ATTITUDE OF THE UNIVERSITY STUDENTS AND TEACHERS TOWARDS MENTALLY ILL, IN LAHORE, PAKISTAN

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Background: Although, much is known about the attitudes and beliefs people hold towards mental illness in the west, no such work has been done in the developing countries. It is difficult to measure the attitudes of the general public in developing countries due to differences in terminology and concepts of the illness. However, majority of educated people in the developing countries can recognise common psychiatric disorders by their western names. We therefore, decided to measure attitudes of university students and teachers in Lahore, Pakistan. This study was carried out to assess the attitude of university students and teachers in Lahore, Pakistan. **Methods:** A survey form was circulated among the university students and the teachers in Lahore, Pakistan. Of the 300 survey forms 194 were returned. **Results:** Majority of the respondents held negative attitudes towards people with schizophrenia, depression and drug and alcohol disorders. **Conclusions:** The views held by the university teachers and students reveal negative attitudes towards mentally ill. Attitudes of those who knew someone with mental illness were similar to those who did not.

INTRODUCTION

A lot of work has been done in the West to explore the beliefs people have towards mentally ill. It appears that generally, people hold negative attitudes towards mentally ill.[1-5] However, recently there has been a drive towards educating people about psychiatric disorders and to improve the perception of the mentally ill. Although, there is some improvement in people's perception of the mentally ill due to public education campaigns, a lot of work still needs to be done. According to Byrne[6] in two identical UK public opinion surveys little change was recorded over ten years, with over 80% endorsing the statement that "most people are embarrassed by mentally ill people" and about 30% agreeing " I am embarrassed by mentally ill persons". Most surveys have revealed that people in the west believe mentally ill to be; dangerous, unpredictable and responsible for their mental illness. It is also believed that people with psychiatric illnesses do not improve with treatment, and that they never recover. The general stereotypes of the mentally ill include, psychokiller/maniac, indulgent, libidinous, pathetic sad characters and figures of fun. Attitude of people towards mentally ill is shaped by multiple factors; including, historical, religious, ethnic and cultural issues. The impact of the media and the political culture, has only added to the complexity of the problem.

Fabrega[7] in a review of the literature pertaining to the psychiatric stigma in the non-western societies concluded that; "this is a topic that has not received much systematic attention in the developing countries, (and that), stigma is variable in the more elementary societies. It is present in India and especially in china, but studies suggest that social stigma is less prevalent in Islamic societies". He has reviewed, status and stigma of mentally ill in the medieval Islamic, Indian and the Chinese medicine. Understandably, psychiatric illnesses and their status were complex and complicated in the cultures in which these medicines were being practiced.

The relationship between the culture and the stigma attached to an illness is rather complex. It is probably even more complicated in the developing countries. It appears that different illnesses have different status attached to them. Although, some are medicalised and stigmatised, others are not. It has also been suggested that, in most of these societies some supernatural, religious, moralistic, and magical approaches to illness and behaviour exist. This can complicate the issue further. Much variation and ambivalence is found in all societies regarding the valuation of and response to psychiatric illness. Such differences, as well as those pertaining to the theories that explain the illness, are related to complex cultural, sociological and economic factors that a theory of psychiatric stigma will ultimately have to address.

Study of stigmatisation in developing countries is very important. This can be used as a baseline, as well as a first step in educating the general public and the professionals about mental illnesses. Stigmatisation of the psychiatric patients not only affects the way people seek help individually, but can also have enormous implications on the development of a national policy.

Pakistan like most developing countries has severe problems in terms of resources in the health sector. There are only a limited number of psychiatrists and rarely available psychiatric services. Majority of psychiatric patients seek help from faith healers and religious leaders. The culture in itself has complicating and sometimes confusing origins. Nothing is known about views of people towards mental illnesses.

We decided to study stigma attached to mental illness among the students and teachers of a university in Lahore, Pakistan. It was felt that members of this group might be aware of the common mental disorders. We also believe that this group is easy to approach if there is need for further work.

MATERIAL AND MEHTODS

The survey was conducted in two stages. The questionnaire focused on items from a survey, developed by crisp et al, 2000. Questions were asked about the common mental illnesses, to assess respondents attitudes towards following aspects of the mentally ill; dangerousness, unpredictability, ability of doctors to talk to them, whether they look different from other people, focus of blame, treatment and recovery. Additional information was gathered on demographic variables, such as age, gender, marital status, as well as professional background and experience.

In the first stage, the main items of the survey were discussed with a small group of university students and teachers (number=15), to see whether they are familiar with the psychiatric terminology, and to explore the areas of concern expressed by them, regarding mentally ill patients. This was also, to make sure that all the respondents were aware of the terminology and the names of the psychiatric disorders. based on this the final questionnaire was formulated.

Three hundred survey forms were distributed by hand randomly to both the students and the teachers. The completed survey forms were then returned in pre paid envelopes.

Analyses were carried out using SPSS 10.0. Since most of the variables were categorical, non-parametric tests were used. When measuring normally distributed data, parametric analyses were carried out. For most non-parametric calculations comparisons were made using crosstabs. Where significance testing was needed, chi square test was used. Missing cases were treated by removal from the final analysis.

RESULTS

A total of 194 survey forms were returned, thus giving a response rate of 65%. The average age of respondents was 27.87 years (range=17-55). For ease of comparison, respondents were divided into two age groups [up to 24=51.0%, 25 and more = 49%]. Table 1, shows other demographic and related data.

