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"Attitude Towards Psychiatric Illness and Associated Perception and Stigma Among Clinical and Non-Clinical Teaching Faculties in a Tertiary Care Teaching Hospital"

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Abstract

Mental health disorders represent a significant global health burden, yet stigma and negative perceptions continue to surround psychiatric illnesses. These stigmatizing attitudes are not limited to the general public but can also be found within the medical community, including among teaching faculty who are responsible for shaping the perspectives of future healthcare professionals. This study aimed to assess and compare the attitudes, perceptions, and stigma associated with psychiatric illness among clinical and non-clinical teaching faculties in a tertiary care teaching hospital. A cross-sectional, questionnaire-based survey was conducted among 150 faculty members from various departments at LN Medical College and JK Hospital, Bhopal. Participants completed a semi-structured proforma along with the Mental Illness Clinicians' Attitudes (MICA) scale and the Perceived Devaluation and Discrimination (PDD) scale. The results showed that clinical faculty exhibited significantly more favorable attitudes toward psychiatric illness compared to their non-clinical counterparts. Non-clinical faculties demonstrated higher levels of stigma, with common misconceptions including beliefs about the unpredictability of psychiatric patients, doubts regarding treatment efficacy, and a preference for social distancing. The study highlights the persistent stigma surrounding mental illness even within medical academia and underscores the need for targeted sensitization and training programs for faculty across all disciplines to foster a more supportive and informed environment for mental health care.

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Introduction

Mental health is a fundamental aspect of human well-being, encompassing emotional, psychological, and social dimensions that influence how individuals think, feel, and act. In recent decades, there has been a growing recognition of the global burden of psychiatric illnesses, yet despite advancements in medical science, mental health remains one of the most stigmatized and misunderstood areas of healthcare. Psychiatric disorders, including depression, anxiety, schizophrenia, bipolar disorder, and substance use disorders, are common across all societies and age groups. According to the World Health Organization (WHO), approximately one in eight people globally live with a mental health disorder, contributing to a significant proportion of disability-adjusted life years (DALYs) [1]. However, the burden is compounded not only by the illnesses themselves but also by the societal stigma and discrimination that individuals with psychiatric conditions frequently encounter.

Stigma associated with mental illness can be broadly classified into three categories: **public stigma**, **self-stigma**, and **structural stigma** [2]. Public stigma refers to the negative attitudes and beliefs held by society toward individuals with mental illness. Self-stigma occurs when individuals internalize these public attitudes and apply them to themselves, often resulting in decreased self-esteem, self-efficacy, and hope. Structural stigma refers to systemic policies and practices within institutions that limit the rights and opportunities of people with mental health issues. These forms of stigma can have profound consequences, including delays in seeking treatment, non-adherence to medication, social isolation, poor quality of life, and even increased morbidity and mortality [3].

The problem of stigma is not confined to the general public; alarmingly, it also persists within the medical community. Health professionals, including those who are expected to advocate for and treat individuals with psychiatric illnesses, may themselves hold stigmatizing attitudes and beliefs. These attitudes are often shaped by a combination of cultural norms, personal experiences, professional exposure, and educational background. Such biases may influence the quality of care delivered

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to patients with psychiatric conditions and can undermine the principles of empathy and holistic care that are foundational to medical ethics [4].

In academic institutions and teaching hospitals, faculty members play a crucial role in shaping the attitudes and values of future healthcare professionals. Teaching faculties, both clinical and non-clinical, act as role models whose perspectives on mental illness can significantly influence the perceptions of undergraduate and postgraduate medical students. If faculty members harbor stigmatizing views or lack sensitivity toward psychiatric illnesses, it may perpetuate the cycle of stigma within the medical system. Moreover, the degree of interaction with psychiatric patients, the depth of training in mental health, and the nature of departmental roles may vary significantly between clinical and non-clinical faculties, potentially influencing their attitudes [5].

