Stigmatization by Nurses towards Mentally Ill People

T. Fertalova (Terezia Fertalova)[1], I. Ondriova (Iveta Ondriova)[1], L. Hadasova (Livia Hadasova)[1]

[1] University of Presov in Presov, Faculty of Health Care Presov, Department of Nursing, Presov, Slovakia.

E-mail address:

terezia.fertalova@unipo.sk

Reprint address:

Terezia Fertalova
Head of Department of NursingFaculty of Health Care
University of Presov in Presov
Partizanska No 1
Presov 080 01
Slovakia

Original Article

Abstract:

Background: People with mental illness face two major problems at the same time. The first is the disease itself which they must learn to live with and to manage all its symptoms. The second, often more serious problem, is the presence of stereotypes and prejudices which are the result of insufficient knowledge about mental illnesses and their misunderstanding. The aim was to explore the current state of stigmatization by nurses towards mentally ill people.

Methods: In this quantitative exploratory research we used an existing questionnaire (the Opening Minds Scale for Health Care Providers) with randomly selected nurses who treat mentally ill patients.

Results:A significant difference in the degree of stigmatization with respect to the age of the nurses was not found. However,

in terms of the overall assessment, specifically in the domain of attitudes, the rate of stigmatization was higher among younger respondents. Nurses with shorter professional experience proved a lower degree of stigmatization than nurses with longer professional experience.

Conclusion: It is expected that the rate of mental illnesses will increase. Therefore, we recommend continuing to pay increased attention to destigmatization within the education of and developing more destigmatizing initiatives among nurses.

Introduction

Advances in neuroscience, technology, and sophisticated research have greatly improved the understanding of mental disorders, but there are psycho-social aspects that exacerbate the healing process and overall recovery. This set of factors includes prejudice and discrimination, which we refer to as stigma (Wahl, 2012). Stigma is most often defined as a mark of disgrace or infamy; a stain or reproach, as on one's reputation (Kučukalić, Kučukalić, 2017). Stigma can be a reason for refusing to seek help, for even up to 2/3rd of the total number of patients. Untreated mental illness makes a person likely to face long-term individual difficulties which contributes to the disability of the patients. As a result of these facts, mental illness is a burden on public health. Initiatives to reduce stigma are unsatisfactory, though we consider them key to finding the help needed in time (Kaushik *et al*., 2016). Mentally ill people still have trouble living a full life without prejudice, stigma or discrimination. There is evidence of a link between low levels of mental health literacy, negative attitudes towards people with mental illness and a reluctance on the part of the patient to seek help from people who believe that the patient may have a mental disorder (Thornicroft *et al*., 2007). Stigmatization impairs diagnosis, treatment and the results of treatment. Addressing stigma is the basis for providing quality health care and achieving optimal health. Future investments in reducing the degree of stigma should be aimed at mentally ill patients or mentally ill healthcare professionals at the individual level and structural level of stigma (Nyblade *et al*., 2019; Egbe *et al*., 2014).

It is necessary to fundamentally change the attitude of the professional and lay public in relation to mental illness. We will only achieve change by talking openly about mental illness and the problems associated with it. We will not make this topic taboo or trivialize it. Research shows that patients are also stigmatized by people from the ranks of healthcare professionals, including psychiatrists. In a study conducted by Kochański and Cechnicki, they found that psychiatrists, despite their education and professional mission, present similarly stigmatizing attitudes towards the mentally ill as the general population. Increasing the health literacy of professionals about mental illness is proving a necessity (Kochański, Cechnicki, 2017). Training in the right approach to the mentally ill and professional training can lead to less stigma among professionals about mental health care (Mötteli *et al*., 2019). 6 approaches to stigma reduction are described: education; protest; contact-based education; legislative reform; advocacy; stigma self-management (Arboleda-Flórez, Stuart, 2012). In addition to destigmatizing the attitudes of experts, the key challenge in this area is the personal attitude of the mentally ill person and individual destigmatizing self-assessment (Corrigan, Rao, 2012).

Through anti-stigma programs, psycho-education of patients and families about disorders and treatment options, we can give them: an active role in their treatment; restore their dignity, self-confidence and quality of life; reintegrate them into society (Bravo-Mehmedbašić, Kučukalić, 2017).

Materials and Methods

Design

This quantitative explorative research is mapping the level of stigmatization by nurses of mentally ill patients, and aiming to explore the differ-

ences of mentioned levels between selected categories of nurses.

