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Stigma and Attitude of Mental Health Help-Seeking Among a Sample of Working Versus Non-working Egyptian Women

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Abstract

This study was conducted to assess the level of mental health difference between working and non-working women, to explore their stigma and attitude toward seeking psychological help for mental-health problems. World Health Organization's Self-reporting questionnaire (SRQ-20), adoption of Discrimination–Devaluation scale (D–D) scale for measuring self-stigma and attitude toward Seeking Mental Health Services (IASMHS) Inventory were used. The sampled teachers reported a higher attitude towards seeking mental health services when compared to housewives. Social support and personal stigma were the main factors that significantly predict total IASMHS. Although working females are more susceptible to mental health disorders, yet less stigmatized towards mental health problems and a better attitude for seeking mental health services than housewives.

Keywords Mental health · Attitude · Working women · Inventory · Mental health services

Introduction

Mental health is a basic concept of health and wellbeing and is the establishment of individual prosperity and powerful role in the community. Mental health is a state of well-being in which an individual realizes his own abilities, can cope with the normal stress of life, make adequate social and emotional adjustment to the environment, can work productively and is able to make a contribution to the community (Meltzer et al. 2000). Mental disorders have emerged as a major public and occupational health problem (Sanderson and Andrews 2006). Globally, an estimated 450 million people suffer from mental illness; and during a lifetime, one out of four persons will develop at least one of these mental illnesses accounting for 13% or the total disability adjusted life years (DALYs) lost and it has also been estimated to increase to 15% by the year 2020 (WHO 2004). In Egypt, mental disorders have been recognized for millennia; as described in the Ebers and Kahun papyri, they were considered to be physical ailments of the heart or uterus, 5000 years ago (Okasha 2001). Mental illness is regarded as shameful and one of the most common reasons for the minuscule usage of available psychiatric services by the general population is stigma (Coker 2005). Stigmatizing attitudes and discriminatory behaviors towards persons with mental illness are of international concern and have negative personal and social impact on patients and their families which often revolve around dangerousness and incompetence, expectations of poor prognosis, and a desire for social distance (Hinshaw and Cicchetti 2000). Stigma is defined as an amalgamation of three predicaments: lack of sufficient knowledge (ignorance), negative attitudes (prejudice), and exclusion or avoidance behaviors (discrimination) which layers up self-stigma resulting in fear of, and withdrawal from leading to not seek mental health treatment and social support (Ogunsemi et al. 2008; Abd-Malik et al. 2012). Stigma is acting as a barrier that interferes with the efforts for preventing illness during early stages (Goss and Mearns 1997).

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Throughout the human lifecycle, biological, psychological, and social factors interact together to determine the level of mental health. Poor mental health results from rapid social changes, social exclusion, gender discrimination, human rights violation, unhealthy lifestyle and stressful work conditions resulting in high prevalence of mental-health problems in working subpopulation, reflecting that work is being recognized as an important place for conducting different mental-health interventions (Malachowski and Kirsh 2014). Work and mental health are in constant interplay. Previous studies suggest that work can be therapeutic and plays an important role in a person's life as it is a primary source of income, and social identity (Abbas et al. 2013). On the other hand, it is widely recognized that mental illness have drastic impact at work, resulting total work loss due to absenteeism, turnover, impair work functioning when being at work, reducing productivity and is estimated to cost organizations in the UK £26 billion a year (The Sainsbury Centre for Mental Health 2007). Employees were reluctant to use counseling services at work if they believed it would negatively affect their career opportunities (Vogt 2011). Thus the stigma of mental illness has a negative impact on the utilization of healthcare at work and results in delayed seeking early support and waiting until their symptoms severely interfere with their daily functioning (Rüsch and Thornicroft 2014; Szeto and Dobson 2010). Therefore, effective strategies to reduce the stigma of mental illness and to increase help-seeking behavior in the workplace are needed.