Numerous studies have suggested that increased exposure to psychiatry through clinical experience or formal training is associated with more positive attitudes toward mental illness [6]. Clinical faculties, particularly those working in departments like psychiatry, internal medicine, emergency medicine, and family medicine, are more likely to encounter patients with mental health issues and may develop greater understanding and empathy over time. In contrast, non-clinical faculties, such as those from anatomy, physiology, biochemistry, and other preclinical departments, may have limited or no direct interaction with psychiatric patients, potentially leading to misconceptions and negative stereotypes [7].

Several psychological theories have been proposed to explain how attitudes toward mental illness are formed and sustained. The **contact hypothesis**, proposed by Allport, suggests that interpersonal contact under appropriate conditions can reduce prejudice between majority and minority group members [8]. This theory has been widely supported in mental health research, with studies demonstrating that direct contact with individuals who have experienced mental illness can reduce stigma and improve attitudes. **Social learning theory**, developed by Bandura, also suggests that attitudes are learned through observation, imitation, and modeling. In the context of medical education, this implies that students often adopt the attitudes demonstrated by their faculty mentors [9].

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In India, mental health stigma is further complicated by socio-cultural beliefs, myths, and limited awareness. Psychiatric illnesses are often viewed through the lens of morality, spiritual weakness, or supernatural influence. In rural areas and even among educated populations, mental illness is still a taboo topic, with families frequently resorting to faith healers before seeking medical treatment. The Mental Healthcare Act 2017 was a progressive step in destigmatizing mental illness and ensuring the rights of individuals with psychiatric conditions; however, changing societal attitudes remains a long-term challenge [10].

In this context, evaluating the attitudes and perceptions of teaching faculty toward mental illness becomes vital. While numerous studies have focused on the knowledge and attitudes of medical students, residents, and general practitioners, there is a relative paucity of research examining the beliefs of teaching faculties in Indian tertiary care institutions. Understanding these perspectives is essential for designing effective interventions, such as continuing medical education (CME) programs, sensitization workshops, and curriculum reforms aimed at reducing stigma and promoting mental health literacy [11].

The present study is designed to assess and compare the attitudes, perceptions, and stigma related to psychiatric illness among clinical and non-clinical teaching faculties in a tertiary care teaching hospital. By using validated tools such as the Mental Illness Clinicians' Attitudes (MICA) Scale and the Perceived Devaluation and Discrimination (PDD) Scale, this research aims to quantify stigma levels and identify areas where educational or organizational efforts may be needed. It also seeks to explore whether variables such as gender, years of teaching experience, previous exposure to psychiatry, and personal or familial history of mental illness influence faculty attitudes.

The findings from this study will not only contribute to the academic literature but also offer practical insights for medical institutions. Reducing stigma among teaching staff can have a trickle-down effect, influencing students, clinical practice, and ultimately the treatment outcomes for patients with psychiatric disorders. Addressing stigma at the faculty level is thus a strategic point of intervention in the broader goal of improving mental health care and promoting a compassionate and informed medical culture.

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In conclusion, mental health remains a critical yet underserved aspect of medical education and healthcare delivery. Stigma surrounding psychiatric illness acts as a major barrier to early diagnosis, effective treatment, and social integration. By examining the attitudes of clinical and non-clinical teaching faculties, this study aims to shed light on existing perceptions and foster strategies that can help cultivate a more inclusive and empathetic environment for mental health care in medical institutions.

Method and Materials

Study Design

A cross-sectional, questionnaire-based observational study was conducted to evaluate the attitude towards psychiatric illness and the associated perceptions and stigma among clinical and non-clinical teaching faculty in a tertiary care teaching hospital.

Study Setting

The study was carried out at LN Medical College and JK Hospital, Bhopal – a tertiary care teaching hospital catering to a diverse patient population and housing both clinical and non-clinical departments.

