IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 8, Issue 1 Ser. IX. (Jan. - Feb .2019), PP 05-14
www.iosrjournals.org

Perceived Societal Stigma and Coping Orientations among Patients with Mental Illness

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Abstract
Back ground*: societal stigma and discrimination are common among people with mental health problems. Adaptive coping orientations are necessary in maintaining functioning of people with mental disorders.*
Aim: *the study aimed to explore the perceived societal stigma and coping orientations among patients with mental illness.*
Methods*: descriptive exploratory research design was used in this study. A sample of convenience of 126 patients with mental illness was recruited from psychiatric outpatient clinics at Alabbasiah hospital of mental health, Cairo, Egypt.*
Data collection*: data was collected through semi structured interview using three tools: socio-demographic and clinical data sheet, Perceived Devaluation - Discrimination Scale and Stigma Coping Scale.*
Results *: two thirds of participants had average score of societal stigma above the midpoint of 2.5 up to 3.75, deflection coping orientations had the highest mean scores among participants followed by challenging others coping orientation .*
Conclusion*: the study concluded that majority of participants are aware of societal stigma of mental illness. Although stigma coping orientations vary by situation, participants of the current study often choose deflection to cope with societal stigma.*
Keywords*: stigma, societal stigma, coping with stigma, mental illness.*

Date of Submission: 29-01-2019 Date of acceptance:14-02-2019

I. Introduction

Due to the nature of mental disorders, patients have to cope with the psychological, cognitive, biological symptoms of illness and illness treatment. Besides these, they have to face negative consequences that come along with stigma associated with the illness. [1]

Stigma of mental illnesses can be categorized into societal stigma and self stigma. Societal stigma is the prejudice endorsed by the general population and manifests as discrimination toward people with mental illness. Self stigma refers to patients' beliefs about attitudes of the general population toward their condition and toward themselves being a member of a potentially stigmatized group [2]. Due to negative opinions held by society, patients eventually attribute these stereotypes to themselves, which strengthen internalized stigma and reinforce their social isolation to avoid stigmatizing reactions of society [3].

Regarding models of mental illness stigma, [4] referred to stigma as cognitive, motivational, and sociological reactions of the society. The cognitive model postulate that symptoms of mental illness, skills deficits and person's appearance lead to stereotypes and discrimination. Motivational model explains that people stereotype others to take advantage and protect self from shortcomings. Meanwhile, sociological model explains that private and public organizations discriminate mental illness to limit opportunities of patients from holding certain jobs.

Individuals with mental illness are perceived as lacking abilities to carry out social interaction, dangerous and unpredictable, they are labeled accordingly as beyond social norms and ignored by rest of the society. In this respect, [5] conceptualized stigma as "the co-occurrence of five components – labeling, stereotyping, separation, status loss, and discrimination"

Studies have shown that stigma of mental illness has led to threatened social identity, social exclusion, impaired quality of life, unemployment and loss of education and income. Furthermore, people often avoid the use of services for mental health because of fear of being labeled as a "mental patient". People with mental illness live in a society that stigmatizes them have low self esteem, self efficacy, and self confidence, and reduced adherence to psychiatric treatment [6, 7].

Stigma and discrimination experienced by people with mental illness can be considered within a stress and coping framework. The most common coping orientations described in the literature are: (1) secrecy or

hiding mental illness, (2) withdrawal to avoid interpersonal and social interactions, (3) educating others about mental illness (4) challenging others about their stigmatizing attitudes and behaviors, (5) deflection which means that people with mental illness can identify stigma, not applying it to themselves and not allow mental illness to define them [5].

