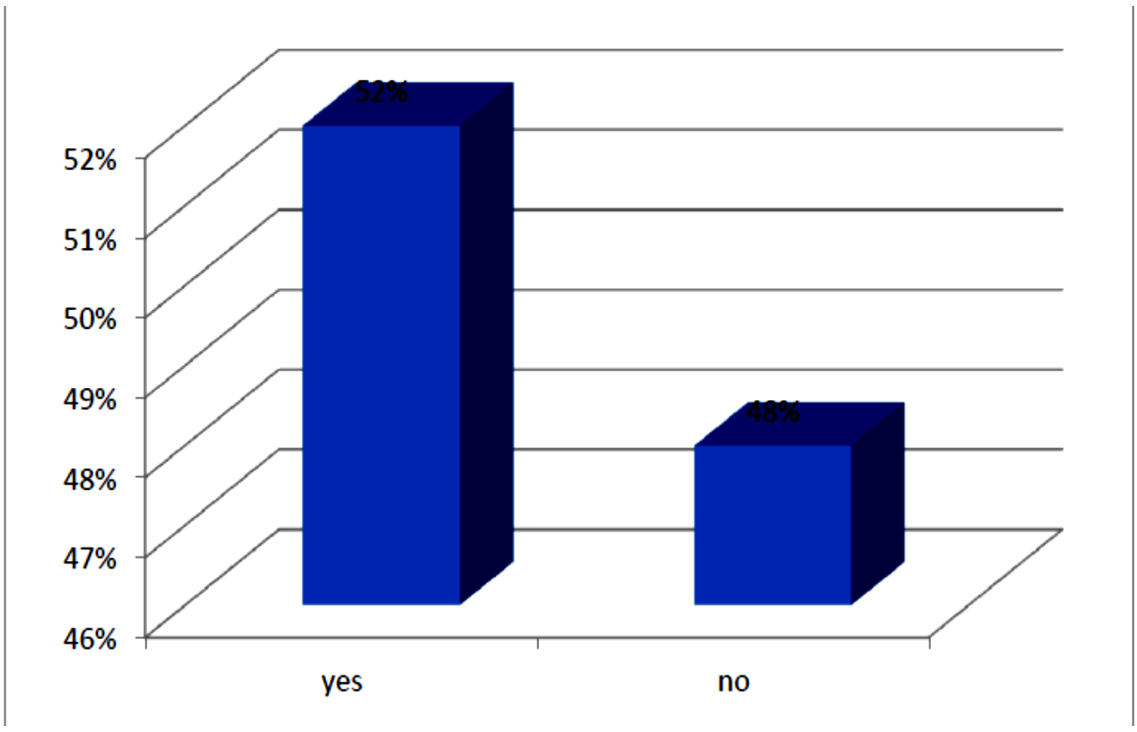

Figure (4.2) Frequency of students who get affected in the academic level

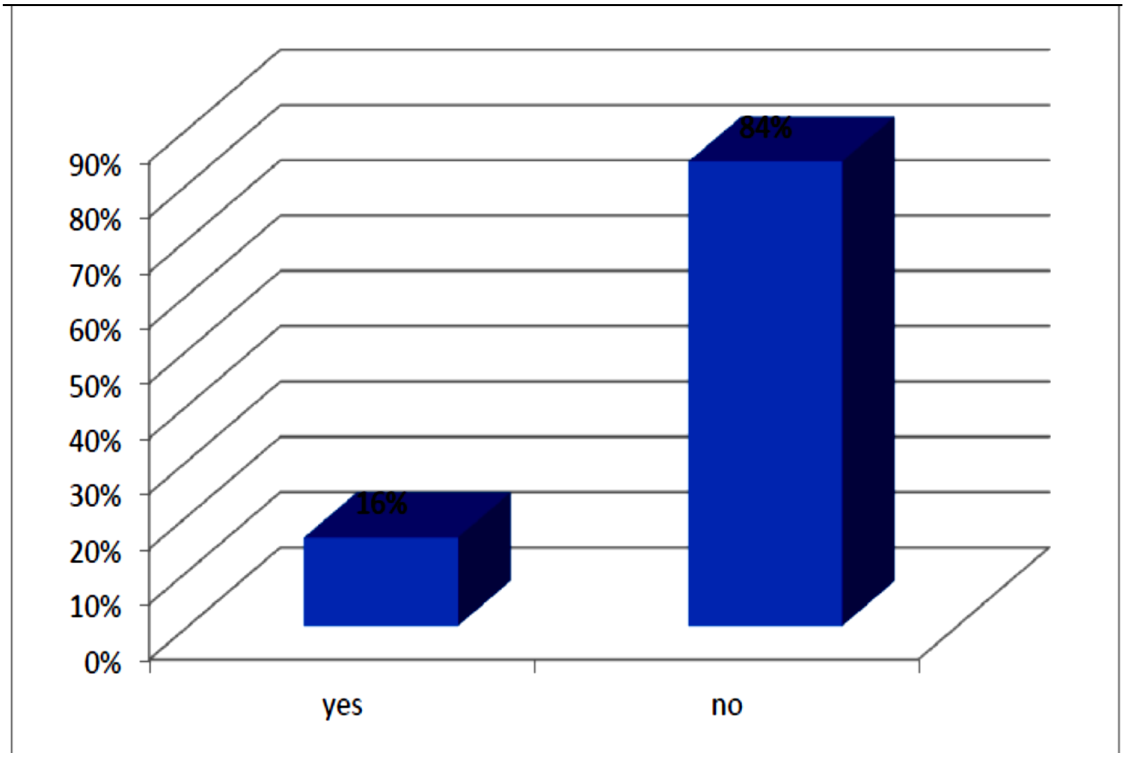

Figure (4.3) Frequency of students who ever seen a psychiatrist

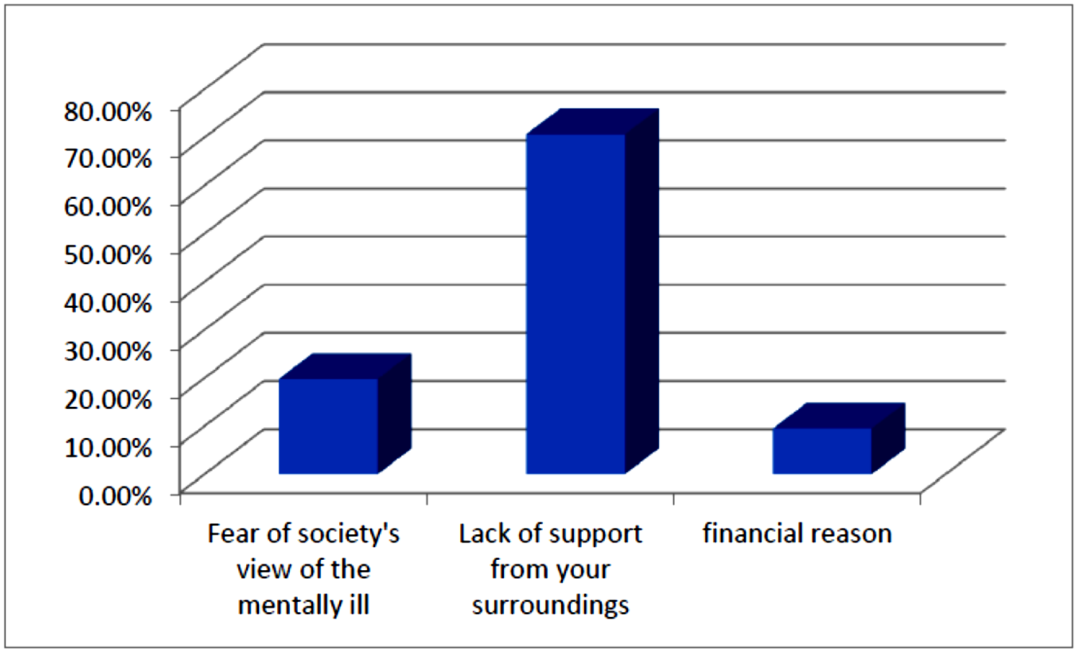

Table (4.4) Frequency of student's reason for not seeing a psychiatrist

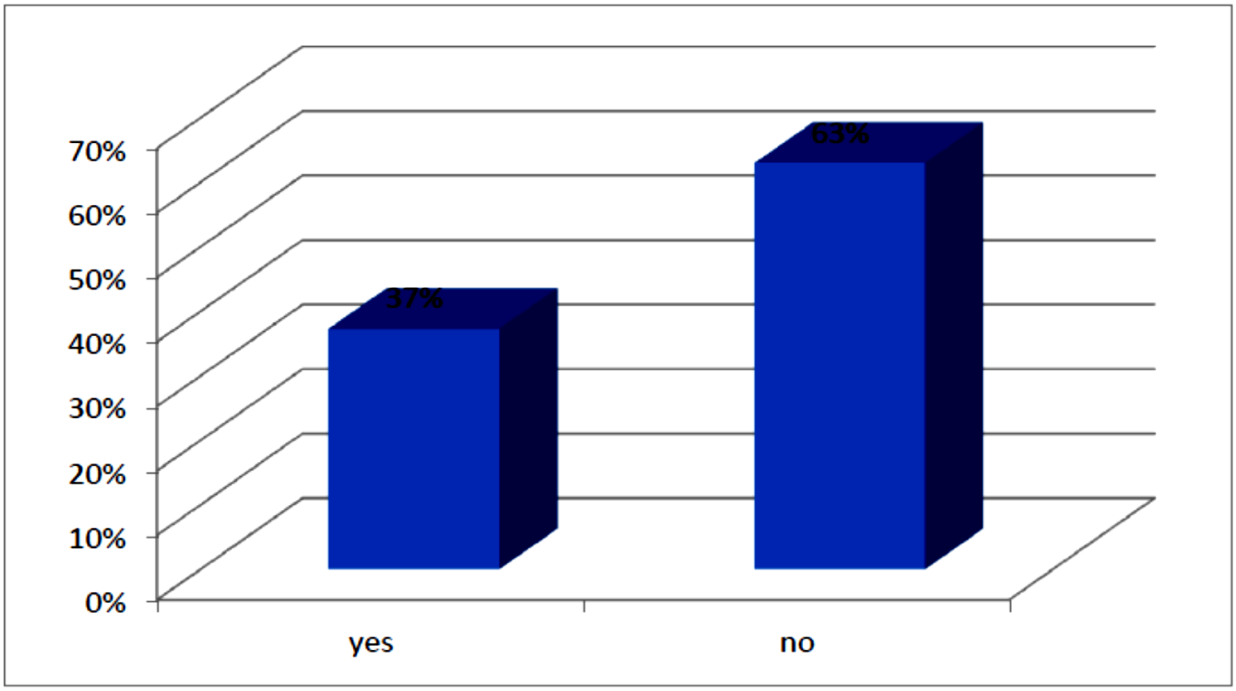

Figure (4.5) Frequency of students who shared they surroundings of they desire to see a psychiatrist

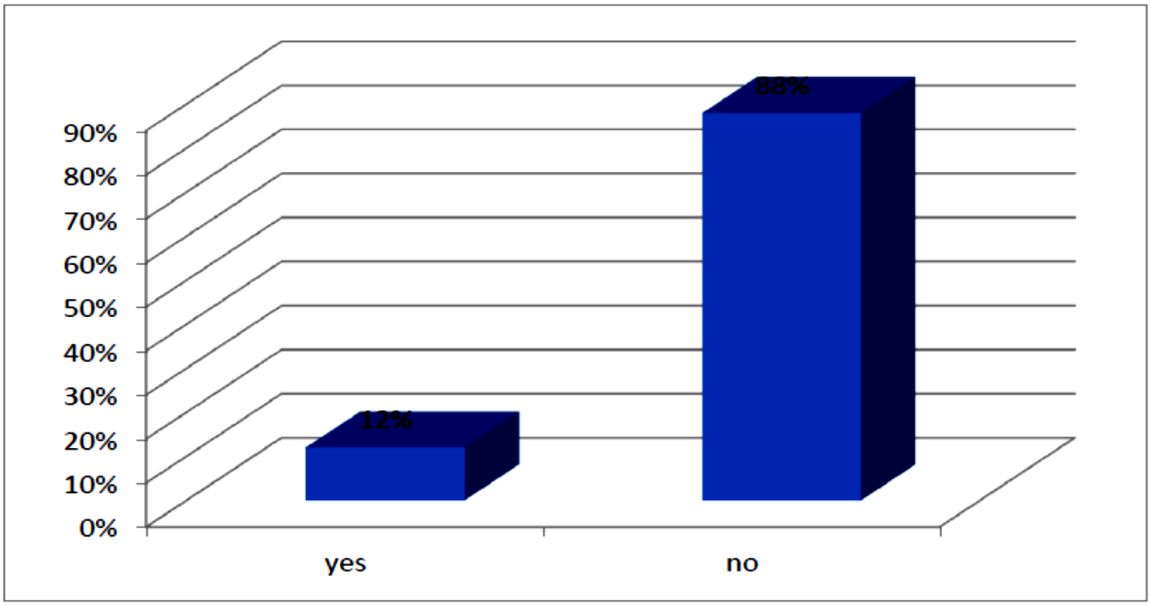

Figure (4.6) Frequency of students who have a family history of mental illness

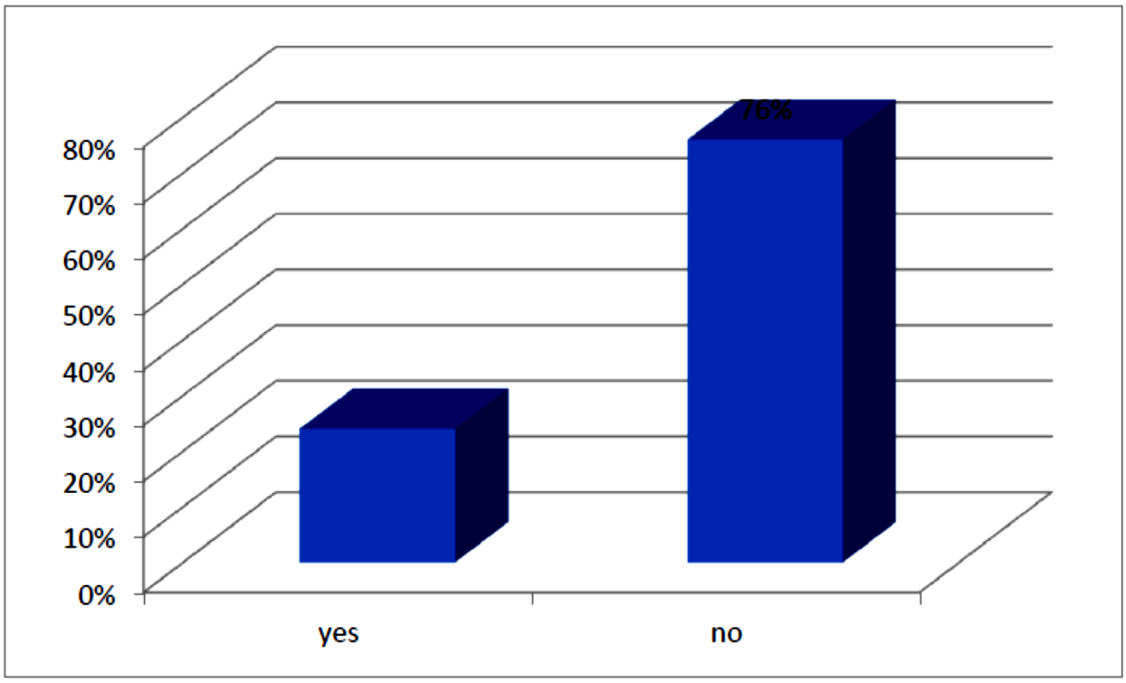

Figure (4.7) Frequency of students who think that mental illness is sign of personal weakness

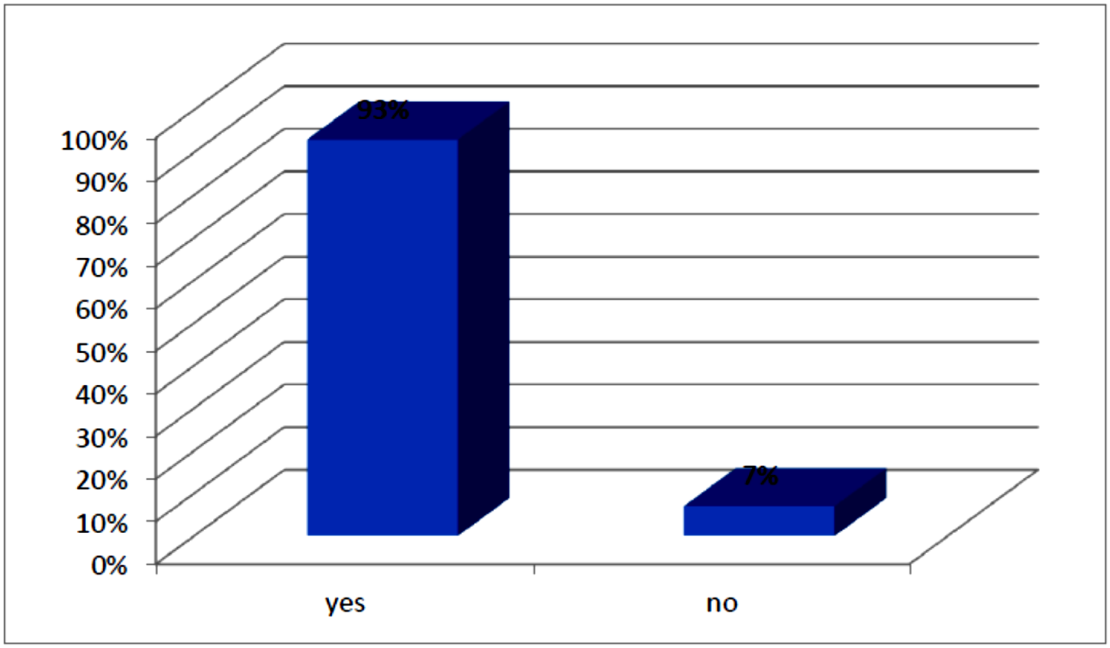

Figure (4.8) Frequency of students answers about if someone shared with them that they needed psychological counseling

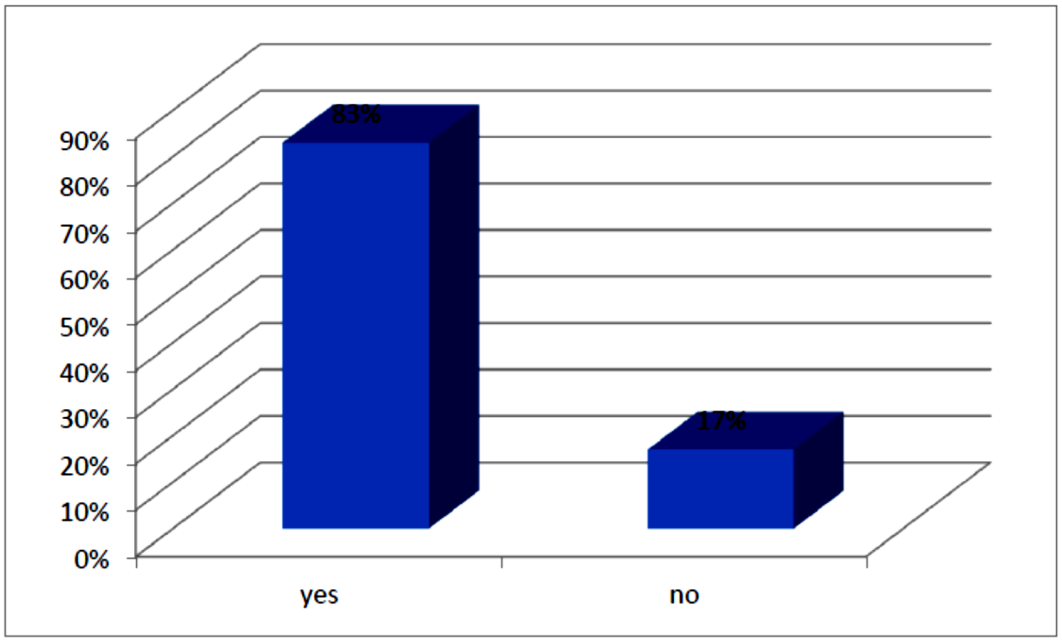

Figure (4.9) Frequency of students who think that people are like less those who treated for mental illness

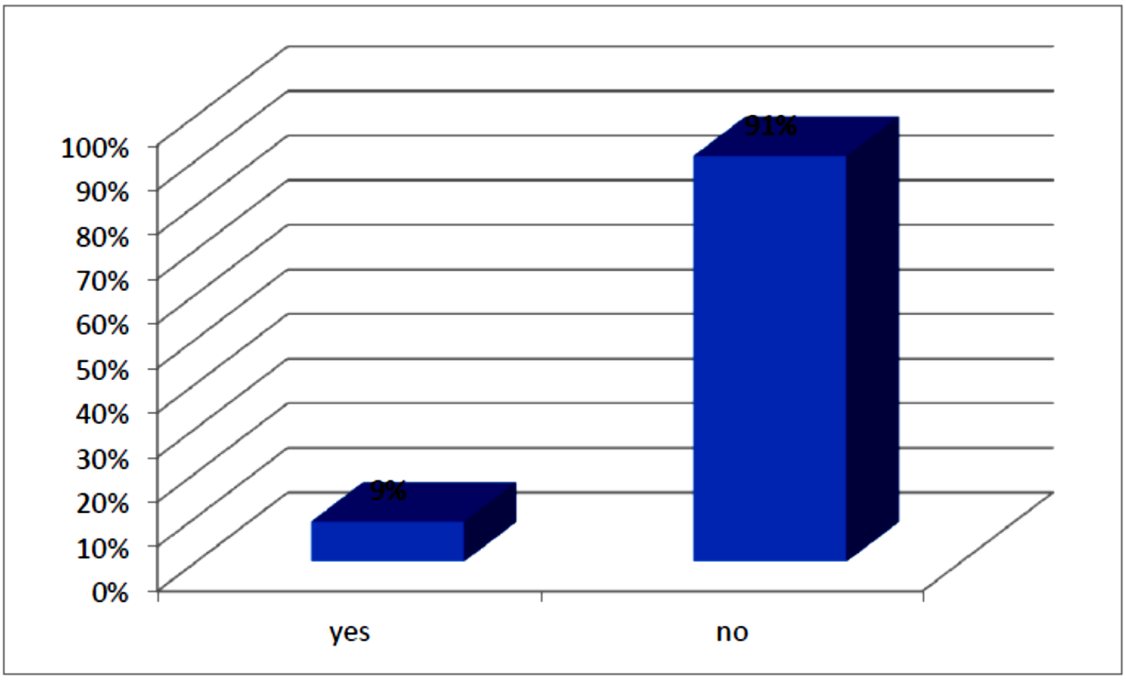

Figure (4.10) Frequency of students who think that is advisable for a person to hide mental illnesses

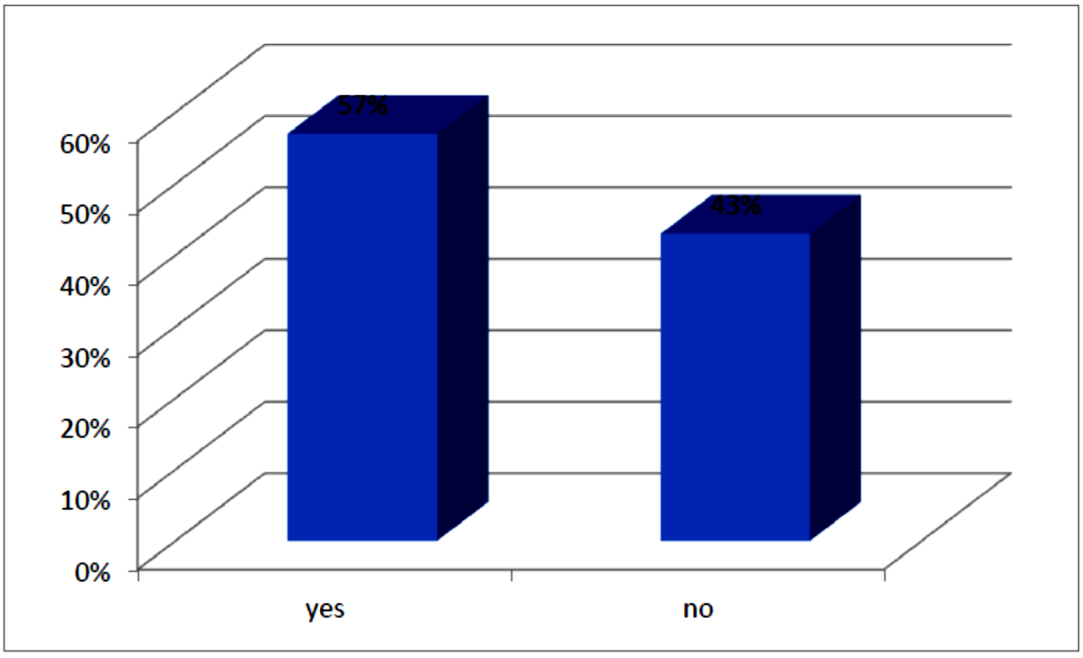

Figure (4.11) Frequency of student's opinions about that stigma affects the request to consult a psychiatrist

The statistical analysis shows a significant correlation between the effect of stigma on delay seeking help as described in table below, seen a psychiatrist (p-value=0.000), shared they symptoms with someone close to him (p-value=0.003), shared they surroundings of they desire to see a psychiatrist (p-value=0.003), request to consult a psychiatrist (p-value=0.004).

Table (24) Show the correlation between Stigma and delay seeking help

	Factors	**P-value**
Stigma	Seen a psychiatrist	0.000*
	Shared symptoms	0.003*
	Shared their surroundings of their desire to see a psychiatrist	0.003*
	Request to consult a psychiatrist	0.004*

CHAPTER FIVE

DISCUSSION

In our study, there was a significant correlation between stigma and poor prognosis, similar results found by (Stolzenburg et al., 2019), who found that (45.4%) of the participants had never received mental health treatment previously, Attributing the present problem to biomedical causes, person-related causes, childhood trauma and stress were all associated with stronger self-identification as having a mental illness.

Also (Oexle et al., 2018), in his study, he found that stigma was significantly associated with suicidal ideation. In the path model and controlling for symptoms, the association between experienced discrimination and suicidal ideation was fully mediated by anticipated discrimination and self-stigma.

in our study, a significant correlation between the effect of stigma and delay seeking help, similar results found by (Blais et al., 2013), he found that self-stigma was negatively associated with help-seeking intentions from a mental health professional. Being married was positively associated with help-seeking intentions. History of previous mental health care engagement was positively associated with help-seeking intentions from a mental health professional, also similar result found by (Conner et al., 2010), who found that depressed older adult participants endorsed a high level of public stigma and were not likely to be currently engaged in or did they intend to seek mental health treatment, also same results found by (Dyrbye et al, 2015), who found that a third of respondents with burnout (154/454; 33.9%) sought help for an emotional/mental health problem in the last 12 months, only a third of medical students with burnout seek help. Perceived stigma, negative personal experiences, and the hidden curriculum may contribute.

CHAPTER SIX
CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

- The statistical analysis shows a significant correlation between stigma and poor prognosis
- The statistical analysis shows a significant correlation between stigma and delay seeking help.
- There was a low incidence of seeing a psychiatrist, lack of support to see a psychiatrist, shared symptoms, shared surroundings of their desire to see a psychiatrist, and a request to consult a psychiatrist among students.

6.2 RECOMMENDATIONS

- More studies should conduct by using large sample size.
- Future studies should test the short- and long-term effects of stigma on suicidality.
- inform efforts to reduce the role of stigma as a barrier to help seeking.

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APPENDIX (1)

Questionnaire

1. Sex:

1- male

2- female

2. Age :

1- 18-25

2- 26-30

3- more than 30

3. Mother's educational level:

1- primary school

2- middle school

3- High school

4- University

5- Post University

4. father's educational level:

1- primary school

2- middle school

3- high school

4- University

5- Post University

5. Have you ever had symptoms of mental illness?

1- yes

2- no

6. Did you feel that any of these symptoms affected your academic level?

1- yes

2- no

7. Have you ever seeking for help visits a psychiatrist?

1- yes

2- no

8. If the answer is yes, did you share with anyone that you met a psychiatrist or not?

1- yes

2- no

9. If your answer is no, what was the reason?

1- financial reason

2- Fear of society's view of the mentally ill

3- Lack of support from your surroundings

10. Any family history of mental illness?

1- yes

2- no

11. Do you think that stigma of mental illnesses is a sign of personal weakness?

1- yes

2- no

12. If someone shared with you that they needed psychological counseling, would you support them? 1- yes

2- no

13. do you think that people tend to like less those who treated for mental illnesses?

1- yes

2- no

14. do you think that is advisable for a person to hide mental illnesses?

1- yes

2- no

15. In your opinion, do you think that stigma affects the request to consult a psychiatrist or not?

1- yes

2- no