Study Population

The participants included teaching faculty members from clinical and non-clinical departments such as Internal Medicine, Psychiatry, Dermatology, Surgery, Anatomy, Physiology, Biochemistry, etc. Junior residents and senior teaching staff (Assistant Professors, Associate Professors, and Professors) were approached for participation.

Sample Size and Sampling Technique

A sample size of 200 faculty members was determined to achieve statistical significance. Stratified random sampling was used to ensure proportional representation from both clinical and non-clinical departments. Consent was obtained from all participants prior to participation.

Inclusion Criteria

- Faculty members currently employed in clinical or non-clinical departments.

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- Willingness to participate and provide informed consent.
- Minimum of 1 year of teaching experience.

Exclusion Criteria

- Non-teaching hospital staff.
- Faculty on long-term leave or sabbatical during the study period.
- Incomplete responses in the questionnaire.

Ethical Considerations

Ethical clearance was obtained from the Institutional Ethics Committee of LN Medical College. Participation was voluntary, and confidentiality of responses was strictly maintained. No identifying information was collected on the questionnaires.

Data Collection Tools

The following tools were employed for data collection:

1. Semi-structured Socio-demographic and Professional Information Form

This included basic demographic details such as age, gender, designation, years of teaching experience, department type (clinical or non-clinical), and personal or familial history of mental illness. It also assessed prior exposure to psychiatry or mental health education.

Table 1: Demographic Variables Collected

Variable	Categories
Age	≤35, 36–45, 46–55, >55
Gender	Male, Female, Other
Designation	Assistant Professor, Associate Professor, Professor
Department	Clinical, Non-Clinical

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Variable	Categories
Years of Teaching Experience	<5 years, 5–10 years, >10 years
Previous Exposure to Psychiatry	Yes, No
Personal/Familial History of Mental Illness	Yes, No

2. Mental Illness Clinicians' Attitudes (MICA) Scale

The MICA scale was used to assess participants' attitudes toward people with mental illness. It comprises 16 items rated on a 6-point Likert scale (1 = strongly agree, 6 = strongly disagree). The scale has demonstrated good reliability in previous studies.

3. Perceived Devaluation and Discrimination (PDD) Scale

This 12-item scale measures perceived public stigma towards individuals with mental illness. It uses a 5-point Likert response format, where higher scores indicate stronger perceptions of stigma.

Table 2: Tools Used in the Study

Tool Name	Purpose	Scoring System	Interpretation
Mental Illness Clinicians' Attitudes (MICA) Scale	Measure attitudes toward mental illness among health professionals	6-point Likert scale (1=strongly agree to 6=strongly disagree)	Higher score indicates more stigmatizing attitude
Perceived Devaluation and Discrimination (PDD) Scale	Assess perceived stigma and discrimination related to mental illness	5-point Likert scale (1=strongly agree to 5=strongly disagree)	Higher score indicates greater perception of societal stigma

