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The Stigma of Mental Illness at the Bahrain Defense Force (BDF) Hospital

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INTRODUCTION

The global burden of mental illness is seen to be increasing, and what is not taken into consideration is the secondary manifestation of perceived stigma as a result of those mental illnesses. Stigma is also known as the "second illness", possibly as a result of mental illnesses not receiving enough research funding or adequate treatment infrastructures, hindering the process of recovery from mental illness (Indiana University Bloomington, 2015). A study published in 2008 showed that perceived stigma was prevalent by 21.9% in the sample of people from all countries with mental health issues, compared to 15.5% in people with chronic physical conditions. Suffering from depression or anxiety was associated with about a twofold increase in the likelihood of stigma. Chronic physical conditions, on the other hand, showed a significantly lower association with stigma (Alonso et al, 2008).

Bahrain is a small, island kingdom in the Middle East, lying in between Saudi Arabia and Qatar. It has a population of 1.316 million (2014 estimate) people and the official language is Arabic, even though English is widely spoken. People come from various ethnic backgrounds and religions, Islam being the most predominant religion (70.2%) (Ministry of Information Affairs, website). People may come from very conservative, moderately conservative or least conservative backgrounds. That is an important factor to address when discussing mental health as it governs how people regard mental issues within the community. However, there is no study correlating conservativeness and mental health in Bahrain.

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In order to provide a better portrayal of the BDF hospital's situation within the country, we would have to explain that are three main public hospitals in Bahrain: Salmaniya Medical Complex (SMC), King Hamad University Hospital (KHUH) and BDF hospital. Each provides psychiatric services for the public, but the main psychiatric hospital, where most people go to for even inpatient facilities is in SMC. KHUH and BDF hospital only provide outpatient psychiatric services and rarely are patients admitted into the medical ward for a psychiatric problem; they are usually referred to SMC for admission should there be a need for that. The BDF hospital is designated for military personnel and their families, and so that is the population described within the scope of this discussion.

Although many people approach the psychiatric clinic for consultations (either willingly or due to a referral), we have seen over the years a staggering behavioral pattern that illustrates the shame that patients feel due to perceived stigma. Stigma is a major issue here due to the fact that not many are well informed about the need to treat psychiatric problems, and therefore the mentally ill would feel marginalized within the community as though they are responsible for what they are going through. That would naturally discourage them from seeking the help that they need and, eventually, depending on the severity of the disorder, it will take a toll on their functionality. It does not just stop at the patients themselves; the issue is multifaceted, whereby it involves their families, social status and communities.

Different definitions of stigma from reliable sources - with the aim of unifying all into one – will be provided. Moreover, the observed behaviors of patients due to perceived stigma will be discussed with the view to propose interventions that will hopefully be effective at reducing this culture of stigma towards the mentally ill within the BDF hospital and beyond.

SETTING OF PSYCHIATRY WITHIN BDF HOSPITAL

The hospital's administration has located the psychiatry clinics within the endocrine outpatient department, so that nobody is seen to be going in to see a psychiatrist, since it has had to cope with the issue of stigma by implementing patient-supportive strategies. As mentioned earlier, there are no inpatient psychiatric services, which is a dilemma for some military staff as they prefer to be admitted in the BDF, and not in SMC with the rest of the non-militarized population. Moreover, there is nothing that indicates the presence of psychiatric clinics within the hospital, such as overhead signs. In fact, many referred patients who are frequent in the hospital psychiatry express their surprise that there is a psychiatric outpatient service in the BDF.

The issue of confidentiality within the hospital's patients' records may not be as tight as it should be. Any physician, nurse or physiotherapist can have access to patient records and go through their medical and hospital visit history. Patients would automatically feel stigmatised after knowing that anyone can read about their psychiatric issues within the hospital's community.

THE MEANING OF *STIGMA*

In common usage, the word *stigma* means "a defect" or "a disgrace". In literature, such as in a book by Goffman (1963), stigma is described as "a trait, which is deeply discrediting". He explains that it is an interactive social process, wherein the blame lies with the person carrying the stigma. He also adds that people who are not able to hide their condition (such as in schizophrenia with tardive dyskinesia) are more often discredited and socially rejected than those who can hide their condition (e.g. in remitting bipolar disorder) (Gray, 2002; Goffman, 1963).