The teaching profession is one of the biggest throughout the whole world and is highly susceptible to physical and psychological health problems. Teachers have been increasingly presented with significant occupational health problems. Mental illness among teachers has become an increasing problem (Carlotto 2002). The work environment and psychosocial factors have been considered largely responsible for the health problems observed in teachers. The synergistic effect from the increased workload, lack of rest breaks, a situation that contributes to high absenteeism and job abandonment, psychiatric and/ or psychosomatic disorders are the leading causes of premature retirement among teachers (Sveinsdottir et al. 2007). Given that the stigma of mental illness at the teachers has been under-investigated, little is known about its prevalence and consequences. The aim of this study is to highlight mental health issue and role of work among sample of Egyptian women for future design emerging mental health need services with the following objectives: to find out difference between working and non-working women regarding the level of mental health and to explore their stigma and attitude toward help-seeking for mental-health problems.

Methods

Subjects and Methods

Study Design and Settings

A comparative cross-sectional study was conducted from March 25, 2017 to April 30, 2017 in all private schools in Zagazig City and the outpatient clinics of Zagazig University, Sharkia Governorate.

Study Population

The total number of registered female teachers working in all 6 private schools in all stages (kindergarten, elementary, middle, and high grade) in Zagazig City, Sharkia Governorate with minimal working period at least 6 months was 135 female teachers; 11 were excluded as they had maternity/childcare leaves or had faced catastrophic stressful situations during the last 3 months as the death of a family members. The remaining, 124 female teachers were invited to participate in this study where 115 agreed to participate with response rate (115/124) = 92.7%.

A comparison group of 125 housewives attending outpatient clinics in Zagazig University Hospitals was recruited in the study and represented the non-working group. Both groups were matched regarding age and education. Female teachers were chosen to represent the working group in our research. The reason for selecting the female gender in this study was based on women predominance of common mental disorders which affect approximately 1 in 3 people in the community and constitute a serious public health problem (WHO 2017). Also, the reason for selection of private schools teachers in this research based on evidence from previous studies that private school teachers differ significantly in mental health in comparison to government school teachers (Delcor et al. 2004; Galgotra 2013). Furthermore, working in the private sector remains predominantly informal with frequent turnover, higher workload, job instability, few constitutional rights with mental health consequences.

Data Collection Tools and Procedures

At the beginning, the investigator read the instructions of answering for the participant, then data was collected from working and non-working educated women using semi-structured validated interviewed (to ensure that all participant follow exactly the same instructions) questionnaire that was filled from the participants in the teacher's lounge during recess for the working group and in the waiting room of outpatient clinics for the non-working group.

The questionnaire consists of four parts;

1. The first part (*Socio-demographic and general characters*): includes age, marital status, number of children, residence, education level, family size, number of persons/bedroom (crowding index), perceived social class, occupational, medical, family history of chronic mental illness.

2. The second part (*World Health Organization's Self-reporting questionnaire 20 items*) (*SRQ-20*): (WHO 1994) which is a common screening tool for mental disorders. The cut-off point used was between 6 and 7, which was the same used in the validated study conducted in Egypt (93.0% sensitivity and specificity of 70%) (Abbas et al. 2013). Accordingly, those with <7 points were categorized as "not suspected" and those with ≥7 points were considered "suspected."

3. The third part (*Discrimination–Devaluation scale (D–D) scale*): a validated 12-item Scale for measuring perceived public stigma (Link 1982; Link et al. 1991). We adopted 4 items from the D–D scale for measuring personal-stigma for mental health, which is "personal thoughts and attitude toward persons with mental health problems" by replacing word "most people" by "I" which is previously used in other studies (Griffiths et al. 2004; Eisenberg et al. 2009; Lally et al. 2013). The last item in the scale was modified to be suitable for our culture and traditions. The scale internal consistency was with Cronbach's alpha 0.78 (Eisenberg et al. 2009).