In spite that coping with societal stigma can help patients to maintain positive self-concept, the outcomes depend on the coping strategy that patients use. Literature suggests that secrecy is associated with more self stigma, lower self-esteem and higher levels of experienced and perceived discrimination. In contrast, active strategies like educating or challenging others were associated with higher self-esteem and not feeling ashamed [8, 9]

Significance of the study

Stigma of mental illness is still prevalent in our society. Messages delivered by the media, family, friends, coworkers and even health care providers, make patients feel judged and rejected. Societal stigma can devastate the patient's ability to live in the community, to disclose illness and to seek treatment. Stigmatizing attitude toward patients can diminishes their awareness of their social rights and hampers social support provision

A better understanding of mental illness stigma contributes to improved nursing practice as nurses become aware of their own values, attitudes and behavior toward patients. Furthermore, nurses should recognize the detrimental impact of stigmatization on the psychological well-being of patients to be able to provide patients with social support and play an important role in the patients' acceptance of the mental illness.

It is important to add to the knowledge of nurses in the field of psychiatric nursing the patients' viewpoint about how they perceive societal attitude toward them and how they respond to that negative attitude. Furthermore, the Egyptian literature has many studies in respect to internalize stigma. None of these studies have investigated societal stigma. The current study will shade the light on societal stigma and coping orientations among patients with mental illness.

Aim of the Study

The aim of this study was to explore the perceived societal stigma and coping orientations among patients with mental illness.

Research Questions

1. What is the patients' perception of societal attitude towards mental illness?
2. What are the coping orientations used by patients with mental illness toward societal stigma?

II. Subjects And Methods

Research design

A descriptive exploratory design was utilized in the current study.

Sample

A sample of convenience of 126 patients with mental illness was recruited for the current study. The sample size was determined by Population Proportion – Sample Size formula: $n = N*X / (X + N - 1)$. Where, $X = Z\alpha/22 *p*(1-p) / MOE2$. Confidence level of 95%, α is 0.05 and the critical value is 1.96. The sample proportion was considered 50%, which is conservative and gives the largest sample size. Inclusion criteria: patients of both genders, age 18 - 60 years, aware of mental illness, various psychiatric diagnoses and duration of illness not less than three years. Exclusion criteria: uncooperative patients, patients with organic brain disorders or communication disorders. According to the formula, sample size was 176; patients' exclusion was according to exclusion criteria.

Setting

The study was carried out in the psychiatric outpatient department at Alabbasiah hospital of mental health. The hospital is affiliated to the ministry of health, Cairo, Egypt.

Tools:

1. Socio-demographic and clinical data sheet: developed by researcher and included: gender, age, level of education, marital status, working status, known diagnosis to the patient, and duration of illness.
2. Perceived Devaluation - Discrimination Scale. It was developed by Link *et al*, 2004. [5]. It consists of 12-item that assesses patients' awareness of general negative beliefs about mental illness. Response categories ranged from 4 (strongly agree) to 1 (strongly disagree). Reverse scoring was used on items 1, 2,3,4,8, 10. Reversed items range from 1 (strongly agree) to 4 (strongly disagree). Scoring: all answers of each

participant were summed and divided by the number of items in the scale. Higher scores above the midpoint (2.5) reflect more stigma awareness. The reliability of the scale after translation using Cronbach's = .814.

3. Stigma Coping Scale. It was developed and modified by [5]. It consists of 26 – items to assess coping orientations with societal stigma: coping by secrecy, coping by withdrawal, coping by educating others, coping by challenging others and coping by deflection. Response categories ranged from 4 (strongly agree) to 1 (strongly disagree). Scoring: the items summed and divided by the number of items in the subscale. Higher scores above the midpoint (2.5) mean that the participants endorse higher coping ability using that coping orientation. The alpha reliability for the scale after translation is .704
4. Awareness of Mental Disorder: one question subscale of Assessment of Insight in Psychosis scale developed by Xavier *et al.,* 1993 [10]. This subscale used in the current study to assess "currently, does the subject believe that he/she has a mental disorder or psychiatric problem**.**

Pilot study

A pilot study was conducted in order to test the reliability and clarity of the translated questionnaires. A total of 10% of the sample were recruited for the pilot study according to the inclusion criteria. The pilot study revealed minimal modifications in the questionnaires. Subjects included in the pilot study were excluded from the main study sample.

