A Cross-sectional Study on the Levels of Internalized Stigma among Persons Suffering from Mental Illness in South Tamilnadu, India

Hindistan'ın Güney Tamilnadu Bölgesinde Ruhsal Hastalıklardan Muzdarip Kişiler Arasında İçselleştirilmiş Damgalanma Düzeylerine İlişkin Kesitsel Bir Çalışma

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Abstract

This cross-sectional study investigates the prevalence and levels of internalized stigma (IS) among individuals suffering from mental illness in South Tamilnadu, India. Conducted between December 2021 and March 2022, the study involved 310 participants diagnosed with mental illness for at least six months. Data were collected using the Internalized Stigma of Mental Illness (ISMI) Inventory and a semi-structured questionnaire capturing socio-demographic details. Statistical analyses, including Pearson correlation, one-way ANOVA, and post-hoc Tukey HSD tests, were employed to determine the relationship between IS and various factors. The findings reveal a high prevalence of IS, with 64.83% of participants scoring above 2.5 on the ISMI scale. Key factors influencing IS include age, education, employment, marital status, economic status, duration of illness, and regular doctor consultation. Young adults, individuals with lower educational attainment, the unemployed individuals, and those with longer illness duration exhibited higher IS levels. Notably, individuals who regularly consulted doctors and those with fewer hospital admissions reported lower IS levels. The study highlights significant socio-demographic disparities in IS, underscoring the need for targeted anti-stigma programs. Enhancing awareness and education about mental illness, improving access to mental health resources, and fostering supportive environments are crucial for mitigating IS. The findings call for comprehensive, individualized treatment plans considering each patient's social context to promote better mental health outcomes and facilitate social integration for individuals with psychiatric illnesses.

Keywords: Internalized Stigma, People Suffering from Mental Illness, South India

Öz

Bu kesitsel çalışma, Hindistan'ın Güney Tamilnadu kentinde mental rahatsızlıklardan muzdarip bireyler arasında içselleştirilmiş damgalanmanın (İD) yaygınlığını ve düzeylerini araştırmaktadır. Aralık 2021 ile Mart 2022 arasında yürütülen çalışmaya, en az altı aydır mental rahatsızlık teşhisi konmuş 310 katılımcı katılmıştır. Veriler, İçselleştirilmiş Ruhsal Hastalık Damgalaması (ISMI) Envanteri ve sosyo-demografik bilgiler için yarı yapılandırılmış bir anket kullanılarak toplanmıştır. Pearson korelasyonu, tek yönlü ANOVA ve post-hoc Tukey HSD testleri dahil olmak üzere istatistiksel analizler, İD ile çeşitli faktörler arasındaki ilişkiyi belirlemek için kullanılmıştır. Bulgular, katılımcıların %64,83'ünün ISMI ölçeğinde 2,5'in üzerinde puan almasıyla yüksek bir İD yaygınlığını ortaya koymaktadır. İD'yi etkileyen temel faktörler arasında yaş, eğitim, istihdam, medeni durum, ekonomik durum, hastalık süresi ve düzenli doktor muayenesi yer almaktadır. Genç yetişkinler, düşük eğitim düzeyine sahip bireyler, işsizler ve daha uzun hastalık süresi olanlar daha yüksek ID düzeyleri sergilemiştir. Özellikle, düzenli olarak doktorlara danışan ve daha az hastane yatışı olan kişilerin daha düşük ID seviyeleri olduğu bulgusu elde edilmiştir. Çalışma, ID'deki sosyo-demografik durumun etkisini vurgulayarak, bu kapsamda anti-damgalama programlarına olan ihtiyacın altını çizmektedir. Mental sağlık hakkında farkındalığı ve eğitimi artırmak, akıl sağlığı kaynaklarına erişimi iyileştirmek ve destekleyici ortamlar oluşturmak, ID'yi azaltmak için oldukça önemlidir. Bulgular, daha iyi mental sağlık sonuçlarını teşvik etmek ve psikiyatrik hastalıkları olan bireyler için sosyal entegrasyonu kolaylaştırmak için her hastanın sosyal bağlamını dikkate alan kapsamlı, kişiselleştirilmiş tedavi planlarının önemine işaret etmektedir.

