DOI: 10.36315/2021inpact013
Psychological Applications and Trends 2021

PERCEPTIONS PERTAINING TO STIGMA AND DISCRIMINATION ABOUT DEPRESSION: A FOCUS GROUP STUDY OF PRIMARY CARE STAFF

Ayesha Aziz[1], & Nashi Khan[2]
[1]Centre for Clinical Psychology, University of the Punjab, Lahore (Pakistan)
[2] Prof. Dr., Project Director, RLMC, Dean FSSH, Rashid Latif Medical Complex (RLMC), Lahore (Pakistan)

Abstract

The present study was conducted to explore the perception and views of primary care staff about Depression related Stigma and Discrimination. The Basic Qualitative Research Design was employed and an In-Depth Semi-Structured Discussion Guide consisted of 7 question was developed on the domains of Pryor and Reeder Model of Stigma and Discrimination such as Self-Stigma, Stigma by Association, Structural Stigma and Institutional Stigma, to investigate the phenomenon. Initially, Field Test and Pilot study were conducted to evaluate the relevance and effectiveness of Focus Group Discussion Guide in relation to phenomena under investigation. The suggestions were incorporated in the final Discussion Guide and Focus Group was employed as a data collection measure for the conduction of the main study. A purposive sampling was employed to selected a sample of Primary Care Staff (Psychiatrists, Medical Officers, Clinical Psychologists and Psychiatric Nurses) to elicit the meaningful information. The participants were recruited from the Department of Psychiatry of Pakistan Medical and Dental Council (PMDC) recognized Private and Public Sector hospitals of Lahore, having experience of 3 years or more in dealing with patients diagnosed with Depression. However, for Medical Officers, the experience was restricted to less than one year based on their rotation. To maintain equal voices in the Focus Group, 12 participants were approached (3 Psychiatrist, 3 Clinical Psychologists, 3 Medical Officers and 3 Psychiatric Nurses) but total 8 participants (2 Psychiatrists, 2 Medical Officers, 3 Clinical Psychologists And 1 Psychiatric Nurse) participated in the Focus Group. The Focus Group was conducted with the help of Assistant Moderator, for an approximate duration of 90 minutes at the setting according to the ease of the participants. Further, it was audio recorded and transcribed for the analysis. The Braun and Clarke Reflexive Thematic Analysis was diligently followed through a series of six steps such as Familiarization with the Data, Coding, Generating Initial Themes, Reviewing Themes, Defining and Naming Themes. The findings highlighted two main themes i.e., Determining Factors of Mental Health Disparity and Improving Treatment Regimen: Making Consultancy Meaningful. The first theme was centered upon three subthemes such as Lack of Mental Health Literacy, Detached Attachment and Components of Stigma and Discrimination. The second theme included Establishing Contact and Providing Psychoeducation as a subtheme. The results manifested the need for awareness-based Stigma reduction intervention for Primary Care Staff aims to provide training in Psychoeducation and normalization to reduce Depression related Stigma and Discrimination among patients diagnosed with Depression.

Keywords: *Stigma and discrimination, depression, primary care staff, mental health literacy, detached attachment*.

1. Introduction

Among psychological disorders, Depression is a debilitating mood disorder causing major burden of disease with a worldwide prevalence estimated at 4.4% and 22% to 60% in Pakistan alone (Ahmed et al., 2016; Charara et al., 2017). Mascayano et al. (2016) and Pescosolido et al. (2013) concluded that the high rates of Depression can be attributed to the factors like Stigma and Discrimination, which is even experienced in health settings too, for example, being provided with insufficient information to the patients, being regarded as lacking the capacity for responsible action, and being patronized or humiliated. Even though, Stigma attached to Depression is to certain extent, less severe than other mental health problems like Schizophrenia, HIV or Tuberculosis, yet, high prevalence of Depression makes addressing Depression related Stigma and Discrimination is an important public health concern in Pakistan (Peluso & Blay, 2009). Therefore, this study was designed to conduct a situational analysis to explore the social and cultural dynamics of Stigma and Discrimination about

Depression in local context from the perspective of the Primary Care Staff to address the emerging needs of health-care problems of the country i.e., Depression related Stigma and Discrimination to promote the health and well-being of individuals diagnosed with Depression.