4. The fourth part (*Inventory of Attitude toward Seeking Mental Health Services* [*IASMHS*]): a 24-items measure designed to assess individuals' attitudes toward seeking professional help for mental health problems (Mackenzie et al. 2004). There are 3 subscales in the IASMHS that measure "*psychological openness*" is openness to acknowledging psychological problems and the possibility of seeking help for them, "*help-seeking propensity*" is the willingness and ability to seek help, and "*indifference to stigma*" is one's concern with how people in their lives would react to their seeking help. Each scale includes 8 questions and responses were measured on a 5-point Likert scale (0 = disagree to 4 = agree), giving a range of each subscale from (0–32). Consequently, the total IASMHS score gives an overall measure of help-seeking intention which ranges from (0–96), with higher scores indicating greater intention to seek help. Those with score percent more than 50% in total IASMHS and its sub-scales was considered adequate attitude. IASMHS have internal consistency coefficients ranging from 0.76 to 0.82 (Mackenzie et al. 2006).

Pilot Study

The questionnaire was translated into Arabic by a bilingual co-investigator and back-translated by another bilingual expert to ensure validity. The necessary corrections, modifications, and rewording after considering any minor differences and discrepancies have been done to ensure clarity of all questions and ease of understanding. The questionnaire has been tested on 10 females. The reliability coefficient test (Cronbach's alpha) was >0.72 for all questions.

Ethical Considerations

An informed consent was obtained from all the participants after clarification of the aim of the study and the privacy of personal data. The necessary official permissions were obtained from the Zagazig University' Institutional Review Board (ZU-IRB #4180) and principals of schools before data collection. Collected data was kept strictly confidential and was used only for research purposes.

Statistical Analysis

The collected data was computerized and statistically analyzed using the SPSS program version 19.0 (SPSS, Chicago, IL, USA). Normality tests (Shapiro–Wilk test) were performed for continuous variables and revealed the normal distribution of the data. Quantitative data were represented as a mean and standard deviation and qualitative data were represented as frequencies and percentages. The independent student's t-test was used to determine the significance of differences between two continuous variables, and the chi-squared test was used to assess for differences in the categorical variables. The independent variables were (working status, level of mental health and self-stigma) and the dependent variable was the attitude toward help-seeking for mental-health problems. Spearman correlation was computed to assess the relationship between important study variables and outcomes and the logistic regression model was performed to find the factors predicting IASMHS. The test results were considered significant when p-value <0.05.

Results

Socio-demographic and general characters of the participated females revealed that; the mean ± SD age in both groups was around 28 years old ($28.9 ± 2.7$ for teachers, $28.6 ± 3.4$ for housewives), more than half (67.8 and 66.4% respectively) were married, having 3 or fewer children (64.35 and 64.0%), living in urban area (78.3 and 53.6%), in rented houses (53.9 and 69.6%), alone, with crowding index <3 in teachers group and ≥3 in housewives group,

most of them were satisfied with their income (58.3% for teachers, 76.8% for housewives). Lastly, 59.1% of the teachers stated that they receive social support compared to 46.4% among housewives. A significant difference found between both groups regarding; residence, housing status, income and social support (p < 0.05).

As regard the medical/family history of the participants; the majority of the females in both groups were not suffering from any chronic diseases with no statistical significant difference, except for irritable bowel syndrome, where 56.5% of teachers were affected oppositely to 34.4% of housewives with p-value (0.001) and also for gastric ulcer where it was common for teachers by 21.7–11.2% for housewives with p-value (0.027). None of the participants in both groups stated a personal history of mental disorder or family history of chronic mental illness.

For exploring occupational data for the working group, the mean working duration was about 4.156 ± 1.78 years and working hours/day was 6.313 ± 1.39 h, and only (5.2%) of them were having a second job.

Figure 1 displayed the mental health state of the participated females using World Health Organization's Self-reporting questionnaire (SRQ-20), where teachers show significantly higher mental suspicion than housewives (40.9, 3.2%) respectively, with p-value = 0.000.

Mean self-stigma for mental health help-seeking among the participated females using Discrimination–Devaluation scale (D–D) scale showed a significant difference between two studied groups; 11.217 ± 1.24 in teacher group and 11.744 ± 1.069 in housewives group, with p = 0.001 (Fig. 2).