Anahtar Kelimeler: İçselleştirilmiş Damgalama, Mental Rahatsızlık Yaşayan Bireyler, Güney Hindistan

Introduction

According to the World Health Organization (WHO) (World Mental Health Report: Transforming Mental Health for All., 2022), people suffering from mental health illness are often exposed to violations of human rights, stigma, and discrimination. Many studies have linked criminality, drug misuse, and prostitution to societal perceptions of mental illness (Angermeyer & Matschinger, 2003; Tzouvara & Papadopoulos, 2014; World Mental Health Report: Transforming Mental Health for All., 2022), and there is less sympathy for those who suffer from mental illness and a significant majority of people think people with mental illness should be marginalized. This could affect the right of those suffering from mental illness to have access to safe housing, treatment, and employment opportunities (Corrigan & Watson, 2002). Individuals who have mental illnesses struggle with the sickness itself, the stigma associated with it, and the opinions of others. Some persons also experience self-stigmatization in addition to the stigma they face from the general society.

Scambler describes 'Felt-stigma or self-stigma or internalised stigma' as the shame and fear of discriminations that prevents people from talking about their issues thereby preventing them from seeking help(Gray, 2002). People with mental health issues bear a severe burden of self-stigma brought on by public stigma. Stereotypes, prejudice, and discrimination are the three main components of both self- and public stigma. Self-stigmatization is a barrier to personal growth and can make it difficult to achieve success in both the personal and professional spheres (Corrigan & Watson, 2002). More self-stigma was linked to worse recovery from mental illness after one and two years (American Psychiatric Association, 2024) . Stigmatization and prejudice against people with mental diseases are major problems. These themes continue to be of particular importance because of the difficulties in carrying out the social integration of persons suffering from psychiatric illness, a core principle of modern psychiatry and therapeutic psychology. Each person's distinct perspective of their social environment must be considered in the creation of an individualized and thorough treatment plan. Psychiatrists need to pay close attention to programs that fight stigma, especially internalized stigma, since it is undeniably one of the biggest obstacles to the development of mental health services (Alemayehu et al., 2020). Harm, a decline in self-esteem, and increased melancholy are manifestations of internalized stigma (IS). People experience guilt and humiliation for having a mental disease. These emotions restrict social relationships and hinder work performance. The internalized stigma of getting help may increase when a patient labels themselves as a person in need of therapy, which can further lower self-esteem. Because of this, engaging in self-stigmatizing conduct is more closely associated with having a mental illness than with seeking therapy (Alemayehu et al., 2020).

Even though the Mental Health Global Action Programme (MH GAP) has adopted the reduction of stigma and discrimination as one of its core strategies, people with various mental disorders consistently experience IS and it has remained a global public health concern over time in both developing and developed countries (Corrigan et al., 2011; Livingston & Boyd, 2010). The majority of studies conducted in Western and Asian nations reveal that patients with depressive disorders have an IS that ranges from 21.7% to 51.4% (Alemayehu et al., 2020; Arthur Kleinman. Yunxiang Yan, 2011; Duko et al., 2020; Jones et al., 2011).

In India, there are very few scientific studies that deal with IS in people suffering from a mental illness. This study aimed to determine how ingrained the issue is because it is still a topic of little interest to researchers. It is extremely critical to understand the scope and causes of the stigma associated with mental illnesses so that it can be addressed. It will help in developing mitigation plans and providing guidance to lessen the harmful effects of IS on the lives of those with psychiatric illness. Additionally,

it will enable the evaluation of institutional-based mental healthcare initiatives in relation to anti-stigma initiatives in India. This study aims to exlpor the prevalence and levels of internalised stigma and its associated factors among people suffering from mental illness in the outpatient department of a south Indian hospital.