2. Objective

This research aimed to investigate Primary Care Staff perspective, opinions and views about Depression related Stigma and Discrimination about the people diagnosed with the Depression.

3. Qualitative inquiry

The Basic Qualitative Research has been employed in the current study (Merriam, 2009), having overtones with Epistemology i.e., the construction of the reality (Creswell, 2013). This approach is based on Social Constructivism, aimed to elicit a rich description of the phenomenon under investigation. The Epistemological approach (Moustakas, 1994) was framed in a central research question as follows:

- What are the opinions and views of the Primary Care Staff about people suffering from Depression about experienced Depression related Stigma and Discrimination?

4. Method

4.1. Sample

A sample of (n=8) Priamry Care Staff i.e., Psychiatrists, Medical Officers, Clinical Psychologists and Psychiatric Nurses were selected from Pakistan Medical and Dental Council (PMDC) recognized Private and Public Sector hospitals and Fountain House, Lahore. Only those participants were recruited who had experience of 3 years or more in dealing with patients suffering from Depression. The General Physicians and Homeopathic were excluded. The details of the sample are given below:

Table 1. Demographic Characteristic of Study Participants (n=8).

Sr. No	Age	Gender	Education	Occupation	Income	Hospital Setting	Job Experience
1	55 years	Male	MBBS and FCPS	Psychiatrist	I lac above	Private and Public	28 years
2.	59 years	female	MBBS and DPM	Psychiatrist	I lac above	Private	6 years
3.	28 years	female	MBBS	Medical Officer	50 thousand	Private	3 years
4.	28 years	female	MBBS	Medical Officer	50 thousand	Private	3 years
5.	59 years	female	Ph. D in Clinical Psychology	Clinical Psychologist	1 lac above	Public Sector	33 years
6.	58 years	Female	Ph. D in Clinical Psychology	Clinical Psychologist	I lac above	Public Sector	32 years
7.	33 years	male	MS in Clinical Psychology	Clinical Psychologist	1 lac above	Public Sector	10 years
8.	60 years	Male	F. Sc.	Male attendant	15000	Private	3 years

4.2. Procedure

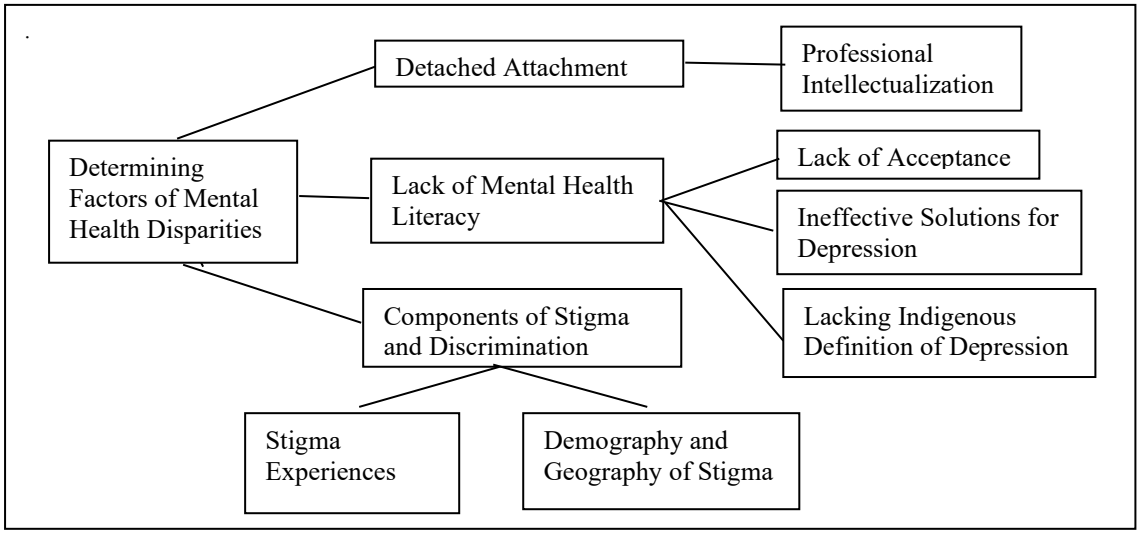
The procedure was consisted of three interdependent activities such as Field Test, Pilot Study and the Main Study. Initially, permission was sought for data collection from relevant authorities. The field tests were conducted to improve Focus Group Discussion Guide (Giorgi, 1998; Merriam, 2009); Ismail et al., 2017). Then, Pilot study was conducted to refine the research methodology before conducting main study (Ismail et al., 2017). For conducting main study, an appropriate location according to the mutual accessibility of the participants, adequate parking and near to public transport was decided. For Assistant Moderator, a Clinical Psychologist was hired, who was a Research Assistant in local university by profession and had a prior experience of conducting Focus Group with different

