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Zlati, Alina
Oh, Jennifer
Baban, Adriana

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MENTAL ILLNESS STIGMA AMONG ROMANIAN ADOLESCENTS

Alina Zlati[a], Jennifer Oh[b], Adriana Baban[a]
[a]Psychology Department, Babes-Bolyai University, Romania
[b]Undergraduate Student in Psychology,
The University of Iowa, United States of America
Contact: adrianababan@gmail.com
alinazlati@gmail.com

Resumo: É rara a investigação sobre adolescentes, e estamos longe de compreender como os adolescentes estigmatizam e porquê. Os objectivos do presente estudo são de avaliar até que ponto os adolescentes da Roménia estigmatizam pessoas com perturbações mentais e avaliar a força e a direcção das relações lineares entre os sub-componentes do estigma e a predisposição para procurar ajuda. Alunos do 10º ano (N=232) preencheram questionários sobre a sua familiaridade com a saúde mental, conhecimento de saúde mental, estereótipos, preconceito, reacções emocionais, discriminação, e comportamentos de procura de ajuda. Os participantes apresentaram um valor baixo em familiaridade e conhecimentos sobre saúde mental. Acreditam que a maioria das pessoas desvalorizaria ou discriminaria um paciente psiquiátrico. Os adolescentes assumem pouca responsabilidade sobre o perigo dos estereótipos, apresentam pouca zanga e medo mas já experienciaram fortemente sentimentos de pena, comportamentos de ajuda, evitamento, coerção e segregação. Relativamente aos comportamentos de procura de ajuda, os adolescentes estavam abertos a procurar ajuda num formato de apoio à família, tratamento psicológico, e medicina tradicional. No entanto, eles não estão abertos a procurar tratamento médico. O sentimento do estereótipo da responsabilidade, de pena, a manifestação de ajuda e coerção, estão associados a altos níveis de abertura à procura de ajuda. A criação de intervenções para lidar com os sub-componentes do estigma e conceitos relacionados com o estigma deveria ser prioridade, de forma a melhorar a saúde mental e os cuidados de saúde mental, uma vez que os comportamentos de rejeição de

outros podem trazer, aos indivíduos que sofrem, uma desvantagem maior que a condição em si.

Palavras-Chave: Adolescentes, Conhecimento de Saúde Mental, Estigma em Saúde Mental

Abstract: Research concerning adolescents is scarce, and we are far from understanding how adolescents stigmatize, and why. The objectives of the present study were to assess the extent to which adolescents from Romania stigmatize people with mental illness and to evaluate the strength and direction of the linear relationships between stigma subcomponents and willingness to seek help. Tenth grade students (N=232) completed questionnaires on familiarity with mental illness, mental health literacy, stereotypes, prejudice, emotional reactions, discrimination, and help-seeking behaviors. Participants scored low on familiarity with mental illness and mental health literacy. Also, they believed most people would devalue or discriminate against a psychiatric patient. Moreover, adolescents marginally endorsed the responsibility and dangerousness stereotypes, they marginally experienced anger and fear but they strongly experienced pity, while manifesting acts of help, avoidance, coercion and segregation. When it comes to help-seeking behaviors, adolescents were willing to seek help in the form of family care, psychological treatment, and folk medicine. However, they are not willing to seek medical treatment. Furthermore, endorsing the responsibility stereotype, experiencing pity, manifesting help and coercion, are all associated with higher levels of willingness to seek help. Tailoring interventions to address these stigma subcomponents and stigma-related concepts should be a priority in order to improve mental health and mental health care, mainly because the rejecting behavior of others may bring greater disadvantage to the afflicted individuals than the mental condition itself.