Method

This is a descriptive study. This study was conducted from December 2021 to March 2022 The participants were people who have been suffering from mental illness. The institutional ethics committee approved this study. Purposive sampling was used, and participants were chosen from people who visited the hospital and were diagnosed with mental illness. The study was conducted among those who met the inclusion criteria and exclusion criteria. The participants were explained about the study and signed an informed consent form.

Inclusion criteria:

● Male and female participants between the ages of 18 to 59 years

● Those who can comprehend the English language.

● Those who are willing to give informed consent.

● Participants who have a confirmed diagnosis of a mental illness according to ICD 10 criteria

● Participants who have been diagnosed with a mental illness for at least 6 months and who are receiving treatment.

Exclusion criteria:

● Participants who have a history of substance abuse or addiction that may interfere with study participation.

● Participants who have cognitive impairment or intellectual disability that may affect their ability to understand and respond to study questions.

● Participants who are currently hospitalized or receiving acute psychiatric care.

Assessments

All the participants filled out a set of questionnaires consisting of

● The semi-structured questionnaire for obtaining the participant's gender, age, education, employment, marital status, type of family, monthly income, economic status, place of living, total duration of illness, family history of mental illness, previous consultation with doctors, number of hospitalizations, and if there was a history of discontinuation of medication.

● The Internalized Stigma of Mental Illness (ISMI) Inventory by Dr. Patrick W. Corrigan and colleagues (Hammer & Toland, 2017) is a self-report scale that is used to measure the level of IS experienced by individuals with mental illness. The scale consists of 29 items that are rated on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). The total scale reliability was 0.84. The total score is divided by the number of items to get the actual score of IS. Scores below 2.5 is considered to have low IS and scores above 2.5 is considered to have high IS (Hamidi et al., 2023).

Procedure

Participants who fulfilled the inclusion and exclusion criteria were selected in the outpatient department of a neuropsychiatric hospital in south Tamilnadu. Participants who agreed and signed the informed consent form were selected for the study. The sample consisted of 343 participants. Researchers administered the study questionnaire. From the 343 responses, 33 had to be discarded because the participants did not complete the forms, and a total of 310 responses were taken for analysis.

Statistical analysis

Data were statistically analysed using the statistical package for social services software, Version 19.0. The Pearson correlation method was used to find the relationship between variables. One-way Analysis of variance was used to find out the significant mean difference between the demographic variables and post-hoc analysis was done to describe the specific relationship within variables. Simple percentage analysis was used with a 95% confidence level, and a significance of P <0.05 was considered to be statistically significant.

Results

The socio-demographic variables were normally distributed. The results indicate that 50.0% of the participants have completed undergraduate and 39.4% of the participants have completed postgraduate, but 56.5% of the participants are unemployed. Table 1 shows that 61.9% of the participants had the illness for more than a year, with a majority of them (>80%) reporting no family history of psychiatric illness.

Table 1: Distribution of Socio-demographic details

	Factors	N (%)
Gender	Male	130(41.9%)
	Female	180(58.1%)
Age	Young adults (18-35 yrs)	193(62.3%)
	Middle Age (36-59 yrs)	117(37.7%)
Education	Primary school	9(2.9%)
	High school	24(7.7%)
	Undergraduate	155(50.0%)
	Postgraduate	122(39.4%)
Employment	Unemployment	175(56.5%)
	Employed-government sector	56(18.1%)
	Private sector	67(21.6%)
	Business	3(1.0%)
Marital Status	Married	109(35.2%)
	Unmarried	149(48.1%)
	Widow	23(7.4%)
	Separated	6(1.9%)
	Divorced	23(7.4%)
Family type	Joint Family	18(5.8%)
	Nuclear Family	292(94.2%)
Annual income	No income	184(59.3%)
	Below 1 lakh	29(9.4%)
	1-3 Lakhs	97 (31.3%)
Economic status	Low	64(20.6%)
	Middle	209(67.4%)
	Upper	37(11.9%)

