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Stigma in Mental Health: Perceptions and Attitudes of Saudi People towards Mental Illness

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Abstract

Background: People who have mental suffering may not strive to seek help from mental health professionals due to stigma, simultaneously when the social environment is stressed for mentally ill, because he/she is stigmatized by public, therefore getting relapses is inevitable. Moreover, successful psychological interventions are partly dependent on public beliefs about the etiology and treatment of mental difficulties and tolerance of community integration.

Aims and Objectives: This study aims at investigating perceptions and attitudes of Saudi community towards individuals with mental illness, which may help in improving outcomes of mental health services.

Materials and Methods: This study examined perceptions and public attitudes towards people with mental illnesses in Saudi Arabia (SA) concerning (a) causes of mental illnesses and the way they are treated and (b) levels of social distance. Responses were collected from a sample of 480 individuals, an on-line questionnaire was distributed through social media's channels. Participants asked to respond to a questionnaire, which includes: beliefs related to causes and managements of mental illnesses and social distance, in additional to a sheet encompasses, demographical data.

Results: In terms of social distance, a majority of participants showed intolerance towards people with mental illnesses in different social situations. A proportion of them thought that mental illnesses can be caused by psychosocial stressors, God's will and early bad experiences and then they can be treating by using both medications and psychotherapy, social support and religious therapy, less participants believed in merely biological backgrounds of mental illnesses (causes and therapies).

Conclusion: These results suggest that Saudi community is intolerant towards people who have mental illnesses and the level of stigma appears to be heightening, both causes and managements of mental illnesses are fallen on psychosocial backgrounds and less to biological explanations and therapies, which might explain negative attitudes they held towards mental illnesses on social distance. Programs targeting tackling stigma are recommended, at the same time, certain programs, aiming at boosting psychological awareness are needed.

Keywords: *Saudi Community; Mental Illness; Perceptions and Attitudes; Stigma*

Introduction

When someone experiences mental illness, he/she suffers peculiar symptoms (e.g. hallucinations, delusions, disorganized thoughts, cognitive deficits, apathy, mood changes, amotivation, avolition, social withdrawal etc.), both insightfulness and poor judgments could be lost due to these symptoms, the insightfulness/judgment refer to the persons' capacity to make good and realistic decisions and act on them in a reasonable way [1]. Moreover, patients may be exhibiting some sorts of violence, aggressiveness, impulsivity and nervousness and behave overtly inappropriately in social situations, which consequently leads to stigma.

Stigma, however is defined as a sign of disgrace or discredit, which sets a person apart from others. Stigma is an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to tainted discounted one [2]. Stigma as a social phenomenon, has its components (e.g. discrimination, prejudice, social isolation, social exclusion, etc). Discrimination, as the fundamental ingredients of stigma is a behavioral response to the emotions and beliefs being generated by prejudice [3]. However, there is an emotional reaction that comes up from attaching stigma to someone, fear for example, is a strong emotion and such a reaction leads to behavioral response. As a result, social distancing is a common response to fears. On the other hand, prejudice is the base of discrimination. Prejudice, however represents a group of negative emotional attitudes being held towards members of a specific social group.

Patients with mental illnesses require increased attention, care, and social integration with other members of a particular society, depending on the severity of the illness. However, the community that is less obliged to accept and protect individuals with mental illnesses is stereotyped and dislikes any associations with those patients, resulting in stigmatization. As a result, general population is less likely to hire, for example people who are labeled "mentally ill" or even deal closely with them [4]. For instance, employers often believe that people with mental disorders may be more possibly to be absent, dangerous, violent or unpredictable, moreover landlords may respond to people with mental illness in a way that is similar to attitudes and behavior of employers. As well as being in romantic relationships for individuals who have mental disorders might be challenging, due to their conditions.