Ethical Considerations

The purpose of the study was explained to all subjects and they were informed that participation in the current study is voluntary and the data collected will be used only for research purpose. To protect confidentiality of participants, a code number was written on questionnaires. Participants were informed that they can withdraw at any time during the interview without giving reasons.

Procedure

Written approval was obtained from the director of Al abbasiah hospital of mental health. Tools were translated to Arabic language and subjected to back translation and reliability test. Data was collected from each participant individually through semi structured interview that lasted for approximately 30 minutes with each participant.

Statistical Design

Statistical analysis was done with the help of software 'SPSS 20' Statistical Package for the Social Sciences. Descriptive statistics including number, percentages, mean and standard deviations was used. Relationship between measures of the study was computed via Pearson's correlation coefficient. The level of significance in this study was (<0.05), and (<0.01) considered highly significant.

III. Results And Data Analysis

Table (1) Socio-demographic characteristics of the studied sample (n=126)

Variable	No	%
Gender		
Male	72	57.1
Female	54	42.9
Age		
18-	39	31
28-	46	36.5
38-	28	22.2
48-60	13	10.3
Mean ±SD 34.51± 11.32		
Marital status		
Single	58	46
Married	38	30.2
Divorced	17	13.5
Widow	13	10.3
Education level		
Basic education	47	37.3
Secondary education	49	38.9
University education	30	23.8
Work status		
Working	44	34.9
Housewives	28	22.2
Students	20	15.8
Not working	34	27

Table (1) shows that slightly more than half of participants (57.1%) were male, (36.5%) were at age of 28- < 38 years, (46%) single, (38.9%) finished secondary education and (34.9 %) are working.

Figure (1) distribution of duration of illness among participants (n=126)

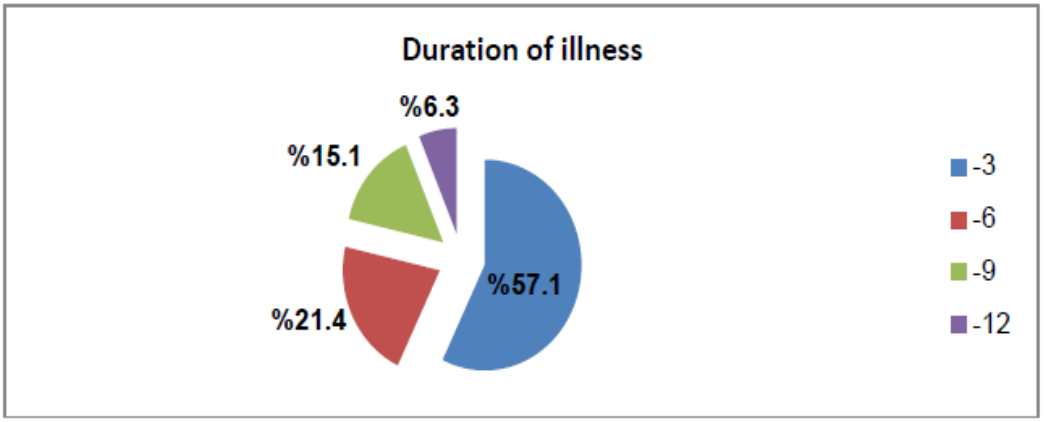

Figure (1) illustrates that (57.1%) of participants had duration of illness 3-< 6 years.

Figure (2) distribution of diagnosis among participants (n=126)