Place of living	Urban	185(59.7%)
	Rural	125(40.3%)
Total duration of illness	Below 6 months	100(32.3%)
	6months-1year	18(5.8%)
	1year and above	192(61.9%)
Family history of psychiatric illness	Yes	36(11.6%)
	No	274(88.4%)
Regular doctor consultation	Yes	143(46.1%)
	No	167(53.9%)
Number of inpatient admissions	No admission	124(40.0%)
	1 time	99(31.9%)
	2 to 5	84(27.1%)
	5 and above	3 (1.0%)
Discontinuation of medication	Yes	172(55.5%)
	No	138(44.5%)

The mean value of IS is 2.66±.38. 64.83% of the participants had scores greater than 2.5 suggestive of high levels of IS as shown in Table 2. The scores ranged from 1.62 to 3.51. Distribution of the scores is shown in Fig 1.
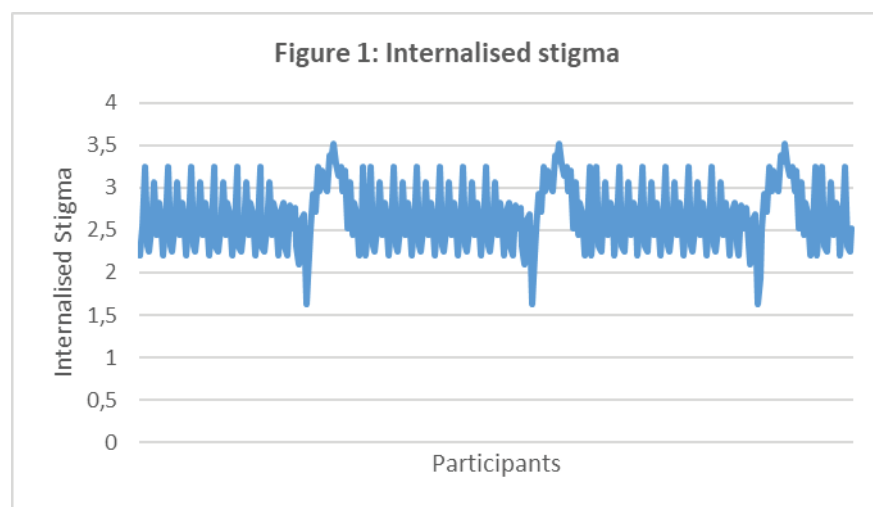

Figure 1: Internalised stigma

Table 2: Distribution of scores of IS

No.of participants	Score	Percentage
201	≥2.5	64.83
109	<2.5	35.17

Analysis of variance was done to determine the relationship between the various socio-demographic variables, the variables related to the illness and the levels of IS. The results are as shown in table 3 indicates that there is no significant difference in IS in terms of gender and place of living and the presence of family history of psychiatric illness.

