

UNIVERSITI TEKNOLOGI MARA (UiTM)

**MEASUREMENT OF STIGMATISATION LEVEL
TOWARDS MENTAL ILLNESS PATIENTS AMONG
URBAN AND RURAL COMMUNITIES**

**NURSYAZANA BINTI HUSIN
(2012677496)**

**Dissertation submitted in partial fulfilment of the requirements for the
Bachelor of Pharmacy (Honours)**

Faculty of Pharmacy

2015

ACKNOWLEDGEMENT

Praise be to Allah for His blessing in completing this research and thesis successfully. Thank-you to the Faculty of Pharmacy, UiTM Puncak Alam Campus, for giving me the opportunity to conduct this research. Sincere thanks to my supervisor, Dr. Nahlah Elkudssiah Ismail Al-Masry for her persistent support and help throughout the research. Thanks to the Research Management Institute (RMI), UiTM, for approving the ethics in order to conduct this study. I would like to express my gratitude to my research partners, Nor Aishah binti Ishak and Atikah Nadhirah binti Johari for helping and giving moral support during the research period. Also, I want to thank my parents and siblings for their big help and support, and not to forget to all respondents who participated in this study.

ABSTRACT

This cross-sectional study was conducted to determine the level of stigmatisation among urban and rural communities towards mental illness patients, to investigate study variables that differentiate, associate, correlate and predict the level of stigmatisation among urban and rural communities on mental illness patients and to determine the validity and reliability of the study instruments. The self-administered bilingual questionnaires consisted of socio-demographic and other (n = 11 items) and attribution questionnaire (AQ-9) (n = 9 items; 9 stereotypes) were disseminated to urban (Shah Alam) and rural (Rembau) adults (≥ 18 years old) that able to speak and write Malay or English using convenience sampling method. Using Rasch analysis, the AQ-9 instrument was found to be reliable and valid. Data were analysed descriptively and inferentially by using Statistical Package for the Social Science (SPSS) version 21.0. The confidence interval was set to 95% and level of significant was set at $p < 0.05$. Urban respondents had a significant higher pity level, and significant lower dangerousness stereotype, lower blame, lower anger, and lower coercion compared to rural respondents. The mean scores obtained by women respondents were significantly higher than men in referring to dangerousness, fear, segregation and coercion stereotypes. Respondents who were familiar with mental illness tend to have significantly higher pity compared to respondents who were not familiar with mental illness. Also, respondents who were familiar with mental illness tend to have significantly lower blame stereotypes compared to respondents who were not familiar with mental illness. There was a significant decrease in blame among respondents who were familiar towards schizophrenia term compared to respondents who were not familiar. The level of stigmatisation among urban and rural communities on mental illness patients was significantly associated to living area and gender of the respondents. The age negatively low correlated with the fear towards mental illness patients among urban and rural communities. Some predictors were found to be significant in a few stereotypes including familiarity with mental illness (pity), gender and highest level of education (dangerousness), gender (fear), familiarity with schizophrenia (blame) and gender and living area (coercion). The elements of stigmatisation toward mental illness need to be addressed to public for betterment in quality of life and health be it the public or respective sufferer in creating concerned and loving communities.

TABLE OF CONTENT

PAGE

TITLE PAGE

APPROVAL SHEET i

ACKNOWLEDGEMENT ii

ABSTRACT iii

TABLE OF CONTENT iv

LIST OF ABBREVIATIONS viii

LIST OF TABLES ix

LIST OF FIGURES x

LIST OF FORMULA xi

CHAPTER 1 (INTRODUCTION)

1.1: Background of study 1

1.2: Problem statement 2

1.3: Objectives 3

1.4: Significant of study 3

1.5: Hypothesis 4

1.6: Study limitations 4

CHAPTER 2 (LITERATURE REVIEW)

2.1: Definition of stigma 5

2.2: Types of stigma 6

2.2.1: Affiliate stigma 6

2.2.2: Public stigma 6

2.2.3: Self-stigma 7

2.2.4: Perceived stigma 7

2.2.5 Comparison of public and perceived stigma 8

2.3: Social concept of stigma

2.3.1: Stereotypes 8

CHAPTER 1

INTRODUCTION

1.1 Background of Study

Health is not only defined based on the presence of disease. According to World Health Organisation (WHO), health is defined as whole physical, mental and social well-being state and not only based on disease absence (WHO, 1997). Mental health can be defined as the well-being state of an individual to endure the life normal stress, able to be productive when working and can contribute to community (WHO, 2014b). Mental health is becoming a major concern nowadays with the increasing number of people suffering from mental and neurological diseases. WHO (2001) estimated mental or neurological disorders will affect one in four people around the world and currently is the leading cause of ill-health and disability worldwide as there are around 450 million people suffering from it.

Individual who suffers from mental or neurological disorders often face stigmatisation directed towards them. Stigma is defined as “an attribute that is deeply discrediting” (Goffman, 1963) and process of marginalised and devalued by society due to values, characteristics or practices of certain groups are different from main cultural group (Ali, Hassiotis, Strydom, & King, 2012). Besides, the stigmatisation also can come from the caregivers of the individual with mental illness. This type of stigma is called as affiliate stigma. Affiliate stigma is response of psychological and individuals identification who are closely related with the target individuals such as caregivers,