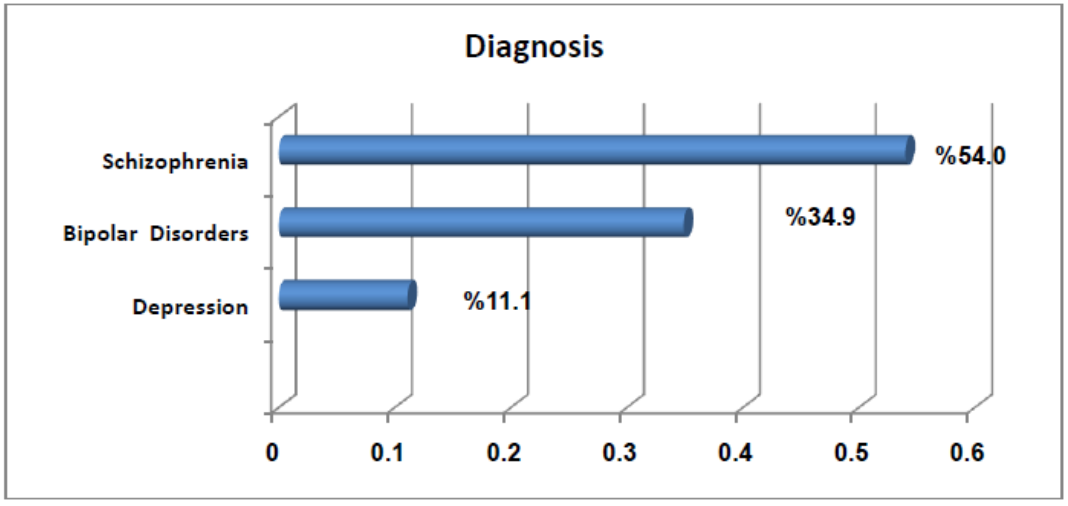

Figure (2) shows that (54 %) of participants had schizophrenia, (34.9%) had bipolar disorders

Figure (3) distribution of previous admission to hospital among participants (n=126)

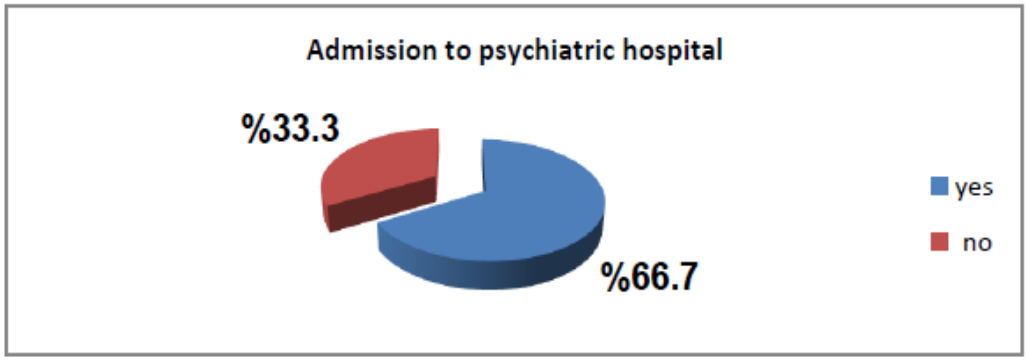

Figure (3) reveals that (66.7%) of participant previously admitted to psychiatric hospital.

Table (2) Perceived devaluation and discrimination among participants (n-126)

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Most people would accept a person who has been in a mental hospital as a close friend ®	17.6 %	**40.3 %**	34.7%	7.4 %
Most people believe that a person who has been in a mental hospital is intelligent as the average person. ®	13.6%	**46%**	35.2%	5.1%
Most people believe that a former mental patient is just as trustworthy as the average citizen ®	19.3%	24.4%	**51%**	5.3%
Most people would accept a fully recovered former mental patient as a teacher of young children ®	18.2%	**39.2%**	31.8%	10.8%
Most people believe that admission to a mental hospital is a sign of personal failure	11.4%	32.4%	**45.6%**	10.7%
Most people would not hire a former mentally ill patient to take care of their children, even if had been well for some time	26.1%	29.5%	**41.5%**	2.8%
Most people think less of a person who had been in a mental hospital.	36.4%	**39.2%**	21%	3.4%
Most employers will hire a former mental patient if he or she is qualified for the job ®	14.2%	28.4%	**49.6%**	7.8
Most employers pass over the application of a former mental patient in favor of another applicant	32.4%	**47.2%**	19.3%	1.1%
Most people in my community would treat a former mental patient just as they would treat anyone ®	19.9%	**50%**	16.5%	13.6%
Most young women would be reluctant to marry a man who has been hospitalized for serious mental disorder	**50.3%**	28.1%	20.5%	1.1%
Once know a person was in a mental hospital, most people will take his or her opinion less seriously	33.5%	**47.2%**	17.8%	1.6%

Table (2) reveals that (50.3%) of participants strongly agreed that most young women would be reluctant to marry a man who has been hospitalized for mental disorder. (48.9%) disagreed that most people believe that a former mental patient is just as trustworthy as the average citizen.

