



Public and Personal Depression Stigma in a Rural American Female Sample



Leigh Ann Simmons^{a,*}, Nancy Y. Yang^b, Qishan Wu^c, Heather M. Bush^c, Leslie J. Crofford^d

^a Duke University School of Nursing

^b Mount Sinai School of Medicine

^c Department of Biostatistics, College of Public Health, University of Kentucky

^d Department of Medicine, Vanderbilt University

ABSTRACT

We examined public and personal stigma among a community sample of 1,000 women living in primarily rural counties of Western Kentucky. Data on demographics, depression, stigma, health information sources, and availability of health services were collected via a random digit dial survey. The prevalence of depression was 15.7%. The majority of respondents (82.2%) reported congruent levels of stigma with 11.6% reporting high public and high personal stigma. However, 17.8% of respondents reported incongruent public and personal stigma. The 7.5% of women with low public and high personal stigma were older and less educated, preferred anonymous sources of health information, and reported better availability of health services. The 10.3% of women with high public and low personal stigma were younger and more educated, preferred interpersonal sources of health information, and reported poorer availability of health services. In multivariate analyses, depression and lower education were associated with any incongruent stigma, while rural residence and White race/ethnicity was associated with high personal and public stigma. Psychiatric nurses should develop community-based and targeted, point-of-care interventions to reduce public and personal stigma among rural women.

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Depression is the leading cause of disease burden for women in the United States, and the burden is 50% higher for women than men (National Alliance on Mental Illness, 2012). However, nationally representative data demonstrate that just over one-half of Americans meeting criteria for a past-year major depressive episode received any treatment, and less than one-fourth received treatment consistent with the American Psychiatric Association's practice guidelines (González et al., 2010). Studies suggest that mental health stigma may be a key contributor to delaying or not seeking help and poor treatment adherence (Barney, Griffiths, Jorm, & Christensen, 2006; Brown et al., 2010; Wrigley, Jackson, Judd, & Komiti, 2005).

Mental health stigma is characterized by a set of negative attitudes and beliefs about mental disorders and their treatment (Corrigan & Watson, 2002; Sartorius, 2007). Two main types of stigma have been identified in the literature. Public stigma has been defined as the stereotypes, prejudices, and discriminations an individual believes are held by the general public, while personal stigma has been defined as the internalization of public stigma, or an individual's own stigmatizing beliefs, attitudes, and prejudices about those with mental disorders, including themselves (Brohan, Slade, Clement, & Thornicroft, 2010; Griffiths et al., 2006).

Research suggests that public stigma leads to personal stigma because of the way individuals internalize the stereotypes and prejudices of the communities in which they live and work (Vogel, Wade, &

Hackler, 2007). Both personal and public stigmas have been shown to influence beliefs about depression and its treatment. For example, in an Australian sample, greater personal stigma was associated with believing that individuals should deal with depression and suicidal ideation by themselves versus seeking help, while lower public stigma was associated with believing that individuals should deal with depression alone, but should seek help with suicidal ideation (Griffiths, Crisp, Jorm, & Christensen, 2011). In a Canadian study, women were more likely to report lower personal stigma if they endorsed evidenced-based treatments for depression, such as seeking help from primary care providers and antidepressant medications (Wang, Fick, Adair, & Lai, 2007). Findings from three primary care practices in the U.S. revealed that stigma interfered with treatment seeking among individuals with moderate depression, placing them at risk for worsening symptoms over time and increased burden of disease (Menke & Flynn, 2009).

Mental health—and specifically depression—stigma is a significant concern for rural women, who experience high rates of depression (Simmons, Huddleston-Casas, & Berry, 2007; Smalley et al., 2010). Structural barriers such as shortages of mental health professionals (Smalley et al., 2010; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009), the cost of time and travel to obtain services (Gamm, Stone, & Pittman, 2010), and approaches to care that do not consider the unique needs of rural individuals (Jameson & Blank, 2007) prevent many women with depression from seeking care. Studies further show that rural residents rely on pharmacotherapy as opposed to psychotherapy because of lack of mental health providers (Fortney, Harman, Xu, & Dong, 2010). These structural barriers are compounded by perceptions

* Corresponding Author: Leigh Ann Simmons, Ph.D., Duke University School of Nursing, DUMC 3322, Durham, NC 27710.

E-mail address: leighann.simmons@duke.edu (L.A. Simmons).

of mental disorders and their treatment. Public stigma toward psychological treatment prevents many rural individuals with a history of depression from seeking care (Jackson et al., 2007; Kitchen Andren et al., 2013). Additionally, the small size of rural communities makes it difficult to retain anonymity when seeking psychological care (Smalley et al., 2010) further hindering those with higher levels of stigma.

Given that depression contributes significantly to the burden of disease for rural women, and stigma is a critical obstacle to seeking treatment, understanding the factors associated with personal and public depression stigma may help to inform nursing interventions aimed at improving treatment seeking and adherence in rural areas of the U.S. Although a limited number of studies have examined stigma in the rural U.S., to our knowledge, no study has investigated stigma for rural women specifically. Importantly, given that public stigma is believed to influence personal stigma (Link & Phelan, 2001; Vogel et al., 2007), it is important to investigate factors associated with incongruent personal and public depression stigma (i.e., one high and one low), which is also novel in the literature. Thus, the purpose of this research was twofold: (1) to investigate the rates of personal and public stigma in a rural female sample; and (2) to understand the factors associated with congruent and incongruent personal and public stigma that may further elucidate the effects of stigma on depression and its treatment.

