STIGMA AND KNOWLEDGE OF DEPRESSION:
A Survey comparing Medical and Non-Medical Students and Staff in Lahore, Pakistan

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ABSTRACT

Background: High rates of depression have been reported in various surveys in Pakistan. However, people have limited knowledge of mental illnesses. There is limited information available on knowledge people have and attitudes they hold towards depression and other mental illnesses. A comparative study of the people's attitudes and knowledge can be a good start to explore this topic further.

Aims & Objectives: To assess and compare the attitudes and knowledge of medical and non medical professionals and students in Lahore, Pakistan.

Methods: A survey was circulated among the medical students and the doctors of the three medical colleges, as well as the students and teachers of The Punjab University in Lahore, Pakistan. Of the medical group, 294 (59%) of the 500 survey forms sent out were returned, while in non medical group 194 out of 300 (64.66%) survey forms were returned.

Results: Fifty percent of the medical students and professionals claimed that they had not heard about depression. A significant proportion of all the people surveyed had a negative attitude towards depressed patients.

Conclusion: The psychiatric conditions need a more prominent place in medical education. The educated sections of the Pakistani society need better information about these conditions. Probably lay press and universities need to look into it.

KEYWORDS: Attitudes, Knowledge, Depression

Declaration of interest: None

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INTRODUCTION

A number of surveys have revealed high rates of depression in Pakistan.[1-3] However, the limited number of psychiatrists and poorly organised services mean only some of the depressed people might have access to these services. Health education in this area is an important unidentified need.

While the attitudes people hold towards mental illnesses has been studied to some extent in Europe.[4-8] Nothing is known about what people think about mental health problems in Pakistan. Depression poses enormous costs to the individual, family and the society. Recent research has demonstrated the very considerable burden that mental disorders impose on person, communities and health services globally.[9,10]

Attitudes and knowledge people have towards depression not only affects the way people seek help individually, but can also have

enormous implications on the development of policy on a national level. There are only a limited number of psychiatrists in Pakistan. The majority of people with mental disorders seek help from faith healers and religious leaders. The culture in itself has complicating, conflicting and sometimes confusing influence on help seeking behaviour of psychiatric patients.

Considering high rates of depression we decided to study people's attitudes towards depression and their knowledge of the problem. We also wanted to see how the attitudes of non medical students and professionals (non medical group) are different from medical students and professionals (medical group).

METHODS

The survey form consisted of questions related to assessment of knowledge and attitudes towards mental illnesses and a demographic data form. The survey forms were distributed to 500 medical students and doctors by hand. Three hundred survey forms were distributed by hand randomly to both the university students and the teachers. The completed survey forms were then returned in pre paid envelopes. Of the medical group, 294 (59%) of the 500 survey forms sent out were returned, while in non medical group 194 out of 300 (64.66%) survey forms were returned.

Statistical Analyses: 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, such as age or years of experience, 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.

Analysis of missing data revealed only partial loss of data, in most cases. We had to remove seven cases because too much information was missing. This is a complicated issue. It is less contentious issue when the scales are being used. Usually missing data is dealt with by either replacing with the either of these; series mean, best scores or the worst scores. This is however, not that straight forward when we are dealing with binary or categorical data. The ideal situation is to remove the missing values. But this can mean loss of valuable information, specially when the data loss is partial, like in our study. For example when data is missing on gender of a case, but the rest of the data is present, we simply can not do anything about the variable gender, but by removing the whole case from analysis, we are depriving ourselves from useful information in rest of the variables on that case. We therefore decided to leave the missing data as it is. However, this means variations in some of the total scores.

RESULTS

Table-I shows differences between two groups on some of the demographic and other variables, statistically significant differences existed between two groups for Gender (X^2=20.81, df=2, P=0.000), and for marital status (X=41, df=3, P=0.000). The members of medical group were younger than non medical group [average age, medical group =22.36, non medical group= 27.87 (t=7.68, f=114, P=0.000).

Table-II displays the results of the questions; whether they had heard of a particular illness or not. Members of the medical group were more likely than the non medical group to have heard of the names of the mental illnesses. Statistically significant differences between the two groups existed for, depression (X^2=2.8, df=1, P=0.09), schizophrenia (X^2=20.67, df=1, P=0.000), panic disorder (X^2=38, df=1, P=0.000), dementia (X^2=40, df=1, P=0.000), alcohol (X^2=2.61, df=1, P=0.1) and drug abuse (X^2=0.16, df=1, P=0.6).

When the participants were asked if they know someone with a mental illness or not, two groups were similar in their responses; medical group [no=129(43.1%) yes=170 (56.9%)], and non medical group [no=76 (39.0%) yes=119 (61.0%). (X2=.84, df=1, P=0.35)].

