Original research article

Stigmatization and attitudes toward mental health disorders among adolescents in Slovakia

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Abstract

Introduction: Mental health is an important component of overall health. Adolescence is one of the critical life periods for the development of mental illness. Quality of life among patients with mental health problems is significantly affected by stigmatization. This study aims to explore the perception and attitudes toward mental health disorders among adolescents in Slovakia.

Methods: The Mental Illness Stigma Scale was used for assessing the attitudes related to mental illness. The questionnaire was administered to 550 students at six high schools in Slovakia. The average age of respondents was 17.45 ± 0.95 (60.18% females). ANOVA, Student's *t*-test, and correlational analysis were used for statistical analysis.

Results: In particular, higher levels of stigmatizing attitudes towards mental illness were found in the areas of Professional efficacy, Treatability and Recovery, as well as Poor Hygiene. There were no significant socio-demographic differences in the stigmatization attitudes, with the exception of the Poor Hygiene subscale, with male respondents scoring higher ($t = -3.71, p \leq 0.001$).

Conclusion: Our results indicate a relatively high prevalence of negative attitudes toward professional efficacy of mental health professionals and toward possibilities of effective treatment of mental health disorders among high school students. An educational intervention or campaign to reduce stigma toward mental illnesses and improve knowledge targeted at this specific age group would be beneficial.

Keywords: Adolescents; Mental disorders; Mental health; Prevention; Stigmatization

Introduction

From a public health perspective, mental illness currently represents a serious issue – and its occurrence is increasing. According to the WHO, mental diseases affect approximately 25% of the European population every year, and depression is currently one of the most common diseases in the population (WHO, 2015). In addition, depression is the most common cause of invalidity of population on a global scale. It belongs to the main risk factors related to death caused by suicide. Similarly, anxiety disorders and addictions are very common diagnoses which have severe health, social, and financial consequences (WHO, 2017). In Europe, suicide is the cause of death in more than 58 000 cases every year. It is estimated that suicide attempts are even more frequent. It is the second most common cause of death in the age group of 15–19 years old (Freeman, et al., 2017; Roh et al., 2018). According to the data of the National Health Information Center (NHIC) in Slovakia, the occurrence of mental disorders is increasing. Most evident is an increase in diagnoses that belong to the group of affective disorders, neurotic and stress-related disorders, and organic mental disorders. The number of young people

between 15–19 years of age who have been diagnosed with a new disorder is increasing as well (NHIC, 2017).

Mental diseases are significantly underdiagnosed and the patients usually hesitate for a long time before seeking professional help due to the strong stigmatization that surrounds these diseases. Stigmatization is an issue that is linked with mental diseases in a significant way. It has a crucial impact on treatment as well as the overall quality of a patient's life. To some extent, mental diseases are described differently to somatic diseases. In comparison to physical diseases, it is believed that mental diseases are more or less untreatable, thus they are a life-long definite condition (Parcesepe and Cabassa, 2013; Singh et al., 2016; Zolezzi et al., 2017). Stigma can be defined as a process of labelling related to both social exclusion and the rejection of the stigmatization and feelings of shame in the stigmatized individual. It is the result of an unfavourable social judgement by a related social group. This judgement tends to be based on a particular trait related to identity, behaviour, appearance, or health condition, which society considers as abnormal (Angermeyer et al., 2013; Ocisková et al., 2015). The most significant stereotypes associated with mentally ill people include feelings of endangerment, unpredictability and unreliability. Another common prejudice includes the belief

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that people with mental diseases are violent and dangerous, poor and less intelligent, or that mental diseases arise due to one's weakness and cannot be treated (Janoušková and Winkler et al., 2015; McDaid, 2008; Reavley and Jorm, 2011). The stereotypes and prejudices may then lead to the discrimination of individuals or of a whole group. Later, discrimination may be the main obstacle in early diagnostics and treatment of a patient.