Professionals (Hampson, et al., 2020). The focus group was conducted for approximately 90 minutes and commenced through introduction, explaining ground rules and exploring the Focus Group Discussion Guide, consisted of 7 open-ended questions, developed on the basis of Pryor and Reeder Model of Stigma and Discrimination (2011). Filed notes were taken in a section reserved for notes in the Focus Group Discussion Guide. The data was managed through source ID, data labels, in a separate folder. The data was transcribed based on the recommendations of Kvale and Brinkmann (2009); Oliver et al. (2005); Davidson (2009); and the transcriptions were verified by two pass verification method (Hagens et al., 2009; Davidson, 2009).

4.3. Results

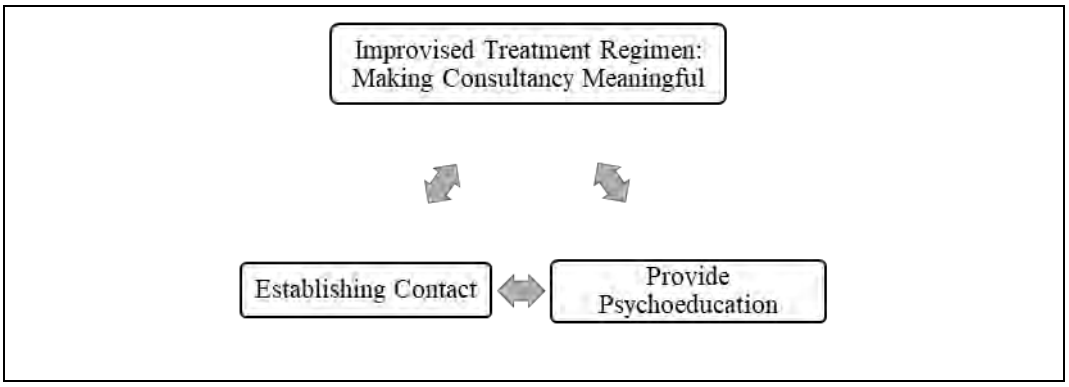
The Reflexive Thematic Analysis was employed and each step was diligently followed such as Familiarization with the Data, Coding, Generating Initial Themes, Reviewing Themes, Defining and Naming Themes. The findings indicated two main themes i.e., Determining Factors of Mental Health Disparity and Improving Treatment Regimen: Making Consultancy Meaningful. The depiction of theme 1 is as follows:

Figure 1. Thematic Map 1.