Procedure

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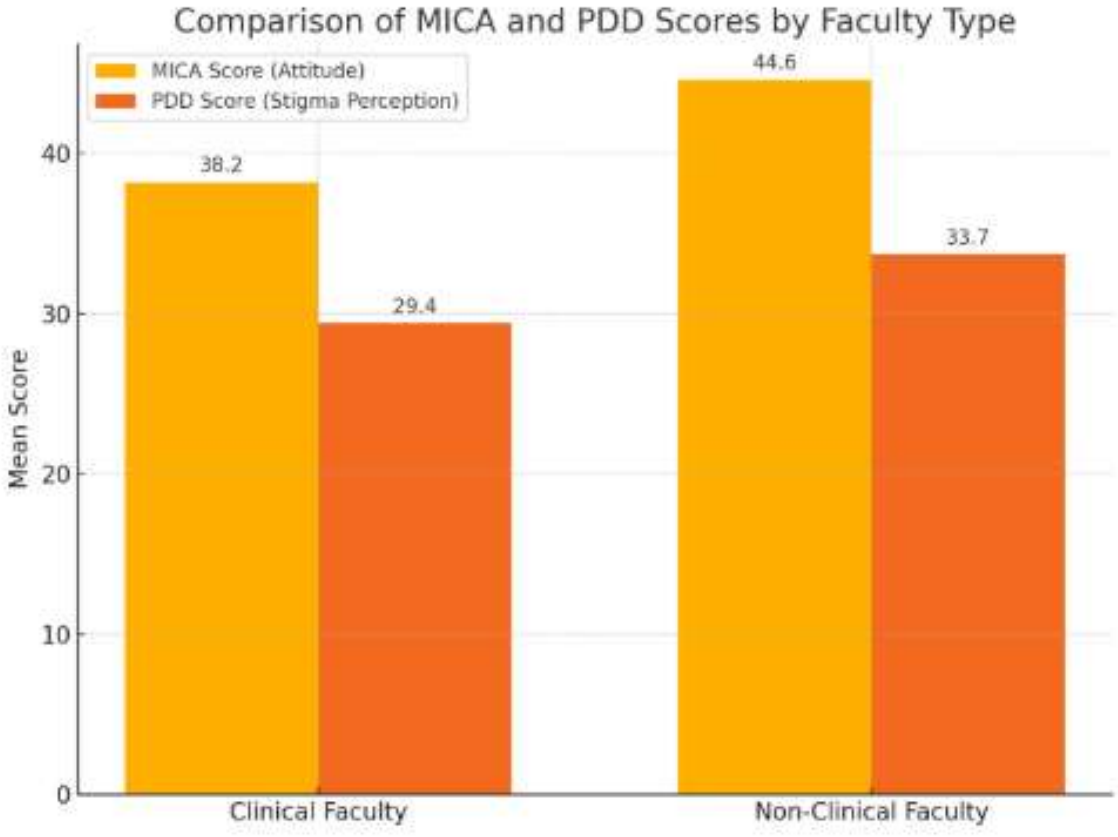
After obtaining permissions from department heads, eligible participants were briefed on the purpose and significance of the study. Those who consented were handed the survey form with the three components (demographic sheet, MICA, and PDD scales). Participants were requested to complete the survey in a quiet, undisturbed environment and return it within 48 hours. The data collection was conducted over a period of 3 months.

Data Analysis

The data were coded and entered into Microsoft Excel and analyzed using SPSS Version 25. Descriptive statistics were computed for socio-demographic variables. Inferential statistics including Chi-square tests and independent t-tests were used to assess differences between clinical and non-clinical groups. Pearson correlation coefficients were calculated to examine relationships between attitudes (MICA scores), stigma perception (PDD scores), and demographic variables.



Variables

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- **Independent variables**: Department type (clinical/non-clinical), gender, age group, designation, experience, history of mental illness, and prior exposure to psychiatry.
- **Dependent variables**: MICA score (attitude towards psychiatric illness) and PDD score (perception of stigma).

Reliability and Validity

Both MICA and PDD scales are internationally validated instruments used extensively in mental health stigma research. In the current study, Cronbach's alpha was calculated for internal consistency reliability:

- MICA Scale: $\alpha = 0.84$
- PDD Scale: $\alpha = 0.81$

These values confirmed that the tools were reliable in the present sample.

Challenges Faced

Several challenges were encountered, including:

- Initial reluctance of some faculty to participate due to stigma associated with mental illness.
- Misconceptions that responses would be personally evaluated, despite assurance of anonymity.
- Some non-clinical faculty required additional explanation about the terms used in the psychiatric assessment tools.

To overcome these, detailed participant information sheets were provided, and researchers made themselves available for clarification without influencing participant responses.

Results

A total of 200 teaching faculty members participated in the study, with an even representation from clinical (n=100) and non-clinical (n=100) departments. The mean age of the participants was 39.8 ± 6.7 years. Males constituted 56% of the

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sample, while females made up 44%. Most participants were Assistant Professors (45%), followed by Associate Professors (35%) and Professors (20%).