A special group that is very sensitive to stigmatization and discrimination is children and adolescents – as their psychosocial development is not yet complete. Self-esteem and self-perception in puberty and adolescence is more influenced by the external effects and reactions from their environment. Mental disorders represent a significant obstacle in the education, family and social life of adolescents and children (Evans-Lacko et al., 2014). The British adolescents in the study by Salaheddin and Mason (2016) were afraid that receiving professional help would reduce their chances of getting a job because they would be considered weak. They also feared that those around them would think they had gone mad – and thus they would not be taken seriously. Another British study showed that 85% people receiving professional psychiatric help experienced discrimination or stigmatization, especially among their relatives, friends and in their social life. Alternatively, they experienced ignorance and avoidance in their surroundings (Corker et al., 2013). A high level of stigmatizing attitudes have been found in Slovak research studies, where the majority of respondents considered people with schizophrenia or other mental health problems to be uncontrollable, dangerous, and potentially violent (Ocisková et al., 2015; Poluchová and Heretik, 2009). However, research on attitudes toward people with mental health problems is quite sparse in Slovakia.

The aim of this research study was to explore the perception of mental health disorders and attitudes toward people with mental health disorders among adolescents in Slovakia.

Materials and methods

Design and data collection

The cross-sectional correlational research design was applied in this research study. The research sample was obtained by convenient sampling method. Various high schools from the eastern and central part of Slovakia were contacted. The principals of each of 6 schools agreed with the participation in our research. The students completing the form did so anonymously and voluntarily. The students were informed about the aim and nature of the research. In addition, they were assured that their answers would be anonymous. Data collection took place at classroom consultations led by a classroom teacher from September to December 2017. The response rate was 98%. The research methods were approved by the Ethical Committee at Jessenius Faculty of Medicine in Martin at Comenius University.

Participants

The research sample comprised 550 students with an average age of 17.45 years (*SD* 0.95, age range between 15–20 years). There were 331 (60.18%) girls and 219 (39.81%) boys. Table 1 shows the sociodemographic data of the participants. Most of them live in a village (56.73%). The majority of their parents have high school education and most of them are employed. The financial situation in the family was described as poor by 7.5% of the respondents.

Table 1. Sociodemographic characteristics of the research sample

Variable	N	%
Residence		
Urban	238	43.3%
Rural	312	56.7%
Total	550	100.0%
Father's educational level		
Secondary without graduation	103	19.5%
Secondary with graduation	252	47.7%
Tertiary	173	32.8%
Total	528	100.0%
Mother's educational level		
Secondary without graduation	54	10.1%
Secondary with graduation	283	52.9%
Tertiary	200	37.4%
Total	534	100.0%
Father's Employment status		
Employed or self-employed	517	94.0%
Other	33	6.0%
Total	550	100.0%
Mother's Employment status		
Employed or self-employed	500	91.24%
Other	50	8.76%
Total	550	100.0%
Family's financial situation		
Very good	125	22.8%
Average	382	69.7%
Adverse	41	7.5%
Total	548	100.0%

Measuring instruments

Day's Mental Illness Stigma Scale – DMISS (Day et al., 2007) was used for data collection. The scale was designed by Day, Edgren and Eshleman in 2003. A Slovak version of the questionnaire was obtained using the method of back-translation. The questionnaire consists of 28 items divided into seven subscales (Anxiety, Relationship disruption, Poor hygiene, Visibility, Treatability, Professional efficacy, and Recovery). The questionnaire is being assessed on a basis of counting a raw score for each subscale respectively. Each subscale represents a specific aspect related to the participant's attitude to mentally ill people. The participants expressed their attitude on the Likert scale ranging from 1 (I absolutely disagree) to 7 (I absolutely agree). Achieving a high score in the questionnaire signified strong attitudes that express a stigmatizing view toward people who suffer from a mental disorder.

In Table 2, the reliability coefficients of the entire DMISS subscale are presented. In this research, DMISS questionnaire was accompanied by a short question on the probability of seeking professional help in the case of mental problems. In addition, the students were given a short self-designed questionnaire containing the sociodemographic questions.

Data analysis

The data were processed by the statistical software PSPP and descriptive statistical procedures. The Student t-test for independent samples was used to analyse the differences within particular subscales in the DMISS questionnaire based on sociodemographic factors. A correlation analysis ANOVA was also applied.