Instrument

The main objective of our research is to map the current state of stigmatization by nurses towards mentally ill people and to observe how socio-demographic characteristics affect the degree of their stigmatization. In this work, we used an existing psychometrically tested questionnaire- the *Opening Minds Scale for Health Care Providers (OMS-HC)* (Kassam *et al*., 2012; Modgill *et al*., 2014). We addressed a larger number of respondents with a questionnaire in a short time. The individual items of the questionnaire are systematically arranged and clear, which is a positive for the respondents in terms of ease and time required to complete it. The questionnaire represents an easy and clear method of analysis and interpretation of the obtained data. OMS-HC was created to measure stigma in the population of health care providers. It takes the form of a self-report in which a person evaluates their attitudes and the intentions of their behavior towards people with mental illness. The questionnaire consists of a series of items. The respondent can choose one of the answers:

I strongly agree; I agree; I don't disagree either; I disagree; I strongly disagree. Each item is assigned a score from 1 to 5. A high score indicates that there is a more stigmatizing attitude. The full OMS-HC contains 20 items, the score of which can range from 20 (least stigmatizing attitude) to 100 (most stigmatizing attitude). More often, however, a 15-point questionnaire is used that has better results for reliability. With a 15-point questionnaire, the score can range from 15 (least stigmatizing attitude) to 75 (most stigmatizing attitude). The whole questionnaire is divided into 3 subscales. Items 9 ,10 ,11 ,12 ,13 ,15 require reverse coding in the analysis. The questionnaire is divided into 3 domains.

Sampling

Our respondents were nurses who most often treat and care for mentally ill patients within their professional work. Inclusion criteria were: nurses working on the department of psychiatry; the department of trauma surgery; the department of geriatrics and internal medicine; the department of anesthesiology and intensive care. Exclusion criteria were: nurses working in departments other than those mentioned above. We collected empirical data in the period from December 2018 to January 2019. The total number of randomly selected respondents was 89.

Statistical Analysis

We used relevant tests to test hypotheses, specifically Student's t-test and ANOVA. Important data are the value of statistical significance (p), which must be less than 0.05 (5%) for significance to be confirmed, and the values of the Mean (M) and the differences between the individual items of the variables.

Results

Demography

The largest age group of respondents was up to 35 years, with 40.4% (n = 36), slightly fewer between 35-55 years- 37.1% (n = 33), and the fewest in the group aged 55 years and above- 22.5% (n = 20); 42.7% (n = 38) of respondents stated that they had from 10 to 30 years of experience, slightly fewer had less than 10 years, specifically 41.6% (n = 37); respondents with 30 and more years- 15.7 % (n = 14) of the total sample. In the monitored group of nurses, most respondents worked in psychiatric departments, specifically 30.3% (n = 27), and the fewest, 20.2% (n = 18), worked in the anesthesiology and intensive care departments. Respondents working on the department of geriatrics and internal medicine made up 27% (n = 24) of the sample, and a fewer respondents were working in the department of trauma surgery- 22.5% (n = 20).

Means and Differences

Table 1 describes the statistical parameters and testing of Hypothesis 1 which assumes that younger nurses will have a statistically significantly lower rate of stigma towards mentally ill people. The first part of the table describes the results of the ANOVA test (F) and the statistical significance of the results (p) together with the specific number of respondents and the average of their answers. The second part of the table gives specific differences in averages of stigmatization and compares the level within different age categories. Based on the data from the first part of the table we do not record statistical sig-

nificance between the individual age categories for the degree of stigmatization by respondents. The first and second parts of the table report the highest values for the difference between respondents under the age of 35 and from 35-55 years in terms the overall evaluation of stigmatization in domain 1, with the first group scoring higher.

We state that there is no statistically significant difference and Hypothesis 1 was not confirmed. We add that overall, younger nurses have a lower rate of stigma towards mentally ill people than older nurses. Specifically in the attitude domain, younger nurses scored higher than older ones, so stigmatization is higher in younger nurses.

Table 2 presents the statistical parameters and test of the hypothesis that nurses with longer experience will have a statistically significantly lower rate of stigma towards mentally ill people. The first part of the table describes the results of the ANOVA test (F) and the statistical significance of the results (p) together with the specific number of respondents and the average of their answers. The second part of the table lists specific differences in average stigmatization and compares levels between individual categories of length of practice. Based on the data from the first part of the table, we do not record statistical significance in the comparison of individual categories of length of practice in the degree of stigmatization in respondents. The second part of the table gives information about the highest value of the difference between respondents with from 10-30 years and over 30 years of experience, both in terms of the overall assessment of stigmatization and specifically in all three domains.