Table (3) distribution of score of stigma scale of studied sample (n=126) using a midpoint of 2.5

Categories	No	%
< 2.5	18	14.3
2.5	25	19.8
> 2.5 - 3.75	83	65.9

Table (3) shows that (65.9%) of participants had average scores of societal stigma above the midpoint.

Table (4) scores of coping orientation "Distancing" among participants (n =126)

Deflection coping	Strongly Agree	Agree	Disagree	Strongly Disagree
You do not have the same problems that other people experience as a consequence of mental illness.	26.1%	**51.7**%	21.0%	1.1%
Most people who have been hospitalized for mental illness have very different problems than you have	33.0%	**45.5**%	18.2%	3.4%
You think that you are very different from most people who have mental illnesses	26.1%	**47.7**%	25.0%	1.1%
Mean ± SD	**3.03 ± 0.595**			

Table (4) shows that (51.7%) of participants agreed that "they do not have the same problems that other people experience as a consequence of mental illness." Furthermore, (47.7%) agreed that "they are very different from most people who have mental illness.

Table (5) scores of coping orientation "challenging others" among participants (n=126)

Challenging others coping	Strongly Agree	Agree	Disagree	Strongly Disagree
When someone says something stigmatizing people with mental illness, you let him know you disagree with him.	29.5%	**34.7**%	23.3	12.5%
It is better to confront stigmatizing behavior than ignoring it.	25.0%	32.4%	**36.4**	6.3%
You've found that it's best to help the people close to you understand what psychiatric treatment is like.	28.1%	**38.4**%	27.8	5.7%
You thought an employer felt uneasy hiring a person who was in psychiatric treatment; you would try to make him understand that most ex-patients are good workers.	25.0%	**44.3**%	26.1	4.5%
Mean ± SD	**2.94 ±1.06**			

Table (5) shows that (44.3%) of participants agreed that "they would try to make an employer understand that most ex-patients are good workers". Meanwhile, (36.4%) disagreed that "It is better to confront stigmatizing behavior than to ignore it".

Table (6) scores of coping orientation "educating others" among participants (n=126)

Educating others coping	Strongly Agree	Agree	Disagree	Strongly Disagree
After you entered psychiatric treatment, you educate others about what it means to be a psychiatric patient	25.0%	**42.0**%	30.7%	2.3%
You would participate in an organized effort to teach the public about psychiatric treatment	29.5%	27.3%	**35.8**%	7.4%
You think a friend was uncomfortable with you because your psychiatric treatment, you would educate him about it	25.0%	**32.4**%	30.1%	12.5%
Mean ± SD	**2.82 ± 0.780**			

Table (6) shows that (42.0%) of participants agreed to educate others about what it means to be a psychiatric patient". Meanwhile, (35.8%) would not participate in an organized effort to teach the public about psychiatric treatment.

Table (7) scores of coping orientation "Secrecy" among participants (n=126)

