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Personal and Perceived Depression Stigma among Jordanian Adolescents: Associations with Depression Severity and Personal Characteristics

Latefa Ali Dardas [a,*], Susan G. Silva [a], Moria J. Smoski [b,c], Devon Noonan [a], Leigh Ann Simmons [a]

[a] School of Nursing, Duke University, United States
[b] Department of Psychology and Neuroscience, Duke University, United States
[c] Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, United States

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ABSTRACT

BACKGROUND: In Arab communities, the selection, utilization, and attitudes towards mental health services are substantially affected by existing mental illness stigma. However, little is known about how the stigma of depression manifests among Arab adolescents, which makes it difficult to design, implement, and disseminate effective anti-stigma interventions for this vulnerable population. Therefore, the purpose of this study was to determine levels of depression stigma among Arab adolescents. The specific aims were to (1) describe the severity of personal and perceived depression stigma among Arab adolescents and its relationship to severity of depression, and (2) determine characteristics associated with severity of depression stigma among Arab adolescents.
METHODS: This study was conducted in Jordan, a Middle Eastern Arab country. A nationally representative, school-based survey was utilized. A total of 2349 Jordanian adolescents aged 12–17 completed and returned the survey packets, which included measures on individual characteristics, depression severity, and depression stigma.
RESULTS: The majority of the adolescents (88%) reported scores indicating moderate to high depression stigma. Adolescents reported higher rates of perceived stigma than personal stigma. Depression stigma was not significantly associated with severity of depression, but with adolescent's sex, age, region of residence, parents' education, and history of mental health problem.
CONCLUSIONS: This is the first Arab study to isolate the influence of adolescent depression and personal characteristics on personal and perceived depression stigmas, and highlight the presence of these distinctions early in adolescence. Such distinction can inform the design and implementation of policies and interventions to reduce both personal and perceived stigma. The study provides important recommendations on when, how, and why to utilize school settings for anti-depression stigma interventions.

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INTRODUCTION

Adolescence is considered a critical time for early detection and adequate treatment of depression, which is projected to be the largest contributor to global disease burden by 2030 (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006; WHO, 2008). Unfortunately, research reveals that due to the stigma associated with mental disorders, adolescents do not readily report on emotional or behavioral manifestations of mental health problems like depression (Cook, Peterson, & Sheldon, 2009). Moreover, they often have poor engagement in, adherence to, and utilization of mental health services due to fears of discrimination (Arbanas, 2008; Sheffield, Fiorenza, & Sofronoff, 2004; Williams & Pow, 2007).

Adolescents with depression may experience two types of stigma: personal stigma, which is the negative feelings and attitudes they have towards themselves (Goffman, 1963), and perceived stigma, which reflects how individuals perceive the general public's attitudes towards depression (Corrigan, 2000). Research has established a connection between personal and public stigma such that personal stigma exists when the stigmatized individual internalizes others' negative ideas and responses leading to negative thoughts and emotional reactions towards themselves (Corrigan & Watson, 2002; Gary, 2005). Interestingly, Armstrong and Secker (2000) suggested that adolescents experience an enhanced sensitivity to public stigma because of the strong influence of their friends and peer group, making them at increased risk for internalizing the public's negative views about them.

* Corresponding author at: School of Nursing, Duke University, DUMC 3322, Durham, NC 27710, United States.
E-mail addresses: Latefa.dardas@duke.edu, l.dardas@ju.edu.jo (L.A. Dardas), susan.silva@duke.edu (S.G. Silva), moria.smoski@duke.edu (M.J. Smoski), devon.noonan@duke.edu (D. Noonan), leighann.simmons@duke.edu (L.A. Simmons).

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In Arab communities, the attitudes towards seeking help for mental illness are substantially affected by existing mental illness stigma. Arab families often try to conceal, delay, or deny the mental illness or needed treatment, resulting in poor prognosis and a complicated illness trajectory (Fakhr El-Islam, 2008). However, the stigma of depression *per se* has not yet been fully examined among Arab adolescents. In an earlier pilot investigation (Dardas, Silva, Noonan, & Simmons, 2016), we collected data from 88 Jordanian adolescents, and the preliminary findings suggested that these adolescents may experience depression-related stigma that affects their attitudes and willingness to seek professional help. We emphasized the need for research with representative samples to further address these issues and to highlight the distinctions between personal and perceived depression stigma within the Arab context. The lack of research on how depression stigma manifests among Arab adolescents makes it difficult to design, implement, and disseminate effective interventions to improve the detection and treatment of adolescent depression in the Arab region (Dardas, Bailey, & Simmons, 2016).