Table 3: Analysis of variance between internalised stigma and the variables

Factors		N	Mean	SD	F	P
Gender	Male	130	2.62	.42	2.19	.14
	Female	180	2.69	.34		
Age	Young adult	193	2.74	.39	22.86	**<.001****
	Middle age	117	2.53	.32		
Education	Primary school	9	2.93	.46		
	High school	24	2.88	.52	29.49	**<.001****
	Undergraduate	155	2.78	.37		
	Postgraduate	122	2.44	.21		
Employment	Unemployment	175	2.79	.37		
	Government sector	56	2.50	.30		
	Private sector	67	2.42	.29	19.67	**<.001****
	Business	3		.00		
	Homemaker	9	2.95	.27		
Marital status	Married	109	2.58	.32		
	Unmarried	149	2.68	.36		
	Widow	23	2.20	.00	34.99	**<.001****
	Separated	6	3.05	.36		
	Divorced	23	3.24	.00		
Family type	Joint family	18	2.43	.41	7.20	**.008***
	Nuclear family	292	2.67	.37		
Annual income	No income	184	2.96	.00		
	Below 1 lakh	29	2.38	.36	22.85	**<.001****
	1-3 lakhs	97	2.49	.21		
Economic status	Low	64	2.91	.43		
	Middle	209	2.56	.33	26.62	**<.001****
	Upper	37	2.79	.32		
Place of living	Urban	185	2.66	.41	.06	.811
	Rural	125	2.65	.32		
Duration of illness	Below 6 months	100	2.45	.28		
	6month-1year	18	2.72	.30	27.49	**<.001****
	1year & above	192	2.77	.38		
Family history of psychiatric illness	Yes	36	2.58	.41	2.10	.148
	No	274	2.67	.37		
Regular doctor consultation	Yes	143	2.83	.38	61.93	**<.001****
	No	167	2.51	.31		
Number of inpatient admissions	No admission	124	2.49	.30		
	1-time admission	99	2.64	.32	30.69	**<.001****
	2-5 Admission	84	2.91	.39		
	5 & above	3	3.38	.00		
Discontinuation of medication	Yes	172	2.76	.34	28.33	**<.001****
	No	138	2.54	.39		

** Significant at P <.001

* Significant at P <.01

In doing the Post hoc comparisons using the Tukey HSD test, the level of education indicated that those who had post graduate level of educations were feeling lesser levels of IS than all the others. The marital status of the participants showed that participants who were widowed showed significantly lower levels of IS than all the others and those who were divorced faced significantly higher levels of IS than those who were separated. With regard to employment status, those who were unemployed had significantly higher levels of IS than those who were employed in private and government sector and those who

were employed in private sector had significantly lower levels of IS than homemakers. The participants who were ill for less than 6 months had significantly lower levels of IS when compared to those who were undergoing treatment for more than a year. Participants who never had an inpatient admission had significantly lower levels of IS than those who have had 2-5 and more than 5 admissions.

Discussion

The socio-demographic characteristics and illness-related variables of the study participants reveal significant insights into the relationship between these factors and internalized stigma (IS). The sample consisted of 130 males (41.9%) and 180 females (58.1%), predominantly young adults (62.3%) aged 18-35 years. Educational attainment was high, with 50.0% having completed undergraduate studies and 39.4% holding postgraduate degrees. Despite this, a notable 56.5% were unemployed. A majority of participants (61.9%) had been living with their illness for more than a year, and over 80% reported no family history of psychiatric illness. This suggests a significant chronicity of illness without a genetic predisposition in most cases.

IS Levels and Socio-Demographic Variables: The mean IS score was 2.66±.38, with 64.83% of participants scoring above 2.5, indicating high levels of IS. This is a higher percentage of higher scores in IS when compared to studies done with similar populations in other countries. A study in Qatar in 2021 (Kehyayan et al., 2021) showed that only 9.8% of the participants had high/severe IS. Studies done in Ethiopia and Iran in 2023 showed 27.9% and 58% of the participants, respectively, had severe/high IS (Asrat et al., 2018; Hamidi et al., 2023). A similar study done among African-American population in the USA in 2013 reported that 35% of the participants had high levels of IS (Drapalski et al., 2013). Another systematic analysis study on IS among those having mental illness in Africa showed that 29.05% of the participants had high levels of IS (Alemu et al., 2023). The reason behind this could be a lack of awareness regarding mental illness and its treatment. The analysis of variance indicated no significant differences in IS based on gender or place of living, nor was there a significant difference related to the presence of a family history of psychiatric illness. However, several other variables showed significant associations with IS levels.