The first theme centered upon exploring factors i.e., determining mental health disparities among people diagnosed with Depression. The Focus Group participants shared that people diagnosed with Depression experienced detached attachment with primary care staff. The Professionals related this perception to professional intellectualization and believed that the Professional maturity required the primary care staff to respond to the patient objectively i.e., through mental disengagement while physically involving at the same time. Further, this theme was further organized into two subthemes as lack of mental health literacy and components of Stigma and Discrimination. According to their perspective, initially, majority of the participants suffered from physical symptoms but due to lack of knowledge about the true nature of their disorder, these symptoms were considered as a routine muscular problem in most of the cases. The Professionals believed that the reason behind it was that Pakistani culture was lacking in indigenous definition of Depression. As in Pakistan, the culture is heavily influenced by magical and superstitious beliefs, the symptoms of depression were commonly perceived as drama, attention seeking behaviors, effect of possession, supernatural causes and black eye. Further, lack of financial resources also increases the popularity of seeking alternative treatments for mental health. This might have driven the people's choice not to see a Psychiatrist or mental health specialist and to visit general practitioners. In a hierarchy of preferred solutions about Depression, mental health Professional were standing in last step. Owing to the importance given to various beliefs held across cultures, much of these disparities in care is attributed to another important factor that were components of Stigma and discrimination such as self-Stigma, Stigma by Association Public Stigma and structural Stigma. Further the geography, demography of Stigma and Discrimination such as low educational background, role in the family and female gender, along with different elements such as myths of dangerousness, controllability, personal weakness and social avoidance creating a hindrance in problem management. Further, the Professionals reported that inadequate information provided by the doctor resulted in early discontinuation of treatment.

Figure 2. Thematic Map 2.



According to Professionals, the above mentioned mental health disparities of Depression, Primarily Stigma and Depression can be managed in primary care through two steps i.e., providing Psychoeducation and establishing contact. As providers of care, Professionals assumed that primary care staff has the knowledge and experience that patient and their families did not know. The only way to bridge the treatment gap created through Stigma and Discrimination was to share the information in a comprehensible and structured way i.e., Psychoeducation, which includes considering patient as a model, explaining the purpose of Psychoeducation, establishing rapport, fundamental importance of diagnosis, explaining the etiology of the Depression, elucidating strategies to reduce Stigma and Discrimination and addressing regular follow-up and medicine adherence. The Professionals further argued that Stigma and Discrimination was also due to lack of meaningful contact of patient with their primary care taker. A continuous effective contact aided in interpersonal divide and facilitate positive interaction and connection between the patient, family and the Primary Care Staff.

5. Discussion

The findings of this study have been supported by Dalky et al. (2020), who found that the causal factors such as lack of knowledge, and cultural dynamics played a vital role in initiating and maintaining Stigma and Discrimination. Shafiq (2020) have validated the current findings that people living in Pakistan have little to no knowledge about Depression. The perceptions, superstitions and misconceptions were shaped by the specific culture of Pakistan in which Mental Illnesses were neglected and have been a disadvantaged domain due to lack of indigenous definitions. In terms of treatment or help-seeking, alternative measures are considered more effective and people consulted traditional or spiritual healers in times of help which were believed to be the ineffective solutions for Depression. These findings have been supported by theoretical dimensions of Pryor and Reeder model of Sigma and Discrimination too (2011). Though, Professional did not believe in Structural Stigma as they addressed it as a Professional maturity. Further, Corrigan et al. (2013) found that physicians with less experience, training and knowledge along with perceived Stigma became a major barrier in giving effective ad effective treatment towards patients along with negatively influencing patient's help-seeking behaviors. In discussing the prognostic factors, Contact and providing Psychoeducation was experienced as an essential ingredient by Primary Care Staff.

5.1. Strength

To the best of the Researcher knowledge, this is the first ever qualitative study incorporating Basic Qualitative Research as a method of inquiry to explore Stigma and Discrimination from the perspective of Primary Care Staff. Further, the Focus Group Discussion Guide was developed to understand the quality and content of the participants views and perceptions. The conduction of the Pilot study contributed in existing knowledge in terms of improving methodological underpinnings, refinement of data collection techniques, the appropriateness of theoretical approaches and the efficacy of analysis procedures.

5.2. Implications

This study highlighted the need to incorporate Islamic perspective of equality i.e., to avoid Discrimination and Stigmatization. This would further help in sharing pain of those people who have been diagnosed with Depression. A need for awareness-based Stigma reduction intervention was emerged to be provided to Primary Care Staff and significant support providers for training them in Psychoeducation and normalization about Depression to reduce the treatment gap in mental disorders.

5.3. Conclusion

This study highlighted that the Lack of Mental Health disparity is the core reason behind Stigma and Discrimination. The findings suggested the need to provide Psychoeducation and to improve the Professional detachment of the Professionals by employing Contact interventions with an aim to overcome this interpersonal divide and to facilitate positive interaction and connection between the participants diagnosed with Depression and the first level service providers i.e., Primary Care Staff.