Stigma is a global phenomenon, affecting all societies and communities, although it varies from one community to another. Lauber., *et al*. [5] studied stigma among Asian populations, they found that mental illnesses are attributed to supernatural, religious and magical causes, which had led to stigma. Fitzgerald [6] created 13 focus groups composed of Karen, Bhutanese, Somalian, and Ethiopian individuals to investigate stigma and to identify reasons beyond difficulties to discuss mental health among refugees. They found that components of shame, fear and culture played big roles in discussing matters related to mental health, driving to stigma, such groups were fearful of being labeled as crazy, having fears of alienation from one's community, fears of being hospitalized, fears that there are no effective treatments, and lastly worrying about losing their jobs or being homeless. Kendra., *et al*. [7] argued that the portrayal of the mentally ill in the society is a risk factor for the discrimination, in addition educational sectors had also been infiltrated by negative stereotypes regarding mental illnesses, stereotyped cognitive schemes compose of the primary factors that cause the rejection and isolation of psychiatric patients [8].

Perceptions and attitudes of pubic people towards mental illnesses could be influenced by the diversity of cultures. Fabrega [9] examined attitudes of Western and non-Western societies towards mental illness, findings showed that Western societies were more tolerant in comparing to non-Western, who showed intolerance. Similar results, Kent., *et al*. [10] found that Saudi people were more social distance in comparing to the UK people, which revealed a high level of stigma among Saudis.

Further, perceptions and attitudes of health providers towards mental illnesses might take same directions of what public people believe on, they may hold misperceptions and negative attitudes to people with mental illnesses, an anticipate is that health professionals should be more tolerant. Wahass., *et al*. [11] investigated attitudes of mental health professionals in Saudi Arabia and Britain towards mentally ill, who hear voices (auditory hallucinations), the major symptoms of psychosis, they found that UK sample were less social distance (more tolerant) than Saudi sample, which may had interpreted that Saudi professionals shared same beliefs general people hold towards patients with psychotic symptoms, as prolonged to the culture they came from. Added, a survey distributing to 300 fifth year medical students to define their perceptions and attitudes towards mental illness patients, findings indicated that only 4% of them would be interested to work with the psychiatric patients, while the rest majority of them were not, reporting a sort of intolerance towards mentally ill [8]. Wahass [12] searched attitudes of medical students towards mental illness before and after a completion of the clerkship in psychiatry, results showed that although there were changes in their beliefs on possible causes, diagnosis and types of managements after the clerkship towards scientific evidences, but their attitudes on social distance had remained the same "negative" before and after the clerkship, meaning that they had negative attitudes before the clerkship that couldn't be changed after, which might had stemmed

from social stigma general people held, as part of their original culture. Furthermore, according to Byrne [13], health practitioners share similar attitudes towards mental illnesses in place of the public accommodates, which lead to stigmatization. Chambers., *et al*. [14] investigated attitudes of nurses towards mental illnesses in five European countries, findings were interestingly contradictory, for example, Lithuanian nurses were found to hold more negative attitudes, while Portuguese nurses had more positive attitudes, such variant outcomes might be traced back somehow to the cultures they came from.

On account of stigma, surrounding mental illnesses, on one hand, people might seek mental health services, when needed from non-professionals [15]. On the other hand, different aspects of stigma, discrimination and lack of knowledge impair mental health promotion, hindering different types of prevention, including early intervention programs [16], simultaneously stigma maintains symptoms of mental illness, leading to recurrent relapses. Inclusively, stigma is an essential barrier to improve/reform mental health issues worldwide. Efforts for destigmatization seemingly are diminutive, however they are hugely needed.

As summarizing, stigma represents a real challenge and a heavily overburden for all healthcare delivery systems, because it prevents people to seek advices and assistance from mental health professionals; aborts efforts related to mental health promotion and disease prevention; takes a place of burdens on both sufferers and their families, contributes to be responsible for relapses due to family and social negative atmosphere (high expressed emotions) that patients experience.

Aim of the Study

This current paper aims at investigating perceptions and attitudes of Saudi public people towards mental illnesses, results however may contribute on finding solutions, targeting reform and improve the Saudi Mental Healthcare Delivery System on certain areas (development, promotion and prevention of mental health and therapeutic outcomes as well.

Methods

Design

This current study is fallen on a cross-sectional design that investigates how do Saudi people perceive mental illness on causes, treatment and social distance.