We state that there is no statistically significant difference and Hypothesis 2 was not confirmed. We add that nurses with shorter professional experience have a lower degree of stigma towards mentally ill people than nurses with more professional experience.

Discussion

The aim of our work was to map the current state of stigmatization by nurses towards mentally ill people and to observe how socio-demographic characteristics affect the degree of stigmatization by them. We chose age and length of practice as socio-demographic characteristics,

i.e. independent variables. In connection with the selected independent variables, we developed 2 hypotheses based on the available literature, the veracity of which we tested using appropriate statistical methods.

A total of 89 nurses (100%) participated in our research. The education of nurses was also diverse, most nurses had higher education as their highest completed level of education (n = 47; 52.8%), followed by nurses whose highest completed level of education was higher vocational education (n = 18; 20.2%) , there were slightly fewer nurses whose highest completed level of education was a master's degree (n = 16; 18%) and the nurses whose highest completed level of education was secondary education were least represented (n = 8; 9%). If we compare length of practice and the highest level of education achieved, we come to the conclusion that participation in our research was, to the highest degree, nurses with up to 10 years' experience and university education of the 1st degree (n = 28). It is also evident from the obtained data that almost all the less experienced nurses have completed a university degree, while more experienced nurses (over 30 years of experience) achieved the secondary education as their highest level of education. Also, nurses in the generation between 10 and 30 years of experience have mostly achieved a master's degree.

The age of nurses was the first independent variable (socio-demographic characteristic) whose influence on the degree of stigmatization we observed. We assumed that younger nurses would display a statistically significantly lower rate of stigma towards mentally ill people. Although the results of our research did not show statistical significance, they showed differences in the degree of stigma between different age categories of nurses. In the overall evaluation, the lowest scores were from nurses aged 35-55 years (M 41.8182), followed by nurses aged under 35 years (M 44.2778) and the highest degree of stigmatization was found in nurses aged 55 years and older (M 44.7000). In domain 1 – attitudes, the largest difference was between nurses under 35 (M 17.3056) and nurses aged 35-55 (M 16.0909). In domains 2 – publicizing / seeking help and domain 3 - social distance, the most significant differences were between nurses aged 33-55 (M 12.6970; M 13.0303) and nurses aged

Table 1 ANOVA test of the Hypothesis 1

Domains	F	Sig.(p)	n/Mup to 35 y	n/M35-55 y	n/M55 y and over
Questionnaire total	1.745	0.983	36/44.28	33/41.8182	20/44.70
Domain 1	0.983	0.378	36/17.31	33/16.09	20/16.95
Domain 2	1.961	0.147	36/13.67	33/12.70	20/13.80
Domain 3	0.563	0.572	36/13.301	33/13.03	20/13.95

Dependent variable	(I) age	(J) age	DifferenceM (I-J)	Sig.(p)
Questionnaire total	up to 35	35-55	2.46	0.255
		55 and over	-0.42	0.970
	35-55	up to 35	-2.46	0.255
		55 and over	-2.88	0.258
	55 and over	up to 35	0.42	0.970
		35-55	2.88	0.258
Domain 1	up to 35	35-55	1.21	0.355
		55 and over	0.36	0.935
	35-55	up to 35	-1.21	0.355
		55 and over	-0.86	0.685
	55 and over	up to 35	-0.36	0.935
		35-55	0.86	0.685
Domain 2	up to 35	35-55	0.97	0.207
		55 and over	-0.13	0.978
	35-55	up to 35	-0.97	0.207
		55 and over	-1.10	0.229
	55 and over	up to 35	0.13	0.978
		35-55	1.10	0.229
Domain 3	up to 35	35-55	0.28	0.927
		55 and over	-0.64	0.734
	35-55	up to 35	-0.28	0.927
		55 and over	-0.92	0.544
	55 and over	up to 35	0.64	0.734
		35-55	0.92	0.544

Table 2 ANOVA test of the Hypothesis 2

Domains	F	Sig.(p)	n/Mup to 10 y	n/M from 10 to 30 y	n/M30 y and over
Questionnaire total	2.439	0.093	37/44.24	38/41.84	14/45.79
Domain 1	1.431	0.245	37/17.27	38/16.03	14/17.50
Domain 2	1.440	0.243	37/13.51	38/12.89	14/14.07
Domain 3	0.954	0.389	37/13.46	38/12.92	14/14.21

