STIGMATIZATION OF PSYCHIATRIC PATIENTS BY MENTAL HEALTH PROFESSIONALS

A Thesis

Submitted to the Faculty of Nursing, University of Alexandria

In partial fulfillment of the Requirements for the degree

Of

Master of Nursing Science

In

Psychiatric Nursing and Mental Health

By

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2009

Introduction

Stigma is conceptualized as a set of prejudicial attitudes, stereotypes, discriminatory behaviors and biased social structures endorsed by a sizeable group about a discredited subgroup. The consequences of being regarded in such a way include shame, humiliation, ostracism and despair [1].

The burden of mental illness is thus made even heavier, not only by the direct effects of stigmatization but by the profound injustice in being thus regarded. The matter of stigma, then, is not merely one of community attitudes and attempts to change them, but it is a human rights issue as well [2].

Stigma has been defined as a mark or flaw resulting from a personal or physical characteristic that is viewed as socially unacceptable. The term 'stigma' means a mark or sign of disgrace or discredit, and 'to stigmatize' means to regard a person as unworthy or disgraceful [3].

Stigma is the most significant obstacle to the development of mental health care and to ensure a quality of life to people suffering from mental illness. Stigma promotes and reinforces social isolation, limits equitable opportunities for employment and recreation, creates, reinforces and sustains pseudo-psychiatric mythology, and is frequently internalized by people with a mental illness resulting in much suffering. Stigma makes community and health decision-makers see people with mental illness with low regard, resulting in reluctance to invest resources into mental health care [4, 5].

There are many types of stigma such as public stigma, self-stigma, and structural stigma. In terms of self-stigma, many people with mental illness are aware of the stigma about their group [6]. Individuals will agree with the stigma and apply it against themselves suffering diminished self-esteem and self- efficacy as a result. People with diminished self-efficacy due to self-stigma are less likely to apply for jobs or apartments patients frequently say:"Someone who is mentally ill like me, can't handle a regular job!" [7].

Public stigma is the reaction that the general population has to people with mental illness. Stigmas about mental illness seem to be widely endorsed by the public in the Western world. The existence of public stigma (i.e., negative views of the person by others) surrounding mental illness and the seeking of psychological services are clear. A study done on public beliefs about, and attitudes towards, people with mental illness: stated that the majority of community respondents report negative attitudes toward people with an identified disorder, and tend to avoid and perceive as dangerous those who are labeled as having been previously hospitalized. Whereas the stigma attached to being a mentally ill patient may not be the same as the stigma associated with being a counseled client [8].

Structural stigma is the process of an external evaluation put upon people in response to societal norms. Structural stigma examines the course of stigma throughout our culture and how it works as a system. It occurs when an institution like a newspaper, rather than an individual, propagates stigmatizing messages about mental illness. It can be defined as attitudes that are institutionalized and incorporated into a structured and usually well-established system [9]. Structural stigma can create tangible barriers for people who have been diagnosed with mental illness. Stigma works to deny people with mental illness things that "normal" people take for granted and often feel entitled to [10].

Stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination. Stereotypes are judgments that characterize collectively agreed upon qualities of groups or persons. They mostly represent the false pairing of person and behavior, e.g. people with mental illness are dangerous and unpredictable. Stereotypes have devastating consequences because people quickly generate impressions and expectations of individuals who belong to a stereotyped group [11, 12].

Prejudice is a consenting emotional reaction to a stereotype or a stereotyped person, lie: all people with mental illness are dangerous, unpredictable, and frightening. Discrimination in turn is the actual behavior based on prejudice, as all people with mental illness are dangerous; they should be avoided [13,14]. These unfavorable views about people with mental illness can be observed in different social contexts and they subsequently affect several life domains of those afflicted. Moreover, the general population argues against mental health services or housing facilities in their neighborhood. Chances to get an employment are limited and the quality of life of people with mental illness is reduced [15]. Finally, evidence-based treatment of mental illnesses is viewed with considerable reservation [16].