Concerning mean score of Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the two studied groups, psychological openness teachers were having (13.33 ± 5.78) to (10.76 ± 7.70) for housewives with a significant difference (p = 0.008), help-seeking propensity shows (13.66 ± 4.17) for teachers and (13.54 ± 4.59) for housewives with no significant difference (p = 0.873), for indifference to stigma; teachers were having mean score of
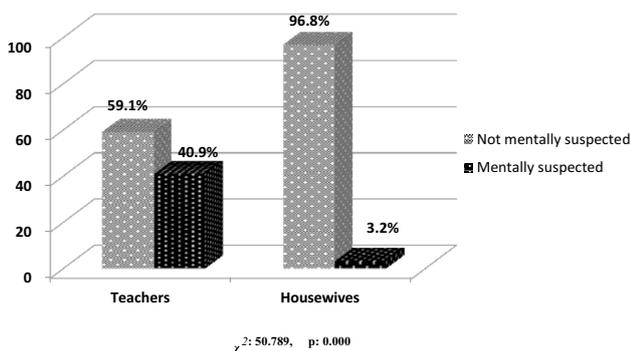

Fig. 1 Mental health state of the studied groups using World Health Organization's Self-reporting questionnaire (SRQ-20)
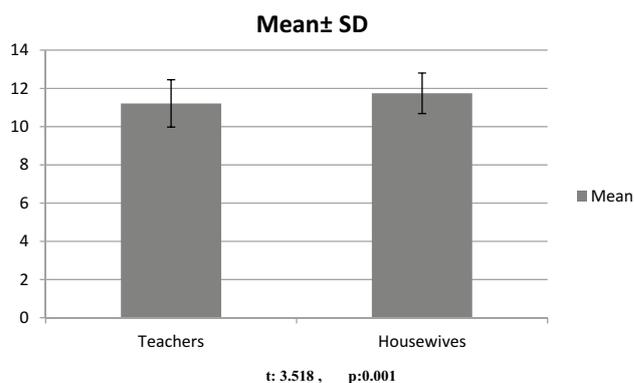
Fig. 2 Personal-stigma for mental health among the studied groups using Discrimination–Devaluation scale (D–D) scale

(2.06 ± 2.53) and housewives' score was (1.68 ± 2.57) with no significant difference (p = 0.080). Lastly, total IASMHS mean score was significantly higher in teachers than housewives $(29.06 \pm 10.26 \ \& \ 25.98 \pm 12.44)$ in a respective order, (p = 0.049).

Figure 3 demonstrated the level of adequate Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the studied groups, where teachers had higher score for total IASMHS (5.6%) versus (4.3%) for housewives, as well as its subscales; psychological openness (42.6%) for teachers, (41.6%) for housewives, health seeking propensity (40%) for teachers to (38.3%) for the other group and lastly, indifference to stigma where teachers were having (1.6%) opposite to (0.8%) for housewives.
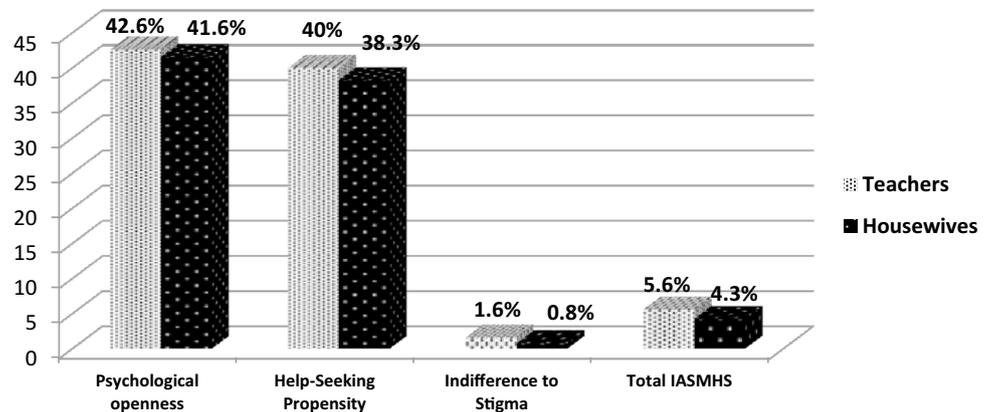
On assessing the correlation between work status, mental health status, self-stigma, and Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the studied females, there were negative significant correlation between; working and mental health state (r = − 0.460 & p = 0.000) and personal-stigma (r = 0.238 & p = 0.000), while working was positively significant correlated with psychological openness (r = 0.171 & p = 0.004) and total IASMHS (r = 0.127 & p = 0.039), regarding mental health susceptibility; there was a significant negative correlation with personal-stigma (r = − 0.166 & p = 0.011), while positive significant correlation was present with psychological openness (r = 0.137 & p = 0.034), total IASMHS (r = 0.148 & p = 0.022). Personal-stigma was having a significant negative correlation with psychological openness (r = − 0.298 & p = 0.000), help-seeking propensity (r = − 0.228 & p = 0.000), and total IASMHS (r = − 0.257 & p = 0.000). Psychological openness; had a significant positive correlation with; help-seeking propensity (r = 0.763 & p = 0.000), Total IASMHS (r = 0.850 & p = 0.000), as well as between help-seeking propensity and total IASMHS (r = 0.816 & p = 0.000) and lastly, between indifference to stigma and total IASMHS (r = 0.294 & p = 0.000) (Table 1).