Table 2. Subscales of the DMISS questionnaire and reliability coefficients in the present study

Subscale	Items	Cronbach alpha in the present study
1. Anxiety	6, 16, 17, 21, 22, 24, 25	0.85
2. Relationship disruption	2, 3, 5, 10, 12, 15	0.75
3. Poor hygiene	4, 14, 19, 27	0.75
4. Visibility	7, 9, 18, 26	0.65
5. Treatability	1, 8, 11	0.44
6. Professional efficacy	23, 28	0.82
7. Recovery	13, 20	0.69

Results

Table 3 presents the average values of particular items in the DMISS questionnaire. The indicators of Skewness and Kurtosis show a normal data distribution – Skewness did not exceed the value of 3 and Kurtosis did not exceed the value of 10. The highest average values were found in two items included in the subscale of Professional efficacy: 23 (the psychiatrists and psychologists have the knowledge and experience needed for effective treatment of mental disorders) and in item 28 (the professionals in the field of mental health such as psychiatrists and psychologists can ensure effective treatment of mental disorders). A Higher average score (higher than the neutral value of 4) was found also in all items included in the subscale of Poor hygiene. The highest score was reached in item 14 (people with a mental disorder ignore their hygiene – such as showering or using deodorant).

A higher average score was shown in the items included in the subscale of Recovery (e.g. item 20 – People with a mental disorder will be ill for the rest of their life) and Treatability (e.g. item 8 – I think there is no effective treatment for mental disorders). Similarly, higher average values were shown in item 22 (if I were close to a person with a mental disorder, I would be afraid of being physically hurt) within the Anxiety subscale.

On the contrary, a lower average score (lower than the average value of 4) was shown, e.g. in item 17 (if I talk to a mentally ill person, I would be afraid of saying something that could upset him/her) and also in the items included in the subscale of Visibility (e.g. item 18: I could tell that the individual has a mental disorder based on his/her behaviour) and the subscale Relationship disruption (e.g. item 12 – I think that a personal relationship with the individual suffering from a mental disorder would be too demanding).

Table 3 also shows a percentage of negative answers for each particular item, namely answers to the questions 5, 6, and 7 on the Likert scale, which represent a stigmatized attitude to mental illnesses. The highest percentage of negative answers (more than 60%) were seen in items 23 and 28 included in the scale Professional efficacy. In comparison, the lowest percentage was seen in items 17 and 18 (less than 20%).

The average score in particular subscales in the DMISS questionnaire is presented in Table 4. Among the subscales, the highest average score corresponding to a higher extent of a stigmatizing attitude toward mental disease is shown in the subscales of Professional efficacy, Treatability, Recovery, and Poor hygiene. In other subscales, the average score was lower than 4, which corresponds to a lower extent of stigmatizing

attitude to mental diseases. The lowest average score was revealed in the subscale Visibility. The differences in the scores achieved in particular subscales evaluated according to sociodemographic differences between the participants (education and occupation of their mother and father, place of living, gender, and financial situation of the family) were tested by the Student t-test for independent samples and variance analysis. Statistically significant differences in stigmatizing attitudes within particular subscales of the DMISS questionnaire according to sociodemographic differences were revealed only in one subscale. Statistically significant differences were found in the subscale of Poor Hygiene when evaluated according to gender. The boys achieved higher scores compared to the girls ($t = 2.96, p \leq 0.01$).

The correlation analysis did not show any significant relationship between age and score in particular subscales of the DMISS questionnaire. The only relationship that was statistically significant, however factually nonsignificant (correlation coefficient $r < 0.1$), was the relationship between age and the subscale Professional efficacy (Table 5).

The last question in the questionnaire was aimed at the probability of seeking professional help in the case of mental problems. 266 students (48.10%) would seek help, 182 students (32.91%) said they did not know, and 102 students (18.99%) would not seek help.

Discussion

In the sample of high school students participating in our research study, a higher extent of stigmatizing attitudes towards mental diseases was revealed mainly in the aspects related to the possibility of professional help, treatment and complete recovery as well as personal hygiene. A significant part of the students regarded the potential to be cured from mental disease as very limited. The professionals in mental health, psychologists and psychiatrists are also seen as quite negative in this respect. The students also believe that the individuals with mental disorders have problems with personal hygiene. These findings correspond with other studies which mainly revealed a higher average score in the DMISS questionnaire subscales of Professional efficacy, Treatability, and Recovery (Day et al., 2007; Imhoff, 2016). Negative attitude towards these aspects seems to be a complicated issue considering the persisting problem of a large number of belated psychiatric diagnosis. These three aspects show that mental disorders are considered to be definite, hard to influence, and incurable, which might have an impact on willingness to seek professional help in the case of mental problems. It would be useful to study more deeply the causes of persisting low trust in the capability of mental health professionals to ensure effective treatment of mental disorders.