Education and IS: Educational attainment showed a significant impact on IS. Participants with postgraduate education reported lower levels of IS compared to those with lower educational levels. This is similar to a study by He et al. (2021) which showed that individuals with higher levels of education were less likely to hold stigmatizing attitudes towards mental illness. This suggests that higher education may provide better coping mechanisms or access to resources that mitigate feelings of stigma.

Marital Status and IS: Marital status also played a significant role. Widowed participants reported the lowest IS levels, while divorced individuals reported the highest. The results are similar to a study by Breslau et al. (2011) which indicated that individuals who have been divorced have a higher likelihood of experiencing social stigma and discrimination compared to those who are currently married. This could reflect the additional societal stigma and personal challenges faced by divorced individuals, exacerbating their sense of internalized stigma.

Employment and IS: Employment status was another critical factor. Unemployed participants had higher IS levels compared to those employed in private and government sectors. A study by Corrigan & Rao (2012) found that stigma towards mental illness is one of the leading reasons why individuals with mental health conditions face significant employment discrimination. Interestingly, homemakers reported the highest IS levels among the employment categories, potentially due to societal undervaluation of their role.

Economic Status and IS: Economic status influenced IS levels, with individuals from low economic backgrounds experiencing higher IS compared to those from middle and upper economic statuses. On the other hand, there are some studies that suggest that the relationship between stigma and economic status is not straightforward. For instance, a study by Corrigan et al. (2010) found that while individuals from lower socioeconomic backgrounds experience more stigma related to mental illness, individuals from higher socioeconomic backgrounds experience more stigma related to substance abuse. The reason could be that stigma can impact an individual's ability to find and maintain employment, which can lead to lower income and financial instability. Financial instability may add to the psychological burden, enhancing feelings of stigma.

Duration of Illness and IS: The duration of illness was strongly associated with IS. Participants who had been ill for less than six months reported significantly lower IS levels compared to those ill for over a year. Some studies have found a positive correlation between stigma and the duration of illness, indicating that longer illness duration may lead to greater stigmatization (Livingston & Boyd, 2010). On the other hand, some studies have found no significant relationship between stigma and the duration of illness. For instance, a study conducted in the United States found that stigma did not vary significantly among individuals with different lengths of illness (Kleinman et al., 2011). This may indicate that prolonged illness increases exposure to stigma and self-stigmatization.

Inpatient Admissions and IS: Inpatient admissions were significantly linked to IS. Participants with no history of inpatient admission reported lower IS levels compared to those with multiple admissions. Frequent hospitalizations might contribute to a heightened sense of stigma due to repeated interactions with mental health institutions.

Regular Doctor Consultations and IS: Participants who had regular doctor consultations reported higher IS levels than those who did not. This counterintuitive finding might suggest that regular consultations, while crucial for management, could also serve as constant reminders of the illness, thereby increasing stigma. a study conducted by Pachankis et al. (2017) found that stigma can create barriers to accessing healthcare, including seeking help from medical professionals.

Discontinuation of Medication and IS: Medication discontinuation was also significantly associated with IS. Participants who had discontinued their medication at some point reported higher IS levels. A study by Ghosh et al. (2022) found that internalized stigma and public stigma were associated with medication non-adherence among individuals with bipolar disorder. A study by Girma et al. (2013) reported that stigma was not a significant predictor of medication non-adherence among individuals with schizophrenia. This could reflect the challenges and frustrations associated with managing their condition, contributing to internalized stigma.

The study examined socio-demographic characteristics and illness-related variables to understand their relationship with internalized stigma (IS) among participants. Key findings include the following information. The mean IS score was 2.66±.38, with 64.83% scoring high, more than reported in similar studies in Qatar, Ethiopia, Iran, and the USA. IS scores did not significantly differ by gender, place of living, or family psychiatric history. Higher education correlated with lower IS levels, similar to other studies suggesting that education may provide better coping mechanisms and resources. Divorced individuals and unemployed participants reported higher IS, likely due to societal stigma. Homemakers had particularly high IS, possibly due to societal undervaluation of their role. Lower economic backgrounds were associated with higher IS levels. Longer illness duration correlated with higher IS, potentially due to prolonged exposure to stigma. Multiple hospitalizations and regular doctor visits were linked to higher IS, possibly due to repeated reminders of the illness. Participants who had stopped

medication at some point reported higher IS, which may relate to challenges in managing their illness and associated stigma.