Keywords: Adolescents, Mental Health Literacy, Mental Illness Stigma

Introduction

Mental illnesses afflict up to half the general population (Kessler, Berglund, Demler et al., 2005; Kessler, Angermeyer, Anthony et al., 2007; Haro, Arbabzadeh-Bouchez, Brugha et al., 2006). Not only are mental illnesses highly prevalent, but the burden associated with mental illnesses accounts for 21% of the total disease burden in the world (Lopez, Mathers, Ezzati et al., 2006). One of the hidden aspects of the burden associated with mental illnesses is stigma (Sartorius & Schulze, 2005). In regards to stigma, the adolescent population is of particular interest. About 10% of young people are affected by mental illnesses (Green, McGinnity, Meltzer et al., 2004) yet only 4% seek help (Potts, Gillies, & Wood, 2001). In addition to the high and constantly increasing rates of mental disorders (Costello, Foley, & Angold, 2006), previous studies have shown that young

people have even more pronounced negative attitudes towards mental illnesses than adults do (Stuart & Arboleda-Florez, 2001). There are several other reasons why adolescents should become a research priority. First, reducing stigmatizing attitudes in adolescents might stop them from becoming family members, health professionals, landlords, employers, lawyers, judges, police officers, and policy makers who stigmatize. Second, differences in cognitive development between adolescents and adults challenge the simple extrapolation of findings from adults to adolescent samples. Third, research concerning adolescents is scarce, and we are far from understanding how adolescents stigmatize, and why.

Given the fact that stigma is a multifaceted construct, permitting various definitions, we chose to take into consideration knowledge, stereotypes, prejudice, emotional reactions, and discrimination as stigma subcomponents, all of which are proposed in three of the most widely used stigma conceptualizations (Link & Phelan, 2001; Corrigan, Markowitz, Watson et al., 2003; Thornicroft, 2006). The objectives of the present study were (1) to assess the extent to which adolescents stigmatize people with mental illnesses, considering knowledge, stereotypes, prejudice, emotional reactions, and discrimination as stigma subcomponents, but also familiarity with mental illnesses and help-seeking behaviors as stigma-related concepts, and (2) to evaluate the strength and direction of the linear relationships between stigma subcomponents (all except knowledge) and willingness to seek help.

Methodology

Participants

Tenth grade students (N=232) were recruited from four comparable high schools. Of the total sample, 59.1% were female with a mean age of 16.57 (SD=.497), and 40.9% were boys with a mean age of 16.48 (SD=.502).

Instruments

Familiarity with mental illness

Familiarity with mental illnesses was assessed with the Level of Familiarity Questionnaire (Corrigan, Edwards, Green et al., 2001). This questionnaire lists twelve items that describe situations of varying degrees of intimacy in relation to individuals with mental illnesses. The final score is the score on the item that showcases the most intimate situation experienced by the respondent.

Knowledge

Mental health literacy encompasses knowledge regarding mental illnesses, with great impact on their recognition, management, and prevention (Jorm,

2000). Questions extracted from the National Survey of Mental Health Literacy in Young People were used to assess the level of mental health literacy (Goldney, Fisher, Dal Grande et al., 2005). The questions were formulated in reference to a vignette, which depicted an individual with typical symptoms of schizophrenia.

Stereotypes

Stereotypes are knowledge structures learned by most members of society (Corrigan, Watson, & Ottati, 2003). This construct was measured with the Devaluation-Discrimination Scale, which consists of twelve items that assess the extent to which the participants believe most people will devalue or discriminate against a psychiatric patient (Link, 1987). The answers are rated on a 6-point Likert Scale, ranging from "strongly disagree" to "strongly agree". The total score is obtained by summing the scores on individual items and dividing the sum by the number of added items.

Prejudice

Prejudice implies endorsing the negative stereotypes learned by most members of society (Corrigan, Watson, & Ottati, 2003). Two of the most common stereotypes are responsibility (individuals are responsible for their mental illnesses) and dangerousness (individuals with mental illnesses are dangerous). These two factors are measured by 6 of the 27 items of the Attribution Questionnaire (Corrigan, Markowitz, Watson et al., 2003). The answers are rated on a 9-point Likert Scale, ranging from "not at all" to "very much". The score on each factor is obtained by summing the scores from individual items and dividing the sum by the number of added items. The higher the score, the more a particular factor is being endorsed by the participant.

Emotional Reactions

Emotional cues are highly relevant because they can be easily detected. Furthermore, emotional reactions are related to subsequent behaviors towards the mentally ill. Such reactions usually range from pity to fear and anger. All these factors are measured by 9 of the 27 items of the Attribution Questionnaire (Corrigan, Markowitz, Watson et al., 2003). The answers are rated on a 9-point Likert Scale, ranging from "not at all" to "very much".