METHODS

Design

A university institutional review board approved the research protocol. Data were from a cross-sectional survey of 1,000 adult women living in 10 counties within Western Kentucky. According to urban influence codes (UIC) as defined by the Economic Research Service (Economic Research Service, 2013), two of the counties were urban (UIC = 2), and eight of the counties were rural (UIC = 5–10).

Procedures

A more detailed description of the procedures has been reported elsewhere (Simmons, Wu, Yang, Bush, & Crofford, 2015). In sum, a Kentucky-based market research firm identified participants utilizing a random digit dial (RDD) survey. Inclusion criteria included female sex, being at least 18 years of age, head of household status, and the ability to understand and speak English. Exclusion criteria included employment by the university or firm conducting the study. A total of 12,765 calls were made. After exclusions based on nonworking or nonresponsive numbers ($n = 7,844$), declining to participate ($n = 2,966$), and not meeting inclusion/exclusion criteria ($n = 955$), 1,000 respondents completed the survey (eligible response rate = 51.2%; cooperation rate = 39.7%), which was administered in English and took approximately 12 minutes to complete.

Measures

Public and Personal Stigma Profiles

Public and personal stigmas were measured using the Depression Stigma Scale (DSS) (Griffiths, Christensen, Jorm, Evans, & Groves, 2004). The DSS is a validated (Chronbach's $\alpha = 0.78$), 18-item instrument on a 5-point Likert scale ranging from 1 = strongly agree to 5 = strongly disagree that measures two domains of stigma: public stigma and personal stigma. Stigma scores are continuous with lower scores indicating greater stigma, and total scores range from 9 to 45 for each subscale. Given that no cut-off scores have been established in the literature, the subscales were divided into tertiles (scores 9–20 indicating “high stigma”; scores 21–33 indicating “moderate stigma”; and scores 34–45 indicating “low stigma”) in order to provide upper and lower extremes of responses with a group in the middle. Using these high/low categories, participants were further grouped into profiles

indicating congruent or incongruent stigma. Those participants who scored either in (1) the highest tertile for public stigma and the lowest tertile for personal stigma, or (2) the highest tertile for personal stigma and lowest tertile for public stigma were defined as having incongruent stigma profiles ($n = 178$). Those participants who scored in the middle tertiles for both public and personal stigma and those with similar (high–high and low–low) tertile membership were defined as having congruent stigma profiles ($n = 822$). There were no cases of moderate scores in one domain and high/low in another.

Demographics

Previous research has demonstrated that social factors such as education, employment, income, marital status, and racial/ethnic background influence women's health outcomes and that these relationships vary based on rural residence (Bice-Wigington, Simmons, & Huddleston-Casas, 2015). Thus, we obtained information on subjects' age, educational level, race/ethnicity, annual household income, marital status, employment status, and rural residence. Age was a continuous variable. Education was measured in 3 categories: < high school education, high school diploma or general education development equivalent, and some college or higher. Race/Ethnicity was measured in 2 categories: White and non-White. Annual household income was measured in 2 categories: <\$20,000, and more than \$20,000 to capture respondents below or above the average median income in the 10 counties. Marital status was measured in 2 categories: married and divorced/separated/widowed/single. Employment was measured in 2 categories: working full-time and other (working part-time, student, homemaker, retired, unemployed, and disabled). Rural residence was measured in 3 categories: metro area, adjacent to metro area, and nonadjacent to metro area.

Depression

A 2-item scale from the Brief Patient Health Questionnaire that has been validated in primary care for identifying patients with an unspecified depressive disorder (Henkel et al., 2004) was used to measure depression. The questions assess two main symptoms of depression, anhedonia and depressed mood, on a 4-point Likert scale ranging from 1 = not at all to 4 = nearly every day. A cut-off score of 4 indicates probable depressive disorder.

Availability of Health Services

Perceived availability of health services was assessed for both general health services and mental health services. Respondents were asked to describe the availability of services for each type on a 5-point Likert scale ranging from 1 = Poor to 5 = Excellent. In analysis, perceived availability of health services was classified into 3 categories: poor/fair, good, very good/excellent.

Sources of Health Information

Sources of health information were assessed for both where subjects obtained general health information and mental health information. Participants were asked, besides their health care providers (doctors/nurses), where they get most of their information, although the option of “no other sources – doctor/nurse only” was permitted. Responses then were categorized into interpersonal and anonymous sources based on Ruppel and Rains (2012) cataloguing. Interpersonal sources included those where the individual could talk to someone, such as their primary health provider only (doctor, nurse), word of mouth (friends/family), health department, hospital, and other. Anonymous sources included those sources where the individual could obtain information without interaction, such as magazines/books/pamphlets, television, newspapers, Internet. Respondents also had the option of responding, “Do not know” and “Do not seek information.” Up to 3 responses were allowed, however, the response rates were low after the first response (36.7% and 9.7% respectively for general health information and 25% and 7.1% respectively for mental health information). Thus, we used only the first response for the final analysis.

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