Research from Western samples has documented that individual characteristics such as age (Peluso Ede & Blay, 2009), gender (Arbanas, 2008; Griffiths, Christensen, & Jorm, 2008; Jorm & Wright, 2008; Sheffield et al., 2004; Williams & Pow, 2007), socioeconomic status and geographic area (Simmons, Yang, Wu, Bush, & Crofford, 2015), depression history (Griffiths et al., 2008; Jorm & Wright, 2008; Sheffield et al., 2004), familiarity with persons who have depression (Arbanas, 2008; Griffiths et al., 2008; Jorm & Wright, 2008; Kelly & Jorm, 2007; Wang & Lai, 2008; Wolkenstein & Meyer, 2009), and familiarity with mental health services (Simmons, Wu, Yang, Bush, & Crofford, 2015) can impact one's experience of depression stigma and attitudes towards seeking professional psychological help. Research has also revealed that adolescents' characteristics have differential impacts on their reported levels of personal and perceived depression stigma (Calear, Griffiths, & Christensen, 2011). These relationships are unknown for Arab adolescents. Therefore, the purpose of this study was to determine levels of depression stigma among Arab adolescents. The specific aims were to: (1) describe the severity of personal and perceived depression stigma among Arab adolescents and its relationship to severity of depression and (2) determine characteristics associated with severity of depression stigma among Arab adolescents.

METHODS

DESIGN

A nationally representative, school-based survey was utilized. The methods for this study were described in detail elsewhere (Dardas, Silva, Smoski, Noonan & Simmons, 2017). Briefly, this large project was designed in collaboration with the Jordanian Ministry of Education and the University of Jordan, and had approval from the Institutional Review Boards at both Duke University and the University of Jordan. A feasibility study was conducted earlier to establish the study methods and methodology (Dardas, Silva, Noonan, et al., 2016; Dardas, Silva, Noonan, & Simmons, 2017). A total of 48 schools were randomly selected using stratified random sampling to represent the 3 main regions of the country (north, central, and south). We obtained passive consent from parents using an opt-out procedure (Courser, Shamblen, Lavrakas, Collins, & Ditterline, 2009), and a returned survey was considered tacit assent from adolescent participants, who ranged in age from 12 to 17 years. Data were collected using a packet of self-administered questionnaires that included measures on sociodemographics, depression symptoms and severity, and depression stigma.

MEASURES

ADOLESCENT CHARACTERISTICS

The sociodemographic and health characteristics questionnaire was used to obtain information regarding the adolescent's sex, age, region of residence, parents' education, family monthly income, whether the adolescent has any chronic health problem, mental health problem, or a learning difficulty, whether the adolescent had a parent, relative, or friend with mental illness, and whether the adolescent has ever sought a psychological treatment.

DEPRESSION SEVERITY

The validated Arabic version of the Beck Depression Inventory-II (BDI-II) (Beck, Steer, & Brown, 1996) was used to assess depression symptoms among Jordanian adolescents. The BDI-II is a self-reported questionnaire that includes 21 items scored from 0 (minimal depression) to 3 (severe depression). The Arabic version of the BDI-II (Al-Musawi, 2001) showed high test-retest stability (0.93), high internal consistency (0.92–0.94), and high construct validity (0.93). A depression total score was calculated by summing the 21-items, with possible total scores ranging from 0 to 63 and higher total scores indicating greater severity of depression. According to Beck et al. (1996), scores ranging from 0 to 13 indicate minimal depression, 14–19 indicate mild depression, 20–28 indicate moderate depression, and 29–63 indicate severe depression.

DEPRESSION STIGMA

We used the 18-item depression stigma scale (DSS) (Griffiths et al., 2008) to assess the stigma associated with depression. The DSS has two subscales (9 items each) that assess personal stigma (personal attitudes towards depression), and perceived stigma (what participants think most other people believe about depression). The DSS assesses the following major themes: depression as an illness, personal control of depression, depression as a character flaw, dangerousness and unpredictability of someone with depression, shame of depression, and avoidance and discrimination of those with depression. Item responses are scored on a Likert-scale (0 = strongly disagree, 4 = strongly agree), with a higher score being indicative of greater stigma. Using a community adult sample, the measure demonstrated adequate test-retest reliability (0.71) and internal consistency (0.78) (Griffiths et al., 2008). Within an adolescent sample, the internal consistency for the personal and perceived subscales 0.70 and 0.77, respectively (Calear et al., 2011). No Arabic version was available for the scale. Therefore, we translated it into Arabic using a systematic procedure that included translation and back-translation by two bilingual professional language editors. An expert panel was then used to ensure that the translated Arabic version had the same meanings as the original measures. The translated measure was piloted with 88 Jordanian adolescents aged 12–17 (Dardas, Silva, Noonan, et al., 2016). A principal components analysis was used to confirm the factor structure of the measure. More details on the validation procedure are provided elsewhere (Dardas, Silva, Noonan, et al., 2017).

ANALYSIS PLAN

All data were analyzed using SAS 9.4 software (SAS Institute, Cary, North Carolina). Descriptive statistics were used to detail the sample characteristics, BDI-II depression total score, and DSS stigma measures. Non-directional statistical tests were conducted with the level of significance set at 0.05 for each two-tailed test. An analysis of covariance approach using a multivariable General Linear Model (GLM) was used to determine the relationship BDI-II depression total scores and each stigma outcome, after adjusting for the sociodemographic and health characteristics of the adolescent (covariates). Each multivariable GLM was then reduced to a pragmatic model using an iterative backward elimination process by which the least significant covariate was omitted until the model included BDI-II depression severity and only statistically significant ($p \leq 0.05$). For each characteristic in the model with a statistically significant effect ($p \leq 0.05$), *a posteriori* pairwise comparisons using *t*-test were conducted to test for between-group differences in the adjusted least-squares means. To address effect size and clinical

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