As regards mental health professionals, the contact with people with mental illness is considered as one of the most important factors influencing the attitude towards those afflicted. To better understand the effect on contact, it is crucial to compare the attitudes of those with regular or even daily contact to mentally ill people to those without contact, e.g. the general population. Secondly, mental health professionals occupy essential positions in the treatment and rehabilitation process of their patients. They are expected to have or develop attitudes that should enable them to competently manage their role and to impartially encounter and treat their patients [17-19]. Finally, it is important to understand attitudes and beliefs of professionals as it is well known that the actual behavior of psychiatric staff and their respective attitudes towards patients are associated, e.g. as to treatment outcome [20].

Thus, it is important to know whether negative stereotypical views about people with mental illness really exist among mental health professionals and if so, how they are and to what extent they are present. However, mental health professionals are not a uniform group, but they consist of different professions, each with a typical professional socialization [21]. Thus, when investigating these professions one has to consider different professional backgrounds. Moreover, the tasks of the different groups are depending on the work setting, burdening work compared with working in outpatient facilities, and negative effect on stereotypes through more working hours.

Thus, the intent of this study is to identify the stigmatization of psychiatric patients by mental health professionals, in order to help them to be aware of their attitude in this domain, for the welfare of the patients.

Literature review

Overview about stigma

Stigma of mental illness seems pervasive in our society. Individuals who are diagnosed with mental illnesses or who seek mental health treatment must face the stigma that is automatically attached to them. Until mental illness is no longer stigmatized, individuals will continually need to interact with others who may treat them differently when their mental illness is revealed [22].

In order to understand the relationship between stigma and mental illness, the origins of stigma must be defined. The term "stigma" has its origin in the Greek language during the middle ages. It means a mark or sign of disgrace or discredit, and 'to stigmatize' means to regard a person as unworthy or disgraceful [23].Stigma is an attribute of diseases or human conditions, which roughly corresponds to some feeling of their unacceptability in the wider community [24]. Corrigan (1999) considers stigmas as" negative and erroneous attitudes about these persons", in other word, stigma is a mark which differentiates an individual from someone else and links the individual to undesirable characteristics. It results in rejection and isolation [25].

The stigma attached to mental illness is the main obstacle to the provision of care for people with this disorder. Stigma does not stop at illness: it marks those who are ill, their families across generations, institutions that provide treatment, the intake of psychotropic drugs, and mental health workers. Stigma makes community and health decision-makers see people with mental illness with low regard, resulting in reluctance to invest resources into mental health care[26].So stigmatization of people with mental disorder not only affects the way people seek help individually, but can also have enormous implications on the development of policy on a national level[27].While efforts are being made to reduce the stigma of mental illness, it would be helpful to educate people with mental illnesses on how to best deal with the stigma they will undoubtedly face. Although many mental health consumers and professionals mention the effect of stigma, there are not any known programs for empowering consumers which primarily focus on coping with stigma [28].

In 1996, the World Psychiatric Association has been developing programs in a number of countries to reduce discrimination and prejudice against individuals with mental illness, and in particular against those with schizophrenia [29].However, stigma against mental disorder has been shown to be strongly rooted, and levels of stigma differ according to region and attributes of residents [30].

Types of stigma

There are several types of psychiatric stigma. These types include structural stigma, self-stigma, and public stigma.

Structural stigma is the process of an external evaluation put upon people in response to societal norms. Structural stigma examines the course of stigma throughout our culture and how it works as a system. It occurs when an institution like a newspaper, rather than an individual, propagates stigmatizing messages about mental illness. It can be defined as attitudes that are institutionalized and incorporated into a structured and usually well-established system [31]. Structural stigma can create tangible barriers for people who have been diagnosed with mental illness. Stigma works to deny people with mental illness things that "normal" people take for granted and often feel entitled to [32].

Structural stigma happens as a process, which includes recognition of cues, activation of stereotypes, and prejudice or discrimination against that person. **A cue** is a social cognitive process of recognizing that something is different about a person. A cue can take different forms, it might be something physical or observable about a person or her behavior, i.e., a psychiatric symptom, a deficit in social skills, or a difference in physical appearance [33].People with mental illness that are experiencing structural stigma may have difficulty finding function or a sense of place in the intersubjective world. Structural stigma permeates attitudes in our culture [34].

