

Magnitude of social stigma in patients with depression: A rural versus urban analysis

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Abstract

A large group of Indian population suffers from mental illness, but they rarely seek treatment. Social stigma against mental disorders is one of the leading causes of such a huge treatment gap. The study was aimed to evaluate social stigma in patients with depression and somatic symptoms alongwith any statistically significant difference regarding social stigma in urban versus rural population. The study included 50 patients, who were subjected to socio-demographic proforma, HAM-D scale and EMIC. The study concludes that social stigma in patients of depression was higher in the rural population.

Key Words: depression.

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INTRODUCTION

In 2001, World Health Organization (WHO) reported that an estimated 25 percent of the worldwide population is affected by a mental or behavioural disorder at some time during their lives. This issue is believed to contribute nearly 12 percent of the disease burden worldwide and is expected to increase to 15 percent by 2020¹. In India, overall unweighted lifetime morbidity for any mental disorder is 13.9%, and the current prevalence is 10.6%. The overall weighted prevalence of depressive disorders was 2.9% for current experience and 5.3% for lifetime experience². Mental illnesses are frequently associated with social stigma, and this issue is probably as old as the civilisation itself. A large number of people believe that a person with mental illness cannot recover and is therefore blamed for the unaccountable. Over centuries the public attitude has increasingly become irrational against all types of mental disorders. As a result, we now find gross discrimination against people with mental illness in all spheres of life including job, housing, marriage,

immigration etc., thus substantially reducing opportunities for their rightful participation in the society. In both low- and high-income countries there is a long history of people with mental disorders being stigmatized along with their families. The myths and misconceptions associated with mental disorders negatively affect the day to day lives of sufferers, leading to discrimination and denial of even the fundamental human rights. Stigmas about mental illness seem to be widely endorsed by general public even in the Western world. Studies suggest that majority of citizens in United States³ and even in Western European nations⁴ have some form of stigma. Current conceptions have dichotomized stigma into two types “enacted stigma” or actual instances of discriminatory behaviour, which have been produced primarily in response to an individual illness and “felt stigma” or the patient’s perception that others in some ways devalue the individual with illness⁵. Ignorance and lack of proper knowledge is the cause of all stigmas. Mental illness is perceived as something strange, mysterious, dangerous and the person is considered in competent in work thus the need to be institutionalized. In various studies, it has been observed that prevalence of stigma against mental illness is more in Indian or Asian population as compared to Westerners. Western patients presenting to psychiatry facilities tend to stress more on psychological symptoms while Asian or Indian patients tend to stress more on somatic or vague symptoms which are relatively less stigmatizing. Stigma for mental illness is even more in patients with rural background compared to urban patients. Urban patients when compared to rural

peers were more likely to agree about the treatment of mental illness⁶. Indian patients are more likely to view somatic symptoms which are relatively less stigmatizing as typical features of depression when compared to patients of United States⁷.

MATERIAL AND METHODS

A cross-sectional study to evaluate, social stigma in patients presenting with depressive and somatic symptoms attending Out patient department, Department of Psychiatry in a tertiary care hospital, Ghaziabad. Due permission of ethical committee and informed consent of all subjects were obtained for the study. A total of 50 patients presenting with depressive, symptoms who fulfilled the DSM IV-TR criteria were enrolled for the study. Method of sampling was purposive sampling. Patients with the concomitant disabling physical illness, co-morbid psychotic illness, mental retardation and history of receiving ECT in past six months were excluded from the study. All patients in the study were subjected to socio-demographic proforma, HAM-D scale, Stigma Score from EMIC. HAM-D scale: to assess the severity of depression
 0-11: no/minor depression
 12-18: less than major depression
 19-24: major depression
 >= 25: severe depression
 Stigma score from EMIC: Prospects such as illness, distress, illness belief, diminished self-esteem and social rejection concern were evaluated. Response to each was coded on a 0-9 scale with higher values indicating higher stigma.