Penn and Martin (1998) have concluded that stigma, when used in the setting of mental illnesses, is a multifaceted construct that involves feelings, attitudes, and behaviors. It is therefore difficult to define *stigma* because concepts about mental illness can be subjective (Overton et al, 2008). This is supported by another account, which relates that the difference between a *normal* and a *stigmatized* person was a question of perspective, not reality (Byrne, 2000).

Therefore, we would like to define stigma (in the context of mental health) as "a subjective, perceived notion about oneself, where the feelings, attitudes and behaviors of others towards the mentally ill are believed to be solely due to their mental illness and that they are blamed for their own illness."

WHAT ENCOURAGES STIGMA?

A number of factors may be reinforcing the presence of the already-existent stigma. Those include influences from media, research funding, education, and the image of the psychiatric patients themselves. What the media shows on newspapers and/or the television has rather been a satirical portrayal of mentally ill people. A film, "Wag the Dog" (1997), for instance, depicts a psychotic soldier who constantly pops antipsychotic medication into his mouth like candy and is then killed whilst raping a young woman. Also, psychiatric characters are usually laughed at than laughed *with* and what is usually depicted on the screen connotes self-infliction, excuses for laziness and criminality. Hyler et al (1991) have written about a number of Hollywood films where the representations of mental illness are of "overprivileged, oversexed, narcissistic parasites" (Byrne, 2000). That simply increases stigma by worsening the negative attitudes that people with mental illnesses encounter and fear (Psychiatric Times, 1998). Alternatively, mental illness may be ridiculed by the entertainment industry, often using psychiatric terminology with barely any regard to their actual significance and meaning (Sharma, website). We have also seen a few onscreen depictions from the Arab entertainment industry that present a similar satirical picture of mentally ill people.

Another factor is the scarcity of funding of psychiatric research on stigma. There is a lack of psychiatric research on stigma and discrimination, and a form of "resistance" to hindering the culture of stigma. For example, Wolff et al (1996) were unsuccessful at achieving ethical approval for their study, and also described staff preconceptions that it would draw attention to the patients' problems, making their integration locally more difficult (Byrne, 2000).

Furthermore, the general public is not adequately educated about psychiatric illnesses. Research has shown that both medical and non-medical individuals hold ideas that are fundamentally incorrect about the role of psychiatry (Aggarwal et al, 2015). Perceptions and attitudes towards the mentally ill and mental illness are covered in strange myths and stereotypes; for example, they are regarded as deranged, violent and dangerous (Sharma, website). An account by a general practitioner from Northern Ireland describes his feelings towards neurotic patients: "...take up far too much of our time and energy – people complaining, miserable, depressed, neurotically whining about how unhappy they are, pouring out all their problems in the surgery and dumping them on my doorstep. It would be really unbearable if I was actually listening to them" (Byrne, 2000).

It is also known that psychiatry has a discreditable history; its contributions to modern medicine are widely regarded as unorthodox, so much so that other medical professionals antagonize psychiatry and psychiatrists. A long list of outdated psychiatric trials on patients (such as frontal lobotomy, insulin coma treatment, treatment for homosexuality, etc.) (Byrne, 2000) is quite engrained in people's minds that some call psychiatric hospitals as "looney house", "where crazy people go", etc. (Hwang et al, 2016; Nunn, 2014).

OBSERVED BEHAVIORS

Similar patterns of behavior have been seen to run within patients who fear social stigma within the hospital. That does not stop at the patients alone; it actually involves their families at times. The behaviors described below were observed and noted down over approximately five years by the psychiatry team, which agreed over this observation, to now be brought together in this piece.

Firstly, patients have been seen to dress differently when approaching the psychiatry clinics. They do not dress like how they would on a day-to-day basis. For instance, women who are unveiled would opt to attend with a veil on, or with sunglasses that would cover most of their face as to avoid being recognized by someone. Men would sometimes come with a cap over their head that is tilted towards their face, or dark sunglasses, that would conceal most of their face. Furthermore, if there were anyone else in the room such as a medical student or an intern, they would turn their whole body towards the consultant and would tend to talk in a soft voice, or even hold back from giving details about sensitive subjects. Certain patients have also been seen to not talk at all unless the consultant is the only one in the room with them. When asked about why they were not able to speak, they said that they are very uncomfortable with other people hearing their story. On a few instances, some patients have asked why

there are students in the room and repetitively look at them before answering any question. The same patients have also reported a feeling of being looked down at by other patients in the waiting area.