After someone has been cued, a **stereotype** is activated. The stereotype groups the person being stigmatized into an expected group. After that, prejudice and discrimination follow. The belief system that society holds about mental illness is so deep that often when someone has an interaction with a person diagnosed with mental illness, his cognitive processes distort the social relationship and lead to both conscious and unconscious behaviors. People may respond with chosen acts of discrimination, unconsciously avoid a group, or divert eye contact in order not to engage socially. The lens that we are looking through make stigmatized groups both easier to see and ignore, depending on the situation and conditions [35].

Self-stigma is another type of stigma. It is when someone ultimately judges him or herself [36].The judgment could be a by-product of messages received from external forces such as other people or societal expectations and norms. But ultimately, it is the individual who is creating the judgment toward him or herself. As children grow and 'develop, they learn the cultural context of stigma the same way they learn language and cultural norms [37].

People develop impressions of mental illness early in life and form expectations about whether people will reject or devalue someone who has been identified as having a mental illness. When a child grows and develops a mental illness, that person attaches the same negative beliefs she has learned as a child. Those negative beliefs become internalized and become a reference to themselves [38].

The internalization can consequently result in self-identification within a negative belief system. This judgment can decrease self-esteem. The persons tell themselves that they don't fit in or are not good enough to live up to expectations put upon themselves and their environment. Self- efficacy, or the belief that someone has the capacity perform, is affected and, consequently, self confidence in the future is greatly reduced [39].

The individual internalizes an identity that feels dehumanizing. A norm is created regarding his identity that may include feelings of inferiority, self-hate, and shame. Often an expectation or fear of rejection will result in a person acting defensively or less confidently, resulting in a strained social interaction [40]. Corrigan (2002) described self-stigma as a private shame that diminishes self esteem and causes self doubt that one can live independently, hold a job, earn a livelihood, or find a life mate [41].

It is customary to consider stigma as primarily a characteristic of others towards persons with mental illness. However, the process of self-stigmatization is an important but less obvious manifestation of stigma that has profound negative effects on the wellbeing of the individual with Psychosis [42-44].

A distinction has been drawn between ‘felt’ stigma and ‘enacted’ stigma ‘Felt’ stigma involves the individual fearing discrimination as a result of the illness, whereas

'enacted' stigma is the actual expression of discrimination by others towards the individual. It has been suggested that 'felt' stigma gives rise to a process of concealment in order to influence the impression one has on others. This may be more disruptive to the lives of the mentally ill than 'enacted' stigma [45-48].

Reduced insight on the part of the patient may be related to feelings of self-stigmatization. That is, patients who hold a negative view of mental illness are more likely to have limited insight into their condition, as the alternative is to accept a stigmatizing label [49].

The existence of public stigma (i.e., negative views of the person by others) surrounding mental illness and the seeking of psychological services are clear. Past research has found that the public often describes people with a mental illness in negative terms [50].

Some researchers have found that people tend to report more stigma surrounding counseling clients than nonclients. For example, people labeled as having used counseling services have been rated less favorably and treated more negatively than those who were not labeled [51,52].

As a result of public stigma, it seems that it is not just having a disorder but seeking psychological services that are stigmatized by the public. Given the negative perceptions of those who seek psychological services, it is not surprising that individuals hide their psychological concerns and avoid treatment to limit the harmful consequences associated with being stigmatized [53]. Surveys done on undergraduate students, have found that those who endorse stigmas of the mentally ill are less likely to seek psychological help [54].

Furthermore, the stigma associated with mental illness has been linked to the early termination of treatment. In all, there is clear support that awareness of the stigma associated with seeking treatment has a negative influence on people's attitudes toward seeking help and keeps many people from seeking help even when they have significant problems [55].

Components of stigma

Stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination

Stereotypes and Myths

In spite of the positive aspects of the psychiatric nursing clinical experience, it is usually emotionally charged. People start with preconceived ideas about psychiatric patients and psychiatric hospital. Stigma attached to mental illness is an added factor of the situation. This stigma is largely related to the public's misunderstanding, misconception and tears associated with mental illness and mentally ill persons. Negative attitudes based on myths and stereotypes of people with mental illness are prevailing in the community. Myths are defined as, an ancient story that is based on popular beliefs or that explains natural historical events, it is a widely believed but false story. While stereotypes are characteristics, which are descriptive of, attributed to, or associated with members of certain social groups or categories [56].