These findings highlight the complex relationships between socio-demographic and illness-related factors and internalized stigma, indicating that higher education and socioeconomic stability may mitigate IS, while prolonged illness and frequent healthcare interactions may exacerbate it.

Conclusion and Recommendations

The study highlights the multifaceted nature of IS and its strong associations with various socio-demographic and illness-related factors. Interventions aimed at reducing IS should consider these variables to provide tailored support. Enhancing education, improving employment opportunities, and providing psychological support for chronic illness management and frequent hospitalizations could be crucial steps in mitigating IS among individuals with psychiatric conditions. Based on the study findings, the following recommendations are suggested to address and reduce internalized stigma (IS) among individuals with mental illness:

1.   Educational Programs: Increase public mental health education to reduce stigma, focusing on communities with lower educational attainment. Awareness programs that provide factual information about mental health can help reduce stereotypes and negative beliefs. Encourage higher educational institutions to integrate mental health awareness into their curriculum to foster supportive environments and empower students with knowledge that can help combat stigma.

2.   Employment Support Initiatives: Establish workplace programs that offer support for individuals with mental health conditions, including flexible work arrangements, mental health days, and access to counseling services. Partnering with organizations to promote inclusive hiring practices can help reduce stigma-related barriers in employment.Provide specialized employment support for homemakers and unemployed individuals, including skill-building workshops and access to community resources, to foster self-worth and reduce stigma associated with unemployment.

3.   Targeted Support for Marital and Socioeconomic Vulnerabilities: Implement targeted mental health services for divorced individuals and those experiencing socioeconomic challenges, as these groups may face heightened social stigma. These services could include access to support groups, counseling services, and financial assistance programs. Develop community-based initiatives that offer social support for low-income individuals, helping them navigate financial and mental health challenges without fear of stigma.

4.   Healthcare Engagement Strategies: Encourage a focus on resilience-building and stigma-reducing language in patient interactions, especially for those with chronic conditions requiring frequent care. Increase outreach for mental health support in community settings, rather than hospital settings alone, to avoid stigma associated with frequent hospitalization and institutionalization.

5.   Encouraging Adherence to Treatment: Address factors contributing to medication discontinuation by providing education on the importance of adherence and addressing concerns around side effects. Peer support programs could encourage individuals to maintain treatment, reducing self-stigma related to medication use. Increase access to personalized treatment plans and psychoeducation, which can empower individuals to manage their illness proactively and with reduced stigma.

6.   Peer Support Networks and Community Engagement: Establish community peer-support groups

where individuals can share experiences and receive mutual encouragement. Such networks may help reduce stigma by providing a platform for individuals to see their struggles as shared rather than isolating. Promote mental health champions and advocates within the community who can share their recovery journeys and normalize seeking help for mental health conditions.

7.   Long-term Support for Chronic Conditions: For individuals with prolonged illness duration, create ongoing support systems that address chronicity-related stigma, including therapy, community support, and resource access to ease their experiences with prolonged stigma exposure. Implementing these recommendations could create a more inclusive environment, reduce internalized stigma, and support individuals with mental health conditions in achieving better quality of life and social integration.

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Contribution of the authors	Mr. Jegadeesh	Mr. Rajkumar	Ms. Bijulakshmi	Dr. Vikhram	Total
The concept, design of the work; acquisition, analysis and interpretation of data,	25%	25%	25%	25%	100%
Drafted the article and revised it critically for important intellectual content,	25%	25%	25%	25%	100%

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