Social support and personal stigma were the factors that significantly predicting adequate Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the studied groups (p < 0.05) (Table 2).

Discussion

Recently, the social role of the women is growing either within their families and/or in the community, with a higher expectation to affect their mental health. Our research was a comparative cross-section study that was conducted among 115 teachers representing the working group and 125

Fig. 3 Comparing the level of adequate Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the studied groups

Table 1 Correlation between work, mental health status, personal-stigma, and Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the studied groups

	Work status	Mental health state	Personal-stigma	Psychological openness	Help-seeking propensity exercise	Indifference to stigma	Total IASMHS
Work status	1						
Mental health state	−0.460**	1					
Personal-stigma	−0.238**	−0.166	1				
Psychological openness	0.171**	0.137*	−0.298**	1			
Help-seeking propensity	0.010	0.042	−0.228**	0.763**	1		
Indifference to stigma	0.113	0.003	−0.064	0.081	0.100	1	
Total IASMHS	0.127*	0.148*	−0.257**	0.850**	0.816**	0.294**	1

Spearman correlation was computed

*Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level

Table 2 Factors predicting adequate Inventory of Attitude toward Seeking Mental Health Services (IASMHS) among the studied groups

Variables	B	SE	P value	Expected B	95.0% CI for expected B	
					Lower bound	Upper bound
Marital events	0.797	0.614	0.194	2.219	0.666	7.390
Financial events	0.256	0.420	0.542	1.292	0.567	2.941
Health events	−0.289	0.494	0.559	0.749	0.284	1.974
Work event	−0.151	0.667	0.821	0.860	0.233	3.177
Social support	6.340	2.981	0.006*	5.841	1.601	10.231
Personal stigma	6.837	1.721	0.004*	4.981	1.213	7.246

*p < 0.05 is significant

housewives females to find out the difference between working and non-working women regarding the level of mental health and to explore their stigma and attitude toward help-seeking for mental-health problems.

Working females in our study are exposed to different work and family responsibilities as the average working hours per day in their schools were about 6 h/day, during which they are exposed to wide variety of work stressors, responsibilities besides their marital duties, which is expected to make them suffer from stress related physical disorders as irritable bowel syndrome and gastric ulcer as revealed from this study, as well as decrease their coping capacity to stressors and exaggerate their exposure to mental fatigue which in turn will make them more susceptible to mental health disorders in the form of anxiety and depression than housewives, which was already suggested to directly affect mental health status of working females (Sveinsdottir et al. 2007).