The nature and content of the myths and stereotypes of the mentally ill are almost exclusively negative and varied. Thus mental patients are perceived as dangerous, unproductive, dirty and neglecting themselves, talking to themselves,

having meaningless speech and bizarre behaviors, Mental patients are viewed as irresponsible, mentally retarded, excited, worthless, they are perceived as unpredictable, strange, tense, intolerant, perplexed, mysterious and withdrawn. Also, mental patients are perceived as irritable, emotionally unstable, suspicious, suicidal and undependable [57, 58].

Many people have negative or prejudiced views of mentally ill patients. These views may arise due to lack of accurate information about mental illness and lack of contact with mentally ill patients. The mentally ill patients are labeled as "different" and are viewed negatively by others. These views have several implications on the patients and their families such as, lower patients' self esteem; contribute to disrupted family relationships, adverse quality of life, affect employability and the patients become demoralized by community rejection [59].

Additionally, psychotic patients experience shame and embarrassment about their emotional problems that patients with physical problems do not experience. Psychotic patients may experience the phenomenon of "blaming the victim' or holding the patients responsible for their illness which may make adjustment to the hospital difficult. These would add to the negative views about the mentally ill persons and perpetuate the unacceptability of these persons [60].

Some of the held views about mentally ill persons are that people with mental illness should be feared, they should not get married or have children because it is believed that heredity is the top cause of mental illness. Mental illness is also viewed as a shameful disease or as a punishment for doing something bad, and those who have mental illness should be hidden from everyone [61].

In addition, people view mental illness as incurable, and if people become mentally ill once, they will easily become ill again (once crazy, always crazy). People think that even after treatment it will be difficult for the mentally ill to return to the community, they are still more dangerous than normal people and one should avoid to be around them and should not make friends with them. Additionally, people view that mental patients and other patients should not be treated in the same hospital, and they should only live among themselves, they cannot hold a job. Finally, there is no future for people with mental illness. 'These are all views of mentally ill persons and their problems. In addition, the public behavioral responses to mentally ill people include avoidance, suspiciousness, hostility and fear. 'The fear is frequently related to the stigmatization component of "un predictability [62].

The stigma associated with mental illness affects everyone who is diagnosed around the world. In many countries, mental illness was seen as a weakness of body, mind, and spirit. Until the medical model of mental illness was proposed, some cultures believed mental illness was an act of the God .The degree of stigma appears to be higher in Japan and China as compared to most other countries. In both countries, mental illness is seen as an inherent weakness, and weakness is not tolerated in either of these regimented cultures [63].

In comparison to American culture, the Chinese have been reportedly quite negative in their attitudes towards those in their country that are mentally ill. In both Japan and China, the term neurasthenia is used as a diagnosis for most mental illness. The term neurasthenia

is not limited to only minor psychiatric illnesses but also include major psychiatric illnesses, for instance schizophrenia, psychotic depression, and paranoia disorders [64].

Beliefs about the causes of mental illness in Egyptian communities vary. Some people view depression as personality weakness and laziness, whereas other mental illnesses such as schizophrenia are considered an illness . Others attribute mental illness to exposure to sudden fright, possession of evil spirits, use of magic, head accidents, emotional trauma, heredity, or due to the evil eye. Fadlalla (2005) points out that people still believe in the evil eye as a source of their psychological and/or physical problems. The evil eye is described as a powerful eye-to-eye gaze and can be dangerous to the envied person, leaving him/her unable to function. She adds in her study that, 'women describe curing the evil eye as extremely difficult, since it violates the integrity of the human body and creates an orifice that attracts other ailments associated with spirits and mysterious diseases'. This is when people resort to use spiritual healing practices such as the "Zar cult" [65, 66].

Prejudice

Allport (1954) defined prejudice as "antipathy based upon a faulty and inflexible generalization". As prejudice included "thinking ill of others without sufficient warrant", the basic two components of his definition were hostility and misinformation**.** Prejudice refers to a special type of attitude (generally negative) toward the members of some social group, based solely on their membership in that group. Prejudice may also involve beliefs and expectations about members of these groups [67, 68].