In order to assess their knowledge about depression more specifically, different questions were asked. The statements about the illness were provided and the respondents were requested to respond in yes or no. Table-III,

shows the response to these questions, in two groups. Statistically significant differences existed between the two groups for all questions except unpredictability. The differences were for; dangerous, (X^2=.15.69, df=2, P=0.00), unpredictable, (X^2=.4.60, df=2, P=0.1), hard to talk to (X^2=6.02, df=2, P=0.04) feel different (X^2=14.87, df=2, P=0.01), themselves to blame (X^2=14.84, df=2, P=0.01), must pull themselves together (X^2=5.93, df=2, P=0.05), don't improve if treated (X^2=11.50, df=2, P=0.003), never recover (X^2=16.51, df=2, P=0.000).

Table-I: Differences between the two groups in Demographic variables

		Medical		*Non medical*	
		Frequency	*Percent*	*Frequency*	*Percent*
Gender	Male	155	52.7	61	31.4
	Female	136	46.3	129	66.5
	Missing values	3	1.0	4	2.1
Grade	Doctor / teacher	92	31.3	87	44.8
	Student medical / other	192	65.3	107	55.2
	Missing values	10	3.4	-	-
Marital status	Single	265	90.1	134	69.1
	Married	19	6.5	52	26.8
	Missing values	10	3.4	8	4.1

Table-II: Showing the difference between two groups regarding whether they had heard of the illness or not

		Medical		*Non medical*	
		Frequency	*Percent*	*Frequency*	*Percent*
Depression	No	152	51.7	116	59.5
	Yes	142	48.2	78	40.5
Schizophrenia	No	120	41.1	122	62.6
	Yes	174	59.1	72	37.4
Panic disorder	No	172	58.5	163	84.1
	Yes	122	41.5	31	15.9
Dementia	No	164	55.8	164	84.1
	Yes	130	44.2	30	15.9
Alcohol dependence	No	130	44.2	100	51.3
	Yes	164	55.7	94	48.7
Drug dependence	No	134	45.5	91	46.7
	Yes	160	54.4	103	53.3

Table-III: Comparison of the responses to questions regarding different aspects of depression

Patients with depression are		*Medical*		*Non medical*	
		Frequency	*Percent*	*Frequency*	*Percent*
Dangerous	disagree	132	44.9	60	30.9
	agree	62	21.2	67	34.5
	no opinion	100	34.0	67	34.5
Unpredictable	disagree	97	32.9	52	26.8
	agree	150	51.2	99	51.0
	no opinion	47	15.9	43	22.1
Hard to talk to	disagree	96	32.6	53	27.3
	agree	147	50.0	90	46.3
	no opinion	51	17.34	51	26.2
Feel different	disagree	44	14.9	48	24.7
	agree	227	77.2	116	59.7
	no opinion	23	7.8	30	15.4
Themselves to blame	disagree	44	14.9	48	24.7
	agree	227	77.8	116	59.7
	no opinion	23	7.8	30	15.4
Must pull themselves together	disagree	74	25.1	60	30.9
	agree	160	54.4	83	42.7
	no opinion	60	20.4	51	26.2
Don't improve if treated	disagree	241	81.9	134	69.0
	agree	23	7.8	28	14.4
	no opinion	30	10.2	32	16.4
Never recover	disagree	256	87.0	142	73.1
	agree	11	3.7	14	7.2
	no opinion	27	9.1	38	19.58

DISCUSSION

Two groups were not very similar. There were more males in medical group. Similarly, there were more single people in the medical group. There was no difference between the two groups in terms of student to doctor/teacher ratio. Both groups had higher ratios of students within them.

More members of the non medical group had not heard of the mental illnesses we had asked about. More surprisingly, nearly half of the medical group had not heard the names of the illnesses either.

The two groups were similar in knowing someone with a mental illness. Nearly half of them admitted to knowing someone with a mental illness. This means indirect experience of depression is not uncommon. However, an important issue is what is interpreted by people as depression, and this leads to the question; are we talking in the same language?

Responses were varied to questions regarding different aspects of depression. Statistically significant differences existed between the two groups for all questions except unpredictability. Nearly half in both groups believed that people with depression are unpredictable. People in the medical group had more negative views of people with depression, regarding; hard to talk to, themselves to blame and must pull themselves together. However, they were more likely to describe positive attitudes towards the following aspects of depression; dangerousness, don't improve if treated, never recover.

People in higher education at the university level are likely to have more realistic knowledge of the psychiatric illnesses and hence an enlightened attitude towards them. From this survey it appears that two third of them believe that the people with depression are themselves to be blamed. This is an indication of unsympathetic attitude and a cause of concern

The results of this survey highlight some worrying trends in attitudes that the medical students hold towards people with depression. Depression is a commonly recognised illness in Pakistan, especially among the educated people. However, the finding that the medical students had negative attitudes and knowledge, regarding the cause of depression is something that needs to be taken into account by the authorities on medical education in Pakistan.

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