Secrecy coping	Strongly Agree	Agree	Disagree	Strongly Disagree
If you had close relative who treated for mental illness, you advise him not to tell anyone about it.	27.3%	**30.7**%	27.8%	14.2%
If you were in treatment for mental illness you would worry about certain people finding out about it.	25.7%	27.7%	**28.4**%%	18.2%
If you have treated for mental illness, the best thing is to keep it a secret.	**33.0**%	26.1%	30.7%	10.2%
There is no reason for a person to hide the fact that he was a mental patient at one time. ®	11.9%	**38.6**%	33.5%	15.9%
In view of society's negative attitudes toward people with mental illnesses, you would advise people with mental illnesses to keep it a secret	30.1%	21.0%	**46.5**%	1.4%
In order to get a job former mental patients have to hide history of hospitalization.	**32.4**%	26.1%	28.4%	13.1%
You encourage the members of your family to keep your mental illness a secret.	26.7%	**30.5**%	28.5%	14.2%
You believe that a person who has recovered from a mental illness should not tell people about it.	26.1%	27.8%	**32.4**%	13.6%
When you meet people for the first time, you make effort to keep the fact of your psychiatric treatment to yourself	26.1%	28.4%	**36.4**%	9.1%
Mean ± SD	**2.69 ± .817**			

Table (7) reveals that (38.6%) of participants agreed that there is no reason for a person to hide the fact that he or she was a mental patient at one time .Meanwhile, (46.5%) of participants disagreed that "to advise people with mental illnesses to keep it a secret".

Table (8) scores of coping orientation "withdrawal" among participants (n=126)

Withdrawal coping	Strongly Agree	Agree	Disagree	Strongly Disagree
You thought someone you know held negative opinions about psychiatric patients, you would avoid him.	23.3%	28.4%	**41.5**%	6.8%
Places of work should be organized so people who have mental illness can work together	10.2%	18.8%	**54.5**%	16.5%
It is easier for you to be friendly with people who are psychiatric patients.	15.3%	34.7%	**39.8**%	9.1%
If a person thoughtless of you because you were in psychiatric treatment, you would avoid him	34.1%	**39.2**%	24.4%	2.2%
People who have had mental illness will find it less stressful to socialize with people who have also mental illness.	14.2%	29.5%	**45.2**%	11.5%
If your friend developed mental illness you advise him to spend most of time with people who have mental illness.	14.2%	17.6%	**59.7**%	8.5%
You believe that people who have mental illness feel most comfortable with people who also have mental illness.	26.1%	31.8%	**37.5**%	4.5%
Mean ± SD	**2.61 ± 0.546**			

Table (8) shows that (39.2%) of participants agreed that "If a person thoughtless of you because you had been in psychiatric treatment, you would avoid him" Meanwhile, (54.5%) disagreed that "Places of work should be organized so that people who have mental illness can work together"

Table (9) Correlation between societal stigma, coping orientations in relation to socio-demographic and clinical data of studied participants (n=126)

variables	Societal stigma		Secrecy coping		Withdrawal coping		Educating others coping		Challenging coping		Deflection coping	
	r	p	r	p	r	p	r	p	r	p	r	P
Gender	.023	.765	.007	.923	.251*	.001	.058	.442.	.101	.183	.149*	.048
Age	.181*	.016	.040	.601	.078	.306	.177*	.019	.002	.978	.075	.323
work Status	.316**	.000	.104	.171	.106	.162	.031	.679	.081	.283	.152*	.045
Marital status	.032	.672	.064	.395	.105	.167	.108	.154	.066	.382	.011	.887
Education level	.061	.420	.029	.704	.056	.462	.072	.344	.079	.296	.002	.981
Diagnosis	.152*	.044	.200**	.008	.163*	.030	.046	.542	.035	.642	.170*	.019
Duration of illness	.052	.492	.128	.091	.037	.623	.058	.446	.033	.664	.054	.475
previous admissions	.065	.392	.053	.487	.271**	.000	.084	.270	.086	.256	.215**	.004

Table (9) shows statistically significant relationship between age, work status, diagnosis and societal stigma (r = 181, .316, .152 at p= .016, .000, .044 respectively). Meanwhile, there is statistical significant correlation between diagnosis and secrecy coping (r=.200 at p=.008), gender, diagnosis, previous admission to hospital and withdrawal coping (r= .251, .163 , .271 at p= .001, .030, .000 respectively), age, residency, diagnosis and educating others coping (r= .177, .173, .170, at p= .019, .022, .019 respectively), gender, work status, previous admission to hospital and deflection coping (r=.149, .152 , .215 at p= .048, .045, .004 respectively)