Table 1. Demographic and other data of the responders

Male	61 (31.4%)
Female	128 (66%)
University students	107 (55.2%)
University teachers	87 (44.8%)
Single	133 (68.8%)
Married	52 (26.8%)
Widowed	1 (0.5%)
Other	8 (4.1%)
People who knew someone with a mental illness	119 (61.3%)

In response to the question whether they had heard of the illnesses, the answers were different for various disorders. Our analyses showed the following results; the number of people who had heard of schizophrenia [yes=73(37.6%), no= 55(28.4%), no response= 66(34%)], depression [yes=114(58.8%), no=8(4.1%), no response=72(37.1%),] dementia [yes= 31(10%), no=98(50.5%), no response= 65(33.5%)], alcohol [yes=95(49.0%), no=24 (12.4%), no response=75(38.7%)], drug abuse [yes=104(53.6%), no=14(7.2%), no response=76(39.2%). We therefore, carried out analyses on data from those who had heard of these disorders only. Since a very small number of the respondents had heard of dementia, we excluded it from our analyses. We are describing results on attitudes towards depression, schizophrenia, alcohol and drug abuse.

The data was analysed to measure attitudes of the respondents towards mental illness after re-coding different grades of agreement or disagreement together (i.e.; adding agree and strongly agree together, for example). Only negative attitudes are being described here.

There was no difference between the male and female respondents in terms of negative attitudes. There were no statistically significant differences in attitudes, between the teachers and students.

Further analysis to compare the attitude of the two age groups (i.e; those who were 24 years or less with those who were 25 years or more) revealed that, for schizophrenia, dangerousness; [24 and less= 86.04%, 25 and more= 61.90% (X^2 =6.45, df=1, P=0.011)], are themselves to blame; [24 and less = 74.41, 25 and more= 36.66% (X^2 =10.40, df=1, P=0.001)], must pull themselves together; [24 and

less = 92.30%, more than 25= 58.62% (X^2 =8.68, df=1, P=0.003)], for depression; dangerous; [24 and less = 77%, 25 and more= 57.40% (X^2 =4.42, df=1, P=0.03)], are hard to talk to, [24 and less= 69.64%, more than 25= 84% (X^2 =3.74, df=1, P=0.05)], for people with drug abuse; dangerousness, [24 and less= 96.66%, 25 and more= 79.31% (X^2 =8.49, df=1, P=0.004)], feel different; [24 and less= 94.02%, 25 and more= 98% (X^2 =3.82, df=1, P=0.05)], are themselves to be blame; [24 and less= 86.88%, 25 and more= 75.60% (X^2 =4.31, df=1, P=0.03)], must pull themselves together; [24 and less= 80%, 25 and more= 60.52% (X^2 =4.23, df=1, P=0.04)], don't improve if treated; [24 and less= 57.35%, 25 and more= 80.35% (X^2 =7.43, df=1, P=0.006).

DISCUSSION

This survey has revealed mainly negative attitudes held by students and teachers of a university in Lahore, towards mentally ill, specially those with depression, schizophrenia, drugs and alcohol abuse. It has been suggested in the past, that the Muslim cultures might be less prejudiced in their views towards mentally ill. Although, we cannot refute this suggestion on the basis of this survey, our survey casts some doubt over this assumption. It is possible that the attitudes of the people in the Muslim cultures have changed over the years, from more acceptable to rather negative attitudes towards mentally ill. At the end of the day, we do not have any information avilable to compare the attitudes of these people with the attitudes in the past. The attitudes of the university students and teachers in Lahore, Pakistan are similar to those from the western studies.

Although there were no differences between males and females and between the students and the teachers, statistically significant differences were found among the older and the younger respondents. These differences were mostly in favour of the older respondents. Thus revealing more negative attitudes of the younger people towards mentally ill. The younger respndents felt that people with schizophrenia, depression and drug abuse are dangerous. They were also less likely to blame people with schizophrenia responsible for their illnesses. On the other hand, they were more likely to blame people with drug absue problems for their drug use.

Our findings could possibly be explained in part due to the influence of the western culture, especially medical culture on Pakistani society. Another important factor could be the influence of the Western media, particularly Hollywood movies. However, we are not in a position to draw any firm conclusions because of the small number of the respondents who were aware of the common psychiatric disorders, a low response rate, and many don't know answers. It is also possible that these attitudes simply do not reflect the beliefs held by the general public.

We need to repeat this work with a bigger sample and with improved methodology. We are also planning to measure attitudes of the general population towards mental illness.

Table 2. Negative attitudes towards mental illness, (% ages), with 95% CI.

	Type of illness			
Opinion	Schizophrenia	Depression	Alcohol addiction	Drug addiction
Danger to Others	74.1 70.2-78.3	66.7 62.4-69.9	89.7 85.8-94.1	88.1 84.6-92.6
Un-predictable	89.2 84.1-94.3	82.5 78.8-86.6	79.4 73.5-84.8	90.2 85.5-95.3
Hard to talk to	76.2 72.7-79.8	77.4 73.3-80.9	85.6 83.8-87.6	86.2 83.3-89.4
Feel different	89.0 85.1-94.3	87.9 82.2-94.1	85.3 81.3-89.7	88.9 83.9-94.3
Themselves to blame	58.9 54.3-62.4	87.9 82.5-91.9	72.6 66.8-78.2	80.0 74.3-85.5
Must pull themselves Together	80.3 76.2-84.8	78.1 73.9-82.2	75.0 70.7-79.8	72.0 67.8-76.3
Do not improve, if treated	88.5 83.9-93.2	67.9 63.8-72.3	75.4 70.8-80.3	67.7 63.2-73.4
Never recover	75.3 71.2-79.4	63.5 59.4-66.9	76.4 73.8-79.5	69.4 65.3-73.8

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