Dependent variable	(I) experience	(J) experience	Difference M (I-J)	Sig.(p)
Questionnaire total	up to 10	from 10 to 30	2.40	0.238
		30 and over	-1.54	0.721
	from 10 to 30	up to 10	-2.40	0.238
		30 and over	-3.94	0.123
	30 and over	up to 10	1.54	0.721
		from 10 to 30	3.94	0.123
Domain 1	up to 10	from 10 to 30	1.24	0.304
		30 and over	-0.23	0.978
	from 10 to 30	up to 10	-1.24	0.304
		30 and over	-1.47	0.400
	30 and over	up to 10	0.23	0.978
		from 10 to 30	1.47	0.400
Domain 2	up to 10	from 10 to 30	0.62	0.497
		30 and over	-0.56	0.734
	from 10 to 30	up to 10	-0.62	0.497
		30 and over	-1.18	0.255
	30 and over	up to 10	0.56	0.734
		from 10 to 30	1.18	0.255
Domain 3	up to 10	from 10 to 30	0.54	0.728
		30 and over	-0.75	0.713
	from 10 to 30	up to 10	-0.54	0.728
		30 y and over	-1.29	0.371
	30 and over	up to 10	0.75	0.713
		from 10 to 30	1.29	0.371

55 and over (M 13.800; M 13.9500). From the above data, despite the lack of statistical significance, it follows that nurses in lower age categories stigmatize the mentally ill slightly less than nurses in the highest age category.

In 2017, Wang *et al*. performed a randomized cross-sectional study involving 395 healthcare professionals. Its aim was to identify risk factors that may contribute to the stigmatization of the mentally ill. The study showed that one of the risk factors is old age, as older healthcare professionals showed significantly higher levels of stigmatization than younger ones (Wang *et al*., 2017). The opposite conclusion was reached by Ewalds-Kvist *et al*. (2013) who used different types of scales to assess attitudes, openness and social distance towards mentally ill people. The study included 2,391 respondents. It was shown that with increasing age, openness, positive and pro-integration attitudes towards people with mental illness also increase in direct proportion, i.e. the level of stigma decreases with age (Ewalds-Kvist *et al*., 2013).

Another variable monitored in relation to the degree of stigmatization was the length of practice of nurses. Based on an overview of foreign research, we assumed that nurses with longer experience will have a statistically significantly lower rate of stigma towards mentally ill people. However, our research yielded different findings. In the overall evaluation, nurses with a length of experience of 10 to 30 years showed the lowest rate of stigmatization (M 41.8421), followed by nurses with a length of experience of up to 10 years (M 44.2432) and nurses with a length of experience over 30 years displayed the highest levels of stigmatization (M 45.7857).

The categories of nurses were placed in the same order in the individual monitored domains - attitudes, publication / search for help and social distance. Although there was no statistical significance between the categories, we can state that nurses with less professional experience showed a lower level of stigmatization towards mentally ill people than more experienced nurses. In 2015, Chiu–Yueh *et al*. published the results of their study which they carried out on a sample of 180 nurses in Taiwan. The aim of their study was to examine the factors influencing the attitudes of nurses towards people with mental illness. The study clearly showed that nurses with longer ex-

perience show significantly lower levels of stigmatization than nurses with shorter experience. This fact is also related to the fact that nurses with longer experience have more clinical experience with mentally ill people (Chiu☐Yueh *et al*., 2015). Kluit *et al*. (2011) also argue that lack of knowledge and short professional experience are associated with more negative attitudes and behavior towards mentally ill (Kluit *et al*., 2011).

Conclusions

Based on our findings, we state and emphasize the need for destigmatization in relation to the mentally ill not only among the general public but also in the professional community. The need to increase health literacy in the field of mental illness seems to be just as important compared to other lifestyle and life-threatening diseases. As reported by Janoušková *et al*. (2019) a practical example of a suitable intervention is the anti-stigmatization exercises of medical students during the psychiatric module of education (Janoušková *et al*., 2019). Contact with people with mental illness during the remission period has a destigmatizing effect. Equally important is communication with people with mental illness by health professionals as words can have a stigmatizing effect (Helmchen, 2013). Given the evolution of demography in the European region and the growing number of mental illnesses, the issue of destigmatization is highly important.

Conflict of interest

There was no conflict of interest in this study.

References

1. WAHL O F (2012) Stigma as a barrier to recovery from mental illness. *Trends Cogn Sci*. 2012;16(1):9-10.
doi:10.1016/j.tics.2011.11.002
2. KUCUKALIC S, KUCUKALIC A (2017) Stigma and Suicide. *Psychiatr Danub*. 2017; 29(Suppl 5):895-899.
3. KAUSHIK A, KOSTAKI E (2016) Kyriakopoulos M. The stigma of mental illness in children and adolescents: A systematic re-

view. *Psychiatry Res*. 2016;243:469-494. doi:10.1016/j.psychres.2016.04.042.