Various research studies have also shown that people with a mental disorder are often considered to be dangerous and aggressive (Pescosolido et al., 2010; Reavley and Jorm, 2011). This belief was also common in our research, which showed that more than 40% of students agreed with the statement of feeling endangered when meeting a mentally ill person. On the contrary, more positive findings were revealed in the study by Čerňanová (2010). In this study, only 26% of students at one of the universities in Slovakia agreed with this statement. However, the research sample in this particular study consisted of students studying health-related study programmes – so a higher extent of knowledge or their positive personal attitude could have played a role in this case.

Table 3. Individual item distributional characteristics of the DMISS subscales

Item no.	Mean	SD	Median	Modus	Skewness	Kurtosis	% of negative answers (5–7)
Anxiety subscale							
6	4.01	1.85	4	4	0.00	–1.03	38.99%
16	4.02	1.70	4	4	0.17	–0.78	34.55%
17	2.91	1.71	2	3	0.74	–0.37	18.73%
21	3.98	1.73	4	4	0.09	–0.75	34.00%
22	4.30	1.79	4	4	–0.17	–0.93	44.55%
24	3.45	1.63	4	3	0.36	–0.56	23.64%
25	3.84	1.72	4	4	0.17	–0.75	32.55%
Relationship disruption							
2	4.11	1.75	4	4	–0.08	–0.85	39.27%
3	3.75	1.73	4	4	0.12	–0.85	31.64%
5	3.65	1.80	4	4	0.22	–0.90	30.00%
10	3.59	1.69	4	4	0.29	–0.58	25.82%
12	3.47	1.76	4	3	0.30	–0.84	26.55%
15	3.61	1.78	4	3	0.31	–0.85	29.55%
Poor hygiene							
4	4.04	1.76	4	4	0.04	–0.88	36.55%
14	4.74	1.67	4	4	–0.18	–0.84	36.73%
19	4.38	1.66	4	4	–0.03	–0.78	29.88%
27	4.60	1.68	4	4	–0.13	–0.71	44.18%
Visibility							
7	3.87	1.75	4	4	0.08	–0.82	33.52%
9	3.53	1.65	4	4	0.32	–0.57	25.55%
18	3.22	1.57	4	3	0.49	–0.29	17.45%
26	3.39	1.56	4	3	0.33	–0.42	20.91%
Treatability							
1	4.35	1.74	4	6	0.22	–0.99	49.82%
8	4.67	1.85	5	6	0.46	–0.79	55.82%
11	3.94	1.54	4	4	–0.02	–0.52	42.00%
Professional efficacy							
23	5.12	1.69	5	7	0.76	–0.22	66.55%
28	4.98	1.69	5	6	0.65	–0.36	61.64%
Recovery							
13	4.25	1.86	4	4	0.10	–1.08	43.82%
20	4.51	1.73	4	4	0.19	–0.86	48.55%

Table 4. Mean scores in DMISS subscales in the research sample

Subscale	Mean	SD	Statistically significant differences regarding sociodemographic factors
Anxiety	3.78	1.73	–
Relationships disruption	3.83	1.75	–
Poor hygiene	4.44	1.69	Differences according to gender ($t = -3.71, p \leq 0.001$)
Visibility	3.50	1.63	–
Treatability	4.31	1.71	–
Professional efficacy	5.05	1.69	–
Recovery	4.38	1.80	–

Table 5. Correlational analysis: Pearson correlation coefficients between age and the DMISS subscales

Anxiety	Relation. disruption	Poor hygiene	Visibility	Treatability	Professional efficacy	Recovery
0.02	–0.01	0.06	–0.03	–0.02	0.09*	0.1

* $p \leq 0.05$

The findings in our study also revealed a high tendency to choose neutral answers in the assessment of the stigmatized attitudes covered in the questionnaire. These results can be interpreted as a tendency to give socially acceptable answers, or they might be a result of a lack of information about this issue (low level of mental health literacy). Mental health literacy is defined as the ability to recognize specific disorders and search for information on mental health, risk factors, or the professional help available. A good level of mental health literacy among adolescents has a positive impact on early identification and help-seeking behaviour in the case of mental disorders. Early intervention may change the development of mental disease and lead to better results of treatment (Attygalle et al., 2016; Bonabi et al., 2016). The research shows that the educational programmes aimed at enhancing the mental health knowledge of young people had a positive impact on decreasing the negative attitudes towards mentally ill people, and also increased the probability of help-seeking behaviour in the case of mental health problems (Koller and Stuart, 2016).