Secondly, some family members of patients are not supportive when it comes to their relatives' mental illness. They would refuse to attend with the patient for providing a collateral history due to the fear of social stigma, making it sometimes difficult to know what the patient is like at home. There have been patients who even stopped seeing their psychiatrist as a whole because their family members (parents, siblings, etc.) have stopped them from seeking psychiatric help. Some have expressed that they fear any psychiatric issue would prevent them from getting a job in the military sector, hence their refusal to have any psychiatric record within the hospital's system. In fact, many ask the psychiatrist to have their visit unregistered within the hospital's computer system, and since such requests must be declined, they resort to going to private psychiatrists and later come back with a prescription for free medications' refill.

As mentioned earlier, this is a military hospital where military personnel and their families come for medical treatment. The fact that those patients come from a military background adds to the problem whereby they are usually taught to "toughen up" and expressing any mental health issue such as anxiety or depression may cause them to be seen as weak, and so, they would not be taken seriously by their peers. The consequences of such behaviors can be serious on many levels. It could affect the patient himself, in the sense that they would internalize their problem due to public stigma, leading to self-stigma, and, ultimately, reduced self-esteem and no motivation to seek help (Corrigan et al, 2002).

INTERVENTIONS

The culture of stigma and the patients' behaviors discussed above shows that there is a lot to be done in order to reduce the effects of perception of stigma on the patients, their families and the public. It is therefore pertinent to propose interventions that would reduce the reinforcement and prevalence of stigma.

Firstly, we refer to the WHO Mental Health Action Plan (2013-2020), which proposes many interventions that are suitable for tackling the issue of stigma locally and internationally. Those include:

1. the integration of mental health care and treatment into general hospitals and primary care and completely abolishing the existent solitary psychiatric hospitals;
2. involving peer workers and other support groups in the treatment of the patient to provide each other with encouragement and a sense of belonging, to make sure that the patient receives a more holistic approach;
3. involving several sectors from the government. This would facilitate access to human rights such as employment, housing and educational opportunities, and participation in community activities, programs and meaningful activities;
4. a greater collaboration with families, religious leaders, faith healers, traditional healers, school teachers, police officers and local nongovernmental organizations;
5. building the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services by introducing mental health into undergraduate and graduate curricula, and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders;
6. implementation of laws and information campaigns that antagonize the stigmatization and human rights violations (rape, physical assault, etc.) towards the mentally ill;
7. promoting research in low-income and middle-income (and not only in high-income countries) in mental health;
8. supporting research aimed at filling the gaps in knowledge about mental health. (World Health Organization, 2013).

In coherence with the abovementioned interventions, we add the following:

1. Education: educate the public about mental health issues and psychiatric treatments as to negate all misconceptions about mentally ill patients and psychiatrists – this can be done by incorporating mental health into school syllabi, holding annual mental health awareness activities and other public-related affairs;
2. Collaboration: coordinating with the Ministry of Information Affairs to prevent the broadcast of any program that would hurt, stigmatize or defame psychiatric patients, including TV series, films, stories, etc.;
3. Integration: encouraging psychiatric patients to talk about their mental illness with other people in a monitored setting so that people can learn about their condition and see that they should not be seen as a source of fear for others;
4. Location: relocating the psychiatric team as an independent department with the establishment of inpatient psychiatric services to promote a more welcoming environment for military personnel who seek mental healthcare. Subsequently, that would even help them with treatment compliance.

CONCLUSION

Stigma is a very prevalent issue within the BDF hospital that is manifested through the varying avoidance behaviors of patients. The factors that encourage stigma should be addressed in order to promote a culture of "psycho-tolerance", where people are not judged for seeking mental help and, subsequently, their social life, career, public image and self-image are not affected. The authorities should gradually begin implementing the proposed interventions and monitor their effectiveness regularly by taking feedback from both the public and psychiatric patients. The major outcome we are hoping for is the improvement of the function of all individuals for the sake of a better present and future for them and their communities. We believe that such can be achieved by eliminating the stigma that is preventing people from seeking help.

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