Discrimination

Discrimination involves direct behavioral responses to the mentally ill, and it can take the form of withholding help, coercion, segregation or avoidance. All these factors are measured by 12 of the 27 items of the Attribution Questionnaire

(Corrigan, Markowitz, Watson et al., 2003). The answers are rated on a 9-point Likert Scale, ranging from "not at all" to "very much".

Help-seeking Behaviors

In order to measure the participant's willingness to seek help if to have a mental disorder, the Treatment Seeking Behavior Scale was used (Hirai, 1999). The questionnaire consists of sixteen statements regarding treatment approaches. The answers are rated on a 6-point Likert Scale, ranging from "completely disagree" to "completely agree". The higher the score, the higher the likelihood of seeking help.

Results

Descriptive Analysis

Familiarity with mental illnesses

Participants scored low on the Level of Familiarity Questionnaire (M=5.323, SD=2.439). On items with a low degree of intimacy, 17.2% of pupils declared they have never observed a person that appeared to them as having a mental illness, 87.1% declared they have observed a person they believed as having a mental illness, 87.9% declared they have watched a movie or television show in which a character depicted a person with a mental illness, and 53.4% declared they have watched a documentary on television about mental illnesses. On items displaying a high degree of intimacy, 26.3% of pupils declared they have a classmate who suffers from a mental illness, 21.1% declared their volunteer work entails interacting with people who suffer from a mental illness, 9.1% declared a friend of the family has a mental illness, 12.9% declared a relative has a mental illness, 2.6% declared they live with an individual who suffers from a mental illness, and 3% declared they themselves have a mental illness.

Knowledge

Most of the participants considered the problem described in the vignette as being a psychological, mental, or emotional problem (75.9%), and more than half the participants considered the problem as being a mental illness (57.8%). However, schizophrenia was mistaken for depression (24.1%), with only 17.7% of the participants correctly identifying schizophrenia as being accountable for the described symptoms. Most of the participants considered psychological causes as a determinant of the described problem (51.7%), followed by both medical and psychological causes (39.2%), individual related causes (21.1%), and medical causes (3.4%). In correspondence to the perceived causes, the majority of adolescents declared that of help can be a psychologist (67.7%), followed by a psychiatrist (60.3%), close friend (28%), close family member (26.7%), counselor (5.6%), and

family doctor (5.2%).

Stereotypes

Participants are aware of the existing stereotypes and believe that most people stigmatize individuals with mental illnesses (M=3.037, SD=.685).

Prejudice

Adolescents marginally endorse both the responsibility (M=4.374, SD=1.249) and the dangerousness (M=4.328, SD=1.720) stereotypes.

Emotional reactions

Participants marginally experience anger (M=3.365, SD=1.597) and fear (M=3.627, SD=1.574), but they strongly experience pity (M=6.181, SD=1.700).

Discrimination

Adolescents manifest help (M=5.355, SD=1.405), but also avoidance (M=5.584, SD=2.094), coercion (M=5.421, SD=1.573), and segregation (M=4.690, SD=1.501).

Help-seeking Behaviors

Participants are most willing to seek family care (M=4.893, SD=.126) and psychological treatment (M=4.304, SD=.1.214). They also scored above average on seeking help from folk medicine (M=3.154, SD=1.151). However, participants are not willing to seek medical treatment (M=2.642, SD=.925).

Correlation Analysis

The relationship between stigma subcomponents (stereotypes, prejudice, emotional reactions, and discrimination; knowledge was not included because no aggregate scores were computed on this variable) and willingness to seek help was investigated using Pearson's correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumption of normality, linearity, and homoscedasticity. There was a small positive correlation between several stigma subcomponents and willingness to seek help (See Table 1).