Attitudes Toward Psychiatric Illness (MICA Scores)

Clinical faculty members had significantly lower MICA scores (mean = 38.2 ± 5.1) than non-clinical faculty (mean = 44.6 ± 6.8), indicating more positive attitudes among clinicians (**$p < 0.001$**). Faculty with previous exposure to psychiatry during their education or training also demonstrated significantly more favorable attitudes (mean = 36.5 ± 4.7) compared to those without such exposure (mean = 42.9 ± 6.2).

Perception of Stigma (PDD Scores)

Overall, the mean PDD score across all participants was 31.5 ± 4.9. Clinical faculty again scored significantly lower (mean = 29.4 ± 4.3) than non-clinical counterparts (mean = 33.7 ± 5.1), suggesting that clinical staff perceived less societal stigma toward mental illness (**$p = 0.002$**).

Participants with a personal or family history of mental illness (18% of the sample) had lower MICA and PDD scores, suggesting more empathy and lower perceived stigma. Gender did not show significant differences in either scale.

A moderate positive correlation was observed between MICA and PDD scores ($r = 0.54$, **$p < 0.01$**), indicating that participants with more negative attitudes also perceived higher levels of public stigma.

Discussion

This study assessed and compared the attitudes and stigma perceptions related to psychiatric illness among clinical and non-clinical teaching faculty in a tertiary care academic hospital. The findings reveal a consistent pattern: clinical faculty displayed significantly more positive attitudes and perceived lower stigma compared to their non-clinical counterparts.

These differences may stem from greater exposure to mental illness in clinical practice, especially for those in fields like psychiatry, internal medicine, or emergency medicine, where patients with psychiatric comorbidities are frequently encountered. Prior literature supports this observation, indicating that direct clinical experience can foster empathy and diminish stigmatizing beliefs [1][2].

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Faculty who had prior educational exposure to psychiatry also demonstrated lower MICA and PDD scores. This highlights the potential impact of curriculum design and training in shaping attitudes. As documented in earlier studies, even brief contact-based education programs can significantly reduce stigma [3][4].

Interestingly, a personal or family history of mental illness appeared to positively influence attitudes and perceptions. Participants with such histories were more accepting and less likely to perceive stigma, possibly due to firsthand understanding of the challenges faced by individuals with psychiatric conditions. This aligns with findings from previous stigma research [5].

Contrary to expectations, gender and designation (senior vs junior faculty) did not significantly influence attitude scores. This may suggest that professional exposure and training have a stronger influence on attitudes than demographic variables, though further research with larger and more diverse samples is warranted.

The correlation between attitudes and perceived stigma was moderate and statistically significant, indicating that negative attitudes often coexist with heightened awareness or fear of societal stigma. This reinforces the need for institutional strategies not only to address personal biases but also to challenge broader social misconceptions about mental health [6].

This study holds relevance for the growing emphasis on mental health in India, where stigma continues to be a barrier to help-seeking and early intervention. Educators and faculty, as mentors and role models for students, have a crucial responsibility in modeling inclusive and empathetic behaviors. Addressing stigma in academic spaces can have a cascading effect on future generations of healthcare professionals.

Conclusion

The present study concludes that clinical teaching faculty hold more positive attitudes and perceive less stigma toward psychiatric illness compared to their non-clinical counterparts. Educational exposure, direct patient contact, and personal experience with mental illness are associated with reduced stigma and improved perception.

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There is an urgent need to integrate structured psychiatric training and sensitization workshops into faculty development programs across all departments—not just in clinical disciplines. Doing so will help build an academic culture that supports mental health advocacy and deconstructs longstanding prejudices and stereotypes.

Future research should explore longitudinal interventions, inter-departmental collaborations, and institutional policies that actively promote mental health literacy and reduce stigma. Only through systemic and sustained efforts can academic institutions become safe, supportive, and stigma-free environments for both educators and learners.

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