Participants

Samples of the current study were 480 individuals. An on-line questionnaire was distributed through social media's channels. Participants asked to read primarily a concise statement shows what does mental illness mean and then to start to respond to items of the questionnaire. The first page of the questionnaire included an apologizing statement for those who might be mentally ill or having a family member with mental illnesses. The valid response number was 238 males and 242 females. All samples perfectly completed the questionnaire.

Measurement tool

A questionnaire was used to assess the amount of stigma through investigating perceptions and attitudes towards mentally ill. The questionnaire had been earlier developed and constructed, based on previous literature on the same area, and then it was primarily used by Kent., *et al*. [10] and Wahass., *et al*. [11] for both English and Arabic languages, however, it was restricted to patients who were hearing voices "auditory hallucinations" and then the questionnaire was modified by Wahass [12] in Arabic language in order to be utilizing to cover mental illness. Besides basic demographical data, participants were asked to report about their level of educational attainment.

Remaining parts of the questionnaire consisted of items assessing; (a) which causes from a list of possibilities they believed, could be responsible for the difficulty (b) their views about the effectiveness of different therapeutic procedures and (c) their attitudes towards the integration into the community of people who have mental health symptoms. The latter measure consisted of items taken from previous research which purport to measure social distance or rejection. Levels of agreement or disagreement were assessed on 5-point scales follows (Likert-type) ranging from strongly agree to strongly disagree. However, the questionnaire was published in previous peer-reviewed journals [10-12].

Procedure

The questionnaire was distributed through online by using Social Media's channels. Social Media can be defined as a group of internet-based applications that allow the creation and exchange of user generated content. Social Media research refers to a set of tools and techniques of extracting and analyzing date from Social Media channels and the Internet. However Social Medias research represents a useful research resources and have increasingly became an invaluable way to extend the reach of heterogeneous populations.

Results

Demographical data

Demographical data includes both the gender (male and female), the educational level (pre-graduate, university's graduate and lastly postgraduate degrees) and the ages (classified on three age groups (20 - 34, 35 - 49, 50 - 65). Table 1 shows that females were few more in comparing to males (49.6, 50.4% respectively), most of participants' ages were between 35 - 49 (41.10%), they were mostly graduated from the university with a bachelor degree (63.1%).

Variables	Frequencies	Percent %
Gender		
Male	238	49.6
Female	242	50.4
Total	480	100.0
Age's groups		
20 - 34	161	33.5
35 - 49	197	41.10
50 - 65	122	25.4
Total	480	100.0
Education		
Pre-graduate	100	20.8
Graduate	303	63.1
Post-graduate	77	16.0

Table 1: *Shows the demographical data.*

Social distance

In terms of social distance, table 2 showed that the majority of participants (47%) were disagree to work with somebody who is mentally ill, while (59%) from them showed a rejection to encourage a family member to get married from someone who is mentally ill.

The level of intolerance looks clear, when one of the family members becomes mentally ill, they disagree to inform others about his/her condition (42%). A proportion of participants (69%) did not trust mentally ill to look after their children. While a member of the family is mentally ill, (79%) of participants welcomed him/her to live with as family member. More tolerance is obvious when a majority of participants (75%, 43% respectively) believed that someone with mental illness should not be institutionalized away from them and they would prefer to deal with mentally ill.

Items of social distance	Reponses	Sample's number	Percent %
I would work with someone who is mentally ill.	Agree	96	20%
	Not sure	157	33%
	Disagree	227	47%
I will not encourage a family member to get marries to mentally ill.	Agree	383	59%
	Not sure	66	14%
	Disagree	131	27%
If one of my family is mentally ill, I would tell others about his/her condition.	Agree	159	33%
	Not sure	121	25%
	Disagree	200	42%
I will not trust mentally ill to look after children.	Agree	333	69%
	Un sure	63	13%
	Disagree	84	18%
If one of my family has mental illness, I would welcome him/her to live with us as a family member.	Agree	381	79%
	Un sure	68	14%
	Disagree	31	6%
I believe that one who is mentally ill should be institutionalized away from the community.	Agree	50	10%
	Un sure	69	14%
	Disagree	361	75&
I would not prefer to deal with a person who is mentally ill.	Agree	188	39%
	Un sure	88	18%
	Disagree	204	43%

Table 2: *Indicates social distance items.*

Causes of mental illness

Table 3 indicates that a proportion of participants (82%, 54%, 43%, respectively) believed that mental illness could be attributed to psychosocial stressors, God's welling, early bad experiences and less beliefs of participants were on causes include individual's sins, Satan and Demons, chemical imbalance, black magic, evil eye and brain damage (95%, 83%, 79%, 77%, 76% and 64%).