Table (10) Correlation between societal stigma and coping orientations of studied sample (n=126)

Variables	Societal stigma		Secrecy coping		Withdrawal coping		Educating others coping		Challenging coping		Deflection coping	
	r	p	r	p	r	p	r	p	r	p	**r**	**p**
Societal stigma												
Secrecy coping	.065	.388										
Withdrawal coping	.033	.664	.477**	.000								
Educating others coping	-.157*	.034	-443**	.000	-.159*	.035						
Challenging others coping	-.109-	.150	-201**	.008	-.206**	.006	.534**	.000				
Deflection coping	.149*	.048	.072	.340	-.041	.586	-.098	.194	-.119	.117		

Table (10) shows significant relationship between societal stigma and deflection (r = .149 at p= .048), and inverse relationship with educating others (r= -.157 at p= .034). There is significant relationship between secrecy and withdrawal (r= .477 at p = .000), challenging others, educating others (r=.534 at p= .000). There is significant inverse relationship between educating others, secrecy, withdrawal (r = -.477, -.159 at p=.000, .035respectively).

IV. Discussion

Results of current study revealed that mean age of participants was 34.51± 11.32; which is congruent with Sidhom *et al* [10]. There is statistical significant relationship with societal stigma which is incongruent with results of Abd-El Monem [12]. There is statistical significant relationship with coping orientation of educating others which is positive coping. This result may be due most of participants are at age of young adulthood which is characterized by positive view in making decisions and solving problems. This result is supported by Singh *et al*. [1] who concluded that age of patients correlated positively with the stigma resistance.

Regarding gender, slightly more than half of participants were male; there is no significant relationship with stigma which is supported by results of [12]. There is significant relationship with coping orientations of withdrawal and deflection which might indicate participants' tendency to use behavioral and cognitive avoidance as means of self-protection from potential rejection. These results are not supported by results of Isaksson *et al*. [6] who found that secrecy was positively associated with being female while challenging others was positively associated with male gender.

Concerning education, results showed that most participants had finished basic or secondary education. Education had no significant relationship with societal stigma which is supported by Singh et al. [1]. Education had no significant relationship with any of the coping orientations which is not supported by [6] who concluded that education is positively associated with secrecy as a coping orientation.

Regarding work status, results indicated that half of participants were students or working which is congruent with Al Mulhim *et al*. [13]. There is significant relationship with societal stigma which might indicate that being working or not, patients anticipate society not to value them as able to be productive. This result is inconsistent with Brohan, *et al*. [14]. Additionally, work status had significant relation with deflection coping. This result is not supported by [6] who concluded that being employed is positively associated with secrecy as a coping orientation.

Regarding marital status, results showed that slightly less than half of participants were currently single which is inconsistent with [11] who found three quarters of study participants were single. There is no significant relationship with societal stigma or any of the coping orientations. This result might reflect the negative effect of mental illness more than being socially stigmatized on the interpersonal relationships of patients. In addition, [1] found highly significant relation of experienced internalized stigma with being single.

When asked about their diagnosis, slightly more than half of participants said" I have split of personality" which is the Egyptian slang name of schizophrenia. This might be due to that schizophrenia is most stigmatizing mental illness due alterations in behaviors and social incompetence. There is significant relationship between diagnosis and societal stigma. This result is congruent with Zelst [15] and Lasalvia *et al*. [11]. Moreover, Brohan [16] studied perceived discrimination among people with bipolar disorder or depression in 13 European countries and concluded that (71.6%) of participants reported moderate or high perceived discrimination.

Moreover, diagnosis is associated with coping orientations of secrecy, withdrawal and deflection which represent negative or unhealthy coping. This could be attributed to nature of mental illness as lack of volition, low self esteem and low self efficacy. These results are supported by Gerlinger *et al* [17] who concluded that in patients with schizophrenia, perceived/experienced stigmas predict more secrecy, and withdrawal as coping strategies. Whereas, Lee [2] studied stigma sentiment in individuals with depression and concluded that participants had high scores on deflecting as a coping orientation.