References

Ahmed, B., Enam, S. F., Iqbal, Z., Murtaza, G., & Bashir, S. (2016). Depression and anxiety: a snapshot of the situation in Pakistan. International Journal of Neuroscience and Behavioral Science, *4*(2), 32. Doi: 10.13189/ijnbs.2016.040202

Charara, R., Forouzanfar, M., Naghavi, M., Moradi-Lakeh, M., Afshin, A., Vos, T., & Mokdad, A. H. (2017). The burden of mental disorders in the eastern Mediterranean region, *PloS one*, *12*(1), e0169575. https://doi.org/10.1371/journal.pone.0169575

Corrigan, P. W., Morris, S.B., Michaels, P. J., Rafacz, J. D., Rüsch, N. (2013). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatr Serv*. *63*(10):963-73. doi: 10.1176/appi.ps.201100529. PMID: 23032675.

Creswell, J. W. (2013). Research design: qualitative, quantitative, and mixed methods approaches (4th ed.). SAGE Publications.

Dalky, H.F., Abu-Hassan, H.H., Dalky, A.F., & Al-Deaimy, W. (2020). Assessment of mental health stigma components of mental health knowledge, attitudes and behaviors among Jordanian Healthcare Providers. *Community Mental Health Journal, 56,* 523-531. Doi: 10.1007/s10597-019-00509-2.

Davidson, C. (2009). Transcription: Imperatives for qualitative research. International journal of qualitative methods, *8*(2), 35-52. https://doi.org/10.1177%2F160940690900800206

Giorgi, A. (1989). Some theoretical and practical issues regarding the psychological phenomenology method. *Say-brook Review,7*(2), 71–85. https://psycnet.apa.org/record/1992-22877-001

Hagens, V., Dobrow, M. J., & Chafe, R. (2009). Interviewee transcript review: Assessing the impact on qualitative research. BMC medical research methodology, *9*(1), 47. DOI: 10.1186/1471-2288-9-4

Ismail, N., Kinchin, G., & Edwards, J. A. (2018). Pilot study, does it really matter? learning lessons from conducting a pilot study for a qualitative PhD thesis. *International Journal of Social Science Research, 6*(1), 1. doi:10.5296/ijssr.v6i1.11720

Krueger, A. (1996). *School resources and student outcomes: an overview of the literature and new evidence from North and South Carolina*. National Bureau of Economic Research.

Kvale, S., & Brinkmann, S. (2009). Interviews: Learning the craft of qualitative research interviewing (2nd ed.). Sage Publications, Inc.

Mascayano, F., Tapia, T., Schilling, S., Alvarado, R., Tapia, E., Lips, W., & Yang, L. H. (2016). Stigma toward mental illness in Latin America and the Caribbean: a systematic review. *Brazilian Journal of Psychiatry*, *38*(1), 73-85. http://dx.doi.org/10.1590/1516-4446-2015-1652

Merriam, S. B. (2009). Qualitative research. A guide to design and implementation (2nd ed.). Jossey-Bass.

Moustakas, C. (1994). *Phenomenological research methods* (1st ed.). Sage Publications

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces*, *84*, 1273-1289.https://doi.org/10.1353/sof.2006.0023

Pescosolido, B. A. (2013). The public stigma of mental illness: What do we think; what do we know; what can we prove?. *Journal of Health and Social behavior*, *54*(1), 1-21.

Pryor, J. B., & Reeder, G. D. (2011). HIV-related stigma. In J. C. Hall, B. J. Hall & C. J. Cockerell (Eds.), HIV/AIDS in the Post-HAART Era: manifestations, treatment, and Epidemiology,790–806. Shelton, CT: PMPH-USA

Shafiq, S., Parveen, S., & Oyebode, J. R. (2020). How people of African Caribbean or Irish ethnicity cope with long-term health conditions in UK community settings: A systematic review of qualitative, quantitative and mixed method studies. *Health & Social Care in the Community*. https://doi.org/10.1111/hsc.13181