People who are prejudiced endorse these negative stereotypes ("That's right; all persons with mental illness are violent!") and generate negative emotional reactions as a result ("They all scare me!") Prejudice is also viewed as a general attitude toward a group. In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative, generally negative component [69, 70].

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, considered as a behavioral reaction. Prejudice that yields anger can lead to hostile behavior [71, 72]. In terms of mental illness, angry prejudice may lead to withholding help or replacing health care with services provided by the criminal justice system. Fear leads to avoidance; for example, employers do not want persons with mental illness nearby, so they do not hire them [73].

Discrimination

Discrimination is defined as an unjust practice or behavior, whether intentional or not, based on race, religious beliefs, color, gender, physical and/or mental disability, marital status, family status, source of income, age, ancestry, place of origin and/or sexual orientation. It has a negative effect on any individual or group. Discrimination against people with mental illness is widespread. It has an impact on the self-esteem and recovery of the patient's people and it affects all aspects of people's lives. Discrimination is a recognized problem, but there is a lack of information regarding the nature of this discrimination [74]. Discriminatory behavior often leads to harassment and has a negative social and economic impact. It also leads to unequal treatment; it occurs when a person is treated differently from another person in the same or similar circumstances. It can be direct or indirect, and it is not always unlawful. People with experience of mental illness

report discrimination in all aspects of their lives from employment and housing, to discrimination from friends and family, and the community [75-77].

The discrimination associated with having a mental illness is often so devastating that it prevents people from seeking help for fear of being labeled. Effectively reducing stigma and discrimination requires concerted action by all interested parties – users, carers, professional groups and civil society – with strong governmental back up. At a World Health Organization (WHO) meeting in Athens in 2001, mental health professionals and members of mental health organizations from the countries of south and southeast Europe signed a declaration encouraging government officials to tackle stigma and discrimination.

Factors affecting stigma

Familiarity with Mental Illness

One of the reasons why some people have fewer stigmas is familiarity with mental disorders, which may cause those groups to have increased empathy for individuals who are stigmatized. Those with fewer stigmas include those who have suffered from the stigma of mental disorder, those who have relatives in that position, and most professionals who have relationships with individuals with stigmatized conditions. Those are all conditions that promote tolerance and not internalization of the stigma [78].Familiarity also was found to reduce the attribution of dangerousness as well as avoidance behavior [79].

Reinforcement of Stigma by Mental Health Professionals

Concerns have been raised about the role played by psychiatrists in promoting stigma. Looking closer at the rules of confidentiality, they can be interpreted as though the reason confidentiality is maintained, is because it may cause some embarrassment to the clients. The idea that mental illness is something that needs to be hidden should not be reinforced. Strict confidentiality rules are applied to protect individuals who seek psychotherapy from being labeled, discriminated against, and hurt [80].

Byrne (2000) argues the need to keep hiding the fact that the person may have a mental disorder is one reason for individuals with mental illness to avoid treatment. Conversely, mental health professionals sidestep the issue by creating or collaborating with some of the rules for confidentiality, they are collaborating with the same secrecy about their illness that prevents people from seeking treatment or discussing the problem, even when they do come to treatment, instead of normalizing the treatment process that the individuals need to go through [81].

A study done in (2000) examined the role of psychiatrists in maintaining or reducing stigma. In his literature review, he documented the findings of significantly more negative attitudes of psychiatrists towards alcohol dependence. In addition, an examination of the attitudes of Australian consultants found similar results. The psychiatrists agreed that personally they would prefer to not treat people with mental illness or learning disabilities. Chaplin endorsed the idea that the nature of psychiatry is clearly powerfully stigmatizing. For instance, some psychiatric offices have two doors so one client would never see another. What this creates is more isolation, in the way that individuals will think they are the only one who are in need for psychiatric cares, instead, of normalizing the process[82].

Confidentiality is another way of keeping secrecy, making it appear that it is something so horrible that clinicians not only refuse to give information about a client, but go so far as to deny that a patient is in the hospital[83].