Causes	Responses	Sample's number	Percent %
Brain damage	Yes	175	36%
	No	305	64%
Black magic	Yes	112	23%
	No	368	77%
Satan and demons	Yes	80	17%
	No	400	83%
Individual's sins.	Yes	23	5%
	No	457	95%
Early bade experiences	Yes	206	43%
	No	274	57%
Psychosocial stressors	Yes	394	82%
	No	86	18%
Heredity	Yes	141	29%
	No	339	71%
Chemical imbalance	Yes	100	21%
	No	380	79%
Evil eye	Yes	114	24%
	No	366	76&
God's will	Yes	257	54%
	No	223	46%
No idea	Yes	28	6%
	No	452	94%

Table 3: *Shows beliefs of participants on responding to causes of mental illnesses.*

Management of mental illness

According to table 4, a majority of participants (63%, 53%, 51%, 41% respectively) believed in combination of medications and psychotherapies, social support, psychotherapy religious therapy and less confidence (95%, 74% respectively) was on exorcism, and medications alone.

Managements	Reponses	Sample's number	Percent %
Medications	Yes	124	26%
	No	356	74%
Psychotherapy	Yes	244	51%
	No	236	49%
Religious therapy	Yes	199	41%
	No	281	59%
Social support	Yes	254	53%
	No	226	47%
Exorcism	Yes	22	5%
	No	458	95%
Combination of medications and psychotherapy	Yes	302	63%
	No	178	37%

Table 4: *Shows beliefs of participants on methods of managements of mental illnesses.*

Discussions

Demographically, females' sample represented few more in comparing to males, the proportion of ages' groups was between 35 - 49 years old, most of the sample graduated with a bachelor degree. Results endorsed that Saudi people were intolerant with people who are mentally ill through expressing negative attitudes towards them in terms of social distances (dealing, sharing, trusting, working and marrying), simultaneously, they showed sorts of tolerance with mentally ill, while a family member of them has mental illnesses, like that may predict how much they are compassionate/passionate towards someone of them who is mentally ill. Final remarks tell that patients who are diagnosed with mental illnesses are stigmatized by general public people in Saudi community. Moreover, Saudi people believed on social stressors and the God's will as underlying causes beyond mental illnesses. Results of the current study predict that there are some better changes have happened, concerning perceptions and beliefs of Saudi general public people towards symptoms of mental illnesses, earlier study indicated that they believed in superstitious and cultural explanations [10]. Based on causes, Saudi general public

people convinced on both psychosocial interventions (psychotherapy, social support and religious therapy) and then combined therapy (medications and psychotherapy) as effective methods of interventions for mental illnesses. On one hand, stigma of Saudi general public community might be interpreted in terms of causes and methods of interventions, on the other hand stigma may be still rooted somehow on social and cultural inheritance that may explain intolerance.

Such perceptions and attitudes of Saudi community are similar to other cultures and sociates. Therefore, developing programs targeting changing these perceptions and attitudes (destigmatization) are suggested through different channels, achieving that will assist people who are in need to seek mental health services, boost mental health promotions, reduce the burden of mental health problems, being put on healthcare delivery system and prevent relapses of mental illnesses and enhance psychological and family interventions.

Further studies are suggested to know how such certain demographic variables might influence the level of stigma, which might would be implemented on destigmatization.

Conclusion

Saudi community looks intolerant with people who are mentally ill, they are stigmatized. Saudi people believe more on psychosocial matters related to both causes and managements of mental illnesses and less trust on biological causes and management. Such beliefs on psychosocial causes and managements of mental illnesses might interpret the social distance they held towards mental illnesses, like that might assist in developing programs for destigmatization.

Informed Consent

Written informed consent was obtained from participants for publication.

Conflict of Interest

No conflict of interest present.

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