4. THORNICROFT G, ROSE D, KASSAM, A (2007) *Discrimination in health care against people with mental illness*. Int Rev Psychiatry. 2007;19(2): pp.113-122. doi:10.1080/09540260701278937.

5. NYBLADE L, STOCKTON M A, GIGER K. *et al.*(2019) Stigma in health facilities: why it matters and how we can change it. *BMC Med*. 2019;17(1):25. Published 2019 Feb 15. doi:10.1186/s12916-019-1256-2.

6. EGBE C O, BROOKE-SUMNER C, KATHREE T, SELOHILWE O, THORNI-CROFT G, PETERSEN I (2014) Psychiatric stigma and discrimination in South Africa: perspectives from key stakeholders. *BMC Psychiatry*. 2014;14:191. Published 2014 Jul 4. doi:10.1186/1471-244X-14-191.

7. KOCHANSKI A, CECHNICKI A (2017) The attitudes of psychiatrists toward people suffering from mental illnesses. *Postawy polskich psychiatrów wobec osob chorujących psychicznie*. *Psychiatr Pol*. 2017;51(1):29-44. doi:10.12740/PP/62400.

8. MÖTTELI S, HORISBERGER R, LAMSTER F, VETTER S, SEIFRITZ E, JAGER M (2019) More Optimistic Recovery Attitudes Are Associated with Less Stigmatization of People with Mental Illness among Healthcare Professionals Working on Acute and Semi-Acute Psychiatric Wards. Psychiatr Q. 2019;90(3):481-489. doi:10.1007/s11126-019-09642-3.

9. ARBOLEDA-FLOREZ J, STUART H (2012) From sin to science: fighting the stigmatization of mental illnesses. Can J Psychiatry. 2012;57(8):457-463. doi:10.1177/070674371205700803.

10. CORRIGAN PW, RAO D (2012) On the self-stigma of mental illness: stages, disclosure, and strategies for change. *Can J Psychiatry*. 2012;57(8):464-469. doi:10.1177/070674371205700804.

11. BRAVO-MEHMEDBASIC A, KUCUKALIC S (2017) Stigma of psychiatric diseases and psychiatry. *Psychiatr Danub*. 2017;29(Suppl 5):877-879.

12. KASSAM A, PAPISH A, MODGILL G, PATTEN S (2012) The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: the Opening Minds Scale for Health Care Providers (OMS-HC). *BMC Psychiatry*. 2012, 12: 62-10.1186/1471-244X-12-62.

13. MODGILL G, PATTEN S B, KNAAK S et al. (2014)Opening Minds Stigma Scale for Health Care Providers (OMS-HC): Examination of psychometric properties and responsiveness. *BMC Psychiatry*. 14, 120 (2014). https://doi.org/10.1186/1471-244X-14-120.

14. WANG Y, WANG X, ZHANG W, LIANG X, TIAN D, QU Z (2017) Risk factors of the stigma towards psychiatric patients among primary healthcare workers in China: a county study. *BMC Psychiatry*. 2017; 17(1):62. Published 2017 Feb 8. doi:10.1186/s12888-017-1215-4.

15. EWALDS-KVIST B, HOGBERG T, LUTZÉN K (2013) Impact of gender and age on attitudes towards mental illness in Sweden. *Nord J Psychiatry*. 2013;67(5):360-368. doi:10.3109/08039488.2012.748827.

16. CHIU–YUEH H, HUEI–LAN L, YUN–FANG T (2015) Factors influencing mental health nurses' attitudes towards people with mental illness. *Int. J. Ment. Health Nurs*. 2015; 24, (3):272-280. https://doi.org/10.1111/inm.12129.

17. VAN DER KLUIT M J, GOOSSENS P J (2011) Factors influencing attitudes of nurses in general health care toward patients with comorbid mental illness: an integrative literature review. *Issues Ment Health Nurs*. 2011;32(8):519-527. doi:10.3109/01612840.2011.571360.

18. JANOUSKOVA M, FORMANEK T, ZRNECKOVA M *et al.* (2019) How to reduce stigmatization of people with mental illness in medical education: READ intervention. Jak omezovat stigmatizaci lidi s dusevnim onemocnenim pri vyuce lekarstvi: intervence READ. *Cas Lek Cesk*. 2019;158(3-4):151-155.

19. HELMCHEN H (2013) Comments on language of psychiatrists and stigmatization of the mentally ill. Nervenarzt. 2013;84(3):334-339. doi:10.1007/s00115-012-3519-4.