Table 1
Pearson Correlations between Stigma Subcomponents and Willingness to Seek Help

Stigma subcomponents	Willingness to seek help
Stereotypes	-.039
Prejudice	
Responsibility	.206*
Dangerousness	.109
Emotional reactions	
Fear	.089
Anger	.093
Pity	.186
Discrimination	
Avoidance	-.040
Coercion	.161*
Segregation	.122
Help	.170*

*p<.05

Discussion

In the attempt to describe the extent to which adolescents stigmatize people with mental illnesses, some rather interesting findings were obtained. Although the level of distant exposure to individuals with mental illnesses is high, similar to the level reported in the literature, the level of intimate exposure to individuals with mental illnesses is low, much lower than the level of familiarity reported in the literature: 26.3% of the participating adolescents declare they have interacted at school with a classmate suffering from a mental illness (vs. 50%), 9.1% declare they have a friend of the family suffering from a mental illness (vs. 28%), 12.9% declare they have a relative suffering from a mental illness (vs. 29%), and 2.6% declare they live with a person with a mental illness (vs. 7%) (Corrigan, Lurie, Goldman et al., 2005). We presume that those who suffer from a mental illness (i.e., classmates, friends, relatives, cohabitants) do not disclose their diagnoses in order to avoid possible repercussions and that the lack of proper knowledge keeps adolescents from recognizing those individuals. Intimate exposure to individuals suffering from mental illnesses is of great importance given the fact that the higher the level of familiarity, the less likely it is to stigmatize (Corrigan, Green, Lundin et al., 2001).

Similar to the assessment of familiarity with mental illnesses, adolescents have a low level of mental health literacy, with trends more or less consistent with those in the literature. Adolescents encounter difficulties in correctly recognizing schizophrenia (17.7% vs. 42.7%), and often misidentify schizophrenia as depression (24.1% vs. 42.5%) (Farrer, Leach, Griffiths et al., 2008). Also, most participants considered the described problem to be psychological in nature, and very few adolescents considered the described problem to be medical in nature. In correspondence to the perceived causes, the majority of participants declared that of help can be a psychologist. However, they also closely reported that of help can be a psychiatrist. We posit that the contrasting results regarding not perceiving the described problem as a medical problem, but believing that a psychiatrist could help, can be explained by the conceptual confusion amongst adolescents in what being a psychiatrist entails.

Adolescents are aware of the existing stereotypes and believe that most people stigmatize individuals with mental illnesses. Furthermore, adolescents marginally endorse both the responsibility and the dangerousness stereotypes and somewhat experience anger and fear, but strongly experience pity, while manifesting acts of help, avoidance, coercion and segregation. These results are partially in line with previous studies that showed adolescents do not experience anger and fear, but do experience pity, and manifest acts of avoidance, coercion, and to a lesser degree segregation (Burns, 2009).

Regarding sources of help, adolescents are willing to seek help in the form of family care, psychological treatment, and folk medicine. However, they are not willing to seek medical treatment, which is consistent with not perceiving the described problem as being medical in nature, but is inconsistent with believing that a psychiatrist can be of help if to encounter the described problem. In what correlates of willingness to seek help are concerned, it appears that endorsing the responsibility stereotype, experiencing pity, manifesting help and coercion, are all associated with higher levels of willingness to seek help.

One of the biggest impediments in navigating through the stigma literature is that the utilized conceptual framework (if one) is not explicitly stated, although the proposed theoretical stigma models are heuristic tools and should guide research. The strongest feature of the present study involves the broad conceptualization of stigma, by including knowledge, stereotypes, prejudice, emotional reactions, and discrimination. Such a broad approach allows a more profound understanding of the stigma phenomenon. However, the present study also has several limitations that need to be taken into account when considering its contributions. The construct under inquiry is very extensive in its nature, which is why assessing all the relevant dimensions for the stigma phenomena represents a challenging task in itself. Although stigma was approached from a rather broad empirical perspective, discrimination was measured by a proxy. Considering that discrimination seemed to be the most pregnant component of stigma, not having data on the actual discriminatory behavior, but on a proxy limits the interpreta-

tion of the results. On the other hand, no implicit measures of stigma were used in order to avoid potential biases as the result of social desirability. Another limit consists in the fact that it is hard to say if the participants were modal pupils, similar to pupils in other high schools, from other cities and regions. As such, it is risky to state that the data can be extrapolated to all adolescents in Romania.

Addressing stigma is one of the directions that need to be taken in order to improve mental health and mental health care, mainly because the rejecting behavior of others may bring greater disadvantage to the afflicted individuals than the mental condition itself. Hopefully, more endeavors focusing on stigma will be pursued in Romania, in order to explain but also to combat the occurrence of stigma.

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