Our research findings illustrate the significant more susceptibility of teachers to mental health problems than housewives (40.9% for teachers vs. 3.2% for the latter), which is nearly the same as the results from the study conducted by Panigrahi et al. (2014) in India where mental susceptibility among working females was (32.9%). Also, the current results clarify the indirect correlation between work status and mental health of the participated females ($r = -0.460$ & $p = 0.000$), these results are the same as that of studies conducted by Dudhatra and Jogsan (2012), and Maqbool et al. (2014) who revealed that mental health score is much low and negatively correlated with work of the females.

Regarding the attitude of seeking mental health services, our results show that levels of IASMHS and its subscales were below the average in both groups that could be referred to our Middle Eastern culture, beliefs, and traditions which act as a barrier against utilization of mental health services. Unfamiliarity with professional psychological services in the Middle East make people tend to deal with mental illness as a private personal issue that should be kept hidden within families where sharing personal experiences and seeking help from families and friends are their first option (Dardas and Simmons 2015). In addition, seeking religion support to compete mental health problems is common in our culture and community (Weatherhead and Daiches 2010), which is in line with the results of a comparable research revealed that the percentage of Arab people who seek mental health services is much lower than those in Western countries (Karam et al. 2006).

However, the mean scores of total IASMHS and its subscales were higher in teachers than housewives, also, working status was positively correlated with psychological openness ($r = 0.171$ & $p = 0.004$) and total IASMHS ($r = 0.127$ & $p = 0.039$), this could be attributed to that work give the females more power, self-esteem and different aspects of

experience also, social support is also expected to improve their attitude toward mental health services (Kopp et al. 2008).

The stigma associated with mental illness in its different forms; the public and personal stigma that arise from the society and self-stigma from the affected person, have a direct effect on the help-seeking intention and behavior for mental disorders (Livingston and Boyd 2010; Schomerus et al. 2009, 2012).

Our results demonstrate that personal-stigma for mental health was significantly higher in housewives than in teachers, this could be attributed to the fact that higher percentages of housewives were married which is expected to increase the fear of stigma from the side of their husbands and families especially that most of them were from rural areas with the deeply rooted cultures, beliefs and stigmatization for mental health problems and this is already reflected in their concern regarding in-stigmatization of seeking health services, as it was lower in that group more than teachers. However, this opinion is compatible with the results from the study conducted by Kramer et al. (2002) in the USA, which concluded that the social pressure represented in cultures and traditions, as well as the attempts to fulfill family expectations, affect mental health and the personal stigma in a negative way. Also, being working made females more confident with higher self-esteem which is considered as a protecting factor from personal stigma (Werner et al. 2008).

Stigma toward mental health problems was negatively correlated with total IASMHS and all subscales, while in contrast indifferent to stigma of seeking mental health service was positively correlated with total IASMHS, that is supported by the meta-analysis study conducted by Nam et al. (2013) and the study of Gearing et al. (2015), these results are expected to be important for policy makers, health service coordinators and researchers to include anti-stigmatization programs in our society within basic health care services and health education programs that will help in increasing utilisation of mental health services which in turn will effect on the levels of mental health problems in our community.

Limitations

Data collection regarding mental health susceptibility was depending on self-reporting, which may carry a risk of inaccuracy, also the nature of our cross-sectional study hinder our ability to establish cause association between independent variables and mental health.

Conclusions

It's concluded that there was a negative correlation between working and mental health status represented in exposing the teachers to more mental health disorders and stress-related

physical disorders than housewives, the attitude of seeking mental health services was below average in both groups, but was higher in teachers than housewives and personal-stigma for mental health was significantly higher in housewives than in teachers with negative correlation with their attitude for seeking mental health services. Lastly, social support and personal stigma were the main factors that significantly predict total IASMHS. Accordingly, it's recommended organizing community-based awareness programs regarding mental health regularity for the working females; development of work and family-based interventions to decrease stressors on working females and adapting stress relieving exercises; development of effective-culture-based interventions against the stigmatizing attitudes for mental illness and mental health service reform to provide accessible mental health services and encourage society member who are suffering from mental illnesses to seek psychological help.

Compliance with Ethical Standards

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