Results of the current study revealed that slightly more than half of participants had duration of illness 3-< 6 years, and two thirds of participants were previously admitted to psychiatric hospital with no significant relationship of both variables with societal stigma which is supported by [12] and [18]. Whereas, there is significant relationship between previous admission and coping orientations of withdrawal and deflection which could be attributed to patients' view of psychiatric hospital as a mean of penalty, thus, they avoid situations that might disclose their illness. In this respect, [6] concluded that secrecy was positively associated with not having been admitted to hospital.

Regarding societal stigma, results showed that two thirds of participants reported experiencing high levels of societal stigma which is evident as having average score above the midpoint of 2.5 and scored up to 3.75. That might indicate that participants perceive society attitude toward their condition as negative and discerning. On the one hand, this result is supported by [6]. On the other hand, this result is inconsistent with Chronister et al. [19] who

Studied the effect of societal stigma on internalized stigma and found (82%) of participants had average scores above the midpoint.

On the one hand, half of participants agreed that most young women would be reluctant to marry a man who has been hospitalized for mental disorder, which is congruent with [17]. On the other hand, slightly less than half of participants disagreed that most people believe that a former mental patient is just as trustworthy as the average citizen, meanwhile [13] found that this percent of their respondents disagreed that most people would accept a person who has been in a mental hospital as a close friend.

Meanwhile, participants of current study disagreed that most employers will hire a former mental patient if qualified for the job, which is in the same line of [13] who concluded that (56.6%) suffered from discrimination because of mental illness when applying for a job.

Regarding coping orientations, results of the current study showed that deflection had the highest mean scores 3.03, followed by challenging others 2.94, educating others 2.82, secrecy 2.69 and withdrawal 2.61. This could indicate that, participants of the current study might prefer more to demonstrate being different from other people with mental illness to protect themselves from societal stigma. Moreover, they might try to tackle stigma through challenging negative attitudes toward them but need higher self confidence and social support.

In this respect, reviewed studies revealed that, [6] concluded that secrecy coping reported by (73%) of participants, followed by challenging others reported by (51%). Al Mulhim [13] concluded that (68%) of respondents preferred secrecy. Meanwhile, [19] found challenging others had the highest mean, followed by educating others. Moreover, Schibalskia *et al* [20] studied stigma-related stress and avoidant coping reactions

and concluded that perceived public stigma had direct effects on avoidant stigma coping as secrecy and social withdrawal.

Results of the current study showed significant relationships between societal stigma and deflection coping and inverse relationship with educating others and there are significant relationships between different coping orientations except deflection. This result might suggest that participants may be flexible in how they use coping orientations depending on the situation.

In this respect, [1] concluded that anticipated discrimination was associated with secrecy and educating others, meanwhile past experience of discrimination was associated with challenge others and negatively with educating others. Moreover, Kroska *et al*. [21] concluded that patients used three types of coping strategies: secrecy, withdrawing, and educating others that helped to protect the patients' self-concepts when faced with public stigma. Moreover, [6] concluded that (81%) participants in their study of coping with stigma and discrimination reported more than one coping orientation according to the type of stigma and discrimination

V. Conclusion

The current study concluded that majority of participants are aware of societal stigma of mental illness. Although stigma coping orientations vary by situation, participants of the current study often choose deflection to cope with societal stigma.

VI. Recommendations

Psychoeducation programs should include teaching patients how to accept mental illness and to make use of positive coping orientations to overcome societal sigma.

1. Programs are needed on the media to raise awareness of the society about the nature of mental illness.
2. Qualitative study is needed to explore the lived experiences of patients with mental illness regarding societal stigma.

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Amal Alhossainy Ramadan. " Perceived Societal Stigma and Coping Orientations among Patients with Mental Illness " .IOSR Journal of Nursing and Health Science (IOSR-JNHS), vol. 8, no.01 , 2019, pp. 05-14.