RESULTS

Sociodemographic variables of the subjects participating in this study were as described (Table 1)

Table 1: Demographic details of the subjects

Variables	n	%
Sex	Male	24 48%
	Female	26 52%
Marital status	Married	30 60%
	Unmarried	20 40%
Residence	Rural	21 42%
	Urban	29 58%
Religion	Hindu	38 76%
	Muslim	12 24%

According to HAM-D scale administered on 50 patients; the majority of subjects (56%) fall in moderate to severe depression score (>=19) (Table 2)

Table 2: HAM-D scale

HAM-D	n	%
Mild (12-18)	22	44%
Moderate (19-24)	12	24%
S severe (>=25)	16	32%

Considering EMIC scores (Stigma Score) about 50% patients had stigma score >=41 and 36% had score in the range of 11-20. (Table 3)

Table 3: EMIC scores

Stigma Score	n**	%
0-10	3	6%
11-20	18	36%
21-30	2	4%
31-40	2	4%
41-50	10	20%
51-60	8	16%
61-70	4	8%
71-80	3	6%

Comparison of mean scores of HAM-D and EMIC of rural vs urban background revealed significant statistical difference which means the level of stigma in rural patients is much higher as compared to urban patients. (Table 4)

Table 4: Comparison of HAM-D and EMIC in rural vs urban patients

	Rural (Mean ±, SD [#])	Urban (Mean ± SD)	t	df ^{##}	P
HAM-D ¹	23.1±5.5	18.6±5.4	2.882	48	0.005 [*]
HAM-A ²	19.5±5.8	16.8±5.0	1.748	48	0.086 ^{**}
EMIC ³	48.0±20.7	25.4±16.9	4.224	48	<0.0001 [*]

When Stigma Scores (EMIC) was analyzed using Pearson correlation with HAM-D scores, it was found to be statistically significant (p< 0.0001) (Table 5)

Table 5: Comparison of patients according to the severity of depression with mean Stigma Scores (EMIC)

	No. of patients	HAM-D [*] (Mean ± SD [#])	Stigma Score (EMIC ^{**})
Mild depression	22 (44%)	14.95 ± 2.01	16.0 ± 10.6
Moderate depression	12 (24%)	21.67 ± 2.02	39.66 ± 13.96
Severe depression	16 (32%)	27.31 ± 2.26	57.38 ± 11.84

DISCUSSION

The study was driven by the fact that the number of patients with depressive disorder presenting to psychiatry OPD are only the tip of the iceberg. A large proportion of patients do not accept their illness mainly because of the associated stigma resulting in high treatment gap. For depression, the treatment gap was reported to be 88 percent^{8,9}. National Mental Health Survey reported almost same treatment gap (85.2%) for major depressive disorders². Various factors that attributed to high treatment gap were low perceived need due to limited awareness, socio-cultural beliefs, values and stigma^{10,11}. In our study, the patients were selected by purposive sampling. Fifty patients who presented with depression symptoms were included in the study. Both EMIC AND HAM-D scales were used. The sample size of the study

was modest, and the results were comparable to studies carried out by Chowdhary AN, Sanyal D *et al*¹² where 29 patients of major depressive disorder were studied and assessed using Explanatory Model Interview Catalogue (EMIC). A similar study carried out by Raguram R, Weiss MG *et al.* included 80 patients¹³. All patients in the study were assessed for stigma scores using Explanatory Model Interview Catalogue (EMIC). Out of 50 patients majority (56%) fall in moderate to severe depression scores (≥ 19). Considering EMIC scores about 50% of patients had stigma scores ≥ 41 , and 36% had scores in the range of 11-20. In a study conducted by Raguram *et al.* (1996) on depression, somatization and stigma in South Indian patients, almost similar results were found. In that study, 80 outpatient patients were assessed with explanatory model interview catalogue (EMIC)¹³. Mean stigma score was 18.2 ± 13 for patients with Somatization Disorder, 36.0 ± 19.0 for patients with depressive disorders and 26.8 ± 16.0 for those with mixed somatoform and depressive disorder. The groups with depression or somatoform disorder only were having a significant statistical difference in stigma scores ($p=0.006$). Our study found that the stigma scores derived from EMIC were positively related with HDRS scores (Pearson correlation $r=0.8401$, $p<0.0001$). The finding of a positive relationship between the severity of depressive symptoms and scores on stigma scale demonstrates that higher degree of depressive symptoms is considered to be comparatively more stigmatizing. Though psychological distress and somatic discomfort co-existed, our findings are consistent with the hypothesis that symptom expression is governed by the perceived stigma attached to psychological problems. The mean stigma score of the patients from the rural background was 48.00 as compared to the urban patients where it was 25.45. The difference in scores is statistically significant. In other words, social stigma was found to be comparatively higher in rural patients as compared to their urban peers, and it may be due to multiple factors such as cultural, literacy, occupation, per capita income etc. Our finding was comparable to the studies carried out by Nieuwsma JA, Pepper CM (2011)⁷.

CONCLUSION

The study was aimed to assess social stigma in patients with depression. Higher mean stigma scores were found in patients with moderate to severe depression compared

to mild depression. Social stigma scores were more in rural patients compared to urban ones.

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