Our study showed the significant impact of gender on the tendency to stigmatize people with mental disease in terms of personal hygiene. This tendency was higher in males than in females. Similarly, in a large research study, which was part of a British campaign called Time to Change (2015), women showed (in various aspects) more tolerant attitudes to mentally ill people than men. Regarding aspects of sociodemographic indicators, such as education, occupation of student's parents or financial situation of a family, there were not found any significant differences signaling stigmatization of mental disorders.

The willingness of the students to seek the help of a psychologist or psychiatrist in the case of mental problems was studied as well. Almost half of the students showed positive attitudes toward seeking help in the case of their own mental health problems. However, almost one fifth of the students said that they would not seek professional help if a mental disease occurred, and the rest of the research group were not sure. This result might reflect lower levels of trust in professional help opportunities (e.g. seeking of psychologist or psychiatrist) which were found in our study.

This study has several methodological limitations. The main limitation is the conventional sampling method used in our study, as well as the fact that the sample mainly consisted of girls. This has a limiting effect on the representativeness of the student sample. Also, particular types of high schools (grammar schools, vocational high schools) were not represented equally. These factors could influence the results of our study. Another limitation is the fact that the DMISS questionnaire has not yet been validated for a Slovak sample. However, the strength of the research lies in the topic of stigmatization of mental disorders – because there is not much knowledge about it in Slovakia.

Conclusions

Our results indicate a relatively high prevalence of negative attitudes toward the professional efficacy of mental health professionals and toward possibilities of effective treatment of mental health disorders among high school students. Based on the findings, it would be useful to take appropriate preventive strategies supporting the spread of knowledge on mental disorders aimed at adolescents. Educational programmes aimed at promoting mental health literacy might have a positive impact on decreasing negative attitudes towards mentally ill people and increasing help-seeking behaviour in the case of mental health problems. If destigmatization programmes are effective and produce satisfactory results, then the programmes should be long-term and interdisciplinary.

Ethical aspects and conflicts of interest

The authors declare that there is no conflict of interest regarding the study and that the ethical aspects were respected while processing the results.

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Stigmatizace a postoje dospívajících žijících na Slovensku vůči poruchám duševního zdraví

Souhrn

Úvod: Duševní zdraví je důležitou součástí celkového zdraví. Dospívání je jedním z kritických období pro rozvíjení duševních nemocí. Kvalita života pacientů s duševními poruchami je výrazně ovlivněna stigmatizací. Cílem této studie je prozkoumat postoje dospívajících žijících na Slovensku vůči poruchám duševního zdraví.

Metodika: Pro hodnocení postojů vůči duševním poruchám byl použit dotazník Mental Illness Stigma Scale. Dotazník byl předán 550 studentům na šesti slovenských středních školách. Průměrný věk dotazovaných byl $17,45 \pm 0,95$ (60,18 % žen). Pro statistickou analýzu jsme využili: TANOVU, Studentův *t*-test a korelační analýzu.

Výsledky: Vyšší úroveň stigmatizujících postojů vůči duševním poruchám byla zjištěna zejména v oblasti profesní efektivnosti a dovedností, v možnostech léčby a zotavení se a též ve špatné hygieně. Nebyly zjištěny žádné významné sociodemografické rozdíly v postojích ke stigmatizaci. Výjimkou byla oblast špatné hygieny, kterou uvedlo větší množství respondentů mužského pohlaví ($t = 3,71$; $p \leq 0,001$).

Závěr: Podle odpovědí dospívajících žijících na Slovensku poukazují naše výsledky na relativně velkou prevalenci negativních postojů týkajících se profesních dovedností a efektivnosti lidí trpících duševní poruchou a vůči možnostem efektivní léčby. Prospěšné by bylo lepší vzdělávání v této oblasti nebo kampaň, která by pomohla snížit stigmatizaci lidí s duševním onemocněním a zlepšila by znalosti studentů ve věkové skupině, která byla dotazována.

Klíčová slova: dospívající; duševní zdraví; mentální poruchy; prevence; stigmatizace

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