Many rules do not appear to have any benefit to the client, but reinforce that in fact their condition is shameful. Therefore, psychologists and psychiatrists in their own way collaborate to help their clients hide their condition. **In** this sense confidentiality, rules that mental health professionals need to follow, also promotes stigma, and they do not help their clients see that treatment is a normal process, and that many people have the same condition [84].

Effect of stigma on patient's families

Mental illness, especially if it necessitates hospitalization, is a crisis for the person and family. Family life can be disrupted by the illness of a member, the family finds itself dependent on strange authority figures, and it undergoes changes in daily routine as the ill person's responsibilities are absorbed by the family members and visits to the person are fit into schedule. The family may be less functional with the sick person out of the home, missing either authoritative or dependent behavior or missing his/her normally healthy disposition or the role of scapegoat for family difficulties. The family may feel threatened by assessment, resenting intrusion into private matters, or fearing that family secrets will be divulged [85-87].

Stigmatization is a further dimension of suffering in addition to the illness experience. It leads to social isolation and limited life chances, family members were often embarrassed by the mental illness. Stigma attached to mental illness often makes it difficult for the family and affected person to cope. The experience of mental illness is more than the burden of symptoms for the patients and their families that, "there is a second illness": the stigma attached to the mental disorder [88]. In recent years, and largely as a result of advocacy by relatives' group like the National Alliance for the Mentally Ill (NAMI), awareness has grown that stigma not only affects people with mental illnesses but also their families. The existing literature suggests that, stigma has long been, and still continues to be a problem for families of psychiatric patients. Thus when people become mentally ill, the patients themselves as well as their relatives are confronted with numerous changes in their everyday lives due to the illness and the stigmatization they experience because of the disorder [89].

As with any other serious illness, emotional, social and financial problems can develop in a family that has a member affected by mental illness. Multiple studies of the families of persons with Serious and Persistent Mental Illnesses (SPMIs) have elaborated on the burden experienced by these families. Family burden is generally regarded as long-standing and pervasive, it includes stress, anxiety, depression with accompanying feelings of hopelessness and powerlessness, a sense of entrapment, disruption in family life, restrictions in social and leisure activities, financial difficulties, and an overall decrease in the quality of life as a result of attending to a seriously mentally ill family member[90].

Families, rather than institutions have become the major providers of the long-term care necessary for those individuals with serious and persistent mental illness. They struggle with the symptoms associated with the mental illness as well as insufficient assistance and information from the mental health care system. Given the multifaceted nature of the burden associated with caring for one with a SPMI, it is

logical to consider these family caregivers as a vulnerable population in need of service and intervention beyond that which is provided for their mentally ill relative [91].

Multiple studies of the families of persons with Serious and Persistent Mental Illnesses have elaborated that, families need information and advice, affirmation, respect, a nonjudgmental approach, a consistent, one—to-one relationship with a health care provider, attentive communication, and an individualized approach[92].

Mackenzie (1998) found that families with members experiencing a serious mental illness felt the need for information and emotional support from health care professionals.Winefield and Harvey (1994) suggested that needs of family caregivers included illness information, strategies for coping with symptoms, earlier intervention in episodes of illness as well as more housing and day treatment options. Nurses are in a key position to provide education and support that specifically addresses these areas of concern [93, 94].

In Egypt, when a person develops a mental illness, the extended family is more tolerant for the relative's bizarre behavior with the attitude of 'maalesh', meaning 'never mind' [95]. They provide ongoing support and attempts are made, by different family members, to show an interest in establishing relationships with the person with mental illness [96]. Emotional and behavioral problems may not be perceived as mental illness among Arab communities. The difficulty in recognizing the emotional and behavioral disturbances is further increased by the patients' tolerance of their symptoms and by their families' tolerance of their behavioral problems. Families reject long-term hospitalization or institutionalization as it is viewed as incarcerating their sick relative [97]. They are afraid of societal attitudes, and how these attitudes may affect the family's reputation among friends and neighbors. They are also afraid that people will discriminate against the relative with mental illness [98].As a result; the stigma associated with mental illness prevents many families from seeking treatment. As with similar cultural groups, Egyptians tend to hide from others that they have a person with mental illness in the family for fear that having a relative with mental illness will bring bad reputation to the family. This fear is due to the high stigma attached to mental illness among Egyptians with feelings of shame, guilt, and blame. In addition, the family will be seen as having bad blood (i.e. mental illness is in the blood, having a genetic factor) and, therefore, will be inherited in the coming generations. This in turn will put their daughters at risk of not being married [99].

Keeping the person with mental illness away from others outside the family circle can also be due to the families' concern and care for their relative with mental illness. They hide the person with mental illness to protect them from other's ridicule and insults [100].

Role of the health team in decreasing stigmatization

There have been over the years a number of different methods employed to reduce the stigma felt by mentally ill people. Mental health professionals can take both collective and individual action to challenge the stigma of mental illness at three levels as professional body, at a service level and as individual practitioners.

Tackling stigma as a professional body

Changing Minds campaign

In 1998, the Royal College of Psychiatrists launched a five-year campaign, "Changing Minds," aimed at reducing the stigma of mental illness. The campaign was informed by a survey of public attitudes towards mental illness [101]. Moreover, it includes several initiatives at national and local levels. These include a cinema advertisement, "1 in

4," which emphasizes how common mental illness is and has been screened in the United Kingdom before being taken up as an international initiative by the World Health Organization.

Tackling stigma at the service level

Liaison psychiatry

Liaison psychiatry is the public face of mental health services for many patients and health professionals. Therefore, a psychiatry team working in a general hospital has many opportunities to combat stigma. An effective and responsive team can challenge such beliefs, which will have direct benefits for both psychiatry team and general hospital patients. Liaison psychiatry reintegrates the mind and the body in health services, which is crucial in combating stigma. It is not the patients who should be pulling themselves together: mental health professionals should look at themselves first [(102)].

It is vital that liaison psychiatrists speak the same language as other hospital colleagues. The conclusions of a psychiatric assessment should be summarized in an understandable form with a clear management plan. Psychiatric jargon should be avoided, or at least explained. With adequate resources, a liaison psychiatry team can become integrated into medical and surgical teams, joining ward rounds and outpatient clinics to provide a psychological dimension to patient care. This involvement reinforces the view that the mind and the body are not separable and that comprehensive care depends on meeting all of a patient's health needs. For many patients, their meeting with a member of the liaison psychiatry team is their first contact with mental health services. This meeting is an opportunity to dispel stereotypes of psychiatry and mental illness [(103)].

Tackling stigma at the individual level

Individual practitioners can reduce the stigma and discrimination associated with mental illness in several ways

Examine personal attitudes

It is important to examine personal attitudes and to consider how these might affect the clinical practice. Maintaining an up to date knowledge of mental illness leaves less room for stereotyping and prejudice to creep in [(104)].

Listen to the patients

Psychiatric patients are important in the education about the consequences of mental illness. How has it affected their relationships with family and friends? Is it more difficult for them to find a job? Mental health professionals can be advocates for vulnerable individuals who have to cope with both their illness and the repercussions of stigma.

Mind the language

Efforts should be made to curb the use of potentially stigmatizing language, such as describing patients as if they were their illness. Describing a patient as a "schizophrenic," rather than as someone with schizophrenia, reduces them to a stereotype and robs them of personal identity. Others should be challenged as well for their stigmatizing language and behavior. The medical profession should aim to make such terminology as unacceptable as the stereotyping language used for race, disability, and sexual orientation [(105)].

Challenge stigma in the media

Challenging stigmatizing language in the media is one way in which individuals can become more active.10 Psychiatrists and psychiatric patients receive more negative press coverage than other medical specialties. Some may see complaining as a role of

professional organizations, but remember that newspapers or television companies take complaints more seriously if they receive a lot of them. One letter from an individual can carry as much weight as a collective response from the Royal College of Psychiatrists [106].

Thus, distinction between the mind and the body is ingrained in people's thinking. However, in the medical training should encourage an integrated biological, psychological, and social view of health care. If patients are recognized as unique individuals, and not as illnesses, it will be harder to stereotype and hold stigmatizing attitudes towards mental illness.

Materials and Method

Materials

Research design:
The design of this study is a descriptive design.

Setting:
The study was conducted at El_Maamoura Hospital for Psychiatric Medicine in Alexandria .The hospital is affiliated to the Ministry of Health and Population. It has a capacity of 840 beds and is composed of twelve wards distributed as follows, five free wards (three for males and two for females), five private wards (three for males and two for females), and two wards for the treatment of drug dependents. The hospital serves three governorates namely Alexandria, El-Beheira and Matrouh. It has also an outpatient clinic which provides services for the eastern part of Alexandria, starting from Sidi Gaber to Tabia. The out patient clinic deals with psychotic and neurotic patients, children with psychiatric problems and people who are drug dependents. It works 6 days a week from Saturday to Thursday from 8 am to twelve pm, except on Fridays and official holidays. It receives approximately 2000 patients monthly.

Subjects:
The study subjects consisted of all staff members who were available during working hours at the time of data collection. Their number amounted to 135 nurses and 45 doctors, and 20 social workers. Twenty nurses, five doctors, and five social workers were not available at the time of data collection for different reasons as sickness, motherhood leaves and some of them refused to share in the study, in addition to 20 mental health professionals who included in the pilot study were excluded from this study.

Tool:
"Patients' stigmatization structured interview schedule" (appendix1).
This tool was developed by the researcher after a thorough review of literature, it included a set of items (48 questions) about professional stigmatization [11, 13, 24].

The structured interview schedule assessed the attitudes of mental health professionals toward psychiatric patients. It consists of 48 questions covering the three main components of stigma: stereotypes, prejudice, and discrimination. The stereotypes were measured by 18 questions. Prejudice was measured by 23 questions. Discrimination was measured by 7 questions.

In addition to, a Socio-demographic data questionnaire (appendix2).
To elicit information about the socio demographic characteristics of the mental health professionals, such as age, sex, occupation, education, and years of experiences.

Method

An Official permission was obtained from the General Secretariat for Mental Health, which is affiliated to the Ministry of Health and Population in Cairo, and from the director of El-Maamoura Hospital for Psychiatric Medicine in Alexandria.

Development of the tool:

The patients stigmatization structured interview schedule was developed by the researcher after a thorough review of literature [28, 47, 73].

All subjects were rate their responses on a five points Likert type scale ranging from strongly agree (1) to strongly disagree (5). In addition, the subscales of items of Stereotypes, Prejudice and Discrimination were classified according to type of attitude as:

Positive, negative or/and neutral attitude.

It was then tested for its content validity by a jury of nine experts in the psychiatric fields to ascertain relevance, clarity, and completeness of tool.

The tool was tested for its reliability (internal consistency) using Cronbach's Alpha test, this test gives the following result (Alpha=0.861).

The pilot study:

Before embarking on the actual study, a pilot study was carried out on twenty mental health professionals who working at free and private wards at El-Maamoura Hospital for Psychiatric Medicine in Alexandria, to ascertain the clarity and applicability of the study tool, and to identify obstacles that may be faced during data collection. The necessary modifications were done accordingly, some questions were restated.

Actual study:

-Oral consent was obtained from the mental health professionals after explanation the purpose and importance of the study. Confidentiality of any obtained information was ensured.

-The Patients' stigmatization structured interview schedule was given to all mental health professionals at the hospital.

-The researcher started data collection with nurses first then doctors, and finally with sociologists. The interview schedules given to five persons at a time.

The time required for filling the interview schedule ranged from 20 to 30 minutes,

Data collection was done five days per week, for about 5 hours per day, it took two months, from February to April (2008).

Statistical Analysis:

After data were collected, it was categorized, coded, and transformed into a specially designed format to be suitable for computer feeding. All entered data were verified for any error. The statistical package for social sciences software package version 10 .0 was utilized for statistical analysis (SPSS).

- Cronbach's Alpha test was used for test retest reliability.

-Descriptive statistics were used to describe the sample characteristics.

-Means, standard deviations, and percentages were calculated to determine the stigma of subjects toward psychiatric patient.

Correlation statistics were used to find out the correlation between **"Patients' stigmatization structured interview schedule items"** and the socio-demographic data of mental health